Behavioral Health

Regional All-Hazards Surge Response

Planning Guide for Community Mental Health Programs

v.5

NW Oregon Health Preparedness Organization

For
NW Oregon Health Preparedness Organization

Prepared by
J. Olivier & Associates, LLC

REGIONAL ALL-HAZARDS PLANNING GUIDE FOR COMMUNITY MENTAL HEALTH PROGRAMS

An overview of the behavioral health role in a large-scale community incident; includes information pertaining to community impact following disaster, roles/responsibilities of government agencies and community organizations, concept of operations and ongoing planning for community mental health programs

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Emergency Operations Plan Template
A useful guide for those tasked to develop or improve existing behavioral health planning annexes; NIMS-compliant format is designed for incorporation into county emergency plans

Behavioral Health Training Summary
Listing of suggested trainings for community mental health staff; helpful to supervisors assembling department training schedules as well as individuals interested in keeping their skills current

Management Team Prioritization Tabletop
Senior staff practices prioritization of requests for behavioral health resources in this discussion-based tabletop exercise. Sample scenarios are included that may also be utilized in small group trainings during clinical staff meetings

Responder Exercise Evaluation
One-page task list contains activities likely to be assigned to a behavioral health field supervisor and a team of responders. This list may be used as an evaluation tool during an exercise or to assess response during an actual community event.

Just-In-Time Training
Materials developed as a "just-in-time" orientation for an audience of potential behavioral health responders; includes a PowerPoint student handout and script for spontaneous trainers that provide an overview of the following:

- *Module 1: Impact of Disaster*
- *Module 2: Role of Behavioral Health in Disaster*
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Introduction

A major community incident like an earthquake or bioterrorist attack can be overwhelming, traumatic, and occur without warning. A large-scale disaster or major medical emergency may cause widespread stress reactions such as anxiety, anger, fear and frustration that may in turn create a temporary surge in demand for behavioral health services in a community. A major incident* may cause community members to go to local medical centers and seek relief from symptoms that are predominantly psychological in nature. For example, following a 1991 scud missile attack in Israel it was observed that approximately 75% of those seeking assistance in medical centers presented only with problems of a psychological nature. After the 1995 Sarin gas attack in a Tokyo subway, about 75% of those seeking treatment reported they were suffering from exposure but were later found to have had no physical exposure *(Shultz, 2007).* Without proper planning, a community surge in service demand could seriously impair the ability of healthcare professionals to provide adequate levels of care for weeks or perhaps months following a response to a large-scale incident. Behavioral health plays a critical supportive role to the larger public health or emergency management response system.

Behavioral health intervention strategies can reduce community anxiety levels, provide comfort to traumatized individuals, support emergency responders and help restore a community to pre-disaster functioning. At the same time, behavioral health resources can also be organized to address the needs of persons with serious mental illnesses or co-occurring substance use disorders that are receiving or may require immediate behavioral health or medical healthcare services. The nature of an incident influences the duration and severity of psychological distress experienced and the behavioral health response needed. The ability of behavioral health community services to adapt and deliver needed services for the duration of the incident requires thoughtful preparation.

**(NOTE: The term "major incident" is used interchangeably with "disaster", "act of terrorism" or "major medical emergency" throughout this document).*

Purpose & Authority

This regional behavioral health disaster planning guide is intended to be used as part of planning, response and recovery services for the NW Oregon Health Preparedness Organization that comprises Clackamas, Clatsop, Columbia, Multnomah, Tillamook and Washington counties. It has been developed in collaboration with local agencies and their community partners as a guide for providing behavioral health services following a major incident. This document has also been developed in alignment with State of Oregon behavioral health planning documents.

(See http://www.oregon.gov/oha/HSD/AMH/docs/behav-hlth-attachment-f.pdf for more information on statewide planning).

While the regional planning guide is full of helpful information and applicable resources for local entities, its content does not establish requirements that override emergency response plans for local or state mental health authorities.

Regional behavioral health disaster planning considers the needs of a community that may extend beyond county borders and may activate mutual aid agreements as needed from a variety of resources throughout the six counties in the region. In the field of behavioral health, community partners (including county mental health agency staff, hospital behavioral medicine personnel, volunteers at local nonprofit organizations, school personnel and faith-based groups) may not routinely interface in their day-to-day work. However, during a large-scale disaster or major medical emergency it may quickly become critical that all these groups work seamlessly together to provide adequate levels of time-sensitive community services. Proper community-wide planning is critical to a successful coordination of service delivery.

Roles and Responsibilities

Government agencies, community organizations, and interested citizens may all play a role to provide behavioral health services during a major incident in their community.

Federal Government

The Robert T. Stafford Disaster Relief and Emergency Assistance Act established requirements for providing mental health crisis counseling services in human-caused or natural disaster response and recovery. One section of this act specifically addresses the mental health function: *(Oregon 2007)*

The President is authorized to provide professional counseling services, including financial assistance, to state and local agencies or private mental health organizations to provide such services or training of event workers to victims of major events in order to relieve mental health problems caused or aggravated by such major event or its aftermath.

In a Presidential-declared disaster, Federal Emergency Management Agency (FEMA) may assist in assessing mental health needs, provide mental health educational materials, assist in arranging training for disaster workers, assess adequacy of applications for federal crisis counseling grant funds and address worker stress issues and needs. FEMA Crisis Counseling Program (CCP) grants provide funding for immediate and longer term crisis counseling, training, public information, and education for services once the state can document that needs cannot be met with state and local resources. FEMA CCP grants provide psychosocial services and education for individuals who live and work in the disaster area.

The Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services is another federal resource that provides technical assistance for all matters related to behavioral health disaster response through their Disaster Technical Assistance Center (DTAC).

State Government

The Governor of a state may declare a "state of emergency" and request federal assistance. Based on requests submitted through the statewide emergency response system, Oregon Emergency Management (OEM) coordinates the state's use of federal resources.

Oregon Department of Health Services Addiction and Mental Health Division (AMHD) provides oversight and guidance for behavioral health programs at a statewide level as local mental health resources become overwhelmed during a large-scale incident. The state is also responsible for the acquisition, coordination and delivery of federal resources and administers disaster behavioral health services funded by FEMA CCP grants.

The *AMHD Emergency Response Coordinator* holds primary responsibility for developing and implementing an effective statewide plan for behavioral health all-hazards preparedness and response. In the response phase of a major incident, the Oregon AMHD *Behavioral Health Emergency Response Team* (BHERT) assembles and is comprised of members with state decision-making authority who are immediately available by a pager system and can coordinate statewide activities *(Oregon, 2007).*

Regional NW Oregon Health Preparedness Organization (HPO)

An event that spans multiple county jurisdictions may require a regionally coordinated behavioral health response. Regional planning and response does not override authority at the local, state, or federal level; rather, regional efforts provide structure necessary to handle incidents that become increasingly complex as they cross local jurisdictional boundaries. Regional behavioral health planning takes into account best ways to coordinate services through preparedness, response, and recovery phases of a major incident and may involve all community stakeholders. Hospitals are generally organized by hospital preparedness program regions, routinely coordinate services and may share resources during a major event. A regional behavioral health response considers the needs of these medical facilities in its supportive efforts.

Local Government

Each county in Oregon provides local mental health services through a community mental health program (CMHP) that is supported in part by state funds. The community mental health programs in Clackamas, Multnomah, and Washington Counties are a department within the county government structure. Clatsop, Columbia, and Tillamook Counties contract their CMHPs with local behavioral health organizations. All programs are considered to be the local mental health authority (LMHA) mandated to provide crisis behavioral health services for their county *(Oregon, 2001).* During a major incident, LMHAs are responsible for continuing to serve the existing county mental health client population to the extent that this is possible given the scope of the event. A CMHP Director or designated representative leads this service.

During a major incident, a surge in service demand is likely. The LMHA -in addition to serving the existing mental health client population- may also be responsible for assessing the need for behavioral health interventions throughout their entire county. Upon completion of an initial assessment, the LMHA reports their findings to the local

public health authority and/or emergency manager. LMHAs may take the lead in working with their contract agencies and community partners to address an identified surge in service demand and then coordinate the delivery of needed services including the activation of local behavioral health responders. The following list represents six typical functions *(Porter, 2007)* that LMHAs may be called upon to provide during response and recovery phases of a major incident:

1. Maintain services to current clients
2. Crisis intervention for those affected throughout the community
3. Information and education
    a. On disaster stress reactions
    b. On behavioral health resources
    c. To various public media
4. Mutual aid to other agencies
5. Consultation and training
6. Stress management for responders

Table 1 summarizes the role of government levels through each phase of a major incident:

Table 1: Government Roles in Disaster Behavioral Health				
	Federal	**State**	**Regional**	**County/Local**
Prepare Phase	**FEMA** reviews requirements for Crisis Counseling Program **(CCP)** grants and provides trainings for state representatives **SAMHSA** provides disaster technical assistance	**AMHD** builds relationships with state public health officials and local mental health authorities **(LMHAs)** Behavioral Health Emergency Response Team **(BHERT**) training **CCP** application training	Regional **HPO** Coordinator works with local agencies to support community planning, outreach & training; ensure planning is coordinated with AMHD Provide resources and support to strengthen regional relationships; identify & support BH responder training	**CMHPs** coordinate with local public health and community partners; develop database & conduct BH responder training **CMHP** business continuity planning; review disaster plans w/staff Identify potential responder team members and field supervisors
Response Phase	**FEMA** issuance of Crisis Counseling Program (**CCP**) grants to qualifying states **SAMHSA** provides disaster technical assistance	**BHERT** coordinates with local mental health authorities **(LMHA)** **State BH Emergency Response Coordinator** organizes statewide response; applies for FEMA **CCP** grant as needed **State BH Liaison Officer** coordinates incident communication as needed with LMHAs	**LMHAs** may coordinate regional behavioral health response in community **LMHAs** may coordinate regional support of surge in demand for hospital patient and family care **HPO** Coordinator may support application of regional response guidelines **LMHAs** may conduct region wide just-in-time training/orientation of BH responders	**LMHA** is responsible authority for local behavioral health response: • Triage behavioral health needs of existing clientele • Assess community needs • Provide mutual aid • Consultation and training to community organizations and businesses • Manage spontaneous volunteers • Coordinate with **BHERT**
Recovery Phase	**FEMA** issuance of continuing assistance through the **CCP** grants (up to 9 months post disaster)	State oversees FEMA CCP grant delivery as needed State coordinates "lessons learned" sessions; completes an After Action Report	**HPO** Coordinators may include regional BH response in after-action reports and meetings to discuss "lessons learned"	Resume **CMHP** services; coordinate referrals to community-based providers Develop follow up treatment plans/referrals for **CCP** grant-funded services; organize response data & recovery needs

When a community experiences a large-scale disaster or major medical emergency, a variety of agencies, affiliates and organizations can work together assisting in the efforts managed by a local mental health authority (LMHA):

Hospitals

Hospitals in the region have behavioral medicine departments and chaplaincy services that can assist in providing counseling to an increased number of people who seek assistance in their facilities. Hospitals can also partner with their Community Mental Health Programs (CMHPs) to develop protocols for an unusually large number of community members seeking assistance. Two methods to address a hospital behavioral health surge may include:

- Family Assistance Center- a location near the hospital for families and friends seeking information about missing or recently-admitted loved ones.
- Psychological Support Center- a location adjacent to the hospital for those requiring further assessment in a safe, calming environment but who do not appear to need immediate medical intervention

Staff from behavioral medicine and/or chaplaincy departments may also support or join local disaster response teams during a large-scale incident to help provide appropriate triaging of medical and behavioral health patients in community settings.

Private Practice, Licensed and Certified Professionals

Behavioral health partners in private practice may participate in a community response to a major incident. Licensed professionals who are able to temporarily leave their practice and assist in community service delivery may include psychiatrists, psychologists, clinical social workers (LCSW), licensed professional counselors (LPC), or licensed marriage and family therapists (LMFT). These licensed professionals, along with spiritual counselors and other certified behavioral health professionals may join local responder field teams or perhaps become part of a hospital response effort.

Medical Reserve Corp (MRC)

MRCs are another local option for healthcare professionals who wish to volunteer during disasters. MRCs generally represent the voluntary staffing arm of a local public health department. All MRCs and the State of Oregon Department of Health Services have enlarged their healthcare volunteer registries to include licensed behavioral health professionals (LPC, LCSW, and LMFT). Some MRCs also include spiritual counselors, school psychologists, and

other certified behavioral health professionals. Currently, a MRC unit is established in Clackamas, Columbia, Multnomah, Tillamook and Washington Counties.

Schools & Universities

Schools may provide counseling and support to children and their families as needed for the duration of a community crisis, large-scale disaster, or major medical emergency. School psychologists, counselors, teachers and other staff may also be able to serve the needs of the larger community if pre-trained as a behavioral health responder and registered in a regional or statewide incident response system.

In the event of a large-scale disaster, college students may be accessible for just-in-time orientation and activation as behavioral health responders in limited and specific service areas. If sponsored and supervised by licensed professionals, these responders may provide basic response services and could also be very useful in long-term community recovery efforts.

Interested Citizens and Voluntary Organizations Active in Disasters (VOADS)

Citizens may become part of a behavioral health response by joining community emergency assistance organizations such as the Oregon Trail Chapter of American Red Cross, Citizen Emergency Response Teams (CERTs) and the National Organization for Victims Assistance (NOVA) through the Oregon Department of Justice Crime Victims Assistance Section. These volunteer-based groups are represented throughout the region and are also affiliated with Volunteer Organizations Active in Disasters (VOAD) that can coordinate very large groups of volunteers as needed. Disaster volunteer groups typically require members pre-register, take specialized training, and participate in regularly-scheduled local exercises. Although the goals of these community groups are not exclusive to the field of behavioral health, their disaster-trained responders (with varying backgrounds and professions) would likely be very helpful to a local behavioral health response operation.

Community Disaster Service Sites and the Role of Behavioral Health

Trained behavioral health responders from all areas of service may be needed at a variety of pre-identified and incident specific community sites. Size, nature, and anticipated duration of the incident would determine actual disaster service sites that may include any of the following:

- Sites where survivors and families of victims gather

- Shelters, meal sites, disaster application centers, Red Cross service centers, hospitals, schools, police stations, survivor's homes, morgues
- Mass care centers
- Mass clinics for dispensing immunizations/medications
- Sites where first responders and other response workers gather (to be coordinated with emergency management)
- Sites conducive to community education and outreach
- Community centers, shopping malls, schools, religious centers, business associations
- Locations for newspapers, radio, television or internet signal centers.
- Organizations that request behavioral health response or services

Table 2 summarizes the role of community partners and possible behavioral health intervention sites through each phase of a major community incident:

Table 2. Community Roles in Disaster Behavioral Health

	Hospitals	VOADS	Private Practice Professionals	Schools	Sample BH Intervention Sites
Preparedness Phase	Training of emergency plans Build relationships between in-patient psych units & other relevant hospital departments Surge response planning with behavioral health (BH) agencies; plan for family service or psych. support centers Identify alternative psychiatric care sites	Build relationships with other VOADS to determine roles and responsibilities Meet with hospitals, public & private sector agencies to outline roles and responsibilities Conduct training and field exercises when possible	Consider contingencies for current clients during a disaster Join a local response team; participate in training Register in a locally recognized disaster volunteer database	Training of emergency plans Train teams in disaster response and special issues dealing with children and trauma University Students: Train and join responder teams	Response team training (throughout the community) Create public info for local newspapers; television, radio, internet broadcast locations Networking with Public Health & Emergency Management agencies
Response Phase	Meet medical needs of community Address surge in behavioral health service demand from community with help of LMHAs Set up family assistance centers &/or psychological support centers as needed Evaluate psychiatric holds; provide psychiatric in-patient services	Implement organizational policies and procedures regarding activation Activate and deploy as part of local/regional response teams; support members of local volunteer organization	Assignment to response team, agency, or community organization as needed… …NO self-deployment!	Assignment to school, response teams or agency as needed	Medical Points of Distribution (P.O.D.s) Shelters, feeding sites, Disaster Relief Centers, hospitals, schools, survivor's homes, morgues, community clinics, Red Cross Service Centers 1st responder workplace On-scene (uncommon) at disaster sites
Recovery Phase	Meet medical needs of community & resume all services Behavioral health information and referral	Referrals to long-term behavioral health services	Coordinate with local CMHPs to provide longer-term behavioral health services	Coordinate with local CMHPs to provide longer-term behavioral health services	Hospitals, private provider offices, CMHPs, health clinics; some volunteer organization headquarters

Vulnerable Populations

Behavioral health (BH) services are expected to be provided to disaster survivors throughout the community in locations where survivors congregate, at first-responder respite locations, and at locations where client populations may be isolated (e.g. group homes and residential care facilities). While all community members are at risk following a disaster, special care will be taken to respond to the needs of priority populations who are considered vulnerable and at greater risk of psychological trauma. Vulnerable populations may include two groups of community members: 1) with little or no ability to successfully address, implement, or be fully responsible for their own emergency preparedness; or 2) whose life circumstances leave them unable or unwilling to follow emergency instructions, as well as anyone unable or unwilling to access or use traditional disaster preparedness response services.

From a behavioral health view, vulnerable populations may include:

- Children or frail elderly (isolated or in group residences)
- Homeless or shelter-dependent individuals
- Refugees and migrants with limited or no English language skills
- Clients of the criminal justice system
- Individuals with pre-existing mental illness

People who are considered to be vulnerable and in need of specialized BH services may live throughout the region in state financed multi-person dwelling places such as long-term care facilities for the frail elderly, group homes for persons with severe and persistent mental illnesses and psychiatric medical facilities for children with significant mental, emotional or behavioral disorders. In the event of a large-scale disaster or major medical emergency, it will be critical for the local mental health authority to quickly determine special needs within their jurisdictions among existing CMHP clientele as well as for residents of these other facilities.

NOTE: "Special populations" is another term often found in emergency preparedness literature to describe specific community groups that may require special assistance -though not necessarily behavioral health in nature- during a major incident. The University of Alabama (2005) describes "special populations" as follows:

> *Physically/mentally/developmentally disabled, blind, deaf, medically dependent/fragile, medically compromised, seniors, clients of the criminal justice system, limited English or non-English speaking, homeless or shelter dependent, culturally isolated, children, single parents, poor, geographically isolated, persons distrusting of authorities, animal owners, emergent special needs, transient special needs*

Concept of Operations

Regional disaster operations include the following nine concepts:

1. A major incident can be overwhelming, traumatic, and often sudden in nature. A disaster or major medical emergency in a community may overwhelm individuals and cause stress reactions of anxiety, anger, fear and frustration that in turn may create demand for behavioral health services to increase or "surge".

2. Incident phases define the changing roles of behavioral health responders in preparation for, response to, and recovery from a community crisis, large-scale disaster, or major medical emergency

3. Behavioral health intervention strategies can reduce anxiety levels, provide comfort to traumatized individuals, support emergency responders and help restore a community to pre-disaster functioning. At the same time, behavioral health resources can also respond to the needs of persons with serious mental illnesses or co-occurring substance use disorders that are receiving or may require immediate behavioral health services.

4. The official local mental health authority (LMHA) is typically the County Mental Health Program (CMHP) that serves as the central point of contact and coordination for a behavioral health disaster response.

5. Behavioral health plays a supportive role to a larger**,** multi-disciplinary disaster response. In addition to normal CMHP responsibilities, LMHAs may also be called upon to organize a community response in support of a public health federal mandate found in Federal Emergency Services Function Annex ESF#8: Health and Medical Services *(EMI, 2008)* that would be coordinated through established incident command systems.

6. Depending upon the nature of the incident, activation requests for behavioral health services may originate in law enforcement, public health, or emergency management and managed by incident command system (ICS) protocols.

7. It may become necessary to activate large groups of community members to play a supportive role in behavioral health disaster response and recovery. If so, it is important

to prepare agencies and community organizations that do not typically work together to quickly coordinate effective shared service delivery.

8. Prior to an incident, behavioral health responders are responsible for accessing appropriate training and participating in community exercises to maintain an appropriate level of skill. Responders are also expected to ensure their own contact information is current and available to their agency or the community organization(s) for which they wish to volunteer.

9. During the response phase of a major incident, behavioral health responders must be prepared to provide services in difficult or unusual circumstances, remain flexible, and know not to exceed their personal level of safety, comfort and skill.

Local vs. Regional Operations

The complex and varied role of behavioral health disaster services requires an efficient coordination of resources among government agencies and community organizations. Prior to a major incident, the six counties located in the region will find it beneficial to identify areas for potential mutual aid. It may be helpful to coordinate disaster response policies and procedures that could quickly expand from local to regional operation. Procedures that typically need to quickly expand include emergency communication, access to psychiatric medication and verification of credentials for spontaneous volunteers. Local responder notification and activation procedures may be set up to quickly expand into a regional response as needed- with a clear understanding of the activating agency for each responder or responder team.

Making a Disaster Response Operational

The concept of an organized, community wide disaster response for behavioral health (BH) services is comparatively new to emergency management and poses its own set of challenges. One difficulty to coordinating a behavioral health response operation lies in the fact that services are quite varied and somewhat dependent upon the particular needs of an affected individual's experience. Another challenge is connected to a wide variety of behavioral health professionals with varying licenses, certificates, and experiences that could all be very useful in difficult times. One more concern surrounds the likelihood that BH professionals not routinely affiliated with the local mental health authority will want to be informed in a timely manner what community resources are becoming available for the special needs of their current clients or patients.

During a major incident, a large surge in behavioral health services is likely. With no prior planning the enormous multivariate demand could quickly overwhelm a BH response operation. A coordinated response addresses the needs of current community mental health clients *and* considers potential demand in services from the community at large. The following summarizes these issues:

Priority Population Management

Maintain services to current county mental health clients; coordinate special needs assistance to vulnerable BH populations, provide mutual aid to other BH agencies upon request

Community Crisis Management

Provide brief supportive comfort to the community at large, conduct assessments, provide medical or crisis intervention and refer individuals as needed for immediate treatment; also assist media and community groups with information flow regarding the incident

Behavioral Health Roles in Disaster Response

In a large-scale incident, local mental health authorities are charged with assessing and prioritizing community need. The categorization of services in *Table 3* may be useful as a guide to match special skills of responders wherever need is determined to be most critical. Although some responders may be qualified to assist anywhere needed, it should be assumed that all responders who wish to be affiliated with a *behavioral health* response possess adequate skill to provide services for a "community comfort care" operation. However, it should be noted that it is unlikely a BH responder would be assigned to only one area of intervention at a time. *(See Appendix B for more information on behavioral health disaster operations)*

Table 3 further summarizes community behavioral health services -or operations- that may be needed during a major incident:

Table 3. Behavioral Health Roles in Disaster Response Operations					
	Priority Population Management	*Community Crisis Management*			
	Priority Population Care	**Community Comfort Care**	**Emergency Worker Care**	**Crisis Intervention**	**Psych/ Medical Intervention**
Preparedness Phase	• Identify BH high risk or vulnerable populations • Locate psych residential facilities • Attendance at relevant trainings and exercises • Create educational materials for vulnerable populations • CMHP Disaster Plan	• Relationship building among VOADS-Red Cross, NOVA, community-based organizations and LMHA • Agencies develop responder databases and support relevant trainings	• Develop relationships with first responder groups, emergency managers, healthcare and law enforcement unions • Identify support service needs in hospitals and medical facilities • Attend relevant trainings	• Develop relationships with hospitals, safety net clinics, Red Cross & other VOADS • Review county or regional protocols for involuntary psychiatric hospitalization • Attend trainings • Develop educational materials	• Identify regional pharmaceutical vendors, distributors, and suppliers • Attend relevant trainings • Assist with development of psychoeducational materials
Response Phase	• Respond to needs of currently enrolled CMHP clients • Identify & respond to needs of vulnerable groups • Consult issues with all crisis responders • Psycho-educational materials to specific populations	• Assign responders to service delivery sites • Provide brief supportive comfort ("Psychological First Aid") under field supervision • Referrals to crisis intervention team • Distribute educational materials to general public	• Crisis counseling with first responders, healthcare personnel and their families • Stress management with emergency workers (individuals and groups) • Distribute psycho-educational materials	• Provide crisis intervention • Provide mental health triage & assessments • Assess group behavioral health needs in affected community • Supervise "comfort care" operation • Distribute educational materials	• Prescribe and maintain access to behavioral health medications • Support triage / assessment and other BH operations as needed • Assess need & availability for tele-psychiatric systems
Recovery Phase	• Coordination with community-based behavioral health services • Restore individuals to predisaster levels of functioning • Agency debriefings & assessments	• Coordination with community-based recovery agencies & VOADs • Attendance at community debriefings; input to after-action reports	• Continue crisis counseling as appropriate • Referrals for on-going behavioral health treatment • Development of peer support networks	• Continue triage and assessment for longer term mental health and addiction services • Attendance at community debriefings; input to after-action reports	• Treat behavioral health clients as needed in community & private health care settings • Provide tele-psychiatric treatment per need

Emergency Operation Plans

Emergency operation plans address internal lines of authority, identify appropriate actions for preparedness and response, and describe how these actions will fit in with the activities of emergency management and other agencies and organizations following emergency incidents *(Oregon Field Guide 2007).* In Oregon, local emergency management is organized by county. Local jurisdictions are responsible for their initial disaster response and have county-based emergency operation plans. The six counties in the region have each identified a community mental health program that is considered to be their local mental health authority (LMHA).

Activation

During a major incident, emergency management activates behavioral health involvement through the local public health department or by directly contacting their LMHA and coordinating their response with emergency operations. Activation of behavioral health services follows protocols of the incident command system (ICS).

Assessment

Once a request for local behavioral health services has been initiated, the director of a county mental health program may move to their local emergency operations center (EOC) and take the lead for community wide behavioral health assessment and response; or assign a representative to this duty while they remain at their community agency to address the needs of their current client population.

Behavioral health responders are activated and assigned to a location with a field supervisor who continually assesses the current situation in the field, reports findings to the EOC, supervises field reports, and ensures quality continuity of care plus the well-being of behavioral health responders. Field personnel can update the EOC when local resources are becoming overwhelmed. Multi-jurisdictional memorandums of understanding may activate regional resources throughout the affected areas. The Behavioral Health Emergency Response Team (BHERT) supports statewide resource allocation as needed. *(See Oregon AMHD Plan & Field Guide 2007)*

Ongoing Planning

Plan Updates

A viable planning document requires information be updated on a regularly-scheduled basis. Information contained in this regional planning guide may be reviewed and updated by its users on an annual basis or as needed. Local mental health authorities (LMHAs) who would be responsible for community behavioral health response in the event of a major incident would also likely be responsible for incorporating changes in regional and state behavioral health planning into their county behavioral health emergency operation plans. Effective behavioral health planning and response requires coordination with the larger emergency management system. Whenever possible, LMHAs might ensure that behavioral health planning concepts and staff resources are included in exercises, training, and other preparedness efforts throughout their jurisdictions.

The following planning activities may also be useful:

- After a major event, behavioral health response efforts are reviewed for improvements to planning policies and procedures. LMHA attendance at community debriefings and participation in development of “after action reports” can further an efficient incorporation of behavioral health into overall emergency response protocols.

- Behavioral health planning and preparedness efforts go through a formal review every four years. Routine updates and corrections occur annually, improved by exercises and any incidents that may occur where “lessons learned” are incorporated into planning efforts. (NOTE: Contact lists are updated semi-annually).

- A regional response to a major incident is essentially the response of multiple local agencies and organizations working in cooperation with each other through mutual aid agreements or memorandums of understanding (MOUs). These documents that specifically exist for behavioral health response efforts are reviewed and updated annually by LMHAs.

Best Clinical Practice Updates

AMHD Support

In addition to local coordination with emergency management systems, local mental health authorities must ensure that behavioral health efforts correspond with best practices of behavioral health treatment and service delivery during a major incident. Oregon Department of Health Services Addictions and Mental Health Services Division (AMHD) provide oversight and support to ensure best practices are agreed upon and available when needed.

Behavioral Health Advisory Board

As resources permit, a local or regional behavioral health emergency response "advisory board" could assure excellence in clinical protocols toward behavioral health response and recovery. This board may be comprised of county mental health directors, hospital personnel, public health officials, mental health providers, consumer advocates and representatives of volunteer agencies. Members of this board can further represent the interests of behavioral health services as they participate on other committees or task forces that involve emergency planning activities for hospitals, public health, fire, EMS, emergency management, law enforcement, school districts and the business community.

The Association of Oregon Community Mental Health Programs (AOCMHP) supports statewide issues pertaining to behavioral health services with oversight by a board comprised of community mental health directors. As needed, AOCMHP may provide an existing forum to discuss pertinent topics related to the role of behavioral health in disasters.

Professional Skill Updates

Behavioral health responders should participate in some form of training at least once a year to keep their skill set useful and current. A variety of training opportunities may be sponsored by government agencies, local colleges, and disaster volunteer organizations. LMHAs may wish to require specific training or exercises that coincide

with specific needs in their community. Responder training is documented by the responder and/or the agency they represent.

Each behavioral health disaster responder is expected to access updated information on a regular basis that pertains to: a) the field of disaster behavioral health, b) local professional planning efforts, and c) disaster training opportunities. Valuable information may be found by reviewing newsletters and websites of local government agencies, community-based organizations, and professional associations. Information sharing and training support may be a featured part of the work conducted by the behavioral health advisory board mentioned above.

NOTE: As needed, behavioral health responders provide verification of their license or certification to the agency they would represent during a major incident. If not affiliated with an agency or community organization, a behavioral health responder would take steps to ensure that their credential and training documents are current and readily available during a major incident. (For example, a typical practice for a behavioral health professional who is also a disaster responder is to always carry a laminated wallet-size copy of their professional license.)

Acronyms

AMHD	Addictions & Mental Health Division, OR Department of Health Services
ASPR	Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services
AOCMHP	Association of Oregon Community Mental Health Programs
BHBD	Behavioral Health Branch Director (local response position)
BHERT	Behavioral Health Emergency Response Team (state team)
BHRT	Behavioral Health Response Team (local team)
BH	Behavioral Health
BHRC	Behavioral Health Response Coordinator (local position)
CCP	Crisis Counseling Program (FEMA federal program)
CERT	Community Emergency Response Team
CISM	Critical Incident Stress Management
CMHD	County Mental Health Director
CMHP	Community Mental Health Program
DBH	Disaster Behavioral Health
DMORT	Disaster Mortuary Teams (federal team)
EOC	Emergency Operations Center
HPP	Hospital Preparedness Program
ICS	Incident Command System
LMHA	Local Mental Health Authority
MOU	Memorandum of Understanding
MRC	Medical Reserve Corp
NIMS	National Incident Management System
NOVA	National Organization for Victim Assistance
PDD	Presidential-Declared Disasters
SAMHSA	Substance Abuse and Mental Health Services Administration
SNS	Strategic National Stockpile
SPMI	Severely and Persistently Mentally Ill

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