HHS Disaster Behavioral Health

Concept of Operations

December 2011

References

- National Response Framework (NRF)
- National Incident Management System (NIMS)
- National Health Security Strategy (NHSS)
- HHS Concept of Operations for Response (draft)
- Incident Response Coordination Team (IRCT) Field Operations Guide (FOG), September 2009
- The National Disaster Medical System (NDMS) Memorandum of Agreement Among the Departments of Homeland Security, Health and Human Services, Veterans Affairs, and Defense, October 24, 2005
- Department of Homeland Security Federal Emergency Management Agency (DHS-FEMA) Typed Resource Definitions: Emergency Medical Services Resources, FEMA 508-3, May 2005
- "Designing a National Emergency Responder Credentialing System" (NERCS; DHS-FEMA Search and Rescue Working Group, November 2006)

Record of Changes

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I. Introduction

This Concept of Operations plan (CONOPS) describes coordination and guidance for federal-level behavioral health response and recovery to disasters and public health emergencies. The plan describes how the Department of Health and Human Services (HHS) transitions from normal day-to-day operations to a coordinated department-wide response to the behavioral health elements of a public health and medical emergency. It is consistent with Homeland Security Presidential Directive 5 (HSPD-5) and the National Response Framework (NRF). It supports the goals and objectives of the National Health Security Strategy (NHSS). The plan describes the overarching conceptual framework that HHS uses to manage federal behavioral health personnel, response and recovery assets, and actions. It explains how the Assistant Secretary for Preparedness and Response (ASPR) coordinates HHS-wide response and recovery activities on behalf of the Secretary in concert with the specific authorities and responsibilities of HHS, HHS Operating Divisions (OPDIVs), and HHS Staff Divisions (STAFFDIVs). HHS will coordinate response and recovery activities with state, territorial, tribal and local public and behavioral health officials and other agencies, as appropriate. (Throughout this document, "STT" refers to states, territories, and federally-recognized tribes).

The goal of this CONOPS is to improve coordination of federal preparedness, response, and recovery efforts concerning behavioral health in a manner consistent with—and supportive of—STT and local efforts. This document will be reviewed as needed (at least annually), under the oversight of the ASPR's Office of Preparedness and Emergency Operations (OPEO) and Office of Policy and Planning (OPP) to ensure that current emergency plans reflect lessons learned from recent response experiences, exercises, and evaluation.

A. Disaster Behavioral Health

Disaster behavioral health is an integral part of the overall public health and medical preparedness, response, and recovery system.[1] It includes the many interconnected psychological, emotional, cognitive, developmental, and social influences on behavior, mental health, and substance abuse, and the effect of these influences on preparedness, response, and recovery from disasters or traumatic events. Behavioral factors directly and indirectly influence individual and community risks, health, resilience, and the success of emergency response strategies and public health directives.

During and after an emergency event, it is common for people—including response workers—in the affected region to experience distress and anxiety about safety, health, and recovery, as well as grief and loss. Most people are to some degree personally prepared for an emergency and have access to pre-existing support systems that contribute to their own and their community's resiliency, and thus are likely to recover from disaster without behavioral health intervention. However, these protective factors vary, as do the nature and impact of the disaster or emergency on individuals, families, and communities. As a result, some people may experience more severe behavioral health reactions that hinder their recovery. In a smaller subset, psychological conditions or substance use/abuse may

[1] SUBCHAPTER II > Part D > subpart ii > §254d of the Public Health Service Act

develop or worsen if not addressed.[2] Therefore, disaster behavioral health aims to provide a continuum of services and activities—ranging from communication, education, and basic support to promoting access to behavioral health treatment—in order to mitigate the progression of adverse reactions into more serious behavioral health conditions.

Disaster behavioral health actions in the response period often focus on supportive, strengths-based basic interventions such as psychological first aid, crisis counseling, and response worker support. These interventions may be provided by behavioral health professionals[3], but are often also provided by paraprofessionals, other health workers, volunteers, and laypeople who have received training in basic disaster behavioral health support. As behavioral health concerns often emerge or evolve in the longer-term recovery period, recovery planning and activities must react to changing needs, which may include access to traditional behavioral health care and treatment.

Some individuals or populations may be at higher risk for more severe reactions. For example, individuals with pre-existing behavioral health conditions or past traumatic exposure may be at greater risk for exacerbation of symptoms or relapse. Individuals with severe pre-existing behavioral health conditions who rely on the behavioral health care infrastructure for their well-being and independence may be greatly affected by damage to that infrastructure. Also of concern are the safety and well-being of at-risk individuals with functional needs, such as in communication, medical care, maintaining independence, supervision, or transportation. Certain at-risk individuals may need functional support during a disaster response for communication, medical care, maintaining independence, supervision, or transportation. Examples of those at risk include children, senior citizens, pregnant women, people with disabilities, the economically disadvantaged, racial and ethnic minorities, people with pre-existing behavioral health conditions or trauma histories, or people with limited English proficiency. (See Appendix D: Web Resources for ASPR-ABC *At-Risk Individuals* and *Special Medical Needs* factsheets). Children, in particular, can be vulnerable to the behavioral health impact of public health emergencies and disasters as they may lack the experience, skills, and resources to independently meet their own behavioral health needs. Their behavioral health may also be indirectly impacted because of behavioral health conditions of caregivers/educators. Trauma, violence, and witnessing violence can also be determinants of behavioral health problems and groups such as children, senior citizens, pregnant women, and people with disabilities can be at higher risk for these concerns. If these issues are not appropriately addressed by trauma informed behavioral health care they may accumulate and compound and behavioral health following a disaster may deteriorate as a result.

Behavioral health is also concerned with influences on decision making in an affected population. Disaster behavioral health practitioners and approaches can inform risk communication and public health messaging to address anxiety, promote compliance with health directives, and prevent misinformation from gaining credibility. Before, during, and after a public health emergency or disaster, behavioral health promotion activities can enhance individual and community resilience.

[2] For more detailed information on, and prevalence of, stress, severe reactions, and behavioral health conditions following disaster please refer to the materials in Appendix D, Web Resources.

[3] SUBCHAPTER II> Part D> subpart ii> §254d of the Public Health Service Act

Surveillance and assessment systems can provide valuable information concerning risks and recovery and research can identify longer-term trends to guide future preparedness efforts.

B. Purpose

HHS supports affected jurisdictions in preparedness, response, and recovery in relation to a variety of hazards, medical emergencies, and events with implications for public health. These include:

- Natural and man-made disasters, public health and medical emergencies;
- Terrorist threats or incidents involving chemical, biological, nuclear/radiological or large explosive devices;
- Infectious disease outbreaks and pandemics;
- National Security Special Events (e.g., G20 Summits, Presidential Inaugurations, Olympics, National Party Conventions); or
- Any other circumstance that creates an actual or potential public health or medical emergency where federal assistance may be necessary.

HHS OPDIVs and STAFFDIVs have responsibilities and carry out behavioral health activities based on their own authorities. This Disaster Behavioral Health CONOPS is intended to support, and not replace or supersede, existing agency authorities. The NRF is a guide to how the nation conducts all-hazards response. Emergency Support Function Annexes (ESFs) of the NRF classify federal resources and capabilities into the functional areas that are most frequently needed in a national response. ESF #8 covers Public Health and Medical Services, including the behavioral health needs of incident survivors and response workers. The Federal ESF #8 response is led by the HHS Secretary, with activities carried out by relevant HHS components and pre-identified ESF #8 support agencies under the principle coordination of the ASPR.

Although this CONOPS focuses on federal-level operations, it is important to note that the vast majority of disaster behavioral health assets and preparedness, response, and recovery activities operate at STT and local levels, with significant support from an intricately woven system of voluntary organizations, government, academia, and behavioral health care and professional organizations. The role of federal disaster behavioral health activities is to communicate and collaborate with these entities to promote preparedness that is integrated into larger public health and medical response and recovery efforts, to supplement these entities' response activities based on STT-defined behavioral health needs, and to partner in longer-term recovery to promote individual and community resilience.

Examples of federal disaster behavioral health activities under ESF #8 include risk communication and public health messaging, behavioral health force protection, technical assistance, coordination, and mission assignments for behavioral health consultation or services. HHS will use this CONOPS to coordinate federal behavioral health response activity whenever the Secretary determines that there is a need for a coordinated department-wide response (whether managed in accordance with the NRF, NDRF, or other authorities).

Disaster recovery is coordinated by the National Disaster Recovery Framework (NDRF). HHS is the coordinating agency for the Health and Social Services Recovery Support Function (H&SS RSF), which

includes behavioral health needs. HHS ASPR coordinates the H&SS RSF on behalf of the Secretary with activities carried out by relevant HHS components and pre-identified NDRF H&SS RSF support agencies. HHS will use this CONOPS to coordinate federal behavioral health recovery activity whenever the H&SS RSF is activated.

ESF #8 response functions and NDRF H&SS RSF recovery functions entail preparedness planning as well as after-action lessons-learned activities. This CONOPS identifies how behavioral health will be coordinated and integrated into these efforts. Sections IV, V, and VI in this document detail the coordination mechanisms and activities that occur during disaster behavioral health preparedness, response, and recovery.

A distinct behavioral health facilitating group supports the national structure that coordinates in each phase. National preparedness is informed by Behavioral Health Preparedness Forums. The public health and medical response activities under ESF #8 are implemented by the Federal Disaster Behavioral Health Group (FDBHG), and the NDRF's H&SS RSF is guided by various lead and supporting agencies with behavioral health responsibilities. Information transmission is both sequential and interrelated among preparedness, response, and recovery and personnel, infrastructure and activities in each phase overlap. Figure 1 schematically illustrates these relationships.

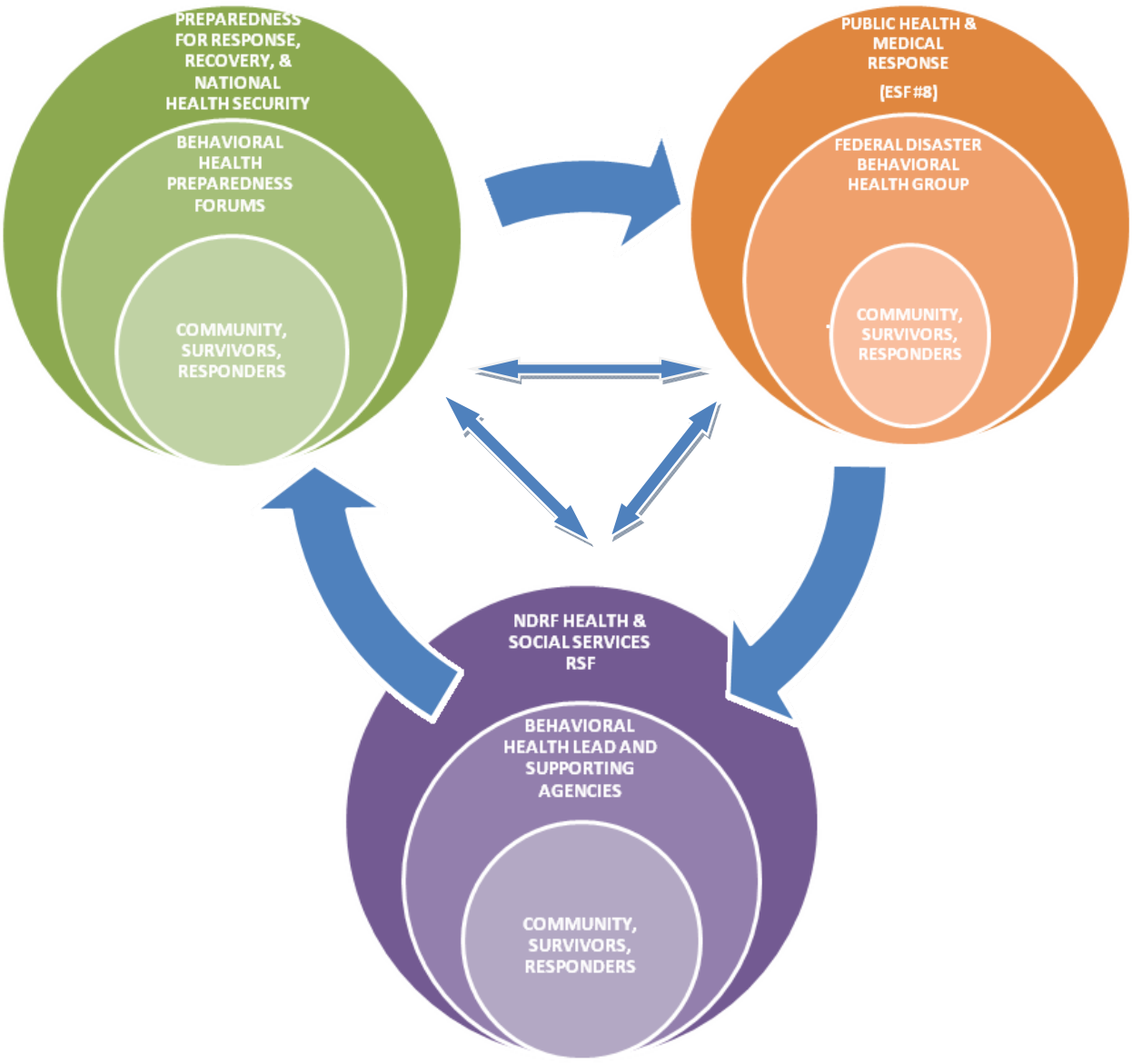

Figure 1: Behavioral Health Coordinating Structure and Information Flow in Preparedness, Response, and Recovery

C. Authorities

Activities performed under this CONOPS will be carried out in accordance with applicable laws, regulations, and Departmental policies. The primary statutory authority for the Disaster Behavioral Health CONOPS is the Public Health Service (PHS) Act, though other laws may provide authority as well.

D. Other Federal Departments

In the course of a disaster or emergency response, HHS may interact with other federal departments that are ESF #8 response partners. The Department of Defense (DoD), Veterans Administration (VA), and Department of Homeland Security (DHS) are key federal players in disaster behavioral health preparedness, response, and transition to recovery. In preparedness activities, the VA National Center for Post Traumatic Stress Disorder, the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, and programs such as Comprehensive Soldier Fitness provide research and education to help prevent or treat behavioral health problems among military members, veterans, and their families. Primary care providers, other medical professionals, and first responders often have additional training in behavioral health techniques through programs such as RESPECT-Mil and Psychological First Aid. Although these professionals primarily serve military beneficiaries, they often assist their entire communities in an emergency.

DoD and VA together operate hundreds of medical treatment facilities that can take on additional responsibilities during the response phase. They operate public health teams that can identify public health needs, including behavioral issues, and assist with response. DoD transportation resources such as Army medevac helicopters and Air Force aircraft, as well as DHS Coast Guard helicopters, are available to move people out of danger zones, as was done in the responses to Hurricanes Katrina, Gustav, and Ike. Finally, the armed forces can provide logistics and security to assist survivors of disasters and facilitate their recovery.

In addition, the U.S. Department of Housing and Urban Development (HUD) plays an important role in supporting disaster housing in response and serves as the Housing RSF coordinating agency in the NDRF. Through this, HUD addresses pre- and post-disaster housing issues and coordinates and facilitates the delivery of federal resources and activities to assist local and STT governments in the rehabilitation and reconstruction of destroyed and damaged housing, whenever feasible, and in the development of other new accessible, permanent housing options.

During the transition to recovery, the VA, DoD, HUD, and DHS continue to play important roles in rebuilding communities struck by disasters and assisting with their behavioral health needs.

E. STT, Local, and Non-governmental Disaster Behavioral Health Systems and Assets

While this CONOPS details federal activities, STT, county, and local efforts serve to address behavioral health needs before, during, and after public health emergencies and disasters. STT and locally-managed behavioral health assets typically consist of a coalition of response groups with varying structures and capacities, including the Office of the Assistant Secretary for Health's Office of the Surgeon General's Division of the Civilian Volunteer Medical Reserve Corps (OASH-OSG-DCVMRC), non-governmental organizations (NGOs), volunteer organizations active in disaster (VOADs), and behavioral health professional associations. Many states have also developed behavioral health responder capacity, within their health or behavioral health departments and within communities, to coordinate with or bolster other voluntary, state, or local assets. These assets may be deployed prior to award of any federal grants or activation of federal response assets. States that belong to the Emergency Management Assistance Compact (EMAC) may use this mechanism to request state-to-state behavioral health support.

Most states have Disaster Behavioral Health Plans that detail how services will be provided and coordinated with ESF #6 (Mass Care, Emergency Assistance, Housing, and Human Services) and ESF #8 and with STT or local emergency response and recovery plans. The majority of states provide and coordinate disaster behavioral health services through a State Disaster Behavioral Health Coordinator. In some states, these responsibilities may be shared by a Disaster Mental Health Coordinator and a Disaster Substance Abuse Coordinator. Typically, Coordinators are activated by, and work closely with, state emergency management agencies and public health departments to ensure that identified behavioral health needs are seamlessly incorporated into an overall health emergency response.

NGOs and VOADs play a vital role in providing behavioral health and human services following emergency events. For example, the American Red Cross (ARC) is an ESF #8 partner with significant disaster behavioral health capacity, including a Disaster Mental Health Director, headquarters staff, and trained disaster mental health professionals across the country in the Disaster Services Human Resources system (a continuously updated roster of national volunteers). ARC has well-defined procedures to provide disaster behavioral health support, assessment, and referral at shelters and disaster response sites. This system relies on a general corps of volunteers trained in ARC Psychological First Aid and on mental health professionals trained in disaster behavioral health. ARC, through its local chapters, offers psychological first aid training for their responders and neighbor-to-neighbor basic psychological support training for the public.

Behavioral health professional associations and guilds also provide technical assistance, educational resources, and trained professionals when requested by STT and local authorities. Unmet needs committees or recovery planning groups that include behavioral health stakeholders, state public health entities, human service agencies, and VOADs often form following the immediate disaster response to ensure that behavioral health needs are met during recovery.

National associations and professional guilds are also significant partners in disaster behavioral health preparedness and response. These include organizations such as the National Association of State Mental Health Program Directors, the National Association of State Alcohol/Drug Abuse Directors, the American Psychological Association, the American Psychiatric Association, the National Association of Social Workers, the Multi-State Disaster Behavioral Health Consortium, and many others. These entities may provide disaster behavioral health training to their members, are excellent conduits for situational awareness and information exchange, and provide valuable insights that can inform governmental activities. Some of these entities have developed disaster behavioral health response capabilities. Academia also can be a valuable partner, providing specialized expertise and identifying scientific research that can inform planning, response, and recovery actions.

II. Assumptions

The following assumptions and priorities apply to the behavioral health response to disasters and public health emergencies:

1. The federal response in predicated on the understanding that STT and local resources are primary and may be overwhelmed. At the request of the STT and if the effects of the public health emergency or disaster are severe or widespread, Federal assistance may be provided. Federal behavioral health clinical resources are limited.
2. Behavioral health is an integral part of the public health and medical response to disaster or public health emergency, and should be fully integrated into preparedness, response, and recovery activities.
3. Disaster behavioral health includes mental health, stress, and substance abuse considerations for survivors and responders, and also addresses the behavioral health care infrastructure, persons with pre-existing serious behavioral health conditions, individual and community resilience, and risk communication and messaging.
4. Disaster behavioral health is part of a layered, multidisciplinary ensemble of response and recovery activities. Private for-profit and non-profit entities; public health and emergency management personnel; national, STT and community behavioral health providers; media; and non-governmental organizations, including VOADs and child caregivers/educators, play an important positive role and are engaged as deemed appropriate to the specific crisis or emergency.
5. Disaster behavioral health activities, as an integral part of overall force health protection, include provision of psychological and stress protection and substance abuse prevention strategies and services to responders.
6. Interventions during disaster response and recovery should be based on accepted professional standards, founded on empirical knowledge, and delivered by trained volunteers, paraprofessionals, and when appropriate, professional personnel.
7. Individuals with pre-existing behavioral health issues will be among survivors receiving medical services.
8. Some individuals or populations may be at higher risk for more severe reactions. For example, individuals with pre-existing behavioral health conditions or past traumatic exposure and at-risk individuals with functional needs. Children, in particular, can be vulnerable as they may lack the experience, skills, and resources to independently meet their own behavioral health needs requiring special considerations for parents, caregivers, educators, and professionals working with children and youth.
9. Primary care providers and emergency responders delivering behavioral health support in the affected community, as well as early care and school age providers and educators, may benefit from technical assistance, support, and referral points for disaster behavioral health services.
10. In certain incidents, such as biologic events or terrorist incidents, emergency departments and health care facilities may experience an influx of patients with psychologically-based complaints or unexplained physical symptoms, as well as more severe behavioral health symptomology than is experienced in other natural disasters, requiring targeted preparedness and response activities.
11. In addition to disaster-related behavioral health services and grant programs, federal steady-state programs addressing behavioral health needs are leveraged—when appropriate and allowable within legal authorities—to provide access to services, bi-directional communication with response and recovery coordinators, and education.
12. Messages, information, and educational materials that specifically address behavioral health issues that may arise following a disaster are essential components of the overall public health messaging strategy. Such behavioral issues include anxiety, stress, fear, grief, the particular

needs of at-risk individuals such as children, separation from pets, or increased risk of substance use/abuse. Messages should be made available in accessible, alternative, and age-appropriate formats.

13. Strong coordination is needed between behavioral health and human services stakeholders as issues and needs in these areas can be closely associated.
14. As many behavioral health issues arise long after the response period has ended, recovery planning and activities must address current and anticipated behavioral health consequences.

III. Roles and Responsibilities

HHS provides disaster behavioral health preparedness, response, and recovery support to STT and local communities through a variety of mechanisms, including NRF and NDRF sponsored efforts and the activities of OPDIVs and STAFFDIVs as part of their normal operations. Services include the provision of technical assistance, educational resources, deployment of trained behavioral health responders, provision and management of grants and emergency funding, and participation in coordination efforts at the local, STT, and national levels.

A. HHS Role in Preparedness, Response, and Recovery

HHS's public health and medical ***response*** to disaster, including behavioral health, generally is managed in accordance with NRF ESF #8. Health and social services disaster ***recovery***, including behavioral health, is managed in accordance with the NDRF H&SS RSF. In both cases, HHS ASPR coordinates activity on behalf of the HHS Secretary, and HHS OPDIVs and STAFFDIVs also provide support, technical assistance, information, and in some cases, assets and services.

When an incident overwhelms STT resources or is expected to do so, the governor of an affected state may request federal assistance. Following a presidential emergency or major disaster declaration, the Stafford Act authorizes the Federal government to provide certain financial and other assistance depending on the declaration to STT and local governments, businesses, and individuals in support of response, recovery, and mitigation efforts. Outside the Stafford Act, HHS may have its own authorities and resources to provide certain assistance to states and other entities during a public health emergency, including leveraging of steady-state federally-supported programs and assets.

In carrying out preparedness, response, and recovery activities, HHS entities work closely with STT and local behavioral health leadership and with non-governmental and voluntary agencies to ensure that provided services are culturally and developmentally appropriate and that at-risk individuals have access to behavioral health care. HHS also ensures that communication strategies are informed by behavioral health concerns and that all implemented strategies foster individual and community resilience.

Appendix C provides descriptions of the general missions and activities of HHS OPDIVS, STAFFDIVS, and sub-divisions with potential disaster behavioral health roles. Specific agency roles related to disaster behavioral health are detailed in the body of this CONOPS.

B. Coordination with ESF #6 Activities

The ESF #8 behavioral health response and the transition from response to recovery requires close coordination with certain aspects of the ESF #6 (Mass Care, Emergency Assistance, Housing, and Human Services) response. Activities in the areas of Human Services and of Mass Care and Housing require particular attention.

Human Services

Human services program roles include the mitigation of economic repercussions to individuals, families, and communities that can impede financial and insurance access to behavioral health care in the community. Human services programs mitigate psychosocial risks and stresses, such as unemployment, loss of housing, disintegration of neighborhoods and communities, that can lead to behavioral health illness and injury. They also work to maintain services to address the functional needs of at-risk individuals to promote independent living.

The Administration for Children and Families (ACF) leads the HHS ESF #6 Human Services response and administers the Disaster Case Management (DCM) program for the DHS Federal Emergency Management Agency (DHS-FEMA). ACF's Office of Human Services Emergency Preparedness and Response (ACF-OHSEPR) works with ASPR's Division for At-Risk Individuals, Behavioral Health, and Community Resilience (ASPR-ABC) to coordinate human services preparedness, response, and recovery activities across HHS. ACF assists with strategic leveraging of federal human services programs, including program flexibilities and waivers, establishes human services liaisons to state, regional, and national emergency operations centers, and advises on the needs of children and at-risk individuals. ACF's Administration on Children, Youth, and Families also addresses the needs of victims of domestic violence and their children through emergency shelter, statewide services coordination, tribal services, and administering the National Domestic Violence Hotline.

Other HHS divisions provide human services-related support, though not necessarily as part of ESF#6 response activities. The Administration on Aging (AoA) works with ACF and ASPR-ABC to address the needs of seniors and persons with disabilities. Behavioral health personnel staged in ASPR National Disaster Medical System (ASPR-NDMS) treatment areas provide community information and referrals for at-risk individuals, e.g., displaced residents of extended care facilities, individuals with special medical needs, and individuals requiring home health care or durable medical equipment. The Centers for Disease Control and Prevention (CDC) advises on human services aspects of communication, surveillance, field investigation, clinical guidance and other issues.

Crisis Counseling Assistance and Training Program (CCP)

The CCP is authorized under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act) and requires a presidential declaration of disaster for individual assistance for short-term behavioral health support when disaster response needs are beyond STT capacity. CCP is funded by DHS-FEMA and administered through an interagency federal partnership between DHS-FEMA and the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services. The CCP consists of two grant programs, the Immediate Services Program (ISP), which is 60 days in duration, and the Regular Services Program (RSP), which is 9 months in duration. STTs are eligible to apply for CCP grants with services typically provided to the affected

areas by behavioral health organizations through contracts with a state's department of mental health. CCPs use a combination of mental health professionals and paraprofessionals, who are trained and supervised to deliver an array of crisis counseling services, including individual and group crisis counseling; basic supportive or educational contact; public education; community networking and support; assessment, referral, and resource linkage; and development and distribution of educational materials and media or public service announcements. CCPs are culturally competent, understanding, respectful, and sensitive to the cultural makeup of communities served. CCP staff are usually indigenous to the affected communities and are sometimes survivors themselves.

Mass Care and Housing

ASPR-ABC works with federal partners (such as FEMA and HUD) and NGOs (such as ARC) to promote the inclusion of behavioral health support in shelters and disaster housing. ACF, AoA, and the Office on Disability (OD) provide subject matter expertise and technical assistance to meet the needs of children and at-risk individuals in mass care and congregate shelters. ASPR-NDMS behavioral health personnel can provide psychological first aid and referral services to shelter residents. Several OPDIVs and STAFFDIVs (including ASPR-ABC and ACF) participate in the National Disaster Housing Task Force, which may be called upon to provide guidance on disaster housing following a major event.

IV. Preparedness

A. Promoting Community Resilience through Disaster Behavioral Health Preparedness

Disaster behavioral health strategies and actions promote community resilience and are an essential part of public health and medical emergency response and recovery. Disaster behavioral health must be integrated into plans and preparedness activities in order to promote effective and comprehensive response, recovery, and national health security.

Planning

1. **QUARTERLY PREPAREDNESS FORUMS:** ASPR-ABC and SAMHSA will establish and convene quarterly Disaster Behavioral Health and Community Resilience Preparedness Forums. The format of these forums will be flexible to meet current preparedness needs, and may include in-person meetings, teleconferences, or web-based venues. At these forums, federal partners* with responsibilities in disaster behavioral health preparedness and the psychological and behavioral aspects of community resilience will:
   - Share information and best practices;
   - Leverage opportunities for coordinated efforts, joint projects, and presentations at national and regional conferences;
   - Incorporate lessons learned in preparedness plans;
   - Gather external stakeholder input through listening sessions;
   - Promote shared objectives (i.e., NHSS, NDRF, Whole Community, and Grant Alignment)

   *Federal partners include but are not limited to HHS's ASPR, SAMHSA, ACF, CDC, Health Resources and Services Administration (HRSA), Indian Health Service (IHS), National Institute of

Mental Health (NIMH), and Office of the Assistant Secretary for Health (OASH); DoD, DHS, DHS-FEMA, VA, and ARC (in ESF #8 partner role).

2. **STATE AND REGIONAL ASSESSMENT:** ASPR Regional Emergency Coordinators (ASPR-RECs) conduct, if applicable, a *Disaster Behavioral Health Capacity Assessment* for each state in their region to establish capacity, address gaps, and promote resilient systems. ASPR-ABC and SAMHSA will provide technical assistance to ASPR-RECs for this process.
3. **MEDMAP:** MedMap will be populated with information about the behavioral health infrastructure in each state, territory, or tribal area, such as availability of STT, community, and private providers of mental health and substance abuse services as well as pertinent federal grantees.
4. **PLANS, DRILLS, AND AFTER-ACTION MEETINGS:** HHS OPDIVs and STAFFDIVs with disaster behavioral health expertise (such as ACF, ASPR, CDC, and SAMHSA) participate in preparedness activities such as disaster response and recovery plan and playbook development, and—in coordination with the ASPR OPEO Training, Exercise, and Lessons Learned (TELL) Division—exercises, after-action meetings, and lessons-learned sessions. During active disaster response, these entities participate in the development of an ESF #8 Incident Coordination Plan (ICP).
5. **RESILIENCE AND SPECIAL TOPICS:** Agencies participating in Preparedness Forums foster the principles of individual and community psychological resilience in preparedness plans and approaches and ensure that special topics with a role in overall well-being and safety (such as family disaster planning, out-of-home caregiver/educator training to react and respond to needs of children, and disaster preparedness in relation to pets) are included in preparedness materials and training.

Resources, Technical Assistance, and Information Dissemination

6. **COOPERATIVE AGREEMENTS/GRANTS:** CDC and ASPR educate STT stakeholders and grantees participating in the CDC's Public Health Emergency Preparedness (PHEP) program and ASPR's Hospital Preparedness Program (HPP) on the importance of including behavioral health as part of public health and hospital preparedness and response.
7. **STATE DISASTER BEHAVIORAL HEALTH CONSORTIUM:** ASPR-ABC and SAMHSA participate in State Disaster Behavioral Health Consortium meetings to exchange information, resources, and best practices.
8. **DISSEMINATION OF INFORMATION:**
   - The disaster behavioral health preparedness forum group works to identify existing behavioral health training opportunities and educational materials to ensure that they are accessible and cross-linked on pertinent government websites, to identify electronic and print dissemination mechanisms, and to address knowledge gaps that require new information development.
   - ASPR-ABC creates assessment tools, educational resources, and factsheets and disseminates them to ESF #8 and STT partners to enhance response capacity and resilience.
   - The SAMHSA Disaster Behavioral Health Information Series (DBHIS) contains themed resource collections and toolkits pertinent to the disaster behavioral health field. (See Appendix D).
   - The SAMHSA Disaster Kit contains SAMHSA disaster behavioral health publications (see Appendix D) for professionals and the general public. Materials may be used to support immediate disaster behavioral health response efforts.
9. **BEHAVIORAL HEALTH PROGRAMS:**
   - SAMHSA's 24/7 Disaster Distress Helpline connects those experiencing emotional distress related to a disaster with crisis center counselors who can provide support and referrals to local resources by calling 1-800-985-5990 or texting TalkWithUs to 66746.

- SAMHSA's National Child Traumatic Stress Network is dedicated to improving access to care, treatment, and services for children and adolescents exposed to traumatic events.
- The DHS-FEMA/SAMHSA CCP provides crisis counseling services to disaster survivors, develops partnerships with local organizations to promote resilience and recovery capabilities, trains and educates community partners and grant recipients, and collects data to evaluate and improve CCP services (see Appendix C).
- SAMHSA's Disaster Technical Assistance Center (DTAC) provides resources that help STT and local entities deliver an effective mental health and substance abuse response to disasters.
- ACF's Administration on Children, Youth, and Families' National Domestic Violence Hotline provides support, information, referrals, safety planning, and crisis intervention in 170 languages to domestic violence victims.
- SAMHSA's National Center for Trauma Informed Care is dedicated to building awareness of trauma-informed care and promoting the implementation of trauma-informed practices in programs and services.

10. **SCIENTIFIC PREPAREDNESS AND RESEARCH:** The National Institutes of Health (NIH) and the National Library of Medicine (NLM) conduct research and literature reviews to determine best practices and evidence-informed approaches to disaster behavioral health and resilience[4]. This includes collecting and disseminating information on disasters and behavioral health from NIMH, SAMSHSA and other agencies via MedlinePlus, PubMed, and the Disaster Information Management Research Center. Awareness of the most up to date findings of the scientific community supports HHS training, guidance, and educational and policy documents.

Training

11. **REGIONAL STAFF TRAINING:** ASPR-ABC, together with SAMHSA and in coordination with ASPR-OPEO-TELL, provides training for ASPR-RECs and other interested ASPR staff on disaster behavioral health at the STT and local levels, and on community resilience and recovery. They also provide training to the ASPR-RECs on how to conduct the Disaster Behavioral Health Capacity Assessment.
12. **INTEGRATED TRAINING SUMMIT:** The annual Integrated Training Summit will cover disaster behavioral health, psychological first aid (PFA), resilience, and recovery. ASPR-ABC will help conference planners identify presenters and develop sessions to promote integration of behavioral health into the nation's public health and medical response and recovery.
13. **IRCT TRAINING:** Annual and introductory training for the IRCT will include a module on disaster behavioral health approaches, services, community partners, and community resilience.
14. **PSYCHOLOGICAL FIRST AID:** All ASPR-NDMS responders take an online introductory course on PFA. The online course is also made available to any ASPR employee who wishes to take it. ASPR-NDMS members with behavioral health or related roles receive in-depth PFA training to meet the emotional and medical needs of survivors and responders.
15. **CDC TRAINING:** CDC offers training in terrorism preparedness and emergency response, including content specific to psychological implications, to CDC employees and contractors and provides training materials to assist local and regional practice partners.
16. **MRC TRAINING:** DCVMRC provides access to educational opportunities to MRC units and volunteers through MRC-TRAIN to ensure that behavioral health and at-risk individual needs are

[4] SUBCHAPTER III> Part A> §282 of the Public Health Service Act

integrated into their preparedness, response, and recovery activities. In many localities, MRC units are incorporating PFA Training in their curricula.

17. **OFFICE OF FORCE READINESS AND DEPLOYMENT (OFRD) TRAINING:** OFRD provides its deployment teams with resident annual training in four areas of competency: disaster behavioral health triage, assessment, analysis, and implementation of sustainable interventions supporting continuity and recovery.

B. Behavioral Health Promotion

Beyond traditional disaster preparedness activities, approaches that promote good behavioral health as part of overall health and that prevent mental illness and substance abuse can be applied to build individual and community resilience, and can potentially ameliorate adverse behavioral health reactions following an emergency event. Behavioral health promotion and mental illness and substance abuse prevention methods empower individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors and lifestyles. In the context of disaster and public health emergency preparedness, behavioral health promotion and illness prevention include a continuum of approaches to educate the public, disaster survivors, and at-risk individuals, as well as medical and behavioral health professionals and early and school age children's caregivers/educators. Such education may be accomplished by developing and delivering training and messaging through live, online, and social media, and through printed materials; by mobilizing and analyzing research; by conducting surveillance of behavioral health concerns; and by pre-developing customizable templates for educational materials. Disseminating information through multiple media, in many languages and in formats that are age-appropriate and user-friendly, is essential when developing response and recovery plans and coordinating services for at-risk individuals.

V. Response

This section details behavioral health response activities, their coordination with external ESF #8 partners, and special considerations for a catastrophic disaster or a public health emergency.

A. General ESF #8 Response Coordination Structure

On behalf of the Secretary of HHS, the ASPR directs and coordinates all federal public health and medical assistance provided by the NRF. The ASPR also acts as the senior-level HHS liaison to DHS and other federal departments and agencies. Within ASPR, OPEO is responsible for ensuring preparedness to respond to and recover from public health and medical threats and emergencies. ASPR-OPEO is also responsible for ensuring that ASPR has the systems, logistical support, and procedures necessary to coordinate the Department's operational response to acts of terrorism and other public health and medical threats and emergencies. Federal ESF #8 preparedness and response activities are coordinated through the HHS Emergency Management Group (EMG) within the Secretary's Operations Center (SOC) and also through the Incident Response Coordination Team (IRCT) that is typically located within the event theater.

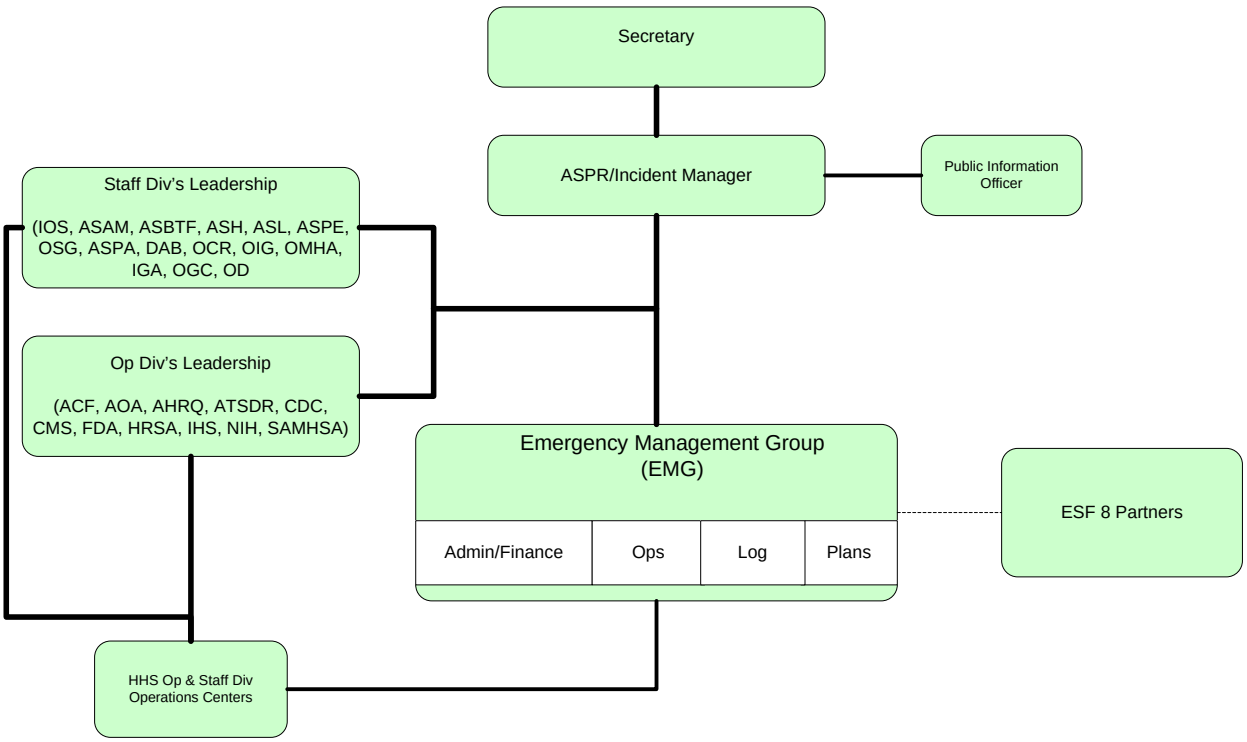

Figure 2: ESF #8 Response Structure

The EMG, established by ASPR, is always activated and routinely functions in an awareness and monitoring posture. On activation to a response level, the EMG transforms to an established Incident Command System (ICS) and coordinates ESF #8 resources, including coordination with HHS's federal partners, to meet requests for assistance (see Figure 2, previous page).

The IRCT is scalable, has a built-in command structure, and directs all ESF #8 response assets in the field. When deployed, it directs and coordinates activities of all deployed HHS personnel, and assists STT, local and other federal and government agencies as applicable. The IRCT staff includes a Behavioral Health Liaison Officer (LNO) who acts as the single point of contact for assisting and cooperating with agency representatives, monitors and facilitates behavioral health force protection for the IRCT, and may serve as liaison with STT and local behavioral health officials.

B. Disaster Behavioral Health Response

Disaster behavioral health response efforts address the needs of three population groups: 1) survivors affected by the emergency who require support; 2) incident responders/workers[5]; and 3) existing recipients of behavioral health services provided by the behavioral health care infrastructure.

Because behavioral health needs evolve in variable ways after public health emergencies and disasters, and because behavioral health response capabilities are spread across many federal, STT, local, voluntary, non-profit, and grant-based organizations, behavioral health generally does not follow as clear a timeline as other emergency public health and medical response activities typically

[5] Incident responders/workers may be interpreted to include health care, human service, child care, and educational providers exposed to the disaster or public health emergency.

follow. Indeed STT, local, voluntary, and NGO entities are often the first to begin to assess health and medical needs and initiate response with existing assets immediately following an emergency event. Nevertheless, key activities can be placed into a general sequence of events, with many of these actions taking place concurrently. For a disaster with a warning period (such as a hurricane), many activities may be completed earlier in the sequence, or even before the disaster's onset. Figure 3 outlines the typical Disaster Behavioral Health Response Sequence of Events; a detailed elaboration of these steps follows.

Action / Capability	Timeframe post Disaster			Lead Agency
STT, local, voluntary, and NGO entities assess health and medical needs and initiate response	<24 hr	<72 hr		STT
ESF #8 activates	<24 hr			HHS/ASPR
HHS OPDIVs/STAFFDIVs activate	<24 hr			ASPR/CDC/ SAMHSA/ARC
Federal Disaster Behavioral Health Group convenes, establishes communication and information gathering channels		<72 hr	Days - weeks	ASPR-ABC
ESF #8 reporting for FDBHG and SOC		<72 hr	Days - weeks	ASPR-ABC
OASH-OSG-DCVMRC Coordination with ESF #8 partners, ESAR-VHP		<72 hr	Days - weeks	OASH-OSG-DCVMRC
Human Services needs assessment and reporting		<72 hr	Days - weeks	ACF
Mission Assignments enacted, assets deployed		<72 hr	Days - weeks	ASPR-EMG
Behavioral health LNO assigned to IRCT		<72 hr		ASPR EMG & IRCT
MedMap analysis of needs, gaps		<72 hr	Days - weeks	ASPR
Distribution of behavioral health information and resource coordination		<72 hr	Days - weeks	ASPR-ABC/CDC /SAMHSA
SAMHSA activates programs and activities, including CCP		<72 hr	Days - weeks	SAMHSA
Centers for Medicare and Medicaid Services (CMS) works with STTs to maximize flexibility in Medicaid/Medicare payment and coverage in the disaster or emergency affected region.		<72 hr	Days - weeks	CMS
Surveillance to gather behavioral health information		<72 hr	Days - weeks	CDC/SAMHSA
Use of research results, subject matter expertise		<72 hr	Days - weeks	NIH/ASPR
Behavioral health force protection integrated into response		<72 hr	Days - weeks	ASPR-EMG & IRCT
Mental Health Teams deployed if indicated		<72 hr	Days - weeks	OFRD
Responder health monitoring		<72 hr	Days - weeks	CDC-NIOSH/ASPR EMG & IRCT
Federal Occupational Health (FOH) Employee Assistance Program (EAP) reports and responds		<72 hr	Days - weeks	FOH

Figure 3: ESF #8 Partner Disaster Behavioral Health Response: General Sequence of Events

Federal Activation

1. **HHS/ESF #8 ACTIVATES:** The Secretary activates a department-wide response based on FEMA activation of the NRF ESF #8 or determination that a significant incident or public health emergency requires a department-wide response. HHS OPDIVS/STAFFDIVS and ESF #8 partners are activated through SOC for response activities.
2. **SUPPORTING AGENCIES ACTIVATE:** The CDC Emergency Operations Center (EOC) Mental/Behavioral Health Functional Desk, ACF Emergency Operations and SOC Liaison, ASPR-ABC SOC liaison and EMG seat, ARC Mental Health, and SAMHSA Emergency Coordination functions activate in response mode and coordinate any immediate outreach to STT partners to address urgent needs.

Coordination, Assessment, and Analysis

3. **FEDERAL DISASTER BEHAVIORAL HEALTH GROUP** (FDBHG)**:** ASPR-ABC convenes the FDBHG, which includes participants indicated by the needs of the disaster such as SAMHSA, ACF, ARC, ASPR, CDC, FOH EAP, HHS Recovery staff, and IRCT and/or ASPR-REC field representatives. The FDBHG provides behavioral health information analysis and coordination in support of ESF #8 operations. The FDBHG does not replace or supersede OPDIV and STAFFDIV authorities, responsibilities, or reporting. Operating until activities transition to recovery operations, the FDBHG:
   - Implements a coordinated outreach approach so that outreach to state and local behavioral health stakeholders is targeted, appropriate, and non-duplicative;
   - Establishes bi-directional communication through relevant agency programs and grants to identify needs, share governmental information, gather essential elements of information, and develop a common operating picture (Appendix B summarizes the Essential Elements of Information (EEI) that are needed to guide the behavioral health response);
   - Analyzes information to identify capabilities, gaps, and response recommendations;
   - Identifies informational and psycho-educational resources related to the disaster event and mobilizes access to this information through public information systems; and
   - Generates information to inform long-term recovery and after-action/lessons-learned activities.
4. **ESF #8 REPORTING:** ASPR-ABC summarizes pertinent information from the FDBHG for ESF #8 situation reports to the SOC and ASPR leadership, and for the Incident Action Plan (IAP) and HHS policy response coordination meetings.
5. **MRC COORDINATION**: OASH-OSG-DCVMRC assists ESF #8 partners in integrating OASH-OSG-DCVMRC members into their response activities, and works with the coordinator of the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP; see Appendix D) to provide liaison to ESF #8 partners on civilian deployment.

Resources, Technical Assistance, and Information Dissemination

6. **HUMAN SERVICES:** ACF contacts program grantees and regional coordinators in affected areas to determine the impact of the disaster on human services provision and related behavioral health needs. ACF can also make use of flexibilities and waivers in its routine grantee programs to provide services as necessary.
7. **MISSION ASSIGNMENTS:** ASPR, along with OFRD, creates rosters of responders eligible for mission assignments that HHS receives from DHS/FEMA in accordance with the Stafford Act. ASPR executes mission assignments and deploys behavioral health assets based on STT and local

requests and needs. ASPR-ABC assists by analyzing and vetting complex behavioral health mission assignments.

8. **BEHAVIORAL HEALTH LNO:** Upon deployment of ASPR-NDMS or OFRD teams, the ASPR-EMG assigns a Behavioral Health LNO to the IRCT to help coordinate federal behavioral health assets with local and voluntary assets, identify needs, and monitor federal behavioral health force protection efforts. ASPR-ABC serves as a reach-back resource on disaster behavioral health for the IRCT, the LNO, and for leadership in the field.
9. **MEDMAP:** The ASPR-EMG compiles and analyzes Behavioral Health MedMap data to inform the response, target resources, and address gaps.
10. **INFORMATION PROMULGATION:** ASPR-ABC works with SAMHSA, CDC, ASPR Public Information Officer, and pertinent stakeholders—using information identified through the FDBHG—to coordinate dissemination of relevant behavioral health information and psycho-educational resources. Activities include providing information on behavioral health, coping, resilience, and resources through HHS social media (e.g., Twitter and Facebook) accounts.
11. **BEHAVIORAL HEALTH PROGRAMS/ACTIVITIES:** SAMHSA:
    - Contacts grantees and response partners to determine impact and coordinates with the State Disaster Behavioral Health Coordinator and stakeholders or other entities holding disaster-related projects or grants in affected region to assess need and offer technical assistance and resources. Examples of relevant projects and grants include the National Child Traumatic Stress Network, Suicide Prevention, block grants, tribal programs, and mental health and substance abuse prevention and treatment programs.
    - Provides technical assistance on CCP (a Stafford Act program) and the SAMHSA Emergency Response Grant (SERG) program to STT and local entities. CCP assists individuals and communities in recovering from the challenging effects of disasters through the provision of community-based outreach and psychoeducational services. Services are typically provided by behavioral health organizations through contracts with a state's department of mental health.
    - Disseminates resource materials via the SAMHSA website, Information Clearance Center, and DTAC.
    - Connects those experiencing emotional distress related to a disaster with crisis center counselors who can provide support and referrals to local resources by calling SAMHSA's 24/7 Disaster Distress Helpline at 1-800-985-5990 or texting TalkWithUs to 66746.
    - Helps VOADs and professional guilds, such as the American Psychological Association, the National Association of Social Workers and the American Counseling Association, who provide behavioral health services, to coordinate their activities with federal and STT activity.
12. **MEDICAID/MEDICARE:** CMS works with states to maximize flexibility in Medicaid/Medicare payment and coverage in the disaster or emergency affected region.
13. **SURVEILLANCE:** Agencies query existing surveillance systems for information about behavioral health and resilience. CDC and SAMHSA, if indicated, tailor existing surveillance systems, such as the Behavioral Risk Factor Surveillance System, to ascertain disaster-related behavioral health trends.
14. **RESEARCH FINDINGS AND SUBJECT MATTER EXPERT (SME) INPUT:** NIH and its NLM identify pertinent research findings and scientific evidence relevant to behavioral health and resilience concerns of the disaster event in order to inform policy and response decisions. NIH, ASPR-ABC, and ASPR's

National Biodefense Science Board (ASPR-NBSB) obtain input from additional behavioral health and resilience SMEs when indicated.

15. **RESEARCH OPPORTUNITIES:** NIH examines the response environment for opportunities to promote research on behavioral health through existing programs, through specialized funding announcements or the NIH unsolicited parent grant announcement.

Responder Behavioral Health

16. **BEHAVIORAL HEALTH FORCE PROTECTION:** The ASPR EMG and IRCT integrate behavioral health force protection assets and materials in federally deployed teams. In catastrophic, complex, or large scale events, behavioral health providers and materials are integrated into the ASPR-NDMS Mobilization Processing Center to provide information, pre- and post-deployment briefings, and informal one-on-one supportive interventions to ASPR responders.
17. **OFRD MENTAL HEALTH TEAMS (MHTS):** OFRD MHTs may be deployed to provide force health protection services, stress mitigation/management, and counseling services for responding agencies' personnel and their family members, crisis intervention including PFA and triage for disaster survivors and incident responders/workers, and public behavioral health agency/community assistance.
18. **CDC RESPONDER RESILIENCY:** Through its Responder Resiliency Program, CDC provides trained team members to monitor and support the well-being and resilience of CDC emergency response personnel and enhance their awareness of psychosocial conditions in the populations they serve.
19. **CDC RESPONDER HEALTH MONITORING:** CDC's National Institute for Occupational Safety and Health (NIOSH) offers guidance for emergency responder health monitoring and provides communication products and technical consultation to employers and worker organizations following requests submitted either through routine channels or through the CDC EOC Worker Safety and Health Function Desk.
20. **FOH EAP SERVICES:** FOH EAP Emergency Response Team reports to impacted agencies requesting services and can provide post-deployment education, support and referrals to responders. Information on how to access the EAP is provided to responders during the mission and after their return home.

C. Considerations for Catastrophic Disaster

Catastrophic disasters impose extensive and urgent behavioral health needs that significantly exceed the response capabilities of localities, STTs, voluntary organizations, partners, and federal assets. Examples of catastrophic scenarios are devastating, widespread natural disasters affecting multiple STTs, large public health emergencies or epidemics, or disasters with very high loss of life and trauma exposure. Catastrophic disasters necessitate actions above and beyond those listed in the CONOPS to ensure that disaster survivors and responders receive the critical behavioral health services they need. Catastrophic events likely entail extensive, acute needs in the population and the potential for damage to the behavioral health infrastructure that would provide treatment. The specific risks, needs, and behavioral health response actions will be dictated by the characteristics of the catastrophic disaster. Depending on legal authorities, presidential or legislative actions, and/or funding support, a number of response resources may be available.

1. **ADDITIONAL PARTNERS:** By reaching out and facilitating coordination, ASPR, localities, STTs, and other organizations may expand their respective responses by maximizing potential surge resources for behavioral health, such as:
   - HHS behavioral health professionals beyond those normally engaged in response activities;
   - VA and DoD;
   - State volunteer behavioral health responders from the OASH-OSG-DCVMRC and the ESAR-VHP network outside the affected area;
   - National VOADs and community and faith-based organizations with behavioral health capabilities from outside the affected area;
   - Behavioral health and health professional associations such as the American Psychological Association's Disaster Response Network, the National Association of County & City Health Officials, the National Association of Social Workers, the American Psychiatric Association, the National Association of State Alcohol and Drug Abuse Directors, the National Association of State Mental Health Program Directors, the American Academy of Pediatrics, the American Medical Association, etc.;
   - State-to-state behavioral health resources available through EMAC;
   - Behavioral health professionals tracked through ESAR-VHP systems; and
   - Behavioral health professionals from other countries and international organizations made available through established international structures.
2. **DEPLOYMENT OF TOOLS AND RESOURCES**: With assistance from the FDBHG, HHS can draw on a number mechanisms and assets to expand the disaster response effort:
   - Facilitating the provision of just-in-time disaster behavioral health training (such as psychological first aid) for additional federally-sponsored volunteers or other responders who may be put on rosters and deployed;
   - Assisting STTs with access to critical psychiatric or substance abuse treatment medications;
   - Using science-based tools to prioritize use of scarce clinical resources;
   - Offering evidence-based interventions at the population and community level to reduce morbidity or severity of psychological illness and injury in situations that hamper or prevent provision of behavioral health treatment to significant numbers of individuals; and
3. **WAIVERS AND SUPPLEMENTAL FUNDING**: The federal role in disaster response may be broadened through utilization of statutory authorities or new authorities enacted by Congress:
   - Exercise of allowable federal program and grant flexibility or waivers to broaden provision of behavioral health services; and
   - Securing supplemental appropriations from Congress to fund critical disaster behavioral health services and determining delivery mechanisms for funding (such as the SERG program, which may also be used without Stafford Act declaration).

VI. Recovery

Mental health reactions and substance abuse conditions often emerge or intensify during recovery, impeding individual and community resilience. Behavioral health is a critical part of a multi-sector recovery approach that engages the whole community to foster partnerships among government and local institutions, the private for-profit and non-profit sectors, and voluntary, community, cultural,

and faith-based groups. The NDRF is a coordinating structure for this effort, with health and social services, including behavioral health, coordinated through the H&SS RSF. HHS, with ASPR coordinating, is the lead agency for the H&SS RSF. H&SS RSF recovery staff are included in both disaster behavioral health preparedness and response activities for continuity and to identify longer-term needs. During recovery, behavioral health is fully integrated into the H&SS RSF.

Transition from Response to Recovery

1. **RECOVERY IN PREPAREDNESS & RESPONSE:** H&SS RSF staff participate in the FDBHG during the disaster response phase as well as in quarterly Disaster Behavioral Health and Community Resilience Preparedness Forums to promote a smooth transition from response to recovery.
2. **FDBHG RECOVERY FOCUS:** ASPR-ABC ensures that FDBHG meetings include behavioral health issues relating to the transition to recovery. The final meeting(s) of the FDBHG are dedicated to the transition to recovery, and involve additional recovery stakeholders, as needed.
3. **TRANSITION:** The transition from federal response to recovery for disaster behavioral health is marked by several organizational changes:
   - Response assets demobilize and the national coordinating structure transitions from the NRF to the NDRF;
   - At HHS, coordination passes from NRF ESF #8 to NDRF H&SS RSF; and
   - The FDBHG stands down, with behavioral health recovery representatives integrating directly into the H&SS RSF under the H&SS National Recovery Coordinator in support of the Field Recovery Coordinator and Departmental recovery efforts.

Coordination, Assessment, and Analysis

4. **H&SS RSF SUPPORT AGENCIES:** H&SS RSF support agencies with behavioral health responsibilities:
   - Maintain bi-directional communication through relevant agency programs and grants to assess and address locally-driven recovery needs and gaps and share governmental information;
   - Provide information to the H&SS RSF to inform recovery assessments and to guide H&SS RSF activities (including requests for support or recovery mission assignments);
   - Identify informational and psychoeducational resources related to disaster recovery and resilience and mobilize access to this information through recovery information channels; and
   - Plan for and implement the transition from recovery operations to steady-state activity.

Resources, Technical Assistance, and Information Dissemination

5. **MEDMAP IN RECOVERY:** The ASPR-EMG compiles and analyzes Behavioral Health MedMap data to inform recovery efforts and track reconstituted infrastructure.
6. **SUPPORT FOR RECOVERY COORDINATORS:** ASPR-ABC provides subject matter expertise and reach-back support to ASPR National and Field Recovery Coordinators.
7. **BEHAVIORAL HEALTH PROGRAMS/ACTIVITIES:** SAMHSA:
   - Partners with STT and local entities to examine behavioral health recovery needs and recommend ways to transition federal response supports into existing structures (e.g., CCP or SERG and/or VOAD or community behavioral health efforts);
   - Offers technical assistance and resources from existing SAMHSA-sponsored programs and grantees such as DTAC, National Child Traumatic Stress Network, Suicide Prevention, block

grants, tribal programs, and mental health and substance abuse prevention and treatment programs; and

- Works in partnership with STT CCP grantees to continue to carry out crisis counseling services to promote individual and community resilience and recovery; compiles and analyzes data from CCP to inform the H&SS recovery.

8. **HUMAN SERVICES:** ACF provides recovery-related technical assistance for ACF programs.
9. **MEDICARE/MEDICAID:** CMS works with STTs to maximize flexibility in Medicaid/Medicare payment and coverage in the disaster or emergency affected region.
10. **SURVEILLANCE:** Agencies query existing surveillance systems for information to track trends in behavioral health recovery in the affected region. CDC, if indicated, tailors existing surveillance systems to continue to ascertain disaster-related behavioral health trends.
11. **RESEARCH OPPORTUNITIES:** NIH, placing the care and safety of disaster survivors above all else and remaining sensitive to the complexities associated with disaster research, examines the recovery environment for opportunities to promote research on behavioral health through existing programs, through specialized funding announcements, or through the NIH unsolicited parent grant announcement.[6]
12. **RESEARCH AND SME INPUT:** NIH and its NLM provide literature reviews and gather pertinent research on recovery and resilience issues. NIH, ASPR-ABC, and ASPR-NBSB obtain input from additional behavioral health, recovery, and resilience subject matter experts when indicated.
13. **FOH EAP SUPPORT:** The FOH EAP and Work/Life program offer information and transition services for qualified individual federal employees, their families, and supervisors after an event. Assistance might include provision of psychological support sessions, information about what to expect in the aftermath of an event, including expectations about work performance, and coaching on specific issues.

Transition from Recovery to Steady-State

14. **PHASE-DOWN AND TRANSITION TO STEADY-STATE:** Transition from NDRF coordinated recovery activity to steady-state federal, STT, and community resources is a key planning consideration throughout the H&SS RSF operational period. The NDRF provides guidance for assessing the progress of this transition. Prior to the transition, phase-down planning is conducted by the H&SS RSF. For behavioral health this involves:
    - Ensuring the disaster-impacted community is aware of any changes in behavioral health service provision and engaged in the transition to steady-state activity, working through H&SS RSF and regional agency personnel, as indicated; and
    - Documenting and applying behavioral health lessons learned through engaging in after-action review activity and revising related recovery documents, including documenting the new organizational relationships, best practices, approaches, knowledge, and resources concerning behavioral health developed though the recovery process that can assist communities to recover and become more resilient.

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Appendices

Appendix A: List of Abbreviations

ACF	Administration for Children and Families
ACF-OHSEPR	ACF Office of Human Services Emergency Preparedness and Response
AHRQ	Agency for Healthcare Research and Quality
AoA	Administration on Aging
APHT	Applied Public Health Team
ARC	American Red Cross
ASA	Assistant Secretary for Administration
ASFR	Assistant Secretary for Financial Resources
ASL	Assistant Secretary for Legislation
ASPA	Assistant Secretary for Public Affairs
ASPE	Assistant Secretary for Planning and Evaluation
ASPR	Assistant Secretary for Preparedness and Response
ASPR-ABC	ASPR Division for At-Risk Individuals, Behavioral Health, and Community Resilience
ASPR-NBSB	ASPR National Biodefense Science Board
ASPR-NDMS	ASPR National Disaster Medical System
ASPR-REC	ASPR Regional Emergency Coordinator
ATSDR	Agency for Toxic Substances and Disease Registry
CCP	Crisis Counseling Assistance and Training Program
CDC	Centers for Disease Control and Prevention
CFBNP	Center for Faith-Based and Neighborhood Partnerships
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CONOPS	Concept of Operations
DAB	Departmental Appeals Board
DBHIS	Disaster Behavioral Health Information Series
DCVMRC	Division of the Civilian Volunteer Medical Reserve Corps
DCM	Disaster Case Management
DHS	Department of Homeland Security
FEMA	Federal Emergency Management Agency
DMAT	Disaster Medical Assistance Team
DMORT	Disaster Mortuary Operational Response Team
DoD	Department of Defense
DSWG	Disaster Surveillance Work Group
DTAC	Disaster Technical Assistance Center
EAP	Employee Assistance Program
EEI	Essential Elements of Information

EMAC	Emergency Management Assistance Compact
EMG	Emergency Management Group
EOC	Emergency Operations Center
EPCO	Emergency Preparedness and Continuity of Operations
ESAR-VHP	Emergency System for Advance Registration of Volunteer Health Professionals
ESF	Emergency Support Function
FACT	Family Assistance Center Team
FDA	Food and Drug Administration
FDBHG	Federal Disaster Behavioral Health Group
FOG	Field Operations Guide
FOH	Federal Occupational Health
HHS	Department of Health and Human Services
HPP	Hospital Preparedness Program
HRSA	Health Resource and Services Administration
HSPD-5	Homeland Security Presidential Directive 5
H&SS RSF	Health and Social Services Recovery Support Function
IAP	Incident Action Plan
ICP	Incident Coordination Plan
ICS	Incident Command System
IGA	Office for Intergovernmental Affairs
IHS	Indian Health Service
IMSURT	International Medical Surgical Response Team
IRCT	Incident Response Coordination Team
ISP	Immediate Services Program
LNO	Liaison Officer
MHT	Mental Health Team
NCPTSD	National Center for Post-Traumatic Stress Disorder
NDRF	National Disaster Recovery Framework
NERCS	National Emergency Responder Credentialing System
NGB	National Guard Bureau
NGO	Non-governmental Organization
NHSS	National Health Security Strategy
NIH	National Institutes of Health
NIMH	National Institute of Mental Health
NIMS	National Incident Management System
NIOSH	National Institute for Occupational Safety and Health
NLM	National Library of Medicine
NRF	National Response Framework
NMRT	National Medical Response Team
NVRT	National Veterinary Response Team
OASH	Office of the Assistant Secretary for Health
OCIIO	Office of Consumer Information and Insurance Oversight

OCR	Office for Civil Rights
OD	Office on Disability
OFRD	Office of Force Readiness and Deployment
OGC	Office of the General Counsel
OGHA	Office of Global Health Affairs
OHR	Office of Health Reform
OIG	Office of the Inspector General
OMHA	Office of Medicare Hearings and Appeals
ONC	Office of the National Coordinator for Health Information Technology
OPDIV	Operating Division
OPEO	Office of Preparedness and Emergency Operations
OPP	Office of Policy and Planning
OSG	Office of the Surgeon General
OSSI	Office of Security and Strategic Information
PAHPA	Pandemic and All Hazards Preparedness Act
PERRC	Preparedness and Emergency Response Research Center
PFA	Psychological First Aid
PHEP	Public Health Emergency Preparedness
PHS	Public Health Service
RDF	Rapid Deployment Force
RSP	Regular Services Program
SAMHSA	Substance Abuse and Mental Health Services Administration
SERG	SAMHSA Emergency Response Grant
SME	Subject Matter Expert
SOC	Secretary's Operations Center
STAFFDIV	Staff Division
STT	State, Territorial, and Tribal
USDA	U.S. Department of Agriculture
USPHS	U.S. Public Health Service
VA	Veterans Administration
VOAD	Voluntary Organizations Active in Disaster

Appendix B: Essential Elements of Information

#	Title/Topic Area	Essential Element of Information (EEI)	Clarifying Questions	Data Source/ Agency
1.	Event	What is the nature and scope of the event?	How many people are affected?	ASPR, CDC
			What members of at-risk or special populations have been affected and how many?	ASPR-ABC, CDC, OFRD
			What are the potential short-term psychological consequences?	ASPR-ABC, CDC, OFRD, SAMHSA
			What are the potential mid and long term consequences?	ASPR-ABC, CDC, OFRD, SAMHSA
2.	Event	Has the event triggered emergency declarations and if so what kind?	What types of federal assistance have been made available (e.g., DHS-FEMA Individual Assistance)?	ASPR, SAMHSA
3.	Event	What is the potential for psychological harm?	What are the acute reactions requiring intervention?	ASPR-ABC, ASPR-NDMS, CDC, NIH, OFRD, SAMHSA
			What are the projected long-term needs?	ASPR-ABC, NIH, OFRD, SAMHSA
4.	Public Health/ Behavioral Health Infrastructure	What is the status of health and behavioral health critical infrastructure in the affected area(s)?	Are there plans for evacuation of inpatient facilities and will federal assistance be needed?	ASPR-REC, OFRD, SAMHSA
			What is the status of outpatient providers in the affected area?	ASPR-REC, OFRD, SAMHSA
			Are psychiatric beds available or being used for non-psychiatric patients?	ASPR-REC, OFRD

5.	Public Health/ Behavioral Health Infrastructure	Where and what kind of health, behavioral health and human services, are being provided?	What STT or local entity is coordinating services and of what nature? How are services being promoted/publicized, and are they accessible?	ASPR-ABC, ASPR-REC, CDC, OFRD, SAMHSA
			What VOADs are active in the area and providing services?	OASH-OSG-DCVMRC, ASPR-ABC, ASPR-REC, OFRD, SAMHSA,
6.	Behavioral Health Care	What is the STT or local capacity for behavioral health care?	What surge capacity exists in the behavioral health care system for the short term?	ASPR-REC, CDC, OFRD
			What long term capacity exists for providing care in the behavioral health care system?	ASPR, OFRD, SAMHSA
7.	Behavioral Health Care	What assistance have state officials requested from HHS agencies and partners relevant to behavioral health?	What agency or partner is providing assistance or preparing to provide assistance (e.g., OFRD, ASPR-NDMS, CDC, SAMHSA)?	ASPR-ABC, ASPR-NDMS, CDC, SAMHSA
			What is the status of HHS Programs (SAMHSA, ACF, CDC, IHS, etc.) in the affected area?	ASPR, CDC, IHS, OFRD, SAMHSA
			What is the nature of assistance being provided?	OFRD, SAMHSA, ASPR, CDC
			What capabilities by specialty are required from HHS?	OFRD, ASPR
8.	Behavioral Health Care	What are STT and local capabilities for providing disaster mental health and emergency behavioral health care (e.g., personnel, psychotropic medication, methadone, etc.)?		ASPR-ABC, APSR-REC, OFRD, SAMHSA

9.	Behavioral Health Care	What are STT and local capabilities for behavioral health care (e.g., personnel, disaster behavioral health/psychological support, treatment, psychotropic medication) and social services?		ASPR-ABC, SAMHSA
10.	Behavioral Health Care	What is the status of the need for behavioral health support to any Federal Medical Stations?		ASPR-ABC, ASPR-NDMS, OFRD
11.	Behavioral Health Care	What behavioral health assets can HHS OPDIVS and ESF #8 partners roster and deploy?		OASH-OSG-DCVMRC, ASPR-NDMS, FOH, OFRD
12.	Behavioral Health Care	What behavioral health care response assets have deployed, including assessment teams or subject matter experts to the IRCT, etc.?	What HHS behavioral health assets have been deployed and what is their mission?	ASPR-NDMS, FOH, OFRD
			What other federal behavioral health assets are providing assistance and what is the nature of the assistance?	ASPR-ABC, OFRD
				ASPR-ABC, OFRD
13.	Behavioral Health Care	What is the plan for transitioning behavioral health care back to the state and local communities, affected workplaces, and/or coordinated disaster recovery efforts as appropriate?		ASPR-NDMS, ASPR-Recovery, FOH, SAMHSA
14.	Human Services and Disaster Case Management (DCM)	What is the status of social services and disaster case management in the affected area?	What human services are available?	ACF
			Has DCM been request by the STT and approved by DHS-FEMA?	
			Has DHS-FEMA issued a mission assignment for DCM or approved a state-requested DCM Grant?	

15.	All Responders	What procedures are in place to monitor the physical and behavioral health and well-being of workers; perform field investigations and studies to address worker health and safety issues; and provide technical assistance and consultation on worker health and safety measures and precautions?		CDC, OFRD
16.	HHS Responders	What is the plan to ensure behavioral health force protection for HHS responders (e.g., orientation, educational materials, support in theater, end-of-mission re-entry support, and follow-up)?	What EAP Services are available and have responders been told how to access them?	ASPR-ABC, ASPR-NDMS, FOH
17.	Surveillance	What social indicators can be tracked to assess community distress and/or resilience (e.g., domestic violence shelter populations, school absences, child abuse reports)?		ASPE, CDC, SAMHSA

Appendix C: HHS OPDIVs and STAFFDIVs

This Appendix briefly describes the missions of HHS OPDIVs, STAFFDIVs, and Sub-divisions and, where appropriate, outlines their activities in emergency preparedness, response, and recovery. A complete organizational chart of HHS divisions is at http://www.hhs.gov/about/orgchart/.

HHS OPDIVs

Administration for Children and Families (ACF)
ACF provides national leadership and direction for planning, managing, and coordinating the nationwide administration of comprehensive and supportive programs for vulnerable children and families. It oversees and finances a broad range of programs, carried out by STT and local governments and by public and private local agencies, for children and families, including unaccompanied youth, victims of domestic violence, Native Americans, persons with developmental disabilities, refugees, and other vulnerable populations.. ACF coordinates many key HHS human services programs with implications for psychosocial risk mitigation, service access, and provision of services to at-risk populations.

The Office of Human Services Emergency Preparedness and Response (ACF-OHSEPR), located within the Immediate Office of the Assistant Secretary for Children and Families, coordinates ACF policy, planning, and response across the emergency management cycle. ACF, through ACF-OHSEPR, leads the ESF #6 Human Services response for HHS. ACF-OHSEPR coordinates emergency preparedness and response activities and plans linking ACF Central and Regional Program Offices, Regional Administrators, and Regional Emergency Management Specialists, as well as external partners such as ASPR-ABC, DHS-FEMA, ARC, and national VOADs. In partnership with ASPR-ABC, ACF-OHSEPR leads the Human Services Group, which serves as a coordinating and policy advisory body for HHS. During a disaster, ACF-OHSEPR focuses on human services response and program coordination in the Regions.

A number of ACF programs fund grantee operations that can provide assistance with behavioral health and other issues arising during and after a disaster. These programs include the Office of Child Care, Temporary Assistance for Needy Families, Head Start, the Child Care and Development Fund, Family Violence Prevention and Services, Domestic Violence Coalitions Grants, Child Support Enforcement, Community Services Block Grants, Social Services Block Grant, the Maternal, Infant, and Early Childhood Home Visiting Program (in collaboration with HRSA), Job Opportunities for Low-Income Individuals, Refugee Resettlement program, the Anti-Trafficking In Persons program, the Runaway and Homeless Youth Street Outreach Program, and the Low-Income Home Energy Assistance Program.ACF conducts surveillance through its Family Violence Prevention and Services Program, which monitors the National Domestic Violence Hotline and maintains contact with family violence service agencies, to identify increases in domestic violence behaviors caused by disasters and public health emergencies.

Administration on Aging (AoA)
AoA's mission is to develop a comprehensive, coordinated and cost-effective system of home and community-based services that helps elderly individuals maintain their health and independence in their homes and communities. AoA works with ACF-OHSEPR and ASPR-ABC to develop and review STT and local emergency response plans and coordinate ESF #8 and ESF #6 activities, and assists HHS OPDIVs and STAFFDIVS to help ensure that the behavioral health and functional needs of at-risk individuals, particularly senior citizens and persons with disabilities, are being addressed. AoA partners in emergency preparedness, response, and recovery activities with 56 state and territory agencies on aging, 244 tribal organizations, 629 area agencies on aging, and nearly 20,000 community-based service providers.

Agency for Healthcare Research and Quality (AHRQ)
AHRQ's mission is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. Information from AHRQ's research helps people make more informed decisions and improve the quality of health care services.

Agency for Toxic Substances and Disease Registry (ATSDR)
ATSDR exists to promote healthy and safe environments and prevent harmful exposures. ATSDR's functions include public health assessments of waste sites, health consultations concerning specific hazardous substances, health surveillance and registries, response to emergency releases of hazardous substances, applied research in support of public health assessments, information development and dissemination, and education and training concerning hazardous substances.

Centers for Disease Control and Prevention (CDC)
CDC's mission is to collaborate to create the expertise, information, and tools that people and communities need to protect their health—through health promotion, prevention of disease, injury and disability, and preparedness for new health threats. CDC conducts numerous scientific activities, including surveillance, prevention research, and health promotion, addressing mental and behavioral health. CDC collaborates with other federal agencies through the NBSB, the Federal Executive Steering Committee on Mental Health and the Federal Senior Partners Work Group established by the President's New Freedom Commission on Mental Health, event-specific projects, and operational exercises and drills. CDC's multidisciplinary Mental Health Work Group and the Disaster Surveillance Work Group (DSWG) provide scientific consultation and collaboration across centers.

CDC conducts field epidemiologic investigations for emerging public health threats at the request of STT and local health authorities. These may include needs assessments at jurisdictional levels, for specific workforces, or through points of health care service delivery for disaster-affected populations. The size and scope of these studies depends on the nature of the public health threat, source of tasking, and available resources.

CDC manages a number of national and state-based health surveillance systems that provide several classes of information regarding mental health: estimates of the prevalence of diagnosed mental illness based either on self-report or recorded diagnoses; estimates of symptoms associated with mental illness; and estimates of the impact of mental illness on health-related quality of life and related domains (e.g., social support). These systems may be tailored, in cooperation with STT

partners, for special studies of mental and behavioral health at the state and local levels. For example, CDC population-based surveys (e.g., Behavioral Risk Factor Surveillance System, National Health Interview Survey, National Health and Nutritional Examination Survey, and Pregnancy Risk Assessment Monitoring System) collect information concerning occurrence of mental illnesses, access to and utilization of health care, and occurrence of comorbid conditions. CDC health care surveys of inpatient and outpatient health care providers provide information on patients' diagnoses, including mental illnesses, and health care use (e.g., National Ambulatory Medical Care Survey, National Hospital Ambulatory Medical Care Survey, National Hospital Discharge Survey, and National Nursing Home Survey). CDC's DSWG represents CDC's effort to coordinate federal, STT and local disaster surveillance activities. DSWG is charged with developing guidelines and tools for morbidity disaster surveillance, which it does through the provision of technical assistance, the expansion and evaluation of surveillance tools, and development of methods and guidance to improve situational awareness and response.

To ensure that behavioral health and at-risk individual needs are being addressed, CDC participates in the NRF National Planning Scenarios, ESF #8, and CDC Emergency Operations Center preparedness document development (CONOPS, SOPs, Playbooks, exercises); contributes to numerous federal disaster plans, public and professional guidance, scientific and lay publications, and legislation; and participates in related interagency workgroups, professional conferences, and expert panels. CDC's School of Preparedness and Emergency Response offers training in terrorism preparedness and emergency response to CDC employees and contractors. CDC's Public Health Readiness Certificate Program offers mental health modules related to emergency response. CDC's Preparedness and Emergency Response Research Centers (PERRCs) conduct research to evaluate the structure, capabilities, and performance of public health systems for preparedness and emergency response. CDC has flexibility to redirect PERRC activities to the particular needs of an active disaster response.

Centers for Medicare and Medicaid Services (CMS)

CMS administers all aspects of the Medicare, Medicaid and Children's Health Insurance programs (CHIP). Mental and behavioral health are included in these services. CMS supports emergency preparedness and response by helping to ensure that strategies are in place for the delivery of safe and high quality health care during disasters, pandemics and other emergencies. The CMS Medicare program will continue to provide all necessary services, including long-term care, managed care, integrated care for dual eligibles, rehabilitation, and other covered behavioral health and/or primary care services. The CMS State Medicaid and CHIP agency partners will help states to provide all the foregoing services, as well as case management services in concert with necessary Medicaid and CHIP services in a state's approved Medicaid and/or CHIP State Plan.

Food and Drug Administration (FDA)

FDA is responsible for protecting the public health by assuring the safety, efficacy and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics, and products that emit radiation. FDA is also responsible for advancing the public health by helping to speed innovations that make medicines more effective, safer, and more affordable and by helping the public get the accurate, science-based information they need to use medicines and foods to maintain and improve their health. FDA also has responsibility for regulating the manufacturing, marketing and distribution of tobacco products to protect the public health and to

reduce tobacco use by minors. Finally, FDA plays a significant role in the Nation's counterterrorism capability. FDA fulfills this responsibility by ensuring the security of the food supply and by fostering development of medical products to respond to deliberate and naturally emerging public health threats.

Health Resources and Services Administration (HRSA)

HRSA is the primary federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable. HRSA's grant programs support community-based behavioral health care provision, which contributes to community resiliency. HRSA's Office of Emergency Preparedness and Continuity of Operations (EPCO) leads HRSA's efforts in preparing for, responding to, and recovering from emergent and public health events. EPCO maintains situational awareness regarding the effect of emergent and public health events on grantees who deliver behavioral health services and coordinates information exchange among HRSA, ASPR, and other stakeholders. EPCO also provides technical assistance to grantees regarding federal disaster assistance programs. HRSA's network of community-based service delivery grantees and nongovernmental organizations is capable of exchanging information that contributes to the community's resilience and behavioral health response and recovery.

Indian Health Service (IHS)

As the principal federal health care provider and health advocate for American Indians and Alaska Natives, the IHS provides a comprehensive health service delivery system for approximately 1.9 million American Indians and Alaska Natives belonging to 564 federally recognized tribes in 35 states. These services are provided directly by IHS as well as by tribes themselves. Currently, over half of the overall national services are provided by tribes via contracts and compacts authorized under Indian Self Determination laws and precedents. IHS is a direct response partner for emergencies and disasters across the tribal communities it serves. IHS services units and its hospitals, clinics, and health stations are engaged in integrated disaster preparedness, response, and recovery activities and services. IHS also assists its tribal partners by providing emergency and disaster services in contracted or compacted tribal programs and reservations and communities.

National Institutes of Health (NIH)

NIH's broad mission is to seek fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce the burdens of illness and disability. Disaster behavioral health falls within that mission. The National Institute of Mental Health and several other NIH Institutes participate in a number of HHS and inter-agency coordination activities, such as the White House Pandemic Psychological Support Working Group, ASPR-NBSB, HHS Disaster Behavioral Health Concept of Operations Working Group, VA National Center for Post-Traumatic Stress Disorder (NCPTSD) Scientific Advisory Board, and the VA-NCPTSD Educational Advisory Board. NIH Institutes also periodically engage service components of the federal government (e.g., SAMHSA, DHS-FEMA), state government agencies, professional organizations, scientific organizations and others to refine NIH research priorities in this area.

NIH supports research on disaster behavioral health without a specialized funding announcement. Proposals can be submitted under any appropriate NIH unsolicited parent grant announcements. NIH may also encourage research through funding announcements targeting specific disaster events or by

issuing specific funding requests for research on behavioral health responses to disaster. Previously, NIH has funded a Disaster Mental Health Research Center, one example of disaster mental health research.

Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. Its work aims to help people with mental and substance abuse disorders and their families, build and support strong communities, prevent costly and painful behavioral health problems, and promote better health and functioning for all Americans. SAMHSA's Emergency Operation is always activated and routinely functions in an awareness and monitoring posture. When an incident occurs with the potential to overwhelm STT behavioral health resources, SAMHSA Emergency Operations utilizes ICS to coordinate SAMHSA resources and steady state programming (e.g., National Child Traumatic Stress Network, Suicide Prevention Lifeline) to meet requests for assistance. SAMHSA maintains close linkages with STT behavioral health partners and engages in preliminary needs assessments throughout the response period.

SAMHSA's response role focuses on coordination, communication, collaboration, and consultation among federal response efforts, response partners, STT and local communities, and the general public. Communication and information dissemination with the public, responders and professional communities is accomplished through multiple mechanisms, including SAMHSA's website and materials warehouse. Technical Assistance and Consultation is supplemented with the efforts of the SAMHSA Disaster Technical Assistance Center (DTAC). When Stafford Act declarations with Individual Assistance are approved, SAMHSA's roles are exercised through DHS-FEMA CCP grants designed to support local efforts in mitigating the behavioral health impact of disasters. SAMHSA works with DHS-FEMA to ensure that crisis counseling services are available to affected communities in a timely and responsible way, ensuring a culturally competent and locally driven program.

CCP consists of two grant programs: Immediate Services Program (ISP; 60 days in duration) and Regular Services Program (RSP; 9 months in duration). The CCP strives to:

- Reach large numbers of people affected by disasters through face-to-face outreach to shelters, homes, and other locations;
- Assess the emotional needs of survivors and make referrals to traditional behavioral health services when necessary;
- Identify tangible needs and link survivors to community resources and disaster relief services;
- Provide emotional support, education, basic crisis counseling, and connection to familial and community support systems;
- Train and educate CCP staff and other community partners about disaster reactions, appropriate interventions, and CCP services;
- Develop partnerships with local disaster and other organizations;
- Work with local stakeholders to promote community resilience and recovery capabilities;
- Collect and evaluate data to ensure service quality and justify program efforts; and
- Leave behind a permanent legacy of improved coping skills, educational and resource materials, and enhanced community linkages.

When disaster related behavioral health needs overwhelm STT behavioral health response systems and no other resources are available, SAMHSA has authority to redirect discretionary program funding to provide, under very strict guidelines, SAMHSA's Emergency Response Grants (SERG). SERGs are designed to meet local emergency substance abuse and mental health needs for primary victims and their families. The SERG program does not have a specific appropriation. Instead, funds are tapped from existing discretionary programs but cannot exceed 2.5 percent of all amounts appropriated in a fiscal year, no matter the level of response. SERG monies are considered "funds of last resort" and cannot supplant or replace other existing funds. As the transition to recovery unfolds, SAMHSA provides technical assistance and ongoing programmatic support.

SAMHSA's Disaster Distress Helpline (DDH) is a confidential and multilingual, 24/7 crisis support service offered via telephone (1-800-985-5990) and SMS/Text ('TalkWithUs' to 66746), and is available to U.S. residents who are experiencing psychological distress as a result of a disaster. This toll-free line and SMS service is answered by trained crisis counselors who connect callers with local resources related to or specific to any natural or man-made disaster, incident of mass violence, or any other Federally-declared or non-declared disasters within the United States and its territories. Maintaining the DDH in a perpetually active state with the same telephone and SMS numbers will ensure that an infrastructure is in place to handle any call volume surges and help guarantee that DDH center staff is up-to-date with respect to resources, public messaging, social media outreach and training.

HHS STAFFDIVs

Center for Faith-Based and Neighborhood Partnerships (CFBNP)
CFBNP leads HHS efforts to build and support partnerships with faith-based and community organizations in order to better serve individuals, families, and communities in need.

Departmental Appeals Board (DAB)
DAB provides administrative review and alternative dispute resolution services for disputes involving HHS programs.

Federal Occupational Health (FOH)
FOH provides occupational health and wellness services to federal employees. It works in partnership with federal organizations nationally and internationally to design and deliver comprehensive solutions to meet their occupational health needs. The emergency response services of the FOH Employee Assistance Program (EAP) and Work/Life Program are provided for federal employees (and their family members) of agencies having an Interagency Agreement with FOH to provide such services. The FOH EAP assists agencies in planning for crisis and emergency events, and responding to the mental health needs of covered people both during and after disaster events. Its services include consultations, emotional first aid, stress management, and meetings with witnesses, survivors, or co-workers to gather facts and assist with individuals' emotional needs. The FOH EAP has a special agreement with DHS-FEMA to provide stress counseling and other mental health services for DHS-FEMA response workers at designated disaster response sites. The FOH Work/Life program assists affected employees and family members with information and practical support in

stabilizing employee and family situations or dealing with the consequences of disaster (e.g., home relocation and repair, articles, guide books, Emergency Plan Cards for the entire family, resources that could assist with locating missing loved ones, links to organizations accepting donations, etc). Of note, some HHS responders may receive EAP and Work/Life services from providers other than FOH; it is best to check with the appropriate HR offices to verify coverage.

Office of the Assistant Secretary for Administration (ASA)
ASA provides leadership for HHS departmental administration, including human resource policy, information technology, and departmental operations.

Office of the Assistant Secretary for Financial Resources (ASFR)
ASFR provides advice and guidance to the Secretary of HHS on all aspects of budget, financial management, and grants and acquisition management. It also helps direct and implement activities related to these responsibilities across the Department.

Office of the Assistant Secretary for Health (OASH)
OASH, formerly the Office of Public Health and Science, oversees 14 core public health offices. OASH is the principal advisor to the Secretary of HHS on all matters related to public health. OASH directs the Office of the Surgeon General in its management of U.S. Public Health Service (USPHS) Commissioned Corps officers and coordination of the Medical Reserve Corps Program. OASH also directs the activities of the Regional Health Administrators, who are responsible for building relationships with STT and local public health and medical officials, as well as other federal departments within each of the 10 USPHS regions.

OASH Office of the Surgeon General Office of the Civilian Volunteer Medical Reserve Corps (OASH-OSG-DCVMRC)
The Medical Reserve Corps was founded as a Presidential initiative in 2002 and codified by the Pandemic and All Hazards Preparedness Act (PAHPA) in 2006. The OASH-OSG-DCVMRC is a national network of local groups of volunteers committed to improving the health, safety and resiliency of their communities. OASH-OSG-DCVMRC volunteers include medical, public health and behavioral health professionals, as well as others interested in strengthening the public health infrastructure and improving the preparedness and response capabilities of their local jurisdictions. OASH-OSG-DCVMRC units identify, screen, train and organize the volunteers, and use them to support routine public health activities and augment preparedness and response efforts—primarily at the local level.

The OASH-OSG-DCVMRC staff maintains a roster of OASH-OSG-DCVMRC members who indicate that they are willing, able, and approved to support a national/federal-level response. Typically, volunteer members of the OASH-OSG-DCVMRC constitute a local asset, but members who are willing, able, and approved may be federally deployed to respond outside their jurisdiction as part of the federal response to a disaster or public health emergency. These OASH-OSG-DCVMRC members would be deployed by ASPR as unpaid temporary federal employees. During a response, OASH-OSG-DCVMRC units can address behavioral health issues at the STT level, depending on local needs and OASH-OSG-DCVMRC unit capability.

OASH-OSG-DCVMRC provides its partners, stakeholders, and response assets with education and guidance to assist with the implementation of policies and practices addressing the functional needs of at-risk individuals (including children), the behavioral health needs of disaster survivors and responders, and community resilience. OCVMRC also helps STT partners facilitate information collection as they transition from response to recovery.

OASH Office of Force Readiness and Deployment (OFRD)

OASH-OFRD manages USPHS disaster response teams, which provide a wide range of behavioral health services in emergencies and large scale disasters. USPHS officers are capable of deploying directly to assist STT, local, and multilateral resources in responding to a range of disaster and emergency responses. USPHS teams are organized into a 4-tiered system of response assets with different missions, compositions, and expected response times. Tier 1 teams are expected to respond within 12 hours of activation; Tier 2 teams will respond within 36 hours of activation; and Tier 3 will respond within 72 hours of activation. Other tiers will augment existing teams as needed.

Tier 1 includes regional Incident Response Coordination Teams (IRCT), activated by HHS, and five Rapid Deployment Force Teams (RDF). An IRCT provides command and control management support for all deployed OFRD assets (RDF and the Mental Health and Applied Public Health Teams, described below). Operating under National Incident Management System (NIMS) principles, the IRCT delivers mission assignments to the appropriate response teams. The RDF mission is to provide primary medical care, mental health care, and public health services for a sheltered population. Each RDF, composed of 105 officers, can provide high quality care to stabilize and improve the health of up to 250 sheltered special needs residents, as well as provide social service teams to empower residents to successfully re-integrate themselves back into their communities.

Tier 2 includes Applied Public Health Teams (APHT) and Mental Health Teams (MHT). There are five APHTs, each composed of 47 officers, and five MHTS, each composed of 26 officers. They are virtual teams, in that their personnel consists of PHS officers stationed in a variety of locations across the country. The APHT mission is to help a community and its population re-establish essential public health services during a major disaster or emergency when local resources are overwhelmed or non-existent. APHTs report directly to the ICRT, but their role is primarily coordinated through the Director of CDC. The APHTs provide expertise in public health assessment, environmental health, infrastructure integrity, food safety, vector control, epidemiology and surveillance. Each APHT will be capable of replacing or augmenting a decimated county health department and providing comprehensive technical support to regional, STT, and local public health authorities to meet the basic public health needs of the affected community.

The five MHTs are the principal response capability for behavioral health, but other teams may also provide a range of supporting services. They are self-contained and configured to work as a team or be subdivided into sub-teams, as needed. Team members include mental health providers (such as clinical psychologists, social workers, and psychiatrists), incident response team members, and support for logistics, information technology, and communications. The structures and methods to accomplish a given mission would be formulated by the teams themselves in collaboration with behavioral and disaster response systems already in place. Based on mission objectives, the MHT will develop and implement IAPs for its mission assignments. MHT capabilities include assessment of

anticipated behavioral health consequences of a disaster; identification of survivors and responders needing referral to available community services; behavioral epidemiology to identify high-risk populations; public behavioral health collaboration and consultation with local personnel and systems to assess community needs, develop action plans and referral programs, and bolster overwhelmed local resources. Direct services that MHTs can provide include crisis intervention, psychological first aid, and triage; screening and assessment of individuals for a variety of conditions, including those presenting acute danger, and intervention for individuals with serious mental illness or substance abuse disorder until local resources become available.

Tier 3 consists of active duty USPHS commissioned corps officers not assigned to Tier 1 or 2 teams and not deemed mission critical by their OPDIV or STAFFDIV.

Tier 4 consists of the USPHS Ready Reserve Corps.

Office of the Assistant Secretary for Legislation (ASL)
ASL serves as the primary link between HHS and Congress. It is responsible for the development and implementation of the Department's legislative agenda.

Office of the Assistant Secretary for Planning and Evaluation (ASPE)
ASPE advises the HHS Secretary on policy development in health, disability, human services, data, and science, and provides advice and analysis on economic policy. ASPE leads special initiatives, coordinates the Department's evaluation, research, and demonstration activities, and manages cross-Department planning activities such as strategic planning, legislative planning, and review of regulations. Integral to this role, ASPE conducts research and evaluation studies, develops policy analyses, and estimates the cost and benefits of policy alternatives under consideration by the Department or Congress.

Office of the Assistant Secretary for Preparedness and Response (ASPR)
ASPR (formerly the Office of Public Health Emergency Preparedness) was created by PAHPA to lead the nation in preventing, preparing for, and responding to the adverse health effects of public health emergencies and disasters. ASPR focuses on preparedness planning and response; building federal emergency medical operational capabilities; research, advanced development, and procurement of countermeasures; and grants to strengthen the capabilities of hospitals and health care systems in public health emergencies and medical disasters.

During an emergency or disaster, ASPR provides federal support, including deployment of medical professionals through ASPR's National Disaster Medical System (ASPR-NDMS), to augment state and local capabilities. The ASPR serves as the principal advisor to the Secretary of HHS on all matters related to federal public health and medical preparedness and response for public health emergencies. On behalf of the Secretary, the ASPR coordinates the federal health and medical services support functions during a public health emergency. ASPR maintains Regional Emergency Coordinators (ASPR-RECs) in each of the country's 10 disaster planning regions. ASPR-RECs monitor emerging public health concerns, including behavioral health, and provide consultation and technical assistance to STT, local, and private sector authorities. ASPR administers the Hospital Preparedness Program (HPP), which provides leadership and funding through grants and cooperative agreements to

states, territories, and eligible municipalities to improve surge capacity and enhance community and hospital preparedness for public health emergencies. HPP may be used to support behavioral health activities as part of overall hospital preparedness.

ASPR Office of Policy and Planning, Division for At-Risk Individuals, Behavioral Health and Community Resilience (ASPR-ABC)

ASPR-ABC provides its partners, stakeholders, and response assets with subject matter expertise, education, and coordination to ensure that behavioral health issues and the needs of at-risk individuals (including children) are integrated into public health and medical emergency preparedness, response, and recovery activities. During a response, ASPR-ABC is part of the ASPR EMG and supports the ESF #8 mission by maintaining situational awareness and analysis, identifying emerging trends, vetting action requests and mission assignments, responding to requests for information, and providing input to ESF #8 situation reports and IAPs. Central to ASPR-ABC's role is coordinating communication and collaboration among federal partners engaged in emergency related behavioral health activities. ASPR-ABC works closely with ACF-OHSEPR to coordinate activities crossing ESF #8 and ESF #6 and also works with partners to facilitate the transition from response to recovery regarding behavioral health, at-risk individuals, and community resilience issues.

ASPR National Disaster Medical System (ASPR-NDMS)

ASPR-NDMS is a federally coordinated system that augments the nation's medical response capability. The overall purpose of ASPR-NDMS is to supplement an integrated national medical response capability for assisting STT and local authorities in dealing with the medical impacts of major disasters and to provide support to the military and VA medical systems in caring for casualties evacuated back to the United States from overseas armed conventional conflicts.

ASPR-NDMS has three major activities under ESF #8:

- Emergency medical and/or mortuary response, providing medical and/or mortuary teams, equipment, and supplies to a disaster area when local medical resources are overwhelmed;
- Movement of ill and injured patients from a disaster area to unaffected areas;
- Arranging for definitive care of disaster-affected patients at hospitals in areas unaffected by the disaster.

ASPR-NDMS consists of response teams, each with a particular focus:

- 52 Disaster Medical Assistance Teams (DMAT) provide multidisciplinary medical care;
- 10 Disaster Mortuary Response Teams (DMORT) provide victim identification and mortuary services;
- 1 Family Assistance Center Team (FACT) supports the medical examiner/coroner and law enforcement by collecting ante mortem data from families;
- 3 International Medical Surgical Response Teams (IMSURT) provide surgical and critical care;
- 3 National Medical Response Teams (NMRT) provide mass decontamination and medical care to victims of a release of a weapon of mass destruction or a large scale release of hazardous materials.

- 5 National Veterinary Response Teams (NVRT) provide veterinary medicine during a disaster or public health emergency;

The mission of ASPR-NDMS behavioral health is to enhance the effectiveness of its response teams by protecting the psychological, cognitive, and social health of team members. ASPR-NDMS mental health providers may also provide acute, emergency mental health services to civilians being served in federal medical stations and other service locations as part of an interdisciplinary DMAT. However, their primary role is to provide behavioral health force protection for ASPR-NDMS responders.

Office of the Assistant Secretary for Public Affairs (ASPA)
ASPA supports HHS through its handling of media affairs, including Freedom of Information Act and privacy concerns, and through its Policy and Strategy branch, which deals with communication and outreach related to health information.

Office for Civil Rights (OCR)
OCR is the civil rights and health privacy rights law enforcement agency for HHS. In addition to investigating complaints and enforcing rights, it promulgates regulations, develops policy, and provides technical assistance and public education to ensure understanding of and compliance with non-discrimination and health information privacy laws on a range of issues. OCR teaches health and social service workers about civil rights, health information privacy and patient safety confidentiality laws and educates communities about civil rights and health information privacy rights.

Office on Disability (OD)
OD's mission is to oversee the implementation and coordination of programs and policies that enhance the health and well-being of people with disabilities. OD's operational priority in a response is to work with national and local behavioral health disability rights leaders and other agencies across HHS to ensure that rights and safeguards are met. OD maintains a contact list and relationships with behavioral health disability consumer advocacy and rights groups throughout the country, which it uses to disseminate disaster behavioral health information and planning guidance to assist in any response effort.

Office of the General Counsel (OGC)
OGC is the legal team for HHS, providing representation and legal advice for the Department and supporting the development and implementation of HHS programs. Among its many activities, OGC reviews proposed regulations and legislation affecting significant issues of health and human services, and provides advice in areas including privacy of medical records, civil rights, bioterrorism, emergency response, and refugee resettlement.

Office of Global Health Affairs (OGHA)
OGHA is responsible for ensuring a centralized approach to all international matters in several areas. OGHA coordinates technical and policy-related input from HHS in international humanitarian issues and international and domestic refugee health issues. When behavioral health concerns arise as part of international activities, OGHA coordinates with relevant HHS entities, such as ASPR, SAMHSA and CDC, to advise on and address these concerns; in particular, OGHA can make use of international

governmental and interagency relationships to connect HHS response team members with appropriate foreign and U.S. government representatives.

Office of Health Reform (OHR)
OHR, established in May 2009, leads HHS efforts on health care reform in close coordination with the White House.

Office of the Inspector General (OIG)
OIG carries out audits, investigations, and evaluations to protect the integrity of HHS programs as well as the health and welfare of the beneficiaries of those programs. It reports program and management problems to the Secretary of HHS and to Congress, along with recommendations to correct them.

Office for Intergovernmental Affairs (IGA)
IGA facilitates communication between HHS and state, tribal, and local governments. It both represents state and tribal perspectives in the federal policymaking process and clarifies the federal perspective to state and tribal representatives.

Office of Medicare Hearings and Appeals (OMHA)
OMHA is responsible for Level 3 of the Medicare claims appeal process, and certain other appeals.

Office of Security and Strategic Information (OSSI)
OSSI supports OPDIV and STAFFDIV components in physical and personnel security and strategic information.

Appendix D: Web Resources

WEB SITES

- **HHS Assistant Secretary for Preparedness and Response (ASPR**)
  http://publichealthemergency.hhs.gov/preparedness/pages/default.aspx
- **ASPR Division for At-Risk Individuals, Behavioral Health, and Community Resilience (ASPR-ABC)**
  http://publichealthemergency.hhs.gov/preparedness/planning/abc/Pages/default.aspx
- **Centers for Disease Control and Prevention (CDC) Emergency Preparedness and Response Page**
  http://emergency.cdc.gov/
- **National Library of Medicine**
  http://www.nlm.nih.gov/medlineplus/
    - **Coping With Disasters**
      http://www.nlm.nih.gov/medlineplus/copingwithdisasters.html
    - **Post-Traumatic Stress Disorder (PTSD)**
      http://www.nlm.nih.gov/medlineplus/posttraumaticstressdisorder.html
    - **Disaster Information Management Research Center (DIMRC)**
      http://disasterinfo.nlm.nih.gov/
- **Substance Abuse and Mental Health Services Administration (SAMHSA) Coping with Traumatic Events Page**
  http://www.samhsa.gov/trauma/index.aspx
- **SAMHSA Disaster Technical Assistance Center (DTAC)**
  http://www.samhsa.gov/dtac/
- **SAMHSA National Child Traumatic Stress Network (NCTSN)**
  http://www.nctsnet.org/
- **SAMHSA After the Crisis Initiative: Healing from Trauma after Disaster Resource Page**
  http://gainscenter.samhsa.gov/atc/text/papers/trauma_paper.htm

FACT SHEETS

- **ACF Disaster Case Management Program (DCMP)**

The Disaster Case Management Program augments state and local capacity to provide disaster case management services in the event of a major disaster declaration which includes Individual Assistance. This fact sheet explores the options states may exercise in implementing the Disaster Case Management Program. http://www.acf.hhs.gov/ohsepr/dcm/docs/dcm_factsheet.pdf

- **At-Risk Individuals (ASPR-ABC)**

At-risk individuals have needs in one or more of the following functional areas: communication, medical care, maintaining independence, supervision, and transportation. This fact sheet defines "at-risk individuals" and their needs before, during and after an emergency.
http://www.phe.gov/Preparedness/planning/abc/Documents/AtRisk.pdf

- **Disaster Behavioral Health (ASPR-ABC)**

This fact sheet highlights behavioral health concerns affecting survivors/responders and the need for disaster behavioral health capabilities.
http://www.phe.gov/Preparedness/planning/abc/Documents/DisasterBehavioralHealth.pdf

- **Disaster Behavioral Health Capacity Assessment (ASPR-ABC)**

This tool serves as a template for a behavioral health organizational assessment that organizations may opt to use or adjust to identify disaster behavioral health capacity and gaps. The tool was developed during a September 2009 meeting convened by ASPR where representatives from each state in Region I (New England) met with federal representatives to discuss current disaster behavioral health capacity in that region.
http://www.phe.gov/Preparedness/planning/abc/Documents/DisasterBHCapacityTool.pdf

- **Domestic Violence and Disasters Specialized Resource Collection**

This collection of fact sheets and resources highlights the disproportionate vulnerability of women and children to domestic and sexual violence in disaster and emergency situations, and organizes information to help increase the safety and well-being of those at higher risk for violence (or re-traumatization) during and after a major disaster or crisis. This special collection was developed by the National Resource Center on Domestic Violence in consultation with the National Sexual Violence Resource Center, the Alabama Coalition Against Domestic Violence, the Florida Coalition Against Domestic Violence, and the Family Violence Prevention and Services Program Office of the Department of Health and Human Services.
http://www.vawnet.org/special-collections/DisasterPrep.php

- **Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP)**

ESAR-VHP is a national network of state-based systems, which verifies the identity and credentials of health professionals. This fact sheet explains and addresses the need for an ESAR-VHP program and defines the mission of the program.
http://www.phe.gov/esarvhp/pages/about.aspx

- **Family Violence Prevention and Services Act (FVPSA)**

FVPSA provides the primary federal funding stream dedicated to the support of emergency shelter and related assistance for victims of domestic violence and their dependents. FVPSA is located in the Family and Youth Services Bureau (FYSB), a division of the Administration on Children, Youth and Families in the Administration for Children and Families. Through the FVPSA Program (FVPSP), FYSB administers FVPSA formula grants to States, Territories and Tribes, State domestic violence coalitions, and national and special-issue resource centers.
http://www.acf.hhs.gov/programs/fysb/content/docs/FVPSA_program_summary.pdf

- **Federal Occupational Health (FOH) Employee Assistance Program**

The FOH Emergency Preparedness and Response Services fact sheet describes employee services and highlight some of the comprehensive emergency response services available to employees and their families. http://www.foh.dhhs.gov/library/factsheets/emergfactsheet.pdf

- **Force Readiness and Deployment**

This fact sheet describes resources and assistance the U.S. Public Health Service Service Access Team provides to local health authorities in response to public health emergencies and urgent health needs arising from major disasters or other events.
http://ccrf.hhs.gov/ccrf/FactSheets/SAT_Fact_Sheet_FINAL.pdf

- **Medical Reserve Corps (OASH-OSG-DCVMRC)**

This fact sheet defines the role of the OASH-OSG-DCVMRC, its volunteers, and how it can benefit local communities.
http://www.medicalreservecorps.gov/File/MediaKit/MediaKit_FactSheet_English_2007.pdf
Another fact sheet describes the OASH-OSG-DCVMRC Federal Deployment Cadre.
http://www.medicalreservecorps.gov/searchFldr/search?subSearch=MRCDeployment/FAQ/Training

- **National Domestic Violence Hotline**

The National Domestic Violence Hotline is a 24-hour, confidential, toll-free hotline. Hotline staff immediately connect the caller to a service provider in his or her area. Highly trained advocates provide support, information, referrals, safety planning, and crisis intervention in 170 languages to hundreds of thousands of domestic violence victims. 800-799-SAFE (7233)
http://www.thehotline.org/

- **Pet Owners**

Planning for the safe evacuation and/or care of the animals that are an important part of many individual's and families' lives enhances overall well-being in the event of a disaster. These fact sheets provide pet owners with information on planning for pet disaster needs, preparing to shelter a pet, and recommendations for during and after a disaster.

  - Red Cross Pets and Disaster Safety Checklist
    http://www.redcross.org/www-files/Documents/pdf/Preparedness/checklists/PetSafety.pdf
  - DHS-FEMA Information for Pet Owners
    http://www.fema.gov/plan/prepare/animals.shtm#3

- **SAMHSA Crisis Counseling Assistance and Training Program (CCP)**

CCP assist individuals and communities in recovering from the effects of natural and human-caused disasters through the provision of community-based outreach and psychoeducational services. This fact sheet provides a brief overview of the CCP program, key principles of the program, and a link to the CCP application toolkit. http://www.samhsa.gov/dtac/proguide.asp

- **SAMHSA Disaster Behavioral Health Information Series (DBHIS)**

DBHIS is a collection of resources on numerous subjects, including Children and Youth, Deployed Military Personnel and Their Families, Languages other than English, Older Adults, Persons with Functional and Access Needs, Rural Populations, Tribal Organizations, and many more.
http://www.samhsa.gov/dtac/resources.asp#dbhis

- **The SAMHSA Disaster Kit**

The SAMHSA Disaster Kit along with other disaster related materials can be found at http://store.samhsa.gov/product/SMA11-DISASTER or http://www.samhsa.gov/Disaster/

- **Special Medical Needs Populations (ASPR-ABC)**

This fact sheet defines special medical needs populations.
http://www.phe.gov/Preparedness/planning/abc/Documents/SpecialMedicalNeeds.pdf