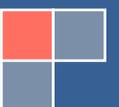


2012

# State of California Mental/Behavioral Health Disaster Framework

DECEMBER 17, 2012

*Final Deliverable to the California Health and Human Services Agency*



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# State of California Mental/Behavioral Health Disaster Framework

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## Overview

The State of California Mental/Behavioral Health Disaster Framework (Framework) provides a comprehensive concept of operations and guidance document to the disaster mental and behavior health community in California. This product is the result of a 10 month long project funded by the California Health and Human Services Agency that took place in 2012. The effort involved approximately one hundred stakeholders throughout the state, covering the landscape of local mental health and public health agencies; emergency services at the local, state and federal levels; state level public health and human services agencies; non-governmental and community based organizations; Tribal interests; and private sector providers of health services.

This diverse coalition of participants worked together through several modes of collaboration to develop this Framework as the project progressed. An initial assessment of issues and processes was undertaken through interviews with several representative stakeholder organizations, along with a review of key reference materials to feed into the Framework development; three statewide workshops were convened to receive comprehensive input on the concepts included in the Framework; and a Core Work Group of selected organizations met numerous times via webinar and in person to help guide the input and revision process. Finally, a small subcommittee of the Core Work Group accomplished advanced editorial and review work in detail, to reach approval on key draft and final editions of the Framework.

The energy and consistent participation throughout the development of this document was exceptional; all parties offered critical input and at many points agreed to negotiate language and concepts that would be acceptable to all in a consensus seeking approach. As a result, this Framework constitutes a strong sense of the field across many disciplines as to the most effective use of best practices and operational systems to achieve coordinated planning, response and recovery for mental/behavioral health issues in disasters. It should be noted that many important ideas and perspectives could not be included in this final document for various reasons, such as: time constraints to complete this project under grant deadlines; an identification of key policy issues that needed additional research and vetting; and organizational changes underway that limited ability to define roles and responsibilities. These limitations are inherent in any complex policy and program development project, and these issues were expected to be encountered. As such, the facilitation team tracked these issues and has produced a 'Gap Analysis/Next Steps' white paper that was distributed to the California Health and Human Services Agency. The white paper constitutes a road map for the next cycle of work effort and maturity of this planning process in 2013 and beyond.

This Framework serves several audiences with this one document—users at the state, local, federal, private, tribal, and NGO levels are encouraged to utilize the elements most relevant to their jurisdictional perspectives. Given that this is the first document of its kind in California, future work is

expected in order to refine the materials addressed here and to consider additional documentation and input to advance the field.

The Framework development process was facilitated under a contract with the Center for Collaborative Policy, California State University, Sacramento, in partnership with Ciralo Consulting and Cauley Consulting.

## Promulgation

This section should include a signed statement by the Secretary, Health and Human Services Agency formally recognizing and adopting the document as the State's Mental/Behavioral Health Disaster Framework. In addition, the promulgation should state that this is a new document and does not supersede any existing documents.

## Record of Changes

Revision			

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## 1 Introduction

The State of California Mental/Behavioral Health Disaster Framework (Framework) is intended to provide a statewide approach to the mental/behavioral health disaster function. It serves as a foundational document that sets out the overall baseline structure to be used by governmental, non-governmental and private sector agencies and organizations to ensure coordination of efforts prior to, during and after an emergency. The Framework also provides guidance for governments, agencies and organizations that are developing, revising, and implementing their own mental/behavioral health disaster policies, plans and procedures.

The Framework recognizes mental/behavioral health as a component of public health and medical services and promotes the integration of these functions to better facilitate the effective and efficient provision of disaster services. The Framework also recognizes that there is not a consistent system of mental/behavioral healthcare in the State; the provision of mental, behavioral, and substance use disorder-related care among public, private, community based, and employer-based programs varies from jurisdiction to jurisdiction.

## 2 Framework Development

This Framework was developed by a Core Work Group with input from stakeholders representing government, non-government, and private sector. The Core Work Group provided guidance to ensure this document included appropriate and helpful topics and information, including traditional emergency operations plan elements<sup>1</sup>, recommended actions, and useful references and resources.

Core Work Group membership included representation from the following entities:

- CA Department of Aging
- CA Department of Alcohol and Drug Programs
- CA Department of Developmental Services
- CA Department of Health Care Services
- CA Department of Public Health, Emergency Preparedness Office
- CA Department of Rehabilitation
- CA Department of Social Services
- CA Department of State Hospitals
- CA Emergency Management Agency
- CA Health and Human Services Agency, Emergency Medical Services Authority (EMSA)
- California Association of Health Facilities
- California Conference of Local Health Officers

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<sup>1</sup> FEMA's Comprehensive Program Guide (CPG) 101: Developing and Maintaining Emergency Operations Plans (Version 2.0, November 2010.)

- California Disaster Mental Health Coalition / American Red Cross
- California Disaster Mental Health Coalition / California Association of Marriage and Family Therapists
- California Disaster Mental Health Coalition / California Psychological Association
- California Disaster Mental Health Coalition / National Association of Social Workers
- California Hospital Association
- California Mental Health Directors Association
- California Primary Care Association
- CaliforniaVolunteers
- Central Coast Employee Assistance & Counseling Services
- Fresno County, Office of Emergency Services
- Health Officers Association of California
- Los Angeles County, Department of Health Services, Emergency Medical Services Agency
- Los Angeles County, Department of Mental Health
- Sacramento County, Department of Health and Human Services
- San Bernardino County, Department of Behavioral Health
- Southern California Disaster Mental Health Coordinators
- University of California, Irvine, School of Medicine, Center for Disaster Medical Sciences

### 3 How to Use This Framework

This Framework serves multiple audiences is intended to be used by jurisdictions and organizations regardless of their knowledge level, core function (emergency services, public health, mental health, etc.) or the stage of development of their disaster mental/behavioral health function. The Framework includes three categories of information:

- *Disaster Mental/Behavioral Health Content:* Each of the sections in this Framework describes situations, structures and activities that can and will be used in California relative to disaster mental/behavioral health. This information should be used as the starting point when developing a Mental/Behavioral Health Disaster Plan or Functional Annex and can be used in whole or in part to provide information and education on the topic.
- *Recommended Actions:* There are items listed in the text boxes titled “Recommended Actions” in many sections of the Framework. These recommended actions are suggested activities to initiate, develop or implement that specific section of the Framework.
- *References:* References to source documents are provided throughout the Framework as footnotes and in Appendix H: References. Appendix H also includes additional references that may be helpful in understanding the mental/behavioral health disaster function.

This document reflects a point in time for the planning process; as organizational and policy issues evolve and change, updates will be needed to reflect current requirements.

## **4 Purpose, Scope, Situation, Assumptions**

### **4.1 Purpose**

The State of California Mental/Behavioral Health Disaster Response Framework addresses the continuum of mental/behavioral health care before, during, and after a disaster by identifying specific emergency operations activities for each phase of a disaster. The Framework guides the statewide response to and recovery from the mental/behavioral health impacts of a disaster. The Framework also serves as guidance to local government and operational areas to assist them with planning efforts and to provide a structure for coordination of State and local response and recovery efforts.

### **4.2 Scope**

The mental/behavioral health effects of disasters include a wide range of emotional effects that range from expected stress responses that may not require any mental health intervention to those effects that may require intervention. For example, exposure to events that may exacerbate or initiate the onset of a variety of mental health conditions including but not limited to post-traumatic stress disorder (PTSD), generalized anxiety disorder, acute stress disorder, major depression, panic disorder, and/or substance use disorder. Mental health issues also cause further stress on an overwhelmed health care system trying to respond to the disaster, and can disproportionately affect specific populations such as children and other “at-risk or vulnerable” populations. Disaster behavioral health includes all phases of disasters (mitigation, preparedness, response and recovery), and is distinguished from other forms of mental and behavioral health in that it is specifically focused on the impact of disasters.

The Framework applies to all hazards and is scalable to any size disaster. The Framework outlines disaster mental/behavioral health activities in the state, including, but not limited to:

- Preparedness strategies to support the disaster mental/behavioral health function;
- Mitigation activities to lessen the mental/behavioral health impacts of disasters;
- Activities in response to and recovery from an event with mental/behavioral impacts, and
- Use of resources to address the consequences of mental/behavioral health impacts.

### **4.3 Relationship to Other Plans**

The Framework is a supporting document to the California Emergency Function (EF) 8 - Public Health and Medical Annex to the State of California Emergency Plan, the California Public Health and Medical Emergency Operations Manual, and the Medical Health Operational Area Coordinator (MHOAC) Program. Jurisdictional and organization-specific disaster mental/behavioral health plans and procedures that are consistent with the Framework support the full implementation of the concepts outlined here.

#### 4.4 Situation Overview

Disasters are associated with a continuum of mental health impacts from transitory distress with a trajectory toward resilience<sup>2</sup> and eventual posttraumatic growth for some<sup>3</sup> to chronic, new incidence disorders (including post-traumatic stress disorder, generalized anxiety disorder, acute stress disorder, major depression, panic disorder, and substance use disorder). Disasters are also associated with a wide range of impairments including work, home, community and school functioning. For those with pre-existing mental conditions disasters can exacerbate difficulties and some may lose access to their life sustaining medications, routine counseling, and other stabilizing processes. Additionally, rates of domestic violence<sup>4</sup>, substance use disorder, and child abuse may increase post disasters. Overall, evidence suggests that the level of disorder post disaster averages somewhere between 30-40%<sup>5</sup>. Furthermore, these impacts can be drawn out and persist over years and decades after disasters and are associated with increased health care costs and health care utilization. An important study<sup>6</sup> reported that PTSD tends to affect 5% to 30% of those impacted by disasters, while up to 25% display a recovery response, with another 15% showing a delayed stress response. Approximately 35% to 65% of people who experience a disaster return to their normal routine shortly after the event, and resilience can be a common response.

Additionally, wide-ranging behavioral as well as mental health impacts of catastrophic incidents have been demonstrated in various types of public health emergencies<sup>7</sup>:

- Loss of credibility for public health, other government authorities, and societal structures. These reactions include lack of adherence with mandatory quarantine measures and massive price inflation and complete supply chain depletion due to panic buying of critical supplies, such as N-95 respirators, pharmaceuticals, hand sanitizer, and disposable gloves;
- Concerned citizens can overload healthcare systems and inundate hospitals. Patients with “multiple unexplained physical symptoms” or “disaster somatic reaction” have ratios above normal patient census that range from 75:1 to 1700:1. For example, presentation of

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<sup>2</sup> Bonanno GA, Brewin CR, Kaniasty K, La Greca AM (2010) Weighing the costs of disasters: consequences, risks, and resilience in individuals, families, and communities. *Psychological Science in the Public Interest* vol. 11 no. 1 1-49

<sup>3</sup> Galea, S., Nandi, A., & Vlhov, D. (2005) The epidemiology of post-traumatic stress disorder after a disaster. *Epidemiologic Reviews*, 27, 78-91.

<sup>4</sup> Norris, Fran H. (2007) Disasters and domestic violence: prevalence and impact of domestic violence in the wake of disasters. <http://www.ptsd.va.gov/PTSD/profesional/pages/disasters-domestic-violence.asp>.

<sup>5</sup> Galea, S., Nandi, A., & Vlhov, D. (2005) The epidemiology of post-traumatic stress disorder after a disaster. *Epidemiologic Reviews*, 27, 78-91.

<sup>6</sup> Bonanno GA, Brewin CR, Kaniasty K, La Greca AM (2010) Weighing the costs of disasters: consequences, risks, and resilience in individuals, families, and communities. *Psychological Science in the Public Interest* vol. 11 no. 1 1-49

<sup>7</sup> Disaster Mental Health Concept of Operations for Public Health of Seattle and King County, 2012.

patients with physical symptoms of SARS, radiation exposure, or other causative factors, despite no evidence of exposure and failure to meet case definitions.

- Job defection rates among health care workers and first responders in infectious disease scenarios; and,
- Increased risk of death from natural and “unnatural” causes (e.g. among parents who lose their children traumatically)<sup>8</sup>.

These impacts act as stressors, are indicators of mental health stress, or impede government response.

The full spectrum of disaster mental health impacts and stressors exceed the capacity of this Framework to adequately describe. Please see Appendix H - References for recommended background readings that fully describe studies of the mental health impacts of such disasters as SARS outbreak, Hurricane Katrina, the Tohoku earthquake, the Tokyo Sarin gas attack, Three Mile Island, the release of a non-ionizing radioactive agent in Brazil, and other incidents. Appendix H also contains additional resources on best practices, after actions review examples (info coming), and other resources.

The 'at risk' population for mental health impacts of a disaster is broad and risk factors include age, type of incident, exposure to traumatic stressors, and loss. Children, parents, and those who directly suffer traumatic loss are significantly at higher risk for long-term depression. Others affected include first responders, emergency personnel, volunteers, and the general population.

Successful disaster mental health activities will depend on the jurisdictional capabilities. Many of the strategies can be deployed prior to an incident, as part of efforts to improve resiliency. Planning guidance for disaster mental health often suggests a “graded range of acute psychological interventions.”<sup>9</sup> Specific strategies for affecting a positive outcome during mass casualty mental health responses include:

- Utilization of a mental health triage, screening and assessment model<sup>10</sup>.
- Disaster Crisis Intervention by mental health professionals;
- Psychological First Aid programs for use by a wide range of mental health professionals, disaster responders and community members;
- Publicizing enhanced coping techniques for the general public via social media, risk communication, and other messaging;

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<sup>8</sup> *Lancet* 2003; 361: 363–67. Published online Jan 14, 2003. <http://image.thelancet.com/extras/02art5149web.pdf>

<sup>9</sup> US Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response hospital preparedness benchmarks for behavioral health acute surge (benchmark 2.8), HRSA, 2004.

<sup>10</sup> Pynoos, R., Schreiber, M., Steinberg, A., & Pfefferbaum, B. (2005) Children and terrorism. In B. Saddock and V. Saddock (Eds.). *Kaplan and Saddock's comprehensive textbook of psychiatry* (pp. 3551-3563). 8<sup>th</sup> ed. Vol 2. New York: NY: Lippincott Williams and Wilkins.

- Development and support of social support systems pre- and post-event to support personal and population-level efforts to continue routine daily activities;
- Access to existing open source available treatments (e.g., internet based, etc.) for specific subpopulations at risk for depression and PTSD;
- The Substance Abuse and Mental Health Services Administration (SAMHSA) /Federal Emergency Management Agency Crisis Counseling Program, including specialized crisis counseling interventions, which relies on paraprofessionals and professionals;
- Immediate crisis intervention by mental/behavioral health professionals, including a range of modalities;
- Brief support by health care workers and providers;
- Tele-health capacities such as the National Disaster Distress Call Line;
- Acute, evidence based interventions; and
- Resiliency toolkits designed for specific populations such as health care workers.

#### **4.5 Framework Focus, Guiding Principles and Assumptions**

This Framework is based on the following guiding principles and assumptions:

##### **Principles**

- Disaster mental/behavioral health activities across the mitigation, preparedness, response, and recovery phases of a disaster represent mandates for public health and emergency medical service agencies. Therefore, the disaster mental/behavioral health function is part of the Medical/Health Operational Area Coordination (MHOAC) program, and mental/behavioral health function competencies should also be required of the Regional Disaster Medical Health Coordinator (RDMHC). It should also be noted that mental health impacts exist after acute medical needs and last well into the recovery phases.
- Disaster mental/behavioral health should not be an isolated, siloed activity in response to a disaster, but rather as an ongoing effort that spans all phases of a disaster that is routinely represented in emergency management systems, response planning, and disaster exercises.
- Interventions during disaster response and recovery should be delivered by licensed mental health professionals, trained volunteers, and paraprofessionals.
- Disaster mental/behavioral health workers will triage, assess, provide early psychological first aid, crisis counseling and make referrals, consistent with their level of training and scope of practice.
- The provision of disaster mental/behavioral health services should be based on current evidence informed/best practices and widely accepted national guidelines such as the SAMHSA National Registry of Evidence Based Practices or Institute of Medicine. (See references and resources in Appendix F)
- Disaster mental/behavioral health is not limited to crisis-oriented individual interventions, but also must address a continuum of risk, needs, and available resources.
- Local jurisdictions maintain primary responsibility to coordinate emergency response in the impacted area. The State carries out response activities in support of and in coordination with local response activities.

- Tribal governments are responsible for the protection and preservation of life, property and the environment on tribal lands. Tribal governments maintain various levels of emergency preparedness, coordination, communication and collaboration with federal, state and local governments. When there is a threat of an emergency or actual emergency tribal authorities must take the appropriate actions to cope with the situation and activate their tribal emergency preparedness procedures and plans.<sup>11</sup>
- Implementation of this Framework is dependent on its release and training.

### Assumptions

- Disaster mental/behavioral health resources will vary by jurisdiction, community, and disaster circumstance. These resources, which together may be seen as constituting a “disaster system of care”, will include public mental/behavioral health agencies, public health agencies, EMS agencies, schools, volunteer organizations, hospitals, and others.
- The provision of mental and behavioral health care is often resource-constrained even during non-disaster times. Because disaster circumstances can produce a massive demand for mental/behavioral health response in excess of available resources, it is critical to use a standardized evidence based tool to identify mental health risks when allocating resources. Disaster mental/behavioral health response must be based on realistic, near-real time assessments of mental/behavioral health risks and needs, available resources, and the gaps between those risks and needs and the available resources and disasters systems of care. Jurisdictions should plan for the use of a consistent, standardized mental/behavioral health triage process across SEMS levels for coordination of mutual aid, requests for CCP and Specialized Crisis Counseling funding and the allocation of scarce resources using a common operating picture and timely situational awareness.
- The American Red Cross, Los Angeles County Emergency Medical Services Agency, State of Minnesota and the District of Columbia, for example, use PsySTART, an evidence based disaster mental health triage system, based on identifying individuals with particularly intense exposure to the disaster who are “at risk” for acute emergencies and chronic outcomes, and prioritizing resource allocation based on available resources<sup>12</sup>.
- All emergencies potentially impact the mental/behavioral health of the affected areas, communities and populations, including response personnel.
- All disasters potentially have mental/behavioral impacts broader than the population physically impacted by the disaster, due to family, social, media, and other connections. These impacts range from normal reactions to an event, stress and fear to new incidence disorders.

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<sup>11</sup> State of California Emergency Plan, July 2009, pg. 28 – 29.

<sup>12</sup> King, M., Schreiber, M., Formanski, S., Fleming, S., Bayleyegn, T., Lemusu, S. (2012) Surveillance of Traumatic Experiences and Exposures after the Earthquake-Tsunami in American Samoa. Disaster Medicine and Public Health2012;6:(doi:10.1001/dmp.2012.11

- Many individuals will recover from a disaster with little or no help from professional intervention, depending on the nature of the event. Nevertheless, jurisdictions should plan for strategies that promote community resilience following a disaster.
- While many individuals will have expected reactions and experience emotional resiliency, some individuals or populations may be at higher risk for more severe reactions. For example, individuals with direct impacts, those with pre-existing mental/behavioral health conditions or past traumatic exposure and at-risk individuals with access and functional needs. Children, in particular, can be vulnerable as they may lack the experience, skills, and resources to independently meet their own mental/behavioral health needs requiring special considerations for parents, caregivers, educators, responders and professionals working with children and youth. Disaster mental/behavioral health plans should include strategies that address the full range of mental health outcomes, from supporting resiliency to the rapid identification and treatment of individuals experiencing adverse mental health outcomes.
- In any event with health incidents, but especially in certain incidents, such as chemical, biological, radiological or nuclear incidents, emergency departments and health care facilities may experience a significant influx of patients with psychologically-based complaints or unexplained physical symptoms, as well as more severe mental/behavioral health symptomology, requiring targeted response activities.
- Existing systems that provide mental/behavioral health services may be damaged, disrupted, or overwhelmed during an emergency. Mental health clinics, schools, places of worship, group homes, hospitals, nursing homes, ambulatory care centers, and other facilities, which provide mental/behavioral health care and support for affected populations, may be damaged or destroyed or may be overwhelmed providing such support. Mental/behavioral health and substance use facilities that survive emergency situations with little or no structural damage may still be unable to operate normally. This could be due to a lack of utilities, an inability for staff to safely report for duty, damage suffered by communication or transportation systems, and/or disruption of the pharmaceutical supply chain.
- Mental/behavioral health and substance use providers, both public and private organizations and individuals, that survive emergency situations, with little or no damage, may be called upon to provide both personnel and physical resources to the community.
- Existing professional mental/behavioral health resources in the community will need help to respond and requires supplementation by volunteers, community organizations and others.

## 5 Mitigation and Preparedness

California promotes collaborative community-based mitigation and preparedness in which stakeholders from all sectors of society and emergency management disciplines work together to ensure an effective response to and recovery from an emergency. The emergency management community includes public agency stakeholders (state agencies, operational areas, local government, special districts, tribal government, other states, federal government agencies) and private sector stakeholders (residents, at-risk individuals, people with access and functional needs, the elderly, businesses, and non-governmental organizations).

### 5.1 Mitigation

In general, mitigation is the act of lessening in severity or intensity. Typically for emergency management, mitigation is used in the context of hazard mitigation which is defined as any sustained action taken to reduce or eliminate long-term risk to people and property from natural hazards and their effects<sup>13</sup>. For the purpose of this Framework, mental/behavioral health mitigation actions refer to activities that (1) support individual and community resiliency and (2) have the potential to reduce the need for disaster mental/behavioral health interventions.

#### RECOMMENDED ACTIONS:

- Implementing resiliency improvement strategies such as disseminating psychological first aid training in the community pre-event.
- Incorporation of psychological first aid training in school curriculum to support students and parents in their day-to-day life as well as during emergencies (example is Los Angeles Unified School District “Model and Teach” program).
- Provision of resiliency training for emergency responders and staff (such as the *Anticipate Plan and Deter* Responder Resilience Program developed for the US Public Health Service and Los Angeles County Emergency Medical Services Agency).
- Educating the public on expected reactions as well as coping strategies such as turning off sensationalized television coverage of an event in order to lessen the possibility of a more serious or continuing psychological response.

### 5.2 Preparedness

Preparedness involves activities undertaken in advance of an emergency to develop and enhance operational capacity to respond to and recover from an emergency. As part of the disaster mental/behavioral health function, involved agencies and organizations should develop plans and procedures, manage resources, establish agreements, train personnel and educate the public.

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<sup>13</sup> FEMA Hazard Mitigation Assistance Unified Guidance (June 2010), pg. 1

### 5.2.1. Planning

There are many planning strategies and products that will facilitate and support the disaster mental/behavioral health function. Below are examples of tasks that could be carried out cooperatively with stakeholders to identify and implement disaster mental/behavioral health planning preparedness initiatives:

#### **RECOMMENDED ACTIONS:**

- Review your jurisdiction's or organization's emergency plan to ensure that mental/behavioral issues or function are adequately integrated and addressed.
- Meet with stakeholders. Review after action reports and relevant publications to identify common mental/behavioral health issues in emergencies and the potential for impact of these issues in your jurisdiction/organization. Establish preparedness priorities for your area.
- Reach out to organizations, practitioners and other jurisdictions that can assist you in initiating or further developing disaster mental/behavioral health preparedness initiatives identified in the previous task.
- Convene a stakeholders group for regional coordination to assist with planning and preparedness efforts for disaster mental/behavioral health in your jurisdiction. (See section 6.2 for a list of potential stakeholders.)
- Establish routine regional mental/behavioral health coordinator meetings and convene an annual statewide meeting.
- Prepare for disaster mental/behavioral health response by adopting, promulgating, and integrating into established emergency management systems methods for obtaining disaster mental health situation reporting, priority setting, resource allocation and mutual aid management for disaster mental/behavioral health.
- Identify the need for establishing or integrating mental/behavioral health priorities into sources of funding for preparedness grant funding, including establishing methods for gathering the necessary elements to support post-disaster grant applications.
- Develop memoranda of understanding (MOU) or statements of understanding (SOU) with key partners, including the local American Red Cross, the local department of mental health, contractors and other private and non-profit partners that can assist in carrying out the post-disaster mental/behavioral health mission.
- Pursue the approval and implementation of a California Mental/Behavioral Health Mutual Aid Plan.

- Work with stakeholders and lead jurisdictional and regional mental/behavioral health partners to develop operational area based Family Assistance Center Plans<sup>14</sup> ) for provision of non-intrusive, culturally sensitive mental/behavioral health support services to family members of the deceased, incident survivors, and responders, if requested following a mass fatality disaster.
- Meet with the hospital/healthcare partners (who have a role in coordinating disaster response to hospitals and clinics in your area) to develop processes for healthcare organizations to request mental/behavioral health support during healthcare surge incidents for healthcare providers, responders, survivors, and families.
- Develop pre-scripted messages to assist with the mental/behavioral health mission for use in an emergency. Establish a method to store, coordinate and share pre-scripted messages prior to and during disasters.
- Clarify and include the appropriate tasks to maintain continuity of operations as an important element for disaster mental/behavioral health during mitigation, preparedness, response and recovery.
- Work with stakeholders to gain consensus on what evidence-based/informed mental health interventions will be used based on phases of the disaster, level of risk, population/culture, age group, number and types of mental health responders, etc.
- Obtain consensus on the use of mental/behavioral health triage information that will be used in the Operational Area level as well as how American Red Cross Disaster Mental Health Surveillance and Triage information<sup>15 16</sup> along with other information will be integrated into mental health response following disasters.
- Work with stakeholders to determine how to train, deploy, partner with and utilize spiritual care providers following disasters.
- Develop guidelines for use of evidence based rapid mental/behavioral health triage at the Operational Area level.
- Conduct baseline mental/behavioral health surveillance to be used to identify the adverse health effects of a disaster. Baseline surveillance data can be used to design, target and implement interventions during response as well as to inform the development of programs to improve community resilience prior to an incident. The analysis of data collected identifies special populations and community characteristics that will be relevant to recovery efforts.

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<sup>14</sup> Los Angeles County Operational Area Family Assistance Center Plan, March 16, 2010, version 16

<sup>15</sup> <http://www.cdcradiationconference.com/presentation/PlanningPsychosocialBehavioralHealthRadiationEmergency-Yin.ppt>

<sup>16</sup> <http://www.cdms.uci.edu/PDF/PsySTART-cdms02142012.pdf>

### 5.2.2. Training and Exercises

Training, tests and exercises are essential to ensure mental/behavioral health personnel, public officials, emergency response personnel and the public are operationally ready. Disaster Mental Health Core Competencies have been developed for use in California (see Appendix D). Training courses and exercises should address these competencies. The disaster mental/behavioral health function should be integrated into the exercise plans for all agencies and organizations with emergency management responsibilities. Each jurisdiction should work to include a surge of psychological casualties and mental health issues (for patients, community members, response staff, etc.) as a regular and expected part of their existing exercise program. Jurisdictions are encouraged to develop a training and exercise program that addresses their individual needs. (Reference the Training Guidelines in Appendix E; Resources outlined in Appendix F, along with the Core Competencies in Appendix D).

#### **RECOMMENDED ACTIONS:**

- Review your jurisdiction's/organization's training and exercise plan/program from a disaster mental/behavioral health perspective. Work with your stakeholder groups to facilitate inclusion of all appropriate mental/behavioral health partners. Ensure that a variety of disaster mental/behavioral health issues, mental health causality estimates etc., are included as a regular and expected part of your exercise program – including post-exercise improvement plans. Determine if additional exercises should be planned in your jurisdiction to offer greater opportunities to test preparedness, response, and recovery initiatives for disaster mental health.
- Work with your jurisdiction's stakeholder group to facilitate the availability of disaster mental health training. The type, source, and frequency of trainings should match the variety of evidence-based practices identified by the stakeholder group, potential impacted populations, as well as core competencies for both licensed and non-licensed mental health responders and volunteers. The training plan should also address training for spiritual care partners, if appropriate.
- Work with stakeholders to promote and advertise disaster mental/behavioral health training for all practitioners including state, tribal, county, and city government and volunteers.

### 5.2.3. Developing Disaster Mental/Behavioral Health Resources

Resource management preparedness activities (resource typing, credentialing, and inventorying) are reviewed on a continual basis to help ensure that resources (personnel and materials) are ready to be mobilized when called to an incident. Below are examples of tasks that could be carried out cooperatively among disaster mental/behavioral health stakeholders:

**RECOMMENDED ACTIONS:**

- Meet with your emergency manager to review your jurisdiction's/organization's current resource management process for mental/behavioral health staff and materials.
- Work with your stakeholder group to identify your jurisdiction's/organization's resources programs, personnel, and equipment that are currently available to support disaster mental/behavioral health tasks following disasters.
- Work in coordination with your stakeholder group of internal and external partners to determine if there are significant gaps in resources based on your anticipated disaster mental/behavioral health needs and identify potential sources to fill those gaps.
- Ensure that your jurisdiction has standardized terms, request forms, procedures, mutual aid and deployment plans to facilitate the effective requesting, identification, credentialing, assigning, identification, mobilization, management, and deployment of disaster mental health staff to needed locations following disasters. Plans should also include the deployment and management of volunteers, as well as pre and post-deployment mental health support for both paid and volunteer staff.
- Determine what resource databases are currently available in your jurisdiction, including SAMHSA, CCP Forms and toolkit, government, private and non-governmental mental/behavioral health resources.
- Encourage potential mental health responders to pre-register as a disaster volunteer. Examples include the American Red Cross disaster mental health activity (which can be done through the local chapter) as well as the Disaster Healthcare Volunteers of California (<https://www.healthcarevolunteers.ca.gov/>).
- Ensure that mental/behavioral health resources, including private sector assets, operate in accordance with EF-8. Develop procedures to request mental/behavioral health resources in accordance with EF-8/EF-6 guidance and the EOM. Identify vendors for resource purchasing during a disaster and the procedures to obtain fiscal authorization to pay for resources during a disaster. Identify private resources that could be accessed during a disaster and develop MOUs for sharing those resources.
- Continue to work with stakeholders to integrate and practice the mechanisms your jurisdiction decided to use in the preparedness step to gather realistic, near-real time assessments of mental/behavioral health risks and needs, available resources, gaps and how resources will be used to fill those gaps.

- Identify the mechanisms the State will use to provide near-real time assessments of mental/behavioral health risks and needs and identify gaps between needs and the available resources, and consider crisis standards of care mental health triage recommendations.<sup>17</sup>

## 6 Response and Recovery

### 6.1 Disaster Mental/Behavioral Health Function

Mental/behavioral health function activities are carried out during the response and recovery phases of a disaster by government agencies, non-governmental organizations and the private sector. These activities must be appropriate to the situation and to the authorities and responsibilities of the organizations.

Examples of disaster mental/behavioral health roles in response and recovery include:

- Implementation of the jurisdiction's mental/behavioral health disaster plan in coordination with the mental/behavioral health director and emergency management agency.
- Mental/behavioral health resource coordination with requesting emergency functions (i.e., Care and Shelter, and Public Health and Medical) and through mutual aid.
- Coordination of crisis counseling response and recovery efforts, which may include the FEMA funded Crisis Counseling Program.
- Mental/behavioral health assessment of disaster survivors and responders.
- Provision of and/or referral to mental/behavioral health services.
- Provision of longer-term, ongoing mental/behavioral health services for the community, including responders.
- Conducting surveillance to identify the range of impacts caused by the incident and to provide data to analyze the mitigation efforts taken.

Disaster mental/behavioral health responders are typically assigned to:

- Emergency Operation Centers (as a part of the SEMS/NIMS structure as well as for staff support)
- Shelters
- Natural gathering sites and open spaces unique to each local community; parks; fields; empty lots
- Casualty collection points
- Family Assistance Centers

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<sup>17</sup> Hanfling, et al., *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response*, 2012 (Institute of Medicine); see section 4, Cross-Cutting Themes: Mental Health

- Public Information
- Call-in centers
- Staff support
- Reception and service centers
- Schools
- Businesses
- Places of worship
- Mental health facilities
- Hospitals and other medical treatment sites
- Isolation and quarantine sites
- Points of distribution and dispensing to the public (e.g., commodities, mass prophylaxis)
- Local Assistance Centers/Disaster Recovery Center

**RECOMMENDED ACTIONS:**

- Work with your stakeholder group to review your jurisdictions recovery plans and procedures to ensure that mental/behavioral health issues are adequately addressed, including enough available resources to support the potential deployment locations for mental health staff (see above).
- Facilitate the participation of all stakeholders in any exercises where recovery functions are practiced. Participate in the after action and improvement planning process including using stakeholders to address plan improvements.

## 6.2 Disaster Mental/Behavioral Health and Identification of Stakeholders

**RECOMMENDED ACTIONS:**

- Use this list to determine the appropriate stakeholder group to assist you with planning for the disaster mental/behavior health mitigation, preparedness, response and recovery initiatives.

### 6.2.1. Standardized Emergency Management System (SEMS) and National Incident Management System (NIMS)

The Standardized Emergency Management System (SEMS) is the cornerstone of California’s emergency response system and the fundamental structure for all activities during the response phase of emergency management. SEMS and the National Incident Management System (NIMS) are designed to be compatible and are based on similar organizational principles. NIMS is the federal version of standardized emergency response for the nation, including federal, state, tribal and local governments; SEMS was a benchmark source document in the creation of NIMS.

There are five SEMS organizational levels (field, local government, operational area, region, state) as well as the federal level as identified in the National Disaster Response Framework (NDRF)<sup>18</sup>. SEMS levels and lead agencies are depicted in Figure 1. The disaster mental/behavioral health function is typically incorporated into emergency response organizations within the Medical/Health Branch under the Operations Section.

### **6.2.2 Tribal Nations**

There are 111 federally recognized Tribes in California<sup>19</sup>, and 106 of these Tribes are located within the Bureau of Indian Affairs (BIA) Pacific Region; the remaining five are land-shared Tribes with the States of Nevada and Arizona which are in BIA's Western Region.

Currently, American Indian and Alaska Native tribes, clinics, and communities are taking action to address health disparities including mental health issues. These include higher rates of substance use, anxiety, depression, and suicide. During disaster situations these issues will increase, as they do in all populations, and it will be important to integrate and honor the cultural healing and resiliency factors that have been in place for centuries, including traditional medicines, healing practices, and spiritual ceremonies. These factors need to be woven into any disaster response plan for indigenous communities.

As conditions require and upon request from the Tribe, the available and appropriate federal, state and local government mental/behavioral health resources will, in accordance with prior arrangements and as authorized by law, be committed to tribal lands.

### **6.2.3 Private Sector Stakeholders**

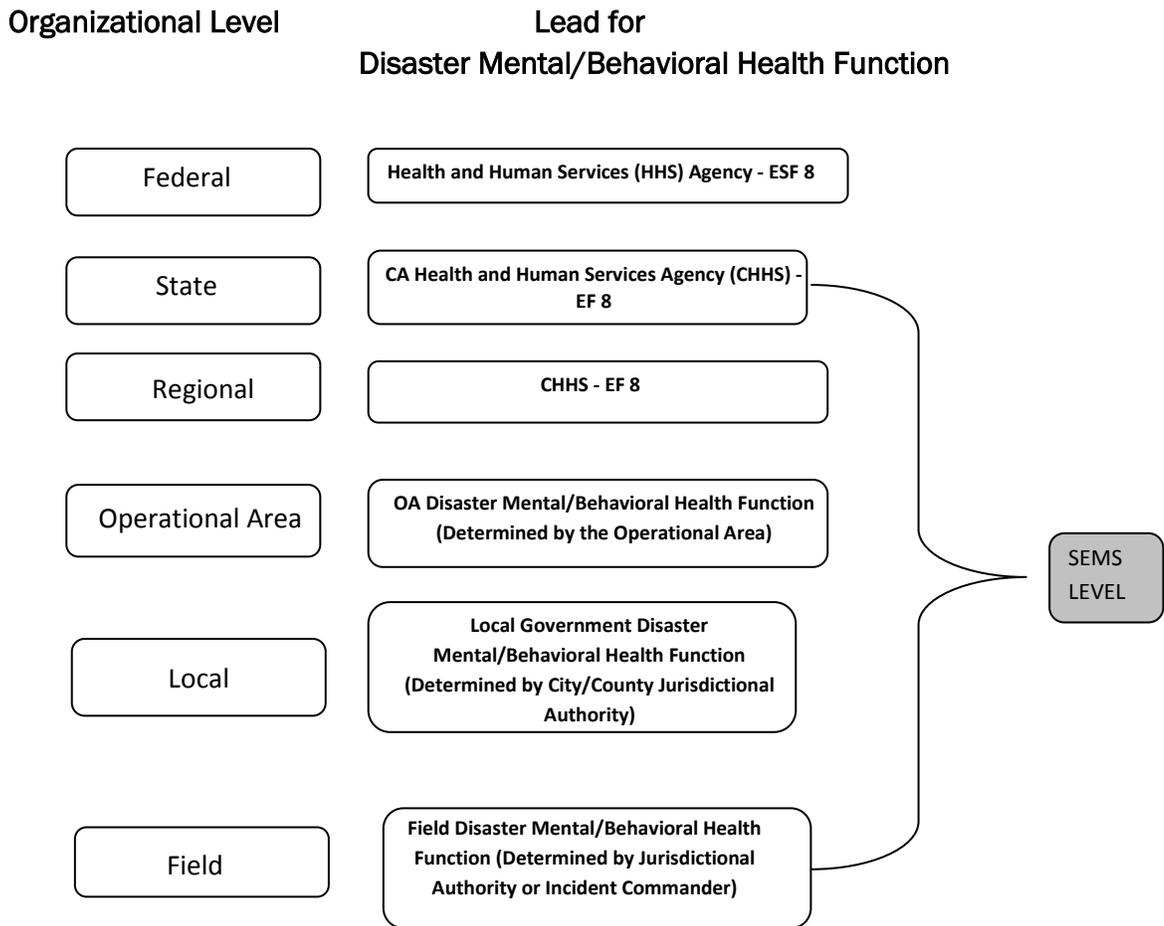
Many non-governmental, community-based and faith-based organizations and businesses provide mental/behavioral health services during an emergency. Provision of services should be coordinated with the disaster mental/behavioral health function at the appropriate SEMS level in order to ensure a coordinated response and prevent duplication of effort.

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<sup>18</sup> FEMA, National Disaster Recovery Framework (September 2011).

<sup>19</sup> For more information see the California Native American Heritage Commission website (<http://www.nahc.ca.gov/default.html>)

**Figure 1 - Disaster Mental/Behavioral Health Organizational Levels**



### 6.3 Disaster Mental/Behavioral Health Programs and Services

This section identifies and provides an overview of programs and services that are used in response and recovery efforts. More detailed information and links to resources are included in Appendix F.

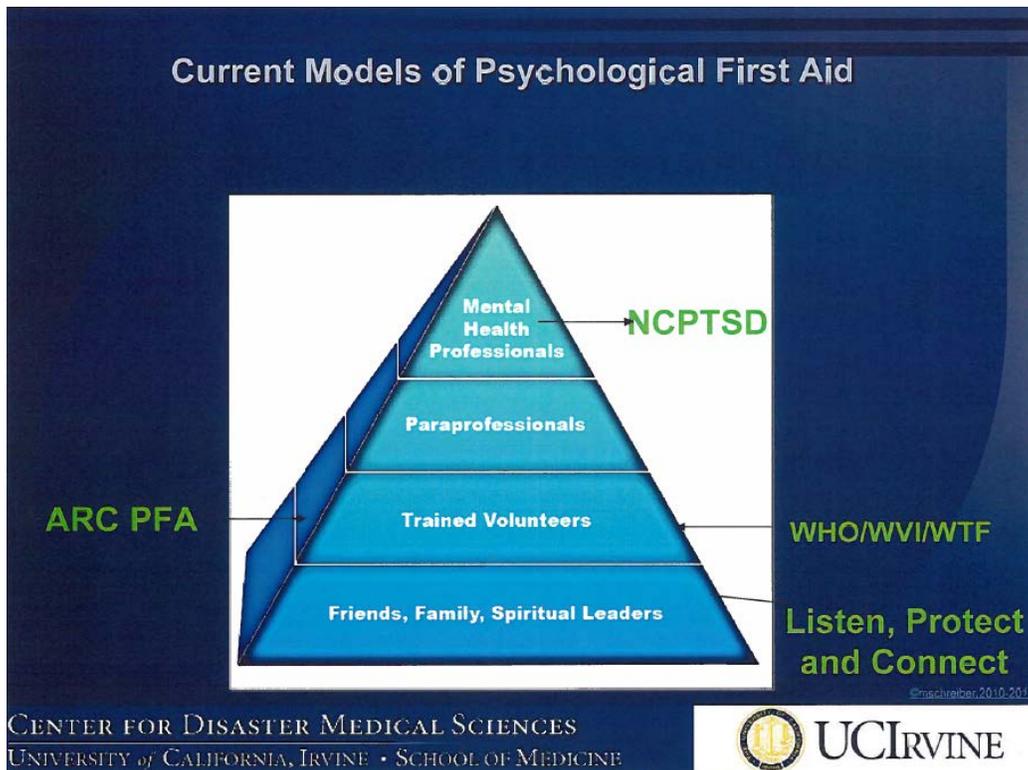
#### 6.3.2 Psychological First Aid (PFA)

PFA is an evidence-informed approach to help survivors and/or emergency response personnel in the immediate aftermath of a traumatic event. It is designed to reduce initial distress caused by these events and to foster short and long term adaptive functioning and coping. PFA is designed for delivery in diverse settings such as shelters, field hospitals/medical triage areas, acute care facilities, staging area/respice centers for first responders/relief workers, emergency

operations centers, feeding locations, local assistance centers/disaster recovery centers, family reception centers, homes, businesses, and other community settings.<sup>20</sup>

There are multiple PFA models available aimed at different levels of PFA providers, including the American Red Cross model<sup>21</sup>; the National Child Traumatic Stress Network and the National Center for PTSD model<sup>22</sup>; and the Listen-Protect-Connect model<sup>23</sup>. Figure 2 is a graphic illustration of the current models and their intended users.

**Figure 2. Current Models of Psychological First Aid<sup>24</sup>**



<sup>20</sup> Tennessee Disaster Mental Health Response, 2012, pg. 9.

<sup>21</sup> Psychological First Aid: Helping Others in Times of Crises. American Red Cross, DSCL 206A. Available at American Red Cross Chapters Nationally. [www.redcross.org](http://www.redcross.org)

<sup>22</sup> <http://www.nctsn.org/content/psychological-first-aid>

<sup>23</sup> [http://www.ready.gov/sites/default/files/documents/files/LPC\\_Booklet.pdf](http://www.ready.gov/sites/default/files/documents/files/LPC_Booklet.pdf)

<sup>24</sup> Disaster Mental Health Concept of Operations for Public Health of Seattle and King County, 2012 (Original Source: UC Irvine).

**RECOMMENDED ACTIONS:**

- Work with stakeholders to review the available PFA models, and determine which model(s) will be used in your jurisdiction.
- Work with stakeholders to determine the best way to train and disseminate PFA to the community using a community-based PFA. Also ensure that PFA is offered in acceptable formats as well as delivery in the appropriate language, and manner that accommodates cultural sensitivity.
- Work with stakeholders to determine the best way to train and disseminate PFA to mental health providers, including licensed professionals as well as volunteers.
- Provide training for first responders in PFA.

**6.3.3 Crisis Counseling Assistance and Training Program (CCP)**

In the aftermath of a presidentially declared disaster, the Stafford Act provides for a number of individual assistance programs including the Crisis Counseling Program (CCP).

**Sec. 416. Crisis Counseling Assistance and Training (42 U.S.C. 5183)**

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

CCP is a FEMA (Federal Emergency Management Agency)-funded program and the Health and Human Services Agency/Substance Abuse and Mental Health Services Administration (SAMHSA) provides grant administration, program oversight, training and technical assistance. (More information about CCP can also be found in Appendix F - Disaster Mental/Behavioral Health Programs and Services.) The CCP provides supplemental funding to States, U.S. Territories, and federally recognized Tribes<sup>25</sup>.

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<sup>25</sup> Federal Emergency Management Agency Crisis Counseling Assistance and Training Program Guidance CCP Application Toolkit, Version 3.4 May 2012 , Pg. 8

**RECOMMENDED ACTIONS:**

- To prepare for FEMA/SAMHSA's strict deadline for the submission of a CCP grant application, familiarize yourself with SAMHSA's guidance materials (see Appendix F – Disaster Mental/Behavioral Health Programs and Services).
- Identify key staff that will become familiar with the process used to apply for the CCP grant programs, including specialized crisis counseling in your jurisdiction. Cal EMA will submit the application to the federal government on behalf of the local jurisdiction and direct local jurisdictions to State subject matter experts that can assist them in completing the application.
- Ensure that key staff are very familiar with how to access federal resources available from Substance Abuse and Mental Health Services Administration (SAMHSA)/ Disaster Technical Assistance Center (DTAC), including the nationwide Distress hotline for crisis counseling and support ([www.disasterdistress.samhsa.gov](http://www.disasterdistress.samhsa.gov)).
- If possible, pre-identify providers from within your jurisdiction that could be used as contractors to provide crisis counseling services in a CCP.
- Ensure that systems are in place to document initial disaster behavioral health response efforts.
- If there is sufficient time during a pre-notification of an event, begin collecting information and writing applicable portions of a grant application in anticipation of a Presidential Disaster Declaration.
- Ensure that your stakeholder group is also educated on federal disaster mental health resources, grants (including fiscal requirements and oversight by the grant administrators - Cal EMA and FEMA), and hotline and to determine how to integrate these resources in your jurisdiction.
- Consider working with Departments of Mental Health statewide to sponsor a training or exercise to practice procedures to apply for CCP funds prior to the next disaster.

The CCP consists of services focused on preventing or mitigating adverse repercussions of a disaster. This goal is achieved through the use of a prevention and public health approach. Beginning with the most severely affected group and moving outward, the program seeks to serve a large portion of the population affected by the disaster. Program services are community based and often are performed in survivor's homes, shelters, temporary living sites, and churches. CCP services include supportive crisis counseling, education, development of coping skills, and linkage to appropriate resources, while assessing and referring those members of the community who are in need of more intensive mental health and substance use treatment to appropriate community resources. The CCP engages community gatekeepers and organizations through direct contact with stakeholder groups, such as unmet-needs committees, and participation in community events in order to facilitate response activities and services to survivors. The CCP is designed to assist with community recovery and collaboration in

order to transition from CCP services to existing community resources upon the phase down of the program.<sup>26</sup>

The CCP is designed to provide immediate behavioral health support, primarily relying on face-to-face contacts with survivors in their communities. The CCP provides these support-centered services to survivors over a specific period of time. The CCP includes the Immediate Service Program (ISP) with funding for up to 60 days after the date of the Presidential disaster declaration and the Regular Services Program (RSP) which provides funding for up to 9 months from the date the RSP is awarded.

Special enhanced projects may be developed following a disaster if circumstances warrant. These added programs are only for very specific situations and only during catastrophic events. In cases of such as 9/11 in New York and Hurricane Katrina for both Mississippi and Louisiana, the states applied for and received grant funding under the CCP for both ISP and RSP. However, due to the types of events and impacts special enhanced projects were developed and eventually funded under the regular CCP. There is evidence that this model can result in significantly improved client outcomes<sup>27 28</sup>. Specialized crisis counseling service interventions are provided by licensed or certified mental health professionals. Currently, FEMA and SAMHSA are working together on guidelines regarding when these types of services may be considered under a CCP and at what level of an event.

#### **6.3.3.1 CCP Services**

Below are eight key principles that guide the CCP approach and a description of the services:

- **Strengths based:** Crisis counselors assume natural resilience in individuals and communities, and promote independence rather than dependence on the CCP, other people, or organizations. Crisis counselors help survivors regain a sense of control.
- **Outreach oriented:** Crisis counselors take services into the communities rather than wait for survivors to seek them.
- **More practical than psychological in nature:** Crisis counseling is designed to prevent or mitigate adverse repercussions of disasters rather than to treat them. Crisis counselors provide support and education, listen to survivors, and accept the content at face value. Crisis counselors help survivors to develop a plan to address

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<sup>26</sup> Information in this section is from the Tennessee Disaster Mental Health Response, 2012, pgs. 11-12.

<sup>27</sup> Donahue, S. A., Jackson, C. T., Shear, K. M., Felton, C.J., & Essock, S.M. (2006). Outcomes of enhanced counseling services provided to adults through Project liberty. *Psychiatric Services, 57*, 1298-1303.

<sup>28</sup> Jones, K., Allen, M., Norris, F., Miller, C. Piloting a New Model of Crisis Counseling: Specialized Crisis Counseling Services In Mississippi after Hurricane Katrina. *Admin. Policy Mental Health (2009)36*: 195-205.

self-identified needs and suggest connections with other individuals or organizations that can assist them.

- **Diagnosis free:** Crisis counselors do not classify, label, or diagnose people; they keep no records or case files. The CCP does not provide mental health or substance use treatment, or critical incident stress debriefing. Services are supportive and educational in nature.
- **Conducted in nontraditional settings:** Crisis counselors make contact with survivors in their homes and communities, not in clinical or office settings.
- **Culturally competent:** Crisis counselors strive to understand and respect the community and the cultures within it, and to demonstrate positive regard when interacting with survivors.
- **Designed to strengthen existing community support systems:** Crisis counselors support, but do not organize or manage, community recovery activities. Likewise, the CCP supplements, but does not supplant or replace, existing community systems.
- **Provided in ways that promote a consistent program identity:** Crisis counselors should work together early to establish a unified identity. The CCP strives to be a single, easily identifiable program, even though it may be carried out by a number of different local provider agencies.

### **6.3.3.2 CCP Primary and Secondary Services**

There are two types of CCP services—primary and secondary. Primary CCP services are higher in intensity as they involve personal contact with individuals, families, or groups. Secondary CCP services have a broader reach and less intensity since they may be provided through written or electronic media. Examples of both are described below.

#### **Primary CCP Services**

##### ***Individual Crisis Counseling***

Individual crisis counseling involves a process of engagement lasting at least 15 minutes. Its focus is to help disaster survivors understand their reactions, review their options, and connect with other individuals and agencies that may assist them in improving their situations. Staff members who provide individual crisis counseling are active listeners who offer reassurance, practical assistance, psycho-education, and emotional support, and who teach behavioral techniques for coping with stress.

##### ***Brief Educational or Supportive Contact***

Educational information or emotional support is provided to individuals or groups, and typically is less than 15 minutes in duration. CCP staff members who provide brief educational or supportive contact are helpful educators and active listeners. They offer general support and provide general information, typically on resources and services available to disaster survivors. During this type of intervention, crisis counselors do not usually engage in in-depth discussion as they would during individual crisis counseling or psycho-education.

### *Group Crisis Counseling*

Group crisis counseling occurs when disaster survivors and community members are brought together to meet for longer than 15 minutes. The group is led by a trained crisis counselor. The structure and format of group crisis counseling may vary, but group members should have similar levels of exposure to the disaster. Groups may be supportive or psycho-educational in nature. CCP crisis counselors who facilitate this service encourage the group members to do most of the talking, and they offer skills to help the group members cope with their situations and reactions. Throughout the process, the counselors assist group members with referrals to services often needed.

In addition to psycho-education or support groups, the CCP also may promote the development of self-help groups. CCP-initiated self-help groups should be facilitated by a professional or paraprofessional crisis counselor. The group can work toward autonomy by inviting a member to be a co-facilitator. Initially, the crisis counselor may be the primary leader of the group. Later, the group may continue without the presence of a professional or paraprofessional counselor, and be led by one or more of the group members. When group members are responsible for their own group process without the benefit of the presence of a professional or paraprofessional (a self-help support group), the group can no longer be considered a CCP effort, since the quality of the group process cannot be guaranteed and lacks reporting or accountability mechanisms.

### *Public Education*

CCP outreach staff provide survivors with information and education about typical reactions, helpful coping strategies, and available disaster related resources. CCP staff members commonly provide this service through public speaking at community forums, professional in-service meetings, and local government meetings. In contrast to the group crisis counselor, the CCP staff member who conducts public education does most of the talking. The need for public educational services is likely to increase throughout the course of the CCP.

### *Assessment, Referral, and Resource Linkage*

Crisis counselors are trained to assess an individual's or family's need for referral to additional disaster relief services or mental health or substance use treatment. Crisis counselors refer survivors experiencing severe reactions to the appropriate level of care. Survivors also may be referred to other disaster relief resources to meet a wide range of physical, structural, or economic needs. The crisis counselors who provide assessment and referral services need to be knowledgeable about local resources and work diligently to engage community organizations.

### *Community Networking and Support*

Crisis counselors build relationships with community resource organizations, faith-based groups, and local agencies. They often attend community events to provide a compassionate presence and to be available to provide crisis counseling services, when

needed. They may initiate or attend unmet-needs committee or long-term recovery meetings, or other disaster relief-oriented gatherings. It is important to note that communities, families, and survivors should “own” their community events. Crisis counseling staff can provide useful consultation during the planning process and valuable information and services at these events to demonstrate their support for members of the community.

### **Secondary CCP Services**

#### *Development and Distribution of Educational Materials*

Flyers, brochures, tip sheets, educational materials, or Web site information is developed and distributed by the CCP workers to educate survivors and the community. Topics include basic disaster information, typical reactions to disaster, coping skills, and individual and community recovery and resilience. Materials that address the needs of at-risk populations, as well as materials developed in multiple languages, should be available. Materials may be handed out or left in public places, published in local newspapers, or mailed to survivors in areas most affected by a disaster. Examples of these materials can be obtained from SAMHSA DTAC. (<http://www.samhsa.gov/dtac/>)

#### *Media and Public Service Announcements*

CCP staff engage in media activities and public messaging in partnership with local media outlets, State and local governments, charitable organizations, or other community brokers of information. Media activities and messaging are designed to reach a large number of people in order to promote access to CCP services, and educate survivors and the community about disaster, disaster reactions and coping skills, and individual or community recovery and resilience. Venues for this messaging vary and may include media interviews with CCP spokespeople, television or radio public service announcements, use of Web sites or e-mail, or advertising.

### **6.3.4 Substance use and Mental Health Services Administration (SAMHSA)/Disaster Technical Assistance Center (DTAC)**

SAMHSA DTAC supports the SAMHSA Center for Mental Health Services in the provision of disaster behavioral health technical assistance grant support to eligible States, Territories, and federally recognized Tribes. SAMHSA DTAC staff members are knowledgeable about the experiences of States that have confronted certain types of disasters, and they can relay lessons learned and best practices that have grown out of these experiences. DTAC staff will assist with identifying suitable publications, psychoeducational materials, and expert consultants. (<http://www.samhsa.gov/dtac/CCPtoolkit/ISP.htm>)

### **6.3.5 SAMHSA Disaster Distress Helpline**

The Disaster Distress Helpline (DDH) is the first national hotline dedicated to providing year-round disaster crisis counseling. This toll-free, multilingual, crisis support service is available 24/7 via telephone (1-800-985-5990) and SMS (text 'TalkWithUs' to 66746) to

residents in the U.S. and its territories who are experiencing emotional distress related to natural or man-made disasters. Callers and texters are connected to trained and caring professionals from the closest crisis counseling center in the network. Helpline staff provides counseling and support, including information on common stress reactions and healthy coping, as well as referrals to local disaster-related resources for follow-up care and support. (<http://disasterdistress.samhsa.gov/>)

## 7 Concept of Operations

This section describes California's response and recovery Concept of Operations (CONOPS) to address the mental/behavioral health impacts of disasters. A CONOPS explains in broad terms the decision maker's or leader's intent with regard to an operation. A CONOPS gives an overall picture of how the response organization accomplishes a mission or set of objectives in order to reach a desired end-state. It offers a clear methodology to realize the goals and objectives to execute the plan. The CONOPS may include a brief discussion of the activation levels identified by the jurisdiction for its operations center and may touch on direction and control, alert and warning, and continuity matters that may be dealt with more fully in annexes or other areas of the plan.<sup>29</sup>

### 7.1 Operational Goals and Priorities

The operational goals of the Framework are to:

- Lessen the psychological impact of disasters by promoting community, responder, and public psychological resiliency before and during a disaster
- Provide long-term mitigation of mental/behavioral health vulnerabilities following recovery activities through Specialized Crisis Counseling Program and other evidence based mental health interventions;
- Respond to disasters with a focus on mental/behavioral health as a basic human need, while coordinating disaster mental/behavioral health response on a population basis using evidence-informed tools and crisis standards of care (see IOM reference above)

The operational priorities of this Framework are to protect mental/behavioral health, personal safety and well-being, and promote community, responder, and public psychological resiliency.

#### 7.1.1 Emergency Activation Levels

Activation of the disaster mental/behavioral health function is scaled to the nature and scope of the emergency and allows the activating authority to appropriately staff incident positions.

Emergency activations may occur during the pre-event phase or after an event has occurred.

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<sup>29</sup> The description of a CONOPS is based on the Federal Emergency Management Agency, *Comprehensive Preparedness Guide 101: Developing and Maintaining Emergency Operations Plans*, November 2010, pg. 3-13.

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### Level I Emergency Activation

Definition	Level I activation represents a minor to moderate incident where <u>local resources are adequate and available</u> . A local emergency may be proclaimed. Emergency Operations Centers (EOC) and/or Department Operations Centers (DOC) may be activated.
Examples	<ul style="list-style-type: none"><li>○ A minor disaster that does not result in major personal loss such as death, destruction, economic or personal losses;</li><li>○ A seemingly manageable earthquake or public health threat;</li><li>○ A mass casualty event such as a crime event or sizeable transportation accident high in injuries or loss of life (airliner, train, severe traffic accident).</li></ul>
Mental/Behavioral Health Response	A disaster mental/behavioral health response based on casualties, injuries and other losses is generally within the capacity of the County Mental/Behavioral Health Department. Typically, a DMH jurisdiction may handle this event from the Disaster Coordinator's office when the DOC has not been activated. Alert the CDPH Duty Officer or Medical Health Coordination Center (MHCC) if activated.

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### Level II Emergency Activation

Definition	Level II activation represents a moderate to severe emergency where <u>local resources may not be adequate and mutual aid is required</u> on a regional or even statewide basis. A local emergency will be proclaimed and a State of Emergency will likely be proclaimed. The Governor proclaims a STATE OF EMERGENCY when a disaster requires extraordinary action by the State in order to protect the lives, property and environment of its citizens. EOCs and DOCs are activated to the extent necessary at the local government, tribal government, operational area, regional and state levels.
Examples	<ul style="list-style-type: none"><li>○ A moderate disaster with escalating degrees of loss (death, destruction, economic and personal losses) and potential for crisis and trauma;</li><li>○ A disaster situation that is escalating slowly or on a continuum and has the potential to expand as more time goes passes;</li><li>○ A public health threat that is challenging to manage and has potential for transmission to other areas or raising public fear and anxiety.</li></ul>
Mental/Behavioral Health Response	Depending on the mental health resources, a disaster mental/behavioral health response may be within the capacity of the County

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### Level II Emergency Activation

Health Response	Mental/Behavioral Health Department. The Mental Health Department Operations Center will usually be activated for a short period of time; the timeframe will depend upon the needs of the incident and coordination with the EOC. The jurisdiction may require additional resources from within the Mutual Aid Region to support an increasing and/or protracted response. Alert the CDPH Duty Officer or MHCC if activated.
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### Level III Emergency Activation

Definition	Level III activation represents a major disaster wherein <u>resources in or near the impacted areas are overwhelmed and needs are extensive. State and or Federal resources are required.</u> The Governor proclaims a STATE OF EMERGENCY first and then requests a PRESIDENTIAL DISASTER DECLARATION on behalf of the affected local governments. EOCs and DOCs are activated at the local government, tribal government, operational area, regional and state levels and by the federal government.
Examples	<ul style="list-style-type: none"> <li>○ A natural disaster with catastrophic impact (earthquake);</li> <li>○ A human-caused incident involving weapons of mass destruction (chemical, biological, radiological, nuclear, explosive) with catastrophic impact;</li> <li>○ A public health emergency with implications of wide-scale illness, contagion, transmission, death and public fear, anxiety and potential for panic;</li> <li>○ A large-scale disaster with extensive economic impacts (e.g., high numbers of unemployed due to a freeze or drought)</li> </ul>
Mental/Behavioral Health Response	A disaster mental/behavioral health response will exceed the capacity of the County Mental/Behavioral Health Departments and will require resources from other Mutual Aid Regions, the State, federal government and/or other states. Alert the CDPH Duty Officer or MHCC if activated.

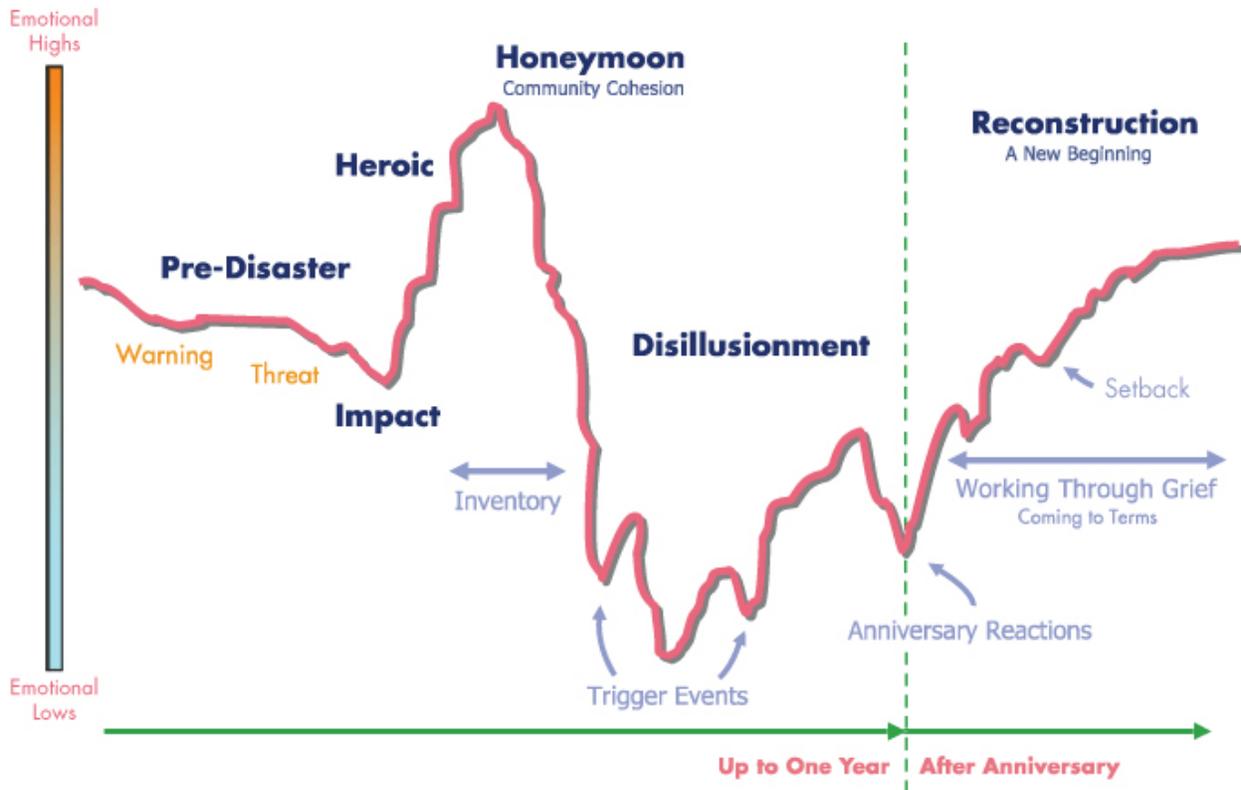
#### 7.1.2 Sequence of Events - Disaster Mental/Behavioral Health Entities and the Community

The sequence of events describes the overall disaster mental/behavioral health activities before, during and after an emergency event for governmental and non-governmental agencies and organizations, as well as the general progression of the disaster effects and reactions on communities. Information from the FEMA/SAMHSA Crisis Counseling Program Application Toolkit, Version 3.4, May 2012, about collective reactions of communities is illustrated in Figure

2 and described, together with the disaster mental/behavioral health and emergency management, in this section.

**FIGURE 2 - PHASES OF DISASTER: COLLECTIVE REACTIONS**

(SOURCE: FEMA/SAMHSA CCP Application Toolkit, Version 3.4, May 2012)



### 7.1.3 Response

#### Pre-Event

Prior to an emergency, agencies/organizations with disaster mental/behavioral health functions monitor events for potential impacts to the mental/behavioral health of individuals and communities. Disasters vary in the amount of warning communities receive before they occur. When there is no warning, survivors may feel more vulnerable, unsafe, and fearful of future unpredicted disasters. The perception that they had no control over protecting themselves or their loved ones can be deeply distressing.

Sufficient warning provides the opportunity for disaster mental/behavioral health agencies/organizations to increase readiness and to effectively respond once the emergency occurs and to ensure the community is warned. This includes, but is not limited to:

- a. Briefing officials of the potential for mental/behavioral health impacts to individuals, including responders, and communities.
- b. Reviewing disaster mental/behavioral health plans and procedures.
- c. Identifying those mental/behavioral health systems and resources which would constitute a likely system of care following a disaster, including both “routine” systems and resources as well as supplemental or “surge” resources.
- d. Preparing and disseminating disaster mental/behavioral health information to the community through approved channels.
- e. Precautionary activation of the disaster mental/behavioral health function, including notifying and briefing agency points of contacts; identifying available personnel for assignment to EOCs and DOCs ; and placing disaster mental/behavioral health personnel or teams on stand-by or alert status.

### **Impact**

During this phase, emphasis is placed on control of the situation, saving lives and minimizing the effects of the disaster, including adverse mental/behavioral health impacts. The impact phase of a disaster can vary from the slow, low-threat buildup associated with some types of floods to earthquakes and other rapid, dangerous disasters with destructive outcomes. The greater the scope, community destruction, and personal losses associated with the disaster, the greater the psychosocial expected effects. In the immediate aftermath of a disaster event, survival, rescuing others, and promoting safety are priorities (the "heroic" phase). Evacuation to shelters, motels, or other homes may be necessary. The conditions associated with evacuation and relocation have psychological significance. When there are physical hazards or family separations during the evacuation process, survivors often experience post-trauma reactions.

Activities carried out during this phase by agencies/organizations with disaster mental/behavioral health functions include, but are not limited to:

**RECOMMENDED ACTIONS:**

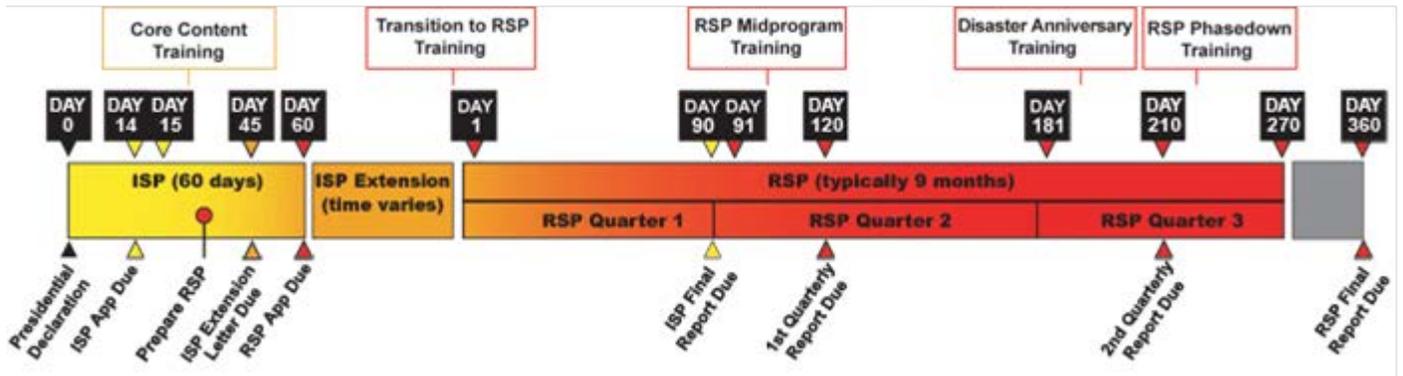
- Alert and notification of disaster mental/behavioral health agencies/organizations about the occurrence of an event usually comes through the local Office of Emergency Management, or participation through other regional and state processes and procedure, including California Health Alert Network (CAHAN) - a secure, web-based communication and information system.
- Activation of the disaster mental/behavioral health function at the field, local government, OA, region and state levels.
- Activation of the local DMH EOC/DOC and implementation of Department Emergency Plans. For example:
  - Emergency Personnel recalled
  - Dispatch of field teams to various impacted locations.
  - Call Center if activated.
  - Filling behind essential programs
- Initiate mental health triage and needs assessment methods including the FEMA CCP program toolkit data collection forms to produce and maintain situational awareness of the scope of disaster mental/behavioral health needs including the timely identification of at-risk individuals, available resources, and response gaps.
- Activation of the disaster mental/behavioral health function at the field, local government, OA, region and state levels.
- Participate in Multiagency Coordination (MAC) groups to coordinate disaster mental/behavioral health activities above the field level and to prioritize the incident demands for critical or competing disaster mental/behavioral health resources.

Prior to a Presidential Disaster Declaration, activities are underway regarding preparation for the CCP. These include:

- Cal EMA Individual Assistance (IA) - Notifies CHHS Disaster Services of disaster/event that has impacts to people and has the potential to elevate to a Presidential Major Disaster Declaration.
- Disaster Services will make initial contact with the impacted County's Mental Health Disaster Coordinator (DC) to verify status and size of County Mental Health activation and response activities.
- CHHS Disaster Services - Surveys impacted local mental health (via a needs assessment) to identify an interest in applying for the ISP grant.

The diagram below depicts the tight timeline that Counties must follow to seek reimbursement from the FEMA funded CCP. It is critical to note that the document must be completely signed off by local officials and hand delivered to the State representative on the 10<sup>th</sup> day, from the date of the disaster.

**FIGURE 3 – Phases of Disaster<sup>30</sup>**



**Short Term Sustained Operations**

As the situation continues, further disaster mental/behavioral health assistance is provided and efforts continue to reduce the impact of the disaster on the mental/behavioral health of individuals and communities.

During the week to months following a disaster (the "honeymoon phase") and before transition into Recovery, formal governmental and volunteer assistance may be readily available. It should be noted that many initial recovery activities are conducted current with short-term sustained operations.

Disaster mental/behavioral health assistance during sustained operations may include:

- Identify triggers and transition to a longer term operation, which may include a CCP funded contractor.
- Continue to provide resources to support response activities.
- Depending on the event, some of the following sites may not be operational. If open, then mental health operations may continue to support shelters, Family Assistance Centers, Local Assistance Centers, reception and service centers, schools, businesses, places of worship, natural gathering sites and open spaces unique to each local community, parks, fields, empty lots, casualty collection points, mental health facilities, hospitals and other medical treatment sites, isolation and quarantine sites, and points of distribution, etc.

<sup>30</sup> Myers, D. & Zunin, L. Phases of disaster. In Myers, D. & Wee, D. (2005). *Disaster mental health services: A primer for practitioners* (pp.18-24). New York: Brunner-Routledge.

#### 7.1.4 Recovery

Recovery has three phases - short, intermediate, and long-term<sup>31</sup>. Short-term recovery begins concurrently with or shortly after the commencement of response operations and may last for days. This phase addresses health and safety needs beyond rescue, assessment of the scope of damages and needs, restoration of basic infrastructure and mobilization of recovery organizations and resources.

Intermediate to long-term recovery per the CCP program may last for weeks or months and involves returning individuals, families, critical infrastructure and essential government or commercial services to a functional, if not pre-disaster, state.

Longer-term recovery may continue for years and addresses complete redevelopment and revitalization of the impacted area, rebuilding or relocating damaged or destroyed social, economic, natural and built environments and a move to self-sufficiency, sustainability and resilience.

Disaster mental/behavioral health recovery activities, many of which will take place concurrently with response activities, may include:

- Monitoring and reporting on approved FEMA CCP Immediate and Regular Services Program Grant activities and Specialized Crisis Counseling Program if available.
- Provision and coordination of disaster mental/behavioral health services to survivors including new or on-going crisis counseling and other interventions for individuals and populations with newly emerging and ongoing mental/behavioral health needs including stress management services for responders and caregivers.
- Identification of informational and psycho-educational resources related to disaster recovery and resilience and provision of access to this information through recovery information channels.

#### **RECOMMENDED ACTIONS:**

- At this point in time, the local jurisdiction should have submitted their application for the FEMA CCP Immediate Service Program.
- Normally a contractor is hired to provider services funded under this grant.
- Implementation of approved FEMA CCP Immediate Services Program Grant activities.
- The local jurisdiction may apply for the FEMA funded Regular Services Grant Program. This grant may continue for approximately nine months.

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<sup>31</sup> FEMA National Disaster Recovery Framework (September 2011). A Southern California Recovery Guide is also in final stages of development through efforts of the Urban Area Security Initiatives (UASI).

## 7.2 Alert and Notification

When an unusual event or emergency system activation occurs, providing incident information to response partners is critical. Prompt notification of response partners is likely to reduce incoming requests for information from multiple sources and allow response partners to anticipate the need for additional resources to support the affected jurisdiction.

### 7.2.1 Notification Methods

Notification methods may include email, telephone, pager or a combination of these through the California Health Alert Network<sup>32</sup> (CAHAN) and other systems as designated by state and local agencies. The method utilized typically reflects the urgency associated with the specific incident.

#### RECOMMENDED ACTION:

- Contact the local Public Health CAHAN Coordinator for information on and inclusion in this network.  
<http://www.bepreparedcalifornia.ca.gov/CDPHPrograms/PublicHealthPrograms/EmergencyPreparednessOffice/CAHAN/Pages/CAHANInformation.aspx>

### 7.2.2 Field

When field-level mental/behavioral health entities become aware of an incident that may impact mental/behavioral health, they should notify local, tribal, and state agencies in accordance with statutory and regulatory requirements and policies and procedures.

### 7.2.3 Local Government

When an emergency includes potential mental/behavioral health impacts, the local government agencies overseeing mental/behavioral health should notify local, tribal, and state agencies in accordance with statutory and regulatory requirements and local policies and procedures, the Operational Area and the CDPH Duty Officer or MHCC if activated.

### 7.2.4 Operational Area

When emergencies occur that affect their jurisdiction, the Operational Area is responsible to carry out notifications within the OA, including tribal governments, in accordance with laws and protocols. The OA also makes initial notifications to the Cal EMA Regional Office/Duty Officer or directly to the California State Warning Center (CSWC) in accordance with existing laws, protocols, or when state assistance is requested or anticipated.

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<sup>32</sup> The California Health Alert Network (CAHAN) is the State of California's web-based information and communications system available on a 24/7/365 basis for distribution of health alerts, dissemination of prevention guidelines, coordination of disease investigation efforts, preparedness planning, and other initiatives that strengthen state and local preparedness.

<http://www.bepreparedcalifornia.ca.gov/cdphprograms/publichealthprograms/emergencyPreparednessOffice>

If the emergency has a significant potential mental/behavioral health impact, the OA should notify the entity responsible for the disaster mental/behavioral health function and, as appropriate, the MHOAC Program of the event. The OA should also advise the Cal EMA Regional Office/Duty Officer or CSWC so that the CDPH Duty Officer or MHCC if activated and the RDMHC Program are notified.

The OA will coordinate notifications to the public within the OA and advise the Cal EMA Administrative Region of the notifications.

#### **7.2.5 Region/State**

Upon notification by the OA or the CSWC of an emergency with significant potential mental/behavioral health impacts within the Cal EMA Administrative Region, the Cal EMA Regional Duty Officer will notify the Cal EMA Executive Duty Officer (EDO).

Cal EMA EDO will notify the CDPH duty officer. In the event the REOC and SOC are activated, notifications of an event with significant potential mental/behavioral health impacts will be coordinated through the REOC/SOC to the CDPH duty officer or MHCC (if activated). The EDO/SOC will notify the FEMA, Region IX of the event overall.

The CDPH Duty Officer or MHCC, if activated, will notify identified agencies and organizations of the potential mental/behavioral health impacts.

Notifications to the public made at the state level will be coordinated through the State Joint Information Center and with all affected governmental levels.

#### **7.2.6 Federal**

The HHS Secretary activates a department-wide response based on FEMA activation of the National Response Framework ESF #8 or determination that a significant incident or public health emergency requires a department-wide response. HHS Operating Divisions/Staff Divisions and ESF #8 partners are activated through HHS Secretary's Operations Center for response activities.

### **7.3 Direction, Control, and Coordination**

Direction, control and coordination of disaster mental/behavioral health response and recovery operations are consistent with SEMS and NIMS. Local government, tribal government, operational area, regional and state emergency operations centers coordinate the provision of governmental, non-governmental and private sector resources to support field operations.

#### **7.3.1 Field Operations**

Field personnel and teams respond to all emergencies using the Incident Command System. The overall tactical responsibility for responding during an emergency is with Incident Command/Unified Command (IC/UC).

Mobilization and deployment of disaster mental/behavioral health personnel and teams to field operations may be requested through the Emergency Operations Center or Department Operations Center by the IC/UC or by emergency functions (i.e., Public Health and Medical or Mass Care and Shelter). Disaster mental/behavioral health workers will not enter an impacted area until their safety can be reasonably assured.

### **7.3.2 Local Emergency Operations Centers**

City and county local governments activate their EOCs to support significant emergency responses, including disaster mental/behavioral health issues. Counties are responsible for coordinating mental health services in California with the exception of the City of Berkeley and the tri-city area of Pomona, Claremont, and La Verne that have their own mental health programs. Local government disaster mental/behavioral health resources are typically drawn from county or city staff, contracted services, and pre-screened and registered volunteers (e.g., from California's Disaster Healthcare Volunteers Registry or ESAR-VP).

They may also be assigned to locations where large numbers of responders or emergency management personnel are working, as these personnel represent identifiable at-risk populations. The local government mental/behavioral health agency coordinates resources. If local government mental/behavioral health resources are not available or are overwhelmed, resource requests will be forwarded to and coordinated by the disaster mental/behavioral health function in the Medical Branch of the Operational Area EOC.

### **7.3.3 Operational Area Emergency Operations Centers**

The operational area (OA) activates its EOC consistent with SEMS to manage and/or coordinate information, resources, and priorities among local governments within the OA and to serve as the coordination and communication link between the local government level and the regional level.

It is anticipated that an event requiring a significant disaster mental/behavioral health response will also require OA EOC activation. In this situation, the OA disaster mental/behavioral health function will be staffed in the EOC. As an integral part of the OA's public health and medical response, the OA disaster mental/behavioral health function should (a) be coordinated as part of the Medical and Health Operational Area Coordinator (MHOAC) Program, (b) be co-located in the OA EOC Medical/Health Branch and (c) serve as liaison to the County Mental/Behavioral Health Department. If OA resources are not available or are overwhelmed, resource requests for personnel and commodities (e.g., medical supplies, pharmaceuticals, equipment, etc.) will be forwarded to and coordinated by the Regional Emergency Operations Center in accordance with SEMS and the Resource Management procedures identified in the Public Health and Medical Emergency Operations Manual. For additional information about types of resources to request, please see Appendix G - Resources.

#### **7.3.4 Regional Emergency Operations Centers**

The California Emergency Management Agency has two Regional Emergency Operations Centers (REOC). The REOC is activated consistent with SEMS regulations to manage and coordinate information and resources among operational areas within the region and between the operational areas and the state level. The regions coordinate overall state agency support for emergency response activities within their boundaries.

When there is or may potentially be a significant mental/behavioral health impact in a disaster, the regional disaster mental/behavioral health function is initially carried out at the REOC by a representative of EF 8. The regional disaster mental/behavioral health function operates under the response goals, priorities and missions as identified in this Framework and as requested by the REOC consistent with operational needs and authorities. As an integral part of the regional public health and medical response, the regional disaster mental/behavioral health function will be co-located with or, at a minimum, must coordinate with the Regional Disaster Medical and Health Coordinator (RDMHC). If regional resources are not available or are overwhelmed, resource requests will be forwarded to and coordinated by the State Operations Center.

#### **7.3.5 State Operations Center**

The State manages state resources in response to the emergency needs of the other SEMS levels, manages and coordinates mutual aid among the regions and between the regional level and state level, and serves as the coordination and communication link with the federal disaster response system. Cal EMA maintains the State Operations Center (SOC) at its headquarters.

When there is or may potentially be a significant mental/behavioral health impact in a disaster, the state disaster mental/behavioral health function at the SOC is assigned to the EF 8 Coordinator. Assignment of the EF 8 coordinator comes from the MHCC. The state disaster mental/behavioral health function operates under the response goals, priorities and missions as identified in this Framework and as requested by the SOC consistent with operational needs and authorities.

Prior to or with the activation of the SOC, the MHCC may also be activated. The MHCC is the EOC for the Public Health and Medical Emergency Response, including mental/behavioral health, shared by CDPH, EMSA and DHCS and expands to provide coordination, information management, and integrated situational status of responding CHHS departments. The role of the MHCC includes the following core functions: coordination; communications; resource deployment and tracking; and information collection, analysis, and dissemination. The disaster mental/behavioral health function will be coordinated between the EF 8 Coordinator at the SOC and the MHCC.

#### **7.3.6 EF 8 Multi-Agency Coordination (MAC) Group**

An EF 8 MAC Group may be convened at the regional or state level with participation across the spectrum of public health and medical entities, including mental/behavioral health, depending on the scope and magnitude of the emergency. EF 8 MAC Group activities may include

prioritization of EF 8 operational objectives, EF 8 resource acquisition and coordination, EF 8 policy management, support for interagency activities, development of emergency public information/risk communication messages and/or coordination with elected and appointed officials. EF 8 MAC Group members immediately share decisions with agencies, emergency response units and emergency management personnel so that implementation is swift and efficient.

#### **7.3.7 Federal/State Unified Coordination**

When the federal government responds to an emergency or disaster within the State, it will coordinate with the state to establish a Unified Coordination Group (UCG) in accordance with Unified Command principles. The UCG will integrate state and federal resources and set priorities for implementation. The UCG may activate a Joint Field Office (JFO) to facilitate the unified operation. When a JFO is activated, the SOC will transfer operations to that facility. An EF 8 Coordinator will deploy to the JFO as requested and will address disaster mental/behavioral health issues as part of their assignment. The MHCC may remain activated to support and coordinate both response and short-term recovery activities.

Federal ESF #8 - Public Health and Medical Services response includes medical needs, public health, mental health, behavioral health, and substance use considerations of incident survivors and response workers. ESF #8 staff in the JFO will conduct a risk analysis, evaluate, and determine the capability required to meet the mission objective and provide required assistance to State, tribal, and local medical and public health officials.

### **7.4 Information Collection, Analysis, and Dissemination**

Emergency operations centers are responsible for gathering timely, accurate, accessible and consistent intelligence during an emergency. Situation reports should create a common operating picture and be used to establish and adjust the operational goals, priorities and strategies. To ensure effective intelligence flow, agencies/organizations with disaster mental/behavioral health tasks at all levels must establish communications systems and protocols to organize, integrate and coordinate intelligence among the affected agencies/organizations.

This section describes situation reporting for events with significant mental/behavioral health impacts.

#### **7.4.1 Disaster Mental/Behavioral Health Information and Intelligence**

Information should support the development of intelligence to estimate people and communities at low, moderate and high risk for mental/behavioral health impacts. This intelligence can support the coordination of disaster mental/behavioral health needs across jurisdictions and organizations to better manage an incident, allocate limited acute-phase psychological resources (such as hospital-based resources), and prioritize mutual aid needs.

Disaster mental/behavioral health information should be integrated through the MOAHC Program with public health and medical information as described in the California Public Health

and Medical Emergency Operations Manual. Information needs will change over time as the incident progresses. However, information gathering and analysis should be streamlined as much as possible and used for different purposes, as applicable, e.g. situation reports and needs assessments.

Listed below are examples of the type of disaster mental/behavioral health information gathered.

- Any population based assessment of mental/behavioral health impacts and needs
- Maintain contact with official sources of fatality, casualty, and other statistics (such as the Coroner, Department of Health, etc.) to obtain ongoing information on numbers of people dead, injured, hospitalized, numbers of homes destroyed/damaged, disaster-related unemployment data, etc. Use this information to determine post-disaster mental health impact and to develop the appropriate community-wide mental health response and recovery plans.
- Information from the CCP application, specifically the CCP Tool Kit database.
- High-risk groups or populations of special concern.
- Potential for psychological harm (acute and long-term).
- Status of mental/behavioral health infrastructure (facility evacuation; status of outpatient providers).
- Patterns of large scale convergence of concerned citizens (worried and well) on health facilities.
- Behavioral/mental health needs of responders.
- Resources for mental/behavioral health care (short term and long term).
- Capabilities for providing disaster mental health and emergency behavioral health care (personnel, medications, etc.), including specific capacity among licensed health care facilities (psychiatric bed counts, pediatric psych bed counts), as well as licensed responders and non-licensed individuals trained in psychological first aid, psychological triage, and other response skills.
- Disaster mental/behavioral health support being provided at shelters, reception and service centers, schools, businesses, places of worship, natural gathering sites and open spaces unique to each local community, parks, fields, empty lots, casualty collection points, mental health facilities, hospitals and other medical treatment sites, isolation and quarantine sites, points of distribution and dispensing, Family Assistance Centers, Local Assistance Centers/Disaster Recovery Centers, call-in centers and other facilities.
- Resources requested.

#### **7.4.2 Field**

Disaster mental/behavioral health information and intelligence will be transmitted from field sites to the appropriate agencies in accordance with established policies and procedures. Information and intelligence will be coordinated through the field site's planning element and disseminated through the command function.

### **7.4.3 Local Government**

Disaster mental/behavioral health information and intelligence will be transmitted from local government EOCs to the OA and appropriate agencies in accordance with established local policies and procedures.

### **7.4.4 Operational Area**

The OA disaster mental/behavioral health function will typically be responsible for gathering disaster mental/behavioral health information and intelligence. The OA disaster mental/behavioral health function should coordinate information and intelligence with the MHOAC Program and establish contact and clear communication lines with the disaster mental/behavioral health function at the REOC.

Information is entered into the OA's specified reporting system and shared within the OA; information is forwarded to the Regional Disaster Mental Health Coordinator (RDMHC) Program as outlined in the California Public Health and Medical Emergency Operations Manual.

Information sources for the OA disaster mental/behavioral health function may include:

- Appropriate City Agencies/EOCs
- Mental/Behavioral Health Department
- Public Health Department
- Department of Social Services
- American Red Cross
- Contracted service agencies
- Community-based organizations
- Health care facilities

### **7.4.5 Region**

The regional disaster mental/behavioral health function is responsible for gathering mental/behavioral health information and intelligence and coordinating information and intelligence with the RDMHC Program and establishes contact and clear communication lines with the disaster mental/behavioral health function at the SOC and MHCC.

Information is processed and forwarded to the state level consistent with the California Public Health and Medical Emergency Operations Manual. Information sources for the regional disaster mental/behavioral health function may include:

- OAs
- Agencies and organizations represented in the REOC, including, but not limited to, Department of State Hospitals, Department of Health Care Services, Emergency Medical Services Authority, Department of Social Services, and American Red Cross.

### **7.4.6 State**

The state disaster mental/behavioral health function is responsible for gathering disaster mental/behavioral health information and intelligence and coordinating the information and intelligence through the MHCC consistent with the EF 8 Annex.

Information sources for the state disaster mental/behavioral health function may include:

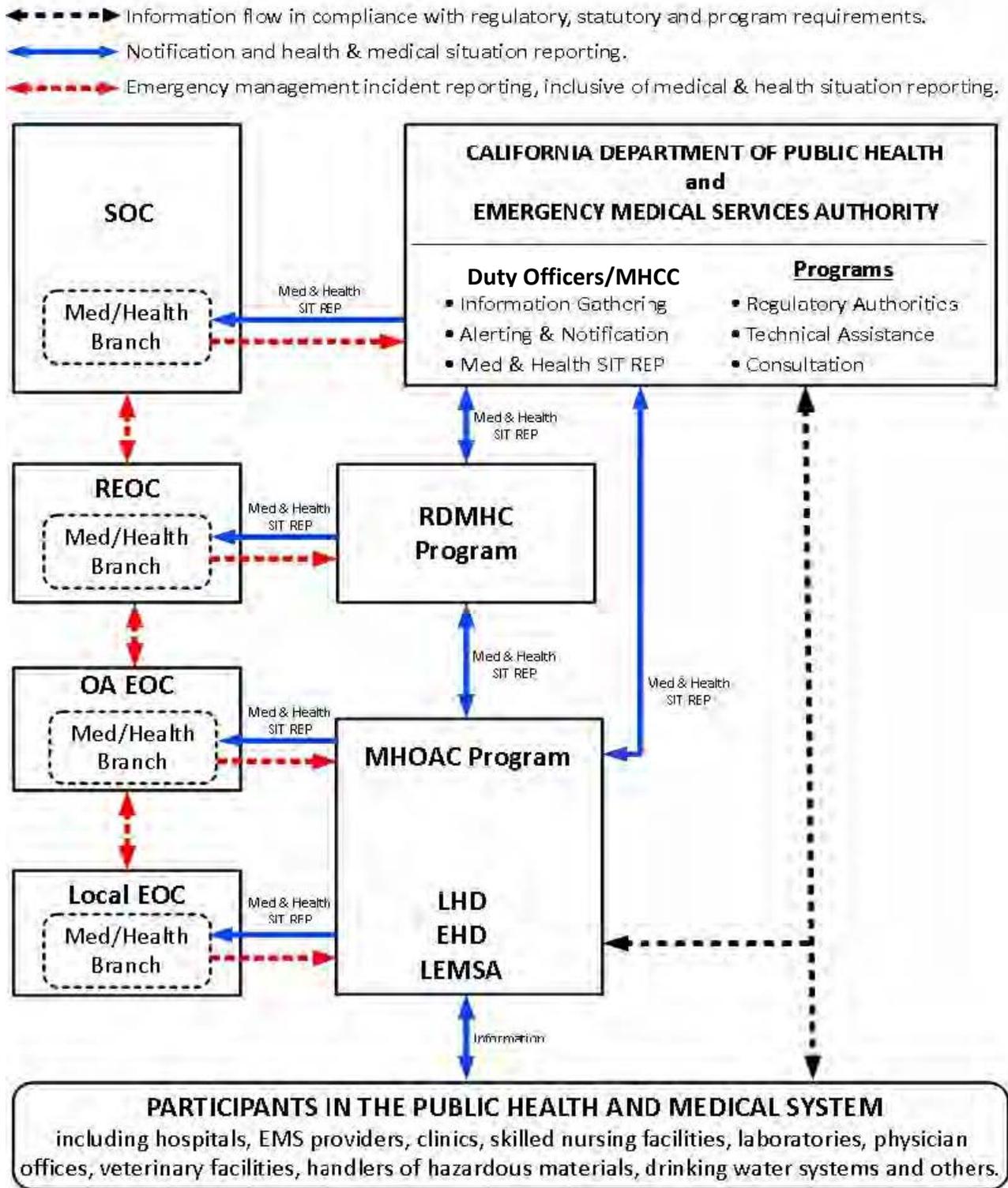
- REOCs
- MHCC
- Agencies and organizations represented in the SOC

When the state-federal JFO is activated, the REOC and SOC situation reports will be assimilated into the JFO situation report. The SOC organization will be collocated with the federal organization at the JFO; the REOC organization may be also collocated at the JFO. A state disaster mental/behavioral health function may be designated under EF 8 at the JFO to provide disaster behavior health-related information.

#### **7.4.7 Federal**

All federal agency coordination of information will be with the ESF #8 Coordinator if/when activated by FEMA.

**Figure 3 - Information Flow during Emergency System Activation<sup>33</sup>**



<sup>33</sup> California Public Health and Medical Emergency Operations Manual (July 2011).

## 7.5 Public Information

This section describes public information coordination and dissemination for events with significant mental/behavioral health impacts at the operational area, region, state, and federal levels. Field and local government level public information activities are the responsibility of the Incident/Unified Command and EOC.

During an emergency it is important that the public receive clear information about how to access mental and behavioral health services. The coordinated and verified information is disseminated through the Joint Information Center (JIC) and/or designated Public Information Officer about the emergency to keep the public informed about what has happened and personal protective measures that should be taken, the actions of emergency response agencies/organizations and the expected outcomes of the emergency actions.

### 7.5.1 Disaster Mental/Behavioral Health Emergency Public Information

Behavioral/mental health officials can assist the emergency public information process by advising the PIO/JIC on risk communication content for the public and methods of delivery (e.g., press conference, social media, etc.) to communicate and promote public intervention activities; promoting resiliency and recovery practices in emergency public information; and by providing information on disaster mental/behavioral health resources and programs. Messages, information, and educational materials that specifically address mental/behavioral health issues that may arise following a disaster are essential components of the overall public health and medical messaging strategy. Messages should be made available in diverse languages and accessible, alternative, cultural and age-appropriate formats. Messages should be delivered in a prompt and frequently by a credible and trusted person.

Typical information needed by the Joint Information Centers from the disaster mental/behavioral health function includes, but is not limited to:

- Recommended public advisories pertaining to disaster mental/behavioral health
- Disaster mental/behavioral health programs available (e.g. CCP, ARC)
- Status of mental/behavioral health infrastructure (facilities, providers/personnel, medications)
- Disaster mental/behavioral health support being provided to and shelters, natural gathering sites and open spaces unique to each local community, parks, fields, empty lots, casualty collection points, Family Assistance Centers, Local Assistance Centers, call-in centers, schools, businesses, places of worship, reception and service centers, mental health facilities, hospitals and other medical treatment sites, isolation and quarantine sites, points of distribution and dispensing, and other facilities.
- Online resources to promote mental/behavioral resiliency, recovery, and self-assessment.

### **7.5.2 Operational Area**

The Operational Area disseminates public information through its EOC structure, which may include a JIC. The OA disaster mental/behavioral health function provides information and advice through the OA EOC structure.

### **7.5.3 Region/State**

The state typically establishes one JIC to coordinate public information for the region and state. The JIC reports to Management in the State Operations Center. Emergency public information and risk communication are coordinated at the state level by Cal EMA through the coordination activities of the JIC and EF 15: Public Information. In a large incident, an EF 8 disaster mental/behavioral health function representative may also be assigned to the State JIC through established SOC protocols and procedures.

### **7.5.4 Federal**

The Department of Homeland Security is the coordinating agency for ESF #15 - External Affairs. DHS Public Affairs engages with State, local, tribal, and affected private-sector counterparts as soon as possible during an actual or potential incident to synchronize overall incident communications to the public. Disaster mental/behavioral health related emergency public information will be coordinated by ESF #8 with ESF #15.

## **7.6 Resource Management**

This section focuses on resource management during an emergency and describes resource agreements and how resources are requested, deployed, and coordinated.

### **7.6.1 Disaster Mental/Behavioral Health Programs and Services**

Key disaster mental/behavioral health response funding sources and assistance programs available for California are listed in Appendix F. State, tribal, and local governments, as well as non-governmental and private entities may request these resources.

### **7.6.2 Disaster Mental/Behavioral Health Resources**

The matrix in Appendix G provides an overview of resources including personnel, teams, facilities, equipment, and/or supplies that may be needed for mental/behavioral health response.

### **7.6.3 Resource Agreements**

In the event of an emergency in California that significantly impacts mental/behavioral health, resources will be needed from government agencies, non-governmental organizations, and the private sector. It is the policy of the State that contracts and agreements for emergency response and disaster repair and restoration should be entered into by the lowest level of government possible. Establishment of emergency assistance agreements between public, non-governmental and private sector organizations at all levels is encouraged to maximize the availability of mental/behavioral health resources and reimbursement.

### **7.6.3.1 Mutual Aid**

The *California Disaster and Civil Defense Master Mutual Aid Agreement (MMAA)* is entered into by and between the State of California, its various departments and agencies and the various political subdivisions, municipal corporations and public agencies to assist each other by providing resources during an emergency. The provision and sharing of resources for disaster mental/behavioral health is covered by the MMAA and is coordinated consistent with SEMS.

Cal EMA coordinates requests for assistance, including disaster mental/behavioral health resources, from other state governments through the *Emergency Management Assistance Compact (EMAC)*.

### **7.6.3.2 Agreements**

#### **Contracts**

Many local governments have entered into agreements with the private sector for the provision of mental/behavioral health services. These private sector resources can be moved under the MMAA and EMAC agreements with concurrence of the local government and if permitted under the service agreements.

#### **Payment for Service**

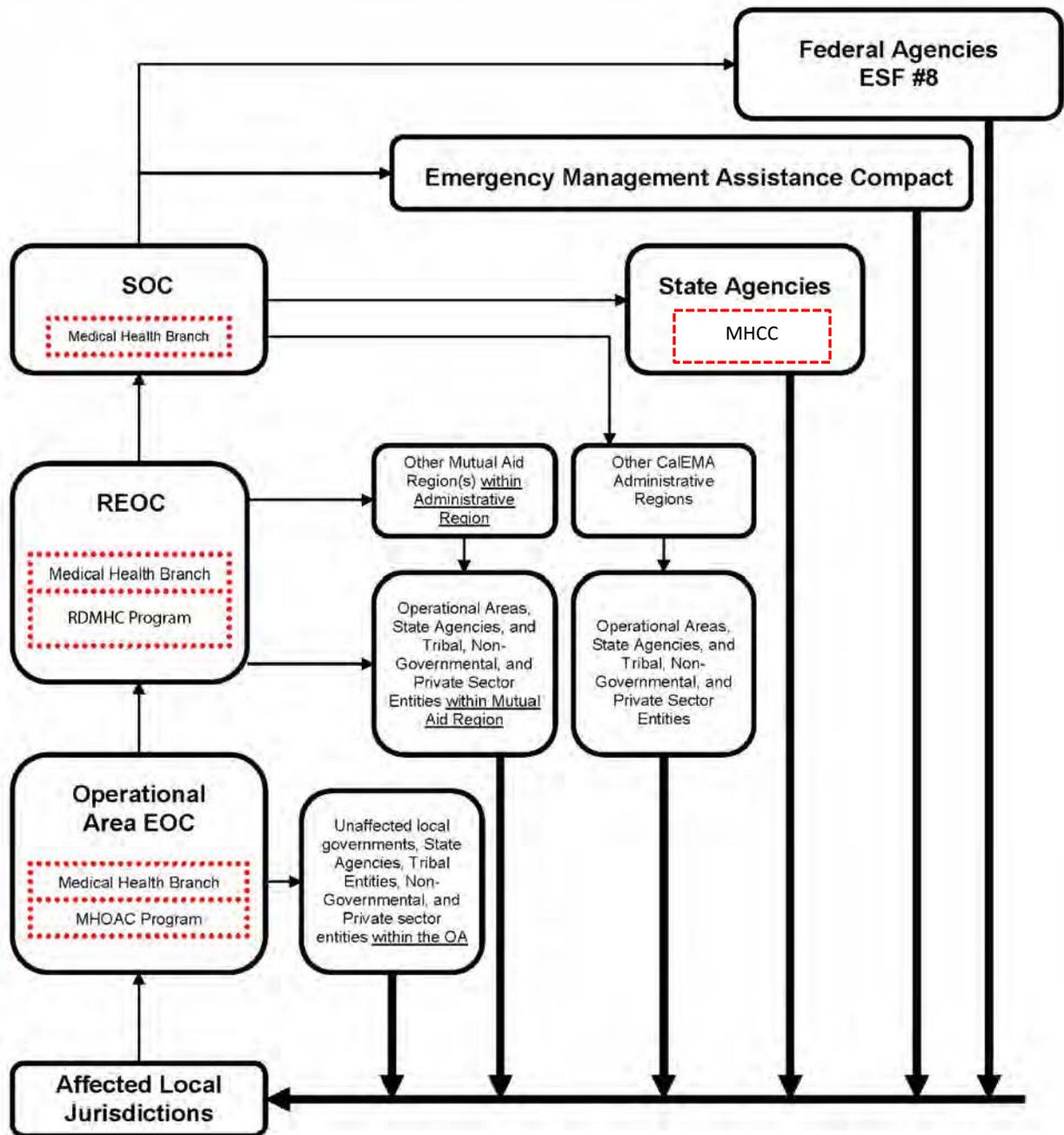
Even under routine, non-disaster conditions, the provision of mental/behavioral health care services varies among a wide mix of payers and providers, including employee assistance programs, health insurance programs, government public assistance programs, hospitals, private therapists, private direct-pay clients, and community based organizations, etc. Part of the mental/behavioral health response to a disaster is to ascertain what system of care is in place. Funding for services may be through the CCP grant or provided voluntarily.

### **7.6.4 Flow of Requests and Resources**

Disaster mental/behavioral health resource requests will be coordinated as stipulated in the California Public Health and Medical Emergency Operations Manual through the MHOAC and RDMHC programs. When resources are not available within the State or through existing agreements with other states, California may request assistance from the federal government. Requests for federal assistance during an emergency will be coordinated through the State Operations Center. Federal resources will be provided to the State for distribution within their system of support. At the direction of the state, resources may be delivered directly to specified locations.

Figure 4 depicts the flow of disaster mental/behavioral health requests and resources in California. In this model, the affected local government has the ability to access resources from all stakeholders at all levels of the system through pre-identified channels. Personnel resources are requested and deployed using this process. If volunteer personnel are most appropriate to fill a need, they will also be deployed using this process.

Figure 4. Flow of Resource Requests and Assistance during Emergencies<sup>34</sup>.



<sup>34</sup> California Public Health and Medical Emergency Operations Manual (July 2011).

### 7.6.5 Allocation of Scarce Resources

Allocation of scarce disaster mental/behavioral health resources should be accomplished using a multi-agency coordination group (MAC Group) above the field level<sup>35</sup>.

#### Opioid Treatment Facilities (OTF)

Methadone is designed as a long-term treatment that includes individual and group counseling centering on assisting the patient in overall lifestyle changes to achieve recovery. Opioid addiction treatment involves administering an appropriate, adequate dose of a long-acting synthetic opiate. This medication acts to stabilize the brain in opiate-addicted individuals. Once an adequate dosage level has been achieved, the patient can expect to experience very little, if any, “craving”, “withdrawal” for at least 24 hours, or other discomfort associated with abstinence from illicit opiate use. “Adequate” dosage is defined as the dose level that relieves withdrawal symptoms and drug craving without producing sedation. At a sufficient dose, Methadone also acts as a blockade for euphoria if opiates, such as heroin, are taken. The dose may be adjusted up or down to achieve this state. Maintaining accessibility to opioid treatment (Dosing) following a catastrophic disaster or other emergency is critical to the ongoing care of the patient. Should the facility become uninhabitable, having a plan in place for dosing and record keeping can be critical to maintain services to patients.

Courtesy dosing and multiple registry checking systems are currently in place and with some pre-planning, these systems can be used refer patients to alternate care sights for dosing. If dosing must be done locally, alternate care sits and control of medications and record keeping should be available.

#### Recommended Actions:

- Write a plan for localized dosing, medication control, and record keeping.
- Broaden the range of OTFs in the geographic area served.
- Establish a call in number with recording instructing patients on where to go to receive medication.

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<sup>35</sup> See also Section 4.6.6, EF 8 Multi-Agency Coordination (MAC) group.

## 8 Administration, Finance, and Logistics

### 8.1 Administration

#### 8.1.1 Documentation

Maintenance of administrative records continues through all phases of an emergency. In preparation for an emergency, training and appropriate forms are provided, including procedures for all units of potential response organization. During a response, entities ensure that adequate documentation is collected through the Documentation Unit at the Incident and EOC, for activities of personnel, use of equipment and expenditures for the emergency. Finally, after the response has been terminated, records should be protected and maintained for audit purposes. The Cost Unit is responsible for cost recovery records and assisting in collecting any missing information. Problem areas are identified, corrective measures taken and employees retrained in the proper, updated procedures.

#### 8.1.2 After Action Reports

Input into post-event reports from a broad spectrum of disaster mental/behavioral health organizations is encouraged and will be valuable to identifying best practices, lessons learned and areas for improvement.

SEMS regulations require that Cal EMA, in cooperation with involved State and local government agencies, complete an After Action Report (AAR) within 120 days after each emergency proclamation. Furthermore, the SEMS regulations under Title IX, Division 2, Chapter 1, Section 2450(a) requires any federal, state, or local jurisdiction proclaiming or responding to a Local Emergency for which the governor has declared a *State of Emergency* or *State of War Emergency* shall complete and transmit an AAR to Cal EMA within 90 days of the close of the emergency period. The regulations also require AARs include a plan of action for implementing improvements.

In addition to actual events, After Action Reports/Improvement Plans (AAR/IPs) are prepared after exercises to identify areas of strength and areas needing improvement. The Improvement Plan identifies a plan for implementing recommended actions.

### 8.2 Finance

A disaster can significantly impact the disaster mental/behavioral health infrastructure and ability to provide necessary services. Disaster assistance is potentially available to local governments, tribal governments, State agencies, special districts, and under certain circumstances, private entities. Disaster assistance may include reimbursement of eligible expenses in addition to funding for mitigation activities to reduce the impact of on-going or future disasters.

It is critical that entities track and monitor potentially eligible expenses so that when and if funding becomes available, the entity is in a position to maximize reimbursement and other forms of assistance as part of the recovery process.

An emergency or disaster proclamation is usually required to make disaster assistance available.

Information about fiscal requirements for the federal Crisis Counseling Program can be found at <http://www.samhsa.gov/dtac/CCPtoolkit/CCPmaterials.htm>.

The State is the applicant on behalf of the local entity, and potential available resources include:

## **8.2.1 Victim Advocacy Programs**

### **8.2.1.1 Project SERV**

CFDA Number: 84.184S

Program Type: Discretionary/Competitive Grants

[www.ed.gov/programs/dvppserv/index.html](http://www.ed.gov/programs/dvppserv/index.html)

This program funds short-term and long-term education-related services for local educational agencies (LEAs) and institutions of higher education (IHEs) to help them recover from a violent or traumatic event, including disasters, in which the learning environment has been disrupted.

## **8.2.2 State Programs**

### **8.2.2.1 Office of Justice Programs**

Victims of Crime

Can be provided after Terrorism Disasters and was provided to California residents impacted by 9/11

[www.ojp.gov/programs/victims.htm](http://www.ojp.gov/programs/victims.htm)

## **8.2.3 Federal Programs**

### **8.2.3.1 Health and Human Services (HHS)/Substance Abuse and Mental Health Administration (SAMHSA)**

- **CSAP/CSAT Discretionary Funds**

- Center for Substance Abuse Prevention (CSAP)

- Center for Substance Abuse Treatment (CSAT)

<http://www.samhsa.gov/Budget/FY2012/SAMHSA-FY11CJ.pdf>

### **8.3 Logistics**

During emergency response and recovery, disaster mental/behavioral health resources are acquired pursuant to the incident objectives through the established emergency management channels consistent with SEMS and NIMS.

Availability of resources is assessed as part of disaster mental/behavioral health planning activities, gap analyses and After Action Report/Improvement Plan processes.

## **9 Training and Exercises**

Lead and supporting agencies and other key stakeholders with disaster mental/behavioral health responsibilities should participate in training and exercises of the Framework both within their organizations and as part of multi-agency training and exercises.

## **10 Framework Maintenance**

CHHS coordinates and facilitates the Framework review and maintenance process, which includes coordination with lead and supporting agencies and other key stakeholders.

## **11 Authorities and References**

### **11.1 Executive Authority Documents and Agreements**

- Constitution of the State of California
- Executive Order W991
- Standby Orders
- Administrative Order with Cal EMA

### **11.2 State Law**

- California Emergency Services Act, Government Code §8550
- California Disaster Assistance Act, Government Code §8680
- Welfare and Institutions Code
- Health and Safety Code
- Penal Code
- California Code of Regulations
- California Code of Regulations (CCR)
- Disaster Service Worker Regulations

### **11.3 State Plans**

- State of California Emergency Plan (SEP)
- California Public Health and Medical Emergency Operations Manual (EOM)
- Other Relevant State Plans

### **11.4 Federal Law**

- The Robert T. Stafford Disaster Relief and Emergency Assistance Act, P.L. 93-288 as amended
- CFR Department of Defense (DoD), national defense, military resources in support of civil authorities
- 44 CFR FEMA federal disaster assistance programs, emergency and major disaster declarations, joint field offices, state and federal coordinating officers
- Rail Disasters:  
<http://www.nts.gov/doclib/tda/ntsb%20federal%20family%20assistance%20plan%20for%20rail%20passenger%20accident.pdf>
- Aviation Disaster Family Assistance Act of 1996 (updated):  
[http://www.floridadisaster.org/EMTOOLS/air\\_safety/SPC9903.pdf](http://www.floridadisaster.org/EMTOOLS/air_safety/SPC9903.pdf)

## **Appendices**

Appendix A – Acronyms

Appendix B - Glossary

Appendix C – Organizational Roles and Assignment of Responsibilities

Appendix D - Disaster Mental/Behavioral Health Core Competencies

Appendix E – Guidelines for Developing a Disaster Mental/Behavioral Health Training and Plan for Your Jurisdiction

Appendix F - Disaster Mental/Behavioral Health Programs and Services

Appendix G - Disaster Mental/Behavioral Health Resources

Appendix H - References

## Appendix A - Acronyms

AAR: After Action Report	HHS: Health and Human Services Agency
ACF-OHSEPR: Administration of Children and Family Office of Human Services Emergency Preparedness and Response	IHEs: Institutions of higher education
AoA: Administration on Aging	IHS: Indian Health Services
ARC: American Red Cross	HPP: Hospital Preparedness Program
ASPR: Assistant Secretary for Preparedness and Response	HRSA: Health Resources and Services Administration
ASPR: Association of Staff Physician Recruiters	IC: Incident Command
ASPR-ABC: ASPR's Response At-Risk Behavior	IOM: Institute of Medicine
ASPR-NDMS: ASPR's National Disaster Medical System	IPs: Improvement Plans
ASPR-REC's: ASPR's Regional Emergency Coordinators	ISP: Immediate Services Program
CAHAN: California Health Alert Network	JFO: Joint Field Office
Cal EMA: California Emergency Management Agency	JIC: Joint Information Center
CDC: Center for Disease Control	LEAs: Local Education Agencies
CDPH: California Department of Public Health	MAC: Multiagency Coordination
CHHS: California Health and Human Services Agency	MHCC: Medical Health Coordination Center
CMS: Centers for Medicare and Medicaid Services	MHOAC: Medical Health Operational Area Coordinator
CONOPS: Concept of Operations	MMAA: California Disaster and Civil Defense Master Mutual Aid Agreement
CSWC: California State Warning Center	MOU: Memorandum of Understanding
DDH: Disaster Distress Helpline	NCPTSD: National Center for Post-Traumatic Stress Disorder
DMH: Department of Mental Health	NIH: National Institutes of Health
DOC: Department Operations Centers	NIMS: National Incident Management System
DoD: Department of Defense	NOVA: National Organization for Victim Assistance
DTAC: Disaster Technical Assistance Center	NRF: National Response Framework
EDO: Cal EMA Executive Duty Officer	NVOAD: National Voluntary Agencies Active in Disaster
EF-8: California Emergency Function 8	OA: Operational Area
EMAC: Emergency Management Agreement	OD: Office on Disability
EMS: Emergency Medical Services	OFRD: Office of Force Readiness and Development
EOC: Emergency Operations Center	OTF: Opioid Treatment Facility
EOM: Emergency Operations Manual	PFA: Psychological First Aid
EPCO: Office of Emergency Preparedness and Continuity of Operations	PIO: Public Information Officials
ESAR-VP: Emergency System for Advance Registration of Volunteer Health Professionals	PTSD: Post-traumatic Stress Disorder
Framework: State of California Mental/Behavior Health Disaster Response Framework	RDMHC: Regional Disaster Medical and Health Coordinator
FEMA CCP: Federal Emergency Management Agency Crisis Counseling Program	REOC: Regional Emergency Operations Center
FEMA: Federal Emergency Management Agency	RSP: Regular Service Program
	SAMHSA: Substance Abuse and Mental Health Services Administration
	SARS: Severe Acute Respiratory Syndrome
	SCCS: Specialized Crisis Counseling

SEMS: Standardized Emergency Management System  
SERG: SAMSHA's Emergency Response Grants  
SOC: State Operations Center  
SOU: Statements of Understanding

State VAL: State Voluntary Agency Liaison  
UC: Unified Command  
UCG: Unified Coordination Group  
WHO: World Health Organization

## Appendix B - Glossary

**Agency Representative** - An individual assigned to an incident or to an EOC from an assisting or cooperating agency who has been delegated authority to make decisions on matters affecting that agency's participation at the incident or at the EOC. Agency Representatives report to the Liaison Officer at the incident, or the Liaison Coordinator at SEMS EOC levels. [SEMS Guidelines, November 2009]

**Behavioral Health** - A state of mental/emotional being and/or choices and actions that affect wellness. Substance abuse and misuse are one set of behavioral health problems. Others include (but are not limited to) serious psychological distress, suicide, and mental illness (SAMHSA, 2011). Such problems are far-reaching and exact an enormous toll on individuals, their families and communities, and the broader society. <http://captus.samhsa.gov/prevention-practice/prevention-and-behavioral-health/behavioral-health-lens-prevention/1>

**Cal EMA Administrative Region** - California is divided into two California Emergency Management Agency (Cal EMA) Administrative Regions – Northern and Southern – which are further divided into six mutual aid regions. (SEP, 2009)

**California Disaster and Civil Defense Master Mutual Aid Agreement** - An agreement entered into by and between the State of California, its various departments and agencies and the various political subdivisions, municipal corporations and public agencies of the State of California to assist each other by providing resources during an emergency. Mutual Aid occurs when two or more parties agree to furnish resources and facilities and to render services to each other in response to any type of disaster or emergency. (SEP, 2009)

**California Health Alert Network** - The California Health Alert Network (CAHAN) is the State of California's web-based information and communications system available on a 24/7/365 basis for distribution of health alerts, dissemination of prevention guidelines, coordination of disease investigation efforts, preparedness planning, and other initiatives that strengthen state and local preparedness. CAHAN participants have the ability to receive alerts and notifications via alphanumeric pager, e-mail, fax, and phone (cellular and landline). <http://www.bepreparedcalifornia.ca.gov/CDPHPrograms/PublicHealthPrograms/EmergencyPreparednessOffice/CAHAN/Pages/CAHAN.aspx>

**California State Warning Center** - Cal EMA operates the California State Warning Center (CSWC) 24 hours per day to receive and disseminate emergency alerts and warnings. Serves as the official state level point of contact for emergency notifications. From this center, Warning Center personnel maintain contact with County Warning Points, state agencies, federal agencies and the National Warning Center in Berryville, Virginia. (SEP, 2009)

**Casualty collection point** - A site for the congregation, triage (sorting), preliminary treatment, and evacuation of casualties following a disaster. Emergency Medical Services Authority, EMS System Standards and Guidelines (June 1993 – EMS #101) <http://www.emsa.ca.gov/pubs/pdf/emsa101.pdf>

**Continuity of operations** - Planning should be instituted (including all levels of government) across the private sector and non-governmental organizations as appropriate, to ensure the continued performance of core capabilities and/or critical government operations during any potential incident. (SEP, 2009)

**Crisis counseling** - A strengths-based, outreach-oriented approach to helping disaster survivors access and identify personal and community resources that will aid the recovery process. Federal Emergency Management Agency Crisis Counseling Assistance and Training Program Guidance - CCP Application Toolkit, Version 3.4 May 2012

**Department Operations Center** - An Emergency Operations Center (EOC), specific to a single department or agency. Their focus is on internal agency incident management and response. They are often linked to and, in most cases, are physically represented in a combined agency EOC by authorized agent(s) for the department or agency. *[SEP, July 2009]*

**Disaster Healthcare Volunteer Program** - DHV is a secure, web-based system that registers and credentials many but not all health professionals who may wish to volunteer during a disaster, including doctors, nurses, paramedics, pharmacists, dentists, mental health practitioners, etc. DHV may be locally accessed by all 58 counties and 43 Medical Reserve Corps Units to support a variety of local needs, including augmenting medical staff at HCFs or supporting mass vaccination clinics. EMSA administers the system, coordinates statewide recruitment efforts and ongoing training opportunities. DHV is California's Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP). (CA Public Health and Medical EOM, 2011)

**Duty Officer** - A person who has been designated by the agency or organization to be the initial point of contact for outside agencies either during a specific period of time or after regular business hours and is responsible for the timely notification and response to emergency situations. *[EF 5 Annex - Management, May 15, 2011]*

**Emergency Function** - The California Emergency Functions (EF) are a grouping of state agencies, departments and other stakeholders with similar functional activities/responsibilities whose responsibilities lend themselves to improving the state's ability to collaboratively prepare for, effectively mitigate, cohesively respond to, and rapidly recover from any emergency. CA-EFs unify a broad-spectrum of stakeholders with various capabilities, resources and authorities to improve collaboration and coordination for a particular discipline. They also provide a framework for the state government to support regional and community stakeholder collaboration and coordination at all levels of government and across overlapping jurisdictional boundaries. *[SEP, July 2009]*

**EF 6: Mass Care and Shelter** - Coordinates actions to assist responsible jurisdictions to meet the needs of victims displaced during an incident including food assistance, clothing, non-medical mass care and sheltering, family reunification and victim recovery. *Lead state agency: Health and Human Services Agency [SEP, July 2009]*

**EF 15: Public Information** - Supports the accurate, coordinated, timely and accessible information to affected audiences, including governments, media, the private sector and the local populace, including the special needs population. *Lead state agency: California Emergency Management Agency [SEP, July 2009]*

**Emergency Function Annex** - An addition to the State Emergency Plan containing information relative to the California Emergency Functions that is dynamic and subject to frequent updates. Such information may include Emergency Function descriptions, documents, forms, composition, etc. *[CA EF Guidance, May 10, 2009]*

**Emergency Function Coordinator** - Individuals assigned to the SOC or REOC to coordinate a functional activity that involves one or more government agencies and non-governmental organizations. An EF Coordinator provides information regarding the capabilities and activities of the EF in supporting the

emergency and directs questions and issues to the appropriate authority. [EF 5 Annex - Management, May 15, 2011]

**Emergency Management Assistance Compact** - A congressionally ratified organization that provides form and structure to interstate mutual aid. Through EMAC, a disaster-affected state can request and receive assistance from other member states quickly and efficiently, resolving two key issues upfront: liability and reimbursement. (SEP, 2009)

**Emergency Operations Center** - The physical location at which the coordination of information and resources to support incident management (on-scene operations) activities normally takes place. An EOC may be a temporary facility or may be located in a more central or permanently established facility, perhaps at a higher level of organization within a jurisdiction. EOC may be organized by major function disciplines (e.g., fire, law enforcement and medical services), by jurisdiction (e.g., federal, state, regional tribal, city, county), or some combination thereof. [SEP, July 2009]

**Emergency Support Function** - The Federal Government organizes much of their resources and capabilities – as well as those of certain private-sector and nongovernmental organizations – under 15 Emergency Support Functions (ESFs). ESFs align categories of resources and provide strategic objectives for their use. ESFs utilize standardized resource management concepts such as typing, inventorying, and tracking to facilitate the dispatch, deployment, and recovery of resources before, during, and after an incident. (NRF, January 2008)

**ESF-8 – Public Health and Medical Services** - ESF-8 provides the mechanism for coordinated Federal assistance to supplement State, tribal, and local resources in response to a public health and medical disaster, potential or actual incidents requiring a coordinated Federal response, and/or during a developing potential health and medical emergency. The phrase “medical needs” is used throughout this annex. Public Health and Medical Services include responding to medical needs associated with mental health, behavioral health, and substance use considerations of incident victims and response workers. Services also cover the medical needs of members of the “at risk” or “special needs” population described in the Pandemic and All-Hazards Preparedness Act and in the *National Response Framework (NRF)* Glossary, respectively. It includes a population whose members may have medical and other functional needs before, during, and after an incident. *Lead state agency: Health and Human Services Agency [SEP, July 2009]*

Public Health and Medical Services includes behavioral health needs consisting of both mental health and substance use considerations for incident victims and response workers and, as appropriate, medical needs groups defined in the core document as individuals in need of additional medical response assistance, and veterinary and/or animal health issues. (ESF-8 Annex, January 2008)

**ESF-15 - External Affairs** - ESF-15 ensures that sufficient Federal assets are deployed to the field during incidents requiring a coordinated Federal response to provide accurate, coordinated, timely, and accessible information to affected audiences, including governments, media, the private sector, and the local populace, including the special needs population. ESF #15 provides the resource support and mechanisms to implement the *National Response Framework (NRF)* Incident Communications Emergency Policy and Procedures (ICEPP) described in the Public Affairs Support Annex. Additional information about External Affairs can be found in the ESF #15 Standard Operating Procedure (SOP), located on the Department of Homeland Security (DHS)/Federal Emergency Management Agency (FEMA) website. (ESF-15 Annex, January 2008)

**Family Assistance Center** - A FAC is an established collection point of family members of victims resulting from a mass fatality or mass casualty incident. The FAC seeks to provide a private place for

families to grieve; protect families from the media and curiosity seekers; facilitate information exchange between key government agencies and families so that families are kept informed and information can be obtained that will assist in identifying the victims. The FAC provides a venues to address family needs (responding quickly and accurately to questions, concerns, and needs—emotional, spiritual, medical and logistical); and to provide notifications to families of victims. (Draft Santa Clarita Mass Care Annex)

**Field level** - The field level commands emergency response personnel and resources to carry out tactical decisions and activities in direct response to an incident or threat. (SEMS regulations)

**Hazard mitigation plan** - The plan resulting from a systematic evaluation of the nature and extent of vulnerability to the effects of natural hazards present in society that includes the actions needed to minimize future vulnerability to hazards. (IS 393 - Introduction to Hazard Mitigation)

**Healthcare surge** - A healthcare surge is proclaimed in a local jurisdiction when an authorized local official, such as a local health officer or other appropriate designee, using professional judgment determines, subsequent to a significant emergency or circumstances, that the healthcare delivery system has been impacted, resulting in an excess in demand over capacity in hospitals, long-term care facilities, community care clinics, public health departments, other primary and secondary care providers, resources and/or emergency medical services. The local health official uses the situation assessment information provided from the healthcare delivery system partners to determine overall local jurisdiction/Operational Area medical and health status. CA Department of Public Health Standards and Guidelines for Healthcare Surge During Emergencies – Foundational Knowledge [http://www.bepreparedcalifornia.ca.gov/CDPHPrograms/PublicHealthPrograms/EmergencyPreparednessOffice/EPOProgramsandServices/Surge/SurgeStandardsandGuidelines/Documents/FoundationalKnowledge\\_FINAL.pdf](http://www.bepreparedcalifornia.ca.gov/CDPHPrograms/PublicHealthPrograms/EmergencyPreparednessOffice/EPOProgramsandServices/Surge/SurgeStandardsandGuidelines/Documents/FoundationalKnowledge_FINAL.pdf)

**Incident Command System** - A standardized on-scene emergency management construct specifically designed to provide for the adoption of an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures and communications operating within a common organizational structure, designed to aid in the management of resources during incidents. It is used for all kinds of emergencies and is applicable to small as well as large and complex incidents. ICS is used by various jurisdictions and functional agencies, both public and private, to organize field-level incident management operations. (SEP, 2009).

**Incident Command** - Responsible for overall management of the incident and consists of the Incident Commander, either single or unified command and any assigned supporting staff. (SEP, 2009)

**Information** - Pieces of raw, unanalyzed data that identifies persons, evidence, events; or illustrates processes that specify the occurrence of an event. May be objective or subjective and is intended for both internal analysis and external (news media) application. Information is the “currency” that produces intelligence. (SEP, 2009)

**Intelligence** - Product of an analytical process that evaluates information collected from diverse sources, integrates the relevant information into a cohesive package and produces a conclusion or estimate. Information must be real, accurate and verified before it becomes intelligence for planning purposes. Intelligence relates to the specific details involving the activities of an incident or EOC and current and expected conditions and how they affect the actions taken to achieve operational period objectives. Intelligence is an aspect of information. Intelligence is primarily intended for internal use and not for public dissemination. (SEP, 2009)

**Isolation and quarantine site** - A treatment site (home, hospital, or healthcare facility) for isolation (for people who *are* sick) and quarantine (for people who *may soon get* sick because they had contact with someone who had the contagious disease). CA Department of Public Health/Centers for Disease Control [http://www.cdph.ca.gov/HealthInfo/environhealth/btagents/Documents/ENG\\_IsoQuar.pdf](http://www.cdph.ca.gov/HealthInfo/environhealth/btagents/Documents/ENG_IsoQuar.pdf)

**Joint Field Office** - Overall, Federal incident support to the State is generally coordinated through a Joint Field Office (JFO). The JFO provides the means to integrate diverse Federal resources and engage directly with the State. (NRF, January 2008)

**Joint Information Center** - A facility established to coordinate all incident-related public information activities. It is the central point of contact for all news media. Public information officials from all participating agencies should co-locate at the JIC. (SEP, 2009)

**Local Assistance Center** - Local Assistance Centers (LACs) are opened by local governments to assist communities by providing a centralized location for services and resource referrals for unmet needs following a disaster or significant emergency. The LAC is normally staffed and supported by local, state and federal agencies, as well as non-profit and voluntary organizations. The LAC provides a single facility at which individuals, families and businesses can access available disaster assistance programs and services. As more federal resources arrive, a state-federal Disaster Recovery Center (DRC) may be collocated with the LACs. (SEP, 2009)

**Local Emergency** - “Local emergency” means the duly proclaimed existence of conditions of disaster or of extreme peril to the safety of persons and property within the territorial limits of a county, city and county, or city, caused by such conditions as air pollution, fire, flood, storm, epidemic, riot, drought, sudden and severe energy shortage, plant or animal infestation or disease, the Governor’s warning of an earthquake or volcanic prediction, or an earthquake, or other conditions, other than conditions resulting from a labor controversy, which are or are likely to be beyond the control of the services, personnel, equipment, and facilities of that political subdivision and require the combined forces of other political subdivisions to combat, or with respect to regulated energy utilities, a sudden and severe energy shortage requires extraordinary measures beyond the authority vested in the California Public Utilities Commission. (CA Emergency Services Act, 2011)

**Local government** - According to federal code a county, municipality, city, town, township, local public authority, school district, special district, intrastate district, council of governments (regardless of whether the council of governments is incorporated as a nonprofit corporation under state law), regional or interstate government entity, or agency or instrumentality of a local government; an Indian tribe or authorized tribal entity, or in Alaska a Native village or Alaska Regional Native Corporation; a rural community, unincorporated town or village, or other public entity. (SEP, 2009)

**Local government level** - Under SEMS this level includes cities, counties, and special districts. (SEMS Guidelines, 2006)

**Medical Health Operational Area Coordination (MHOAC) Program** - A comprehensive program under the direction of the MHOAC that supports the 17 functions outlined in Health and Safety Code §1797.153. (CA Public Health and Medical EOM)

**Mental Health** - A state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. [http://www.who.int/features/factfiles/mental\\_health/en/](http://www.who.int/features/factfiles/mental_health/en/)

**Medical Health Coordination Center** - The co-located Emergency Operations Center for CDPH, EMSA, and DHCS. The role of the JEOC includes the following core functions: coordination, communications; resource allocation and tracking; and information collection, analysis, and dissemination. [CDPH *Emergency Operations Response Plan, October 2010*]

**Mental health assessment** - Mental health assessment is provided by mental health professionals and is systematic approach to understanding the mental status, needs and diagnoses of individuals including children. Part of the disaster “seamless triage to care” model.<sup>36</sup>

**Mental health triage** - Process of sorting individuals based on evidence based risk markers for acute mental health emergencies and/or long term risk for disorder. The first component of the “seamless triage to care model”.<sup>37</sup>

**Mitigation** - Provides a critical foundation in the effort to reduce the loss of life and property from natural and/or manmade disasters by avoiding or lessening the impact of a disaster and providing value to the public by creating safer communities. Mitigation seeks to fix the cycle of disaster damage, reconstruction, and repeated damage. These activities or actions, in most cases, will have a long-term sustained effect. (CA Public Health and Medical EOM)

**Multiagency Coordination System** - Multiagency coordination systems provide the architecture to support coordination for incident prioritization, critical resource allocation, communications systems integration and information coordination. The elements of multiagency coordination systems include facilities, equipment, personnel, procedures and communications. Two of the most commonly used elements are EOC and MAC Groups. These systems assist agencies and organizations responding to an incident. (SEP, 2009)

**Multiagency Coordination System Group** - Typically, administrators/executives, or their appointed representatives, who are authorized to commit agency resources and funds, are brought together and form MAC Groups. MAC Groups may also be known as multiagency committees, emergency management committees, or as otherwise defined by the System. It can provide coordinated decision making and resource allocation among cooperating agencies and may establish the priorities among incidents, harmonize agency policies and provide strategic guidance and direction to support incident management activities. (SEP, 2009)

**Mutual Aid Region** - A mutual aid region is a subdivision of Cal EMA established to assist in the coordination of mutual aid and other emergency operations within a geographical area of the state, consisting of two or more Operational Areas. (SEP, 2009)

**National Incident Management System** - Provides a systematic, proactive approach guiding government agencies at all levels, the private sector and non-governmental organizations to work seamlessly to

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<sup>36</sup> Pynoos, R., Schreiber, M., Steinberg, A., & Pfefferbaum, B. (2005) Children and terrorism. In B. Saddock and V. Saddock (Eds.). *Kaplan and Saddock's comprehensive textbook of psychiatry* (pp. 3551-3563). 8<sup>th</sup> ed. Vol 2. New York: NY: Lippincott Williams and Wilkins for further information on this approach.

<sup>37</sup> Schreiber, M., Formanski, S., Fleming, S., Bayleyegn, T., Lemusu, S. (2012) Surveillance of Traumatic Experiences and Exposures after the Earthquake-Tsunami in American Samoa. *Disaster Medicine and Public Health* 2012; 6 <http://www.dmph.org/current.dtl>; See King, et. Al for further information King, M.

prevent, protect against, respond to, recover from and mitigate the effects of incidents, regardless of cause, size, location, or complexity, in order to reduce the loss of life or property and harm to the environment. (SEP, 2009)

**National Response Framework** - A guide to how the nation conducts all-hazards incident management. (SEP, 2009)

**Operational area** - An intermediate level of the state emergency organization, consisting of a county and all other political subdivisions within the geographical boundaries of the county. (SEP, 2009)

**People with access and functional needs** - Includes people with a variety of visual, hearing, mobility, cognitive, emotional, mental disabilities, and physical limitations. It also includes some older people, people who use assistive devices, people who use service animals, and people who are dependent upon prescription medications. Since the needs of PAFN during emergencies are more complex, specific planning for this population is necessary. (CA Department of Social Services, People with Access and Functional Needs Shelter Annex, Final Draft)

**Point of dispensing** - Temporary emergency health clinics activated and operated to provide medication to those in need as part of the public health response. Los Angeles County Public Health <http://publichealth.lacounty.gov/eprp/masspro.htm>

**Point of distribution** - Centralized locations where the public picks up life sustaining commodities following a disaster or emergency. FEMA/US Army Corps of Engineers IS-26 (Independent Study) Guide to Points of Distribution (December 2008) <http://training.fema.gov/EMIWeb/IS/is26.asp>

**Preparedness** - A continuous cycle of planning, organizing, training, equipping, exercising, evaluating and taking corrective action in an effort to ensure effective coordination during incident response. Within NIMS, preparedness focuses on the following elements: planning, procedures and protocols, training and exercises, personnel qualification and certification and equipment certification. (SEP, 2009).

**Presidential Declaration of a Major Disaster** - “Major disaster” means any natural catastrophe (including any hurricane, tornado, storm, high water, wind driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought), or, regardless of cause, any fire, flood, or explosion, in any part of the United States, which in the determination of the President causes damage of sufficient severity and magnitude to warrant major disaster assistance under this Act to supplement the efforts and available resources of States, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby. (Robert T. Stafford Act)

**Public Information** - Processes, procedures and systems for communicating timely, accurate and accessible information on the incident’s cause, size and current situation; resources committed; and other matters of general interest to the public, responders and additional stakeholders (both directly affected and indirectly affected). (SEP, 2009)

**Recovery** - The development, coordination and execution of service- and site-restoration plans; the reconstitution of government operations and services; individual, private–sector, nongovernmental and public assistance programs to provide housing and to promote restoration; long-term care and treatment of affected persons; additional measures for social, political, environmental and economic restoration; evaluation of the incident to identify lessons learned; post incident reporting; and development of initiatives to mitigate the effects of future incidents. (SEP, 2009)

**Regional Disaster Medical/Health Coordinator Program** - A comprehensive program under the direction of the Regional Disaster Medical and Health Coordinator that supports information flow and resource management during unusual events and emergencies. This program includes the Regional Disaster Medical and Health Specialist. (CA Public Health and Medical EOM)

**Regional Emergency Operations Center** - Facilities found at Cal EMA Administrative Regions. REOC provide centralized coordination of resources among Operational Areas within their respective regions and between the Operational Areas and the State Level. (SEP, 2009)

**Response** - Activities that address the short-term, direct effects of an incident. Response includes immediate actions to save lives, protect property and meet basic human needs. Response also includes the execution of EOP and of mitigation activities designed to limit the loss of life, personal injury, property damage and other unfavorable outcomes. As indicated by the situation, response activities include applying intelligence and other information to lessen the effects or consequences of an incident; increased security operations; continuing investigations into nature and source of the threat; ongoing public health and agricultural surveillance and testing processes; immunizations, isolation, or quarantine; and specific law enforcement operations aimed at preempting, interdicting, or disrupting illegal activity and apprehending actual perpetrators and bringing them to justice. (SEP, 2009)

**Risk communication** - Crisis and emergency risk communication encompasses the urgency of disaster communication with the need to communicate risks and benefits to stakeholders and the public. Crisis and emergency risk communication differs from crisis communication in that the communicator is not perceived as a participant in the crisis or disaster, except as an agent to resolve the crisis or emergency. Crisis and emergency risk communication is the effort by experts to provide information to allow an individual, stakeholder, or an entire community to make the best possible decisions about their well-being within nearly impossible time constraints and help people ultimately to accept the imperfect nature of choices during the crisis. This is the communication that goes on in emergency rooms, not doctors' offices. Crisis and emergency risk communication also differs from risk communication in that a decision must be made within a narrow time constraint, the decision may be irreversible, the outcome of the decision may be uncertain, and the decision may need to be made with imperfect or incomplete information. Crisis and emergency risk communication represents an expert opinion provided in the hope that it benefits its receivers and advances a behavior or an action that allows for rapid and efficient recovery from the event. Centers for Disease Control and Prevention (CDC), *Crisis and Emergency Risk Communication* (September 2002) <http://emergency.cdc.gov/cerc/pdf/CERC-SEPT02.pdf>

**Staging Area** - Established on an incident for the temporary location of available resources. A Staging Area can be any location on an incident in which personnel, supplies and equipment can be temporarily housed or parked while awaiting operational assignment. (SEP, 2009)

**Standardized Emergency Management System** - A system required by California Government Code and established by regulations for managing response to multiagency and multijurisdictional emergencies in California. SEMS consists of five organizational levels, which are activated as necessary: Field response, Local Government, Operational Area, Region and State. (SEP, 2009)

**State Emergency Plan** - The State of California Emergency Plan as approved by the Governor. (CA Emergency Services Act, 2011). It addresses the state's response to extraordinary emergency situations associated with natural disasters or human-caused emergencies. In accordance with the California Emergency Services Act (ESA), this plan describes the methods for carrying out emergency operations, the process for rendering mutual aid, the emergency services of governmental agencies, how resources

are mobilized, how the public will be informed and the process to ensure continuity of government during an emergency or disaster. (SEP, 2009)

**State of Emergency** - “State of emergency” means the duly proclaimed existence of conditions of disaster or of extreme peril to the safety of persons and property within the state caused by such conditions as air pollution, fire, flood, storm, epidemic, riot, drought, sudden and severe energy shortage, plant or animal infestation or disease, the Governor’s warning of an earthquake or volcanic prediction, or an earthquake, or other conditions, other than conditions resulting from a labor controversy or conditions causing a “state of war emergency,” which, by reason of their magnitude, are or are likely to be beyond the control of the services, personnel, equipment, and facilities of any single county, city and county, or city and require the combined forces of a mutual aid region or regions to combat, or with respect to regulated energy utilities, a sudden and severe energy shortage requires extraordinary measures beyond the authority vested in the California Public Utilities Commission. (CA Emergency Services Act, 2011)

**State of War Emergency** - “State of war emergency” means the condition which exists immediately, with or without a proclamation thereof by the Governor, whenever this state or nation is attacked by an enemy of the United States, or upon receipt by the state of a warning from the federal government indicating that such an enemy attack is probable or imminent. (CA Emergency Services Act, 2011)

**State Operations Center** - The SOC is operated by the California Emergency Management Agency at the State Level in SEMS. It is responsible for centralized coordination of state resources in support of the two Cal EMA Administrative Regional Emergency Operations Centers (REOCs). It is also responsible for providing updated situation reports to the Governor and legislature. (SEP, 2009)

**Tribe** - Any Indian tribe, band, nation, or other organized group or community, including any Alaskan Native Village as defined in or established pursuant to the Alaskan Native Claims Settlement Act (85 stat. 688) [43 U.S.C.A. and 1601 et seq.]. (SEP, 2009)

**Unified Command** - An ICS application used when more than one agency has incident jurisdiction or when incidents cross political jurisdictions. Agencies work together through the designated members of the UC, often the senior person from agencies and/or disciplines participating in the UC, to establish a common set of objectives and strategies and a single Incident Action Plan. (SEP, 2009)

**Unified Coordination Group** - Using unified command principles, a Unified Coordination Group comprised of senior officials from the State and key Federal departments and agencies is established at the JFO. This group of senior officials provides the breadth of national support to achieve shared objectives. (NRF, January 2008)

**Worried well** - “The worried well” is now called “concerned citizens” or “multiple unexplained physical symptoms (MUPS) and refers to individuals that seek medical care for themselves or family members (children) based on health concerns due to perceived risk for serious illness in death. In some worldwide, events, the ratio of those concerned about exposure vs. those actually exposed has been over a many hundreds of times of greater adding tremendous additional surge demand. The term worried well” is no longer recommended because it is highly stigmatizing and recent research suggests that this population actually experience deteriorating health status over time despite lack of actual exposure.

## Appendix C – Organizational Roles and Assignment of Responsibilities

The disaster mental/behavioral health agency and organization roles and responsibilities of agencies and organizations are listed below.

### 1 State Agencies

#### 1.1 Lead State Coordinating Agency through its departments (via EF 8) - California Health and Human Services Agency.

Examples include:

- Administers California’s emergency mental health program, identifies and mobilizes available departmental resources to support response activities and supports county mental health in assessing mental health risks to survivors and emergency personnel.
- Coordinates with providers of care and shelter to address mental health issues and the provision of crisis counseling services for disaster survivors and shelter workers. May contribute members to shelter evaluation team to determine adequacy of services.
- Provides health information on disaster mental health status and operations.
- Provide Operational Area Incident management and technical specialist positions and/or teams for mental health.
- Obtain local needs assessment information regarding mental health needs in an emergency.
- Coordinate with local government jurisdictions and county agencies to provide mental/behavioral health services and care and shelter assistance.
- Provide and coordinate resource for local crisis counseling for survivors of disaster.
- Coordinates state grant CCP and Specialized Crisis Counseling Applications with Cal EMA.
- Assist county mental health agencies during disaster.
- Identifying those mental/behavioral health systems and resources which would constitute a likely system of care following a disaster, including both “routine” systems and resources as well as supplemental or “surge” resources.
- Staffing the state disaster mental/behavioral health function role, with duties as described in this Framework, as well as staffing mental/behavioral health positions in the REOCs, MHCC, and/or SOC.

#### 1.2 Supporting State Agencies/Departments/Offices

##### 1.2.1 California Emergency Management Agency

Along with Cal EMA’s ongoing role as the primary coordinator of emergency and disaster response for the state of California, Cal EMA has specific roles during mental/behavioral health response dealing with support to victims of crime, including terrorist events. Listed below:

The Victim/Witness (V/W) Assistance Program is designed to provide comprehensive services to victims/witnesses of all types of violent crime pursuant to California Penal

Code §13835 in each of California's 58 counties. Of the 58 Victim/Witness Assistance Centers, 49 projects are in district attorney's offices, five in probation departments, one in a county sheriff's office and three in community-based organizations.

These services include orientation to the criminal justice system, crisis intervention, emergency assistance, case status/disposition, court escort, direct counseling, victim of crime claims, notification of family, friends and employers, property return, public presentations, resource and referral assistance, restitution, and training for criminal justice agencies.

Additionally, under the Public Safety and Victim Services Division, the California Crisis Response Team (CCRT) is a consortium of trained and skilled agency personnel; local victim witness agencies; and trained professionals responsible for assessing the immediate needs of victims, providing crisis intervention, support services and training to communities in the aftermath of a community traumatic event.

The primary focus of the CCRT is to provide crisis intervention services and assessing trauma inflicted by man-made events such as mass casualty events, however non crime related incidents may warrant the attention and assistance on a case by case basis.

All response team members are trained under the National Organization for Victim Assistance (NOVA) Crisis Response National Model and Protocol.

**Providing:**

- A network of highly trained professionals coordinated through a single system to respond to the needs of victims of disasters or trauma events in a comprehensive and timely manner.
- Follow-up consultation and referrals for those in need.
- Services are provided free of charge with dignity and respect for individual and cultural differences.

**Offering Communities:**

- Crisis Response Team Deployment
- Crisis Response Team Development and Training
- Community Crisis Planning, Support and Training
- Community Crisis Intervention and Debriefings
- Technical Assistance
- Support existing local resources and Crisis Response Teams
- Consultation and assistance in coordinating disaster/crisis response
- Telephone Consultations
- On-scene and other services are offered at no cost to individuals or to agencies.

**1.2.2 Department of Aging**

- Communicates with its network of local partner agencies to help ensure that the needs of older at-risk individuals and persons with disabilities are included in public health and medical emergency preparedness, response and recovery activities. A significant percentage of clients served by CDA's local contractors have dementia and/or mental/behavioral health issues. The needs of these individuals are a focus area in all of CDA's communications, disaster planning program guidance, etc.

- CDA may deploy functional assessment service teams (FAST) members or volunteer emergency services team (VEST) members with expertise in serving older adults and persons with disabilities (including those with mental/behavioral health issues) to shelters as requested by CDSS during disaster events.

### **1.2.3 Department of Alcohol and Drug Programs**

ADP Disaster Roles & Responsibilities during emergencies for mental/behavioral response:

- ADP Duty Officer or department operations center (DOC) provides situational information on substance use disorder services and resource needs to ADP management, staff, and both internal/external stakeholders, as appropriate.
- ADP develops and disseminates emergency warnings/notifications and emergency public information consistent with Statewide messaging in coordination with its Medical Director and/or appropriate State partners.
- ADP's primary response role is to ensure the continued availability of methadone and related narcotic treatment replacement services.
- ADP support to local disaster response may include supporting continuation, expansion, or replacement of substance use disorder services through technical assistance, emergency licensure, resolution of licensing issues, and coordination of mutual aid.
- Provide, in coordination with local government, substance use prevention information & education to disaster survivors.
- Upon Presidential disaster declaration, ADP will work with local Alcohol & Drug Program Administrators of impacted counties in coordinating SAMHSA Crisis Counseling & Assistance Program grant applications through the State's Behavioral Health Plan.
- ADP may deploy functional assessment service team (FAST) or volunteer emergency services team (VEST) members to shelters with experience in identifying substance use disorders. As coordinated through CHSA or CalEMA, ADP may provide staff to support State, regional, or local EOCs; or to support response or recovery efforts as Disaster Service Workers.

### **1.2.4 Department of Developmental Services**

DDS behavioral/mental health-related emergency response activities include:

- Ensures that all DDS centers, state operated community facilities, and regional centers are alerted to any Emergency Warnings and Alerts that impact their geographic area.
- DDS regional centers and state-operated hospitals/community facilities will implement various procedures to protect the health and safety of residents and staff, including, but not limited to,
  - Providing psychological, behavioral and emotional support to the clients, staff and volunteers at state-operated hospitals/facilities utilizing DDS employed psychologists and psychiatrists.
  - Deploying DDS eligible Functional Assessment and Services Team (FAST) members to shelters, alternate care sites, and/or other evacuation points to assist in identifying possible behavioral/mental health needs of DDS client evacuees.

- Coordination with local emergency response and shelter staff to provide and/or obtain mental health resources.
- Adjusting employee work schedules to avoid strenuous assignments that may result in stress and fatigue.
- DDS regional centers will initiate contact with their community emergency preparedness networks to identify resources for assisting impacted individuals with accessing needed services.
- DDS regional centers will initiate contact with service providers and clients who live independently to provide them with information about precautionary measures to protect their health and safety, identification of resources, and other pertinent information.

### **1.2.5 Department of Education**

California has a system of comprehensive school safety planning which requires each school to review and update its comprehensive school safety plan by March 1 of every school year. These plans may include content regarding mental health/behavioral health during a disaster, although inclusion is inconsistent statewide.

The California Department of Education provides technical assistance and electronically distributes materials for the annual systematic safety planning process, but each school district and county office of education is responsible for the overall development of all comprehensive school safety plans for its schools operating kindergarten or any of the grades 1 to 12 pursuant to *Education Code* Section 32281. There is supplemental information on the California Department of Education Web site regarding mental/behavioral health during a disaster which is available to schools when developing their comprehensive school safety plans.

The California Department of Education provides a school safety planning checklist which is available at <http://www.cde.ca.gov/ls/ss/vp/sschecklist.asp>. Currently, the contents of most comprehensive school safety plans emphasize physical safety during a disaster, but the State Superintendent's Student Mental Health Policy Workgroup is recommending that the plans include more content related to mental health. For example, one recommendation is that the State Superintendent of Public Instruction convene a Student Mental Health Strategies Workshop for school administrators that would include how to incorporate student mental health strategies in the comprehensive school safety plan. Crisis teams that are composed of a variety of school staff could be designated when each school annually reviews and updates its comprehensive school safety plan. Mental health professionals could be included as part of this team and be involved in the safety plan development efforts. A point person identified by the plan would be charged with overseeing referrals after a school mental health crisis occurs. Student mental health training, access, and services could be included as part of the School Accountability Report Card (SARC). These recommendations will be addressed in 2013.

Another draft recommendation from the Student Mental Health Policy Workgroup is that the State Superintendent of Public Instruction recommend that all educator credential programs (teacher, administrative, school counselor, school social worker, school nurse, etc.) include curricula about mental health disorders,

including post-traumatic stress disorder. For teachers -- Basic information about mental health and mental health disorders; strategies for supporting students in the classroom; using classroom management to address mental health needs, incorporating social and cultural context; how to link students and families with mental health professionals; and how to work in collaboration with administration and colleagues to support students in the classroom, so that they have better and more equitable access to the curriculum. For administrators this would include basic information about mental health and mental health disorders; how to support all school personnel (including both credentialed and classified) in meeting the mental health needs of students; intervening with students who are chronically absent for reasons related to mental health and referring them to appropriate resources/services; designing a school safety plan that includes and takes advantage of mental health partnerships; and empowering families around mental health.

These recommendations will be reviewed by the State Superintendent of Public Instruction. Information about the Student Mental Health Policy Workgroup is available at <http://www.cde.ca.gov/ls/cg/mh/smhpworkgroup.asp>

The California State Board of Education has approved a policy which reinforces the importance of effective safe school plans that are developed cooperatively by community agencies, school counselors, school social workers, teachers, administrators, and local law enforcement. This State Board of Education policy is found at <http://www.cde.ca.gov/be/ms/po/policy01-02-mar2001.asp>

The state law which defines the required contents of the comprehensive school safety plans, including disaster procedures, is *Education Code* Section 32282.

Information about crisis preparedness is available on the California Department of Education Web site at <http://www.cde.ca.gov/ls/ss/cp/>. This includes information about bio-terrorism, coping with tragedy, and crisis response. The section on crisis response includes AB 103 pupil safety educational materials, best practices in school crisis prevention and intervention, the crisis response box, preparing an institution for a catastrophic event, and responding to a crisis at school. The coping with tragedy section provides practical guidelines for teachers and parents in a crisis, mental health information, and resources from the National Association of School Psychologists.

#### **1.2.6 Department of Health Care Services**

- When a Joint Emergency Operations Center (JEOC) is activated, leadership will be provided by DPH and the Emergency Medical Service Authority (EMSA) and the Department of Health Care Services (DHCS) will assist DPH and EMSA in providing appropriate program coordination and information management for responding Health and Human Services Agency departments.
- Through its role as a member of the JEOC, DHCS will assist DPH and EMSA as needed to coordinate community mental health disaster response services and activities.
- DHCS will assist DPH and EMSA to organize and coordinate communications with the counties and their and county mental health departments related to local mental health disaster response.

- DHCS will assist DPH and EMSA in facilitating applications for federal and other appropriate grants on the behalf of counties in the event of a presidentially declared disaster that includes individual assistance.

### **1.2.7 Department of Managed Health Care**

- The DMHC Consumer Help Center (1-888-466-2219) provides Californians with information and assistance regarding their health plan. This includes providing assistance for mental health services that are covered benefits under the consumers' health plan. Californians can file complaints or request an Independent Medical Review of their health plan's denial of services, including mental health services, from the Help Center staff or online at: [http://www.dmhc.ca.gov/dmhc\\_consumer/pc/pc\\_forms.aspx](http://www.dmhc.ca.gov/dmhc_consumer/pc/pc_forms.aspx).
- DMHC is federally-designated as California's health care Consumer Assistance Program and accepts inquiries from all Californians regardless of health care coverage source. Individuals who are enrolled in coverage outside of the DMHC's jurisdiction are referred to the appropriate entity, such as the California Department of Insurance, the California Department of Health Care Services or the Health Insurance Counseling & Advocacy Program (HICAP), which provides information and counseling regarding Medicare.
- Californians without health coverage are referred to regional community-based organization partners who can assist with enrollment into appropriate coverage programs or provide assistance and referrals to other local resources. California's community-based public mental health services are provided by California counties.
- During a regional or statewide disaster, the DMHC will respond in coordination with the California Health and Human Services Agency through the California Health Alert Network (CAHAN) disaster response system.

### **1.2.8 Department of Public Health**

CDPH has significant responsibilities for Emergency Function 8—Public Health and Medical—for the Health and Human Services Agency. Addressing mental/behavioral health issues during disasters will fall under EF 8. Below are listed the primary roles for CDPH during emergencies under EF 8:

- **Care and Shelter:** Ensures the safety of food, drugs, medical devices and other consumer products in the disaster area. Regulates bottled drinking water plants and distributors and drinking water haulers to ensure the safety of bottled or hauled water used as emergency supplies of drinking water. Provides support to local health departments for infectious disease surveillance and outbreak response and food safety and sanitation standards in shelters. Analyzes impacted areas for safe return of displaced populations.
- **Construction and Engineering:** Provides technical assistance with the construction, operation and inspection of public drinking water treatment facilities and assesses the extent of damage to public drinking water systems in disaster areas. In conjunction with the Office of Statewide Health Planning and Development (OSHPD), inspects healthcare facilities to determine their ability to provide patient care following an emergency.

- **Evacuation:** Supports local jurisdictions in safe evacuation of patients from healthcare facilities due to disaster. Provides assistance/coordination in identifying facilities needing evacuation, setting evacuation prioritizations and in facility re-population. Provides support for infant transport from neonatal intensive care units in coordination with the Emergency Medical Services Authority (EMSA). Provides assessments on radiation levels that require evacuation in a radiological incident.
- **Fire and Rescue:** Provides radiation safety services to responding fire and hazardous materials organizations for large radiological incidents. Provides assessment of health risks to both first responders and the public due to contaminants generated by fires and smoke.
- **Food and Agriculture:** Acts as technical resource on disease-carrying insects and animals and food safety in a disaster area. Provides laboratory and assessment services related to chemical, microbial and radiological contaminants. Identifies and assesses hazards to human health posed by pesticides used to combat agricultural pests.
- **Hazardous Materials:** Coordinates with appropriate agencies to investigate chemical exposures and determine appropriate protective actions. Coordinates emergency medical waste and shellfish protection programs with responsible state and local agencies. Augments local radiological monitoring and decontamination programs in the event of a nuclear power plant or other radiological disaster. Provides laboratory services related to food, drug, hazardous materials, drinking water contamination and testing of environmental samples.
- **Law Enforcement:** Provides guidance to law enforcement organizations on radiation safety. Works with fire and law to determine patient safety within licensed healthcare facilities.
- **Long Term Recovery:** Supports the restoration of healthcare facilities, drinking water systems and safe food supplies. Is the lead department for coordinating recovery activities due to radiological contamination.
- **Management:** Prepares messages to inform the public on appropriate actions to protect their health and safety. Maintains the California Health Alert Network (CAHAN) to notify appropriate response personnel of significant health/medical related events and/or the need to respond. Prepares public health and medical reports in concert with the Emergency Medical Services Authority and other CHHSA departments. Provides technical assistance related to public drinking water systems, communicable disease, hazardous materials, biohazards and radioactive materials and other public and environmental health concerns.
- **Public Health and Medical:** Administers and coordinates disaster-related public health programs and assesses hazards to the public's health. Provides statewide policies on environmental health. Coordinates with local health departments to conduct surveillance of infectious diseases in a disaster area and determines appropriate actions to be taken to prevent and control disease outbreaks. Implements pandemic influenza response plans in coordination with local health departments and other state agencies. Provides epidemiological and laboratory support through state and local public health and clinical laboratories, cooperating federal

health and environmental laboratories. Collects and analyzes data and reports information for public health emergency planning and response. Assesses health, safety, emergency preparedness and response plans for healthcare facilities. Ensures the safety of drinking water supplies. Assesses potential health effects, recommends protective measures and drafts measures to protect public from chemical, biological, radiological and nuclear incidents. Obtains and provides medical supplies and pharmaceuticals following a disaster. Assesses health, safety, emergency preparedness and response plans for facilities that the department regulates. Licensing and Certification Program ensures quality of care and operational readiness to provide care, in coordination with OSHPD structural and operational facility evaluation.

- **Utilities:** Responsible for ensuring the safety of all public water supplies, evaluates public water systems to restore the provision of safe drinking water and drafts measures to protect public from radiation from nuclear power plants.
- **Volunteer and Donations Management:** Provides technical advice and assists with coordinating donated pharmaceuticals, vaccines and medical supplies.

#### **1.2.9 Department of Rehabilitation**

- Provides assistance as requested to support Lead State Agency, California Health and Human Services Agency. May contribute personnel for evaluation teams to assess shelter sites for ability to incorporate special needs populations. May provide staff and available lists of additional personnel for sign language and translation services in other languages.
- Available to prepare informational materials on disaster mental health status and operations in alternative format (Braille) and large print for people who are blind or visually impaired.
- DOR works with individuals with mental health/behavior issues in regards to vocational rehabilitation services and supported employment. Services include employment counseling training and education, mobility and transportation aids, job search and placement assistance. However, DOR does not provide mental health services/treatment per se. DOR works in conjunction with our client's doctors and mental health professionals to develop a plan for the client's employment goals.
- **Evacuation:** Compiles and maintains lists of staff for sign language and fluency in other languages. Prepare crucial emergency materials in alternate format (Braille) and large print for people who are blind or visually impaired.
- **Long Term Recovery:** Assist CDSS and American Red Cross (ARC) shelters in identifying resources for relocation of people with disabilities.

#### **1.2.10 Department of Social Services**

The California Department of Social Services is responsible for supporting local agencies in mass care and shelter activities and programs throughout the state—and mental/behavioral health will be addressed under this responsibility area. The department assists in networking with Operational Areas state agencies, non-

governmental organizations and federal organizations to track resources needed for care and shelter. The department coordinates with the American Red Cross to assist in training for shelter operations. Once activated by Cal EMA the Disaster Services Section staff assists in the mass care and shelter functions by:

- 1.) Tracking shelter status
- 2.) Tracking feeding services
- 3.) Responding to request for state resources
- 4.) Supporting the American Red Cross in shelter operation
- 5.) Ensuring that the needs of emergency responder are being handled by the appropriate State agency.
  - Shelter coordination
  - Mass feeding services
  - Distribution of emergency supplies
  - Emergency first aid within a general population shelter
  - Disaster Welfare Information
  - Support for evacuation and transportation under CA-EF 16
  - Reunification
  - Assistance and support services for people with access and functional needs.
  - Support for services relating to household pets, service animals, and other animals included under CA-EF 11
  - Medical shelter support under CA-EF 8
  - Support for volunteers and voluntary agency coordination provided under CA-EF 17
  - Non-traditional sheltering / non-conventional shelter support
  - Crisis counseling within general population shelters
  - Assistance with disaster case management at shelters (note that initial disaster case management intake within general population shelters is typically conducted by the American Red Cross [ARC]).
  - Referral to recovery services available through governmental agencies (local, state, and federal) and NGOs at shelters, Local Assistance Centers (LACs), and Disaster Recovery Centers (DRCs). Access assistance may include transportation accommodations and information dissemination, particularly with regard to non-housing financial assistance and insurance claims and benefits.
  - Support for transition to interim housing under CA-EF 14.

The department also oversees the federal grant recovery program for individuals and households, and the Emergency Repatriation for California. These responsibilities are delegated to the department through an administrative order from the California Emergency Management Agency. The Health and Human Services Agency has also tasked the department with the development and implementation of the California Emergency Function 6 (Mass Care and Shelter) Annex to the State Emergency Plan (CA-EF 6).

Two other programs that the department administers and oversees are the Functional Assessment Service Team (FAST) Program and the Volunteer Emergency Services Team (VEST) Program. Both programs respond to shelter requests by deploying members to assist with various shelter functions.

While the department does not have a direct responsibility for mental health services, the shelters that are opened throughout the state would have residents arriving that do have mental health conditions. Close coordination between the American Red Cross and the department would be essential in a catastrophic event to ensure mental health needs are met.

#### ***1.2.11 Department of State Hospitals***

- DSH’s primary response role is to assist California’s State Hospitals and Psychiatric Programs in any emergency.
- DSH may deploy functional assessment service team (FAST) or volunteer emergency services team (VEST) members with Mental Health treatment experience to shelters. As coordinated through CHHSA or Cal EMA, DSH may provide staff to support State, regional, or local EOCs; or to support response or recovery efforts as Disaster Service Workers.
- DSH will work closely with CDPH, Cal EMA, and EMSA, and other agencies, during an emergency to assist as needed in all aspects of the response.

#### ***1.2.12 Department of Veterans Affairs***

- The Dept. of Veterans Affairs serves recent and long standing veterans throughout California in a variety of capacities, including job training assistance, housing assistance, health care referrals, education support and mental and behavioral health assistance—either directly or through its robust network across other state agencies, local government offices and contractor services.
- During a time of disaster or emergency DVA will work with its network of service providers and partner organizations to help support the needs of veterans affected by the event. DVA will also work closely with the California Emergency Management Agency, the California National Guard and other state agencies in support of the emergency response, concentrating on the health and needs of client veterans throughout the state.

#### ***1.2.13 Emergency Medical Services Authority***

EMSA has significant responsibilities for Emergency Function 8—Public Health and Medical—for the Health and Human Services Agency. Addressing mental/behavioral health issues during disasters will fall under EF 8. Below are listed the primary roles for EMSA during emergencies under EF 8:

- EMSA is the lead agency responsible for coordinating California's medical response to disasters.
- EMSA Disaster Medical Services Division (DMSD) develops and maintains disaster readiness medical response plans, policies and procedures.
- EMSA DMSD On-Call Duty Officer provides 24 hour coverage for emergency events throughout California.

- EMSA Response Resources Unit deploys to field with mobile medical field assets and personnel.
- EMSA DMSD provides an administrative program and training role for Ambulance Strike Teams with enhanced communication abilities and supplies to support field deployment during disaster events.
- EMSA DMSD serves as emergency medical response managers in various positions at state emergency operations centers such as the California Emergency Management Agency State and Regional Emergency Operations Centers (SOC and REOC), the California Department of Public Health (CDPH) and EMS Authority Medical/Health Coordination Center (MHCC).
- EMSA DMSD coordinates supplying medical resources when requested to local governments in support of their disaster response.
- EMSA DMSD coordinates Ambulance Strike Teams and other transportation to help facilitate evacuation of injured victims to hospitals in areas/regions not impacted by a disaster.
- EMSA DMSD works closely with the Governor's Cal EMA, California National Guard, Department of Health Services and other local, state, and federal agencies to improve disaster preparedness and response.
- EMSA DMSD provides a maintained database system for counties to store the Disaster HealthCare Volunteers data to provide volunteer healthcare professionals for emergency response with those who are appropriately licensed and credentialed.
- EMSA DMSD conducts periodic exercises with local, state, and federal agencies and the private sector to test and evaluate disaster medical response plans, procedures and provides practice for medical response teams.
- EMSA DMSD enhances state and local disaster medical response capabilities through the development of volunteer California Disaster Medical Assistance Teams (CAL-MATs), mission support management teams, disaster medical communications systems, and a statewide medical mutual aid system.

#### ***1.2.14 Office of Statewide Health Planning and Development (Licensing and Certification)***

The Office of Statewide Health Planning and Development (OSHPD) was created in 1978 to provide the State with an enhanced understanding of the structure and function of its healthcare delivery systems. Since that time, OSHPD's role has expanded to include direct delivery of various services designed to promote healthcare accessibility within California. OSHPD is the leader in collecting data and disseminating information about California's healthcare infrastructure, promoting an equitably distributed healthcare workforce, and publishing valuable information about healthcare outcomes.

During disasters and emergencies, OSHPD will specifically focus on the safety and viability of hospital locations and their ability to continue services. After an event, impacted hospitals will be surveyed, and the

resulting data will be given to the Emergency Function 8 community through EMSA and CDPH primarily.

OSHPD monitors the construction, renovation, and seismic safety of hospitals and skilled nursing facilities and provides loan insurance to facilitate the capital needs of California's not-for-profit healthcare facilities. These programmatic functions are distributed across five divisions and one foundation, are advised by five boards and commissions, and are supported by the Office's Administrative Services Division.

The Mission of OSHPD is to promote healthcare accessibility through leadership in analyzing California's healthcare infrastructure, promoting a diverse and competent healthcare workforce, providing information about healthcare outcomes, assuring the safety of buildings used in providing healthcare, insuring loans to encourage the development of healthcare facilities, and facilitating development of sustained capacity for communities to address local healthcare issues.

## **2 Local Government Agencies**

### ***2.1 Lead Agency – Department of Mental Health/Behavioral Health***

Each county has its own unique infra-structure and hierarchy. In some cases, behavioral health is under Public Health (such as San Francisco) whereas in other counties, behavioral/mental health is under a broader category of Health and Human Services as a "division" which coordinates with a Public Health office [such as Sacramento] or is its own Department and coordinates with a Public Health Department [such as Fresno and Los Angeles]. Behavioral/Mental Health coordinates with its designated Public Health partner/lead) during response. The role in County Behavioral Health has been to:

- Participate in coordinated response with County Public Health
- Follow leadership hierarchy with pre-determined, activation plans that can escalate and is robust
- Provide Behavioral Health Services, as needed, up to and including provide assessments/triage of community members and survivors
- Act as a gatekeeper and fiscal reimbursement to inpatient services for indigent and Medi-Cal beneficiaries.
- Provide and participate in local community educational events in Behavioral Health disaster preparedness
- Supporting Agencies may include:
  - Department of Alcohol and Drugs
  - Department of Health Services
  - Department of Public Health
  - Department of Social Services
  - Emergency Management Agency
  - School Districts

### ***2.2 Medical Reserve Corps***

California has numerous Medical Reserve Corps organizations very active throughout the state in support of medical and health emergency response and planning. MRCs work closely with local public health and medical offices, first responders, and support organizations, including the American Red Cross—where they may assist in mass care and mental/behavioral health activities.

- MRC units are community-based and function as a way to locally organize and utilize volunteers who want to donate their time and expertise to prepare for and respond to emergencies and promote healthy living throughout the year. MRC volunteers supplement existing emergency and public health resources.
- MRC volunteers include medical and public health professionals such as physicians, nurses, pharmacists, dentists, veterinarians, and epidemiologists. Many community members—interpreters, chaplains, office workers, legal advisors, and others—can fill key support positions.
- MRC units are provided specific areas to target that strengthen the public health infrastructure of their communities by the U.S. Surgeon General. These are outlined priorities for the health of individuals, and the nation as a whole, which also serve as a guide to the MRC. The overarching goal is to improve health literacy, and in support of this, she wants us to work towards increasing disease prevention, eliminating health disparities, and improving public health preparedness.
- MRC volunteers can choose to support communities in need nationwide. When the southeast was battered by hurricanes in 2004, MRC volunteers in the affected areas and beyond helped communities by filling in at local hospitals, assisting their neighbors at local shelters, and providing first aid to those injured by the storms. During this 2-month period, more than 30 MRC units worked as part of the relief efforts, including those whose volunteers were called in from across the country to assist the American Red Cross (ARC) and the Federal Emergency Management Agency (FEMA).
- During the 2005 Hurricane Season, MRC members provided support for ARC health services, mental health and shelter operations. MRC members also supported the HHS response and recovery efforts by staffing special needs shelters, Community Health Centers and health clinics, and assisting health assessment teams in the Gulf Coast region. More than 1,500 MRC members were willing to deploy outside their local jurisdiction on optional missions to the disaster-affected areas with their state agencies, the ARC, and HHS. Of these, almost 200 volunteers from 25 MRC units were activated by HHS, and more than 400 volunteers from more than 80 local MRC units were activated to support ARC disaster operations in Gulf Coast areas.

### **3 Federal Agencies**

#### **3.1 Lead Federal Agency - Health and Human Services/Office of the Assistant Secretary for Preparedness and Response (ASPR)**

- Created to lead the nation in preventing, preparing for, and responding to the adverse health effects of public health emergencies and disasters.
- During an emergency or disaster, provides federal support, including deployment of medical professionals through ASPR's National Disaster Medical System (ASPR-NDMS), to augment state and local capabilities.

- 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.
- Coordinates the federal health and medical services support functions during a public health emergency.
- Maintains Regional Emergency Coordinators (ASPR-RECs) in each of the country's 10 disaster planning regions. ASPR-RECs monitor emerging public health concerns, including mental/behavioral health, and provide consultation and technical assistance to states, territories, tribes, local, and private sector authorities.
- 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 mental/behavioral health activities as part of overall hospital preparedness.

## **3.2 Supporting Federal Agencies**

### **3.2.1 *FEMA***

- Administers the Crisis Counseling Program consisting of two grant programs: Immediate Services Program (ISP; 60 days in duration) and Regular Services Program (RSP; 9 months in duration).

### **3.2.2 *HHS/Administration for Children and Families***

- ACF programs fund grantee operations that can provide assistance with mental/behavioral health and other issues arising during and after a disaster.
- 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.

### **3.2.3 *HHS/Administration on Aging (AoA)***

- Develops 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.
- Works with ACF-OHSEPR (Administration of Children and Family Office of Human Services Emergency Preparedness and Response) and ASPR-ABC (Assistant Secretary for Preparedness and Response-At-Risk, Behavioral health & Community Resilience) to develop and review state, territory, tribal and local emergency response plans and coordinate ESF #8 and ESF #6 activities and assists HHS entities to help ensure that the mental/behavioral health and functional needs of at-risk individuals, particularly senior citizens and persons with disabilities, are being addressed.

### **3.2.4 *HHS/Centers for Disease Control and Prevention (CDC)***

- Conducts numerous scientific activities, including surveillance, prevention research, and health promotion, addressing mental and mental/behavioral health.
- CDC’s multidisciplinary Mental Health Work Group and the Disaster Surveillance Work Group (DSWG) provide scientific consultation and collaboration across centers.

### **3.2.5 HHS/Centers for Medicare and Medicaid Services (CMS)**

- Administers all aspects of the Medicare, Medicaid and Children’s Health Insurance programs (CHIP), including mental and mental/behavioral health.
- 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.

### **3.2.6 HHS/Health Resources and Services Administration (HRSA)**

- Primary federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable.
- Grant programs support community-based mental/behavioral health care provision, which contributes to community resiliency.
- 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.
  - Maintains situational awareness regarding the effect of emergent and public health events on grantees who deliver mental/behavioral health services and coordinates information exchange among HRSA (Health Resources and Services Administration), ASPR (Association of Staff Physician Recruiters), and other stakeholders.
  - 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 mental/behavioral health response and recovery.

### **3.2.7 HHS/Indian Health Service (IHS)**

- Direct response partner for emergencies and disasters across the tribal communities it serves.
- Services units and hospitals, clinics, and health stations are engaged in integrated disaster preparedness, response, and recovery activities and services.
- Assists its tribal partners by providing emergency and disaster services in contracted or compacted tribal programs and reservations and communities.

### **3.2.8 Bureau of Indian Affairs**

- In consultation with tribal officials, provides—either by itself, by contract with a tribe, or both—a broad variety of services in an emergency including basic law enforcement protection, fire protection, emergency social services assistance to affected individuals and households, and support for all Federal agencies responding to the incident.

### **3.2.9 HHS/National Institutes of Health (NIH)**

- The National Institute of Mental Health and several other NIH Institutes participate in a number of HHS and interagency 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 VANCPTSD Educational Advisory Board.
- 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.

### **3.2.10 HHS/Substance use and Mental Health Services Administration (SAMHSA)**

- When an incident occurs with the potential to overwhelm state, territory and tribal mental/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.
- Maintains close linkages with state, territory and tribal mental/behavioral health partners and engages in preliminary needs assessments throughout the response period.
- 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 mental/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.
- When disaster related mental/behavioral health needs overwhelm state, territory and tribal mental/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 use 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.

### **3.2.11 HHS/OASH Office of Force Readiness and Deployment (OFRD)**

- Manages USPHS disaster response teams, which provide a wide range of mental/behavioral health services in emergencies and large scale disasters, including five Mental Health Teams.

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

- Provides its partners, stakeholders, and response assets with subject matter expertise, education, and coordination to ensure that mental/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, 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.

### **3.2.13 HHS/Office on Disability (OD)**

- Operational priority in a response is to work with national and local mental/behavioral health disability rights leaders and other agencies across HHS to ensure that rights and safeguards are met.
- Maintains a contact list and relationships with mental/behavioral health disability consumer advocacy and rights groups throughout the country, which it uses to disseminate disaster mental/behavioral health information and planning guidance to assist in any response effort.

## **4 Non-Governmental Organizations**

Such as:

### **4.1 American Red Cross**

American Red Cross has approximately 8,000 licensed mental health providers, the largest group of mental health professionals in the United States, to assist in all phases of disaster work. The American Red Cross has memoranda of understanding with the American Psychological Association, American Psychiatric Association, National Association of Social Workers, American Counseling Association, American Association of Marriage and Family Therapists, and several others, to utilize members of all of the major professional mental health associations for service as ARC disaster mental health volunteers. In concert with government partners and other health care providers, health and mental health workers the American Red Cross provides services at shelters, service centers, bulk distribution routes, aid stations and temporary evacuation points.

Local jurisdictions are encouraged to establish a partnership with the local chapter(s) of the American Red Cross in their area prior to and during disasters. Jurisdictions may include the American Red Cross in their Disaster Mental/Behavioral Health stakeholder group and confer with the American Red Cross on their disaster role, disaster mental health related training, deployment of mental health volunteer personnel, mental health impact data (PsySTART Disaster Mental Health Triage System data is collected by the American Red Cross on major disasters) resolution of care and shelter related issues, and collaboration on the best methods to assist the public with complex mental health needs.

#### **4.2 National Organization for Victim Assistance (NOVA)**

Founded in 1975, NOVA is the oldest national victim assistance organization of its type in the United States as the recognized leader in this role. NOVA is a private, non-profit, 501(c)(3) organization.

NOVA works closely with selected companies that help them fulfill its mission. These organizations recognize the value of collaborating with NOVA and demonstrate the highest ideals in the quality of their work and the commitment to the needs of victims.

One of the defining characteristics of a crisis is resulting trauma. When something is unexpected, unique and overwhelming to daily experience, that event can result in traumatic reactions. It is important to recognize that traumatic reactions vary from person-to-person and event-to-event, based upon a number of variables.

Since 1986, NOVA's Crisis Response Team (CRT) training has been providing skills and protocols to mitigate trauma reactions in the aftermath of a critical incident. Especially valuable is the ability to scale the response to a mass-casualty scenario. This nationally recognized instruction is provided in an adult-education, hands-on environment. NOVA also offers Seal of Approval training which is designed to enhance the credibility of victim-sensitive companies. Additionally, the Victim Relations (VR) Training provides coaching and skills to assist victims.

Trained individuals are available to be utilized during emergencies and disasters, and can be engaged through the NOVA website or through contacts with local and state agencies who work with NOVA.

#### **4.3 National Voluntary Agencies Active in Disasters (NVOAD) and Local Voluntary Agencies Active in Disasters**

- National Voluntary Organizations Active in Disaster (NVOAD) is a nonprofit, nonpartisan membership organization that serves as the forum where organizations share knowledge and resources throughout the disaster cycle—preparation, response, recovery and mitigation—to help communities prepare for and recover from disasters. State VOADs and Local Chapters mirror the capacity, services and mission of the NVOAD and provide services and support to both organizations and individuals—including mental and behavioral health support—during times of disasters and emergencies.
- The National VOAD coalition includes over 50 of the country's most reputable national organizations (faith-based, community-based and other non-governmental organizations) and 55 State/Territory VOADs, which

represent Local/Regional VOADs and hundreds of other member organizations throughout the country.

- The 108 members of National VOAD National represent a diverse group of highly competent emergency service organizations who provide a wide range of skills during emergencies and disasters. All organizations have service-oriented missions and include volunteer engagement as a key component of their operations.
- 55 State and Territory VOAD members represent many local and regional VOADs, and hundreds of additional local organizations. All are dedicated to whole community engagement and recognize that the VOAD movement values and practices represent a proven way to build resilient communities. The VOAD combination of faith-based, community-based, and other non-profit, non-governmental organizations (NGOs) represents thousands of professional staff and volunteers with unique skills and resources.
- California has a two statewide VOADs, which can provide a link to many local chapters throughout the State:

1. *North*

Tom Conrad, President  
*Presbyterian Disaster Assistance*  
32 Big Oak Court  
Walnut Creek, CA 94596  
[tgconrad@gmail.com](mailto:tgconrad@gmail.com)

2. *South*

Robin Clegg, Vice President (acting President)  
*Community Recovery Team, Inc.*  
619-778-3582  
[clegg.robin@gmail.com](mailto:clegg.robin@gmail.com)

#### **4.4 Salvation Army**

- The Salvation Army is officially recognized by federal, state and local governments across the country as a sanctioned disaster relief and assistance organization. As a relief organization within the National Voluntary Organizations Active in Disaster (NVOAD). The Salvation Army was involved in the development of the Federal Emergency Management Agency's (FEMA) recently released National Response Framework. The Army is recognized within this framework. The Army provides relief services to communities impacted by both natural and man-made disasters until the service is no longer needed by the community. When initiating a disaster relief operation, the first aim is to meet the basic needs of those who have been affected, both survivors and first responders. Even at this level, The Salvation Army's workers are ministering in that they serve as a means of expressing God's love to those in need. The Salvation Army's primary goals are to offer:
  - Material comfort
  - Physical comfort
  - Spiritual and Emotional comfort

- Throughout the duration and aftermath of a major disaster, The Salvation Army provides spiritual comfort and emotional support upon request to victims and emergency workers coping with the stress of a catastrophe. Salvation Army counselors, who are often ordained as clergy (officers), may simply offer a “ministry of presence,” but often people who know about The Salvation Army as representatives of God may ask for prayer or help from the Bible. Other activities may include comforting the injured and bereaved, conducting funeral and memorial services or providing chaplaincy service to disaster workers and emergency management personnel. Disaster relief and recovery services are provided to all in need without discrimination.

## **5 Private Organizations**

### **5.1 Community Health Centers**

Many resources for medical and health support are located within the private or non-profit sectors through local Community Health Centers/Organizations. These locations frequently provide neighborhood and regional assistance for a range of community needs, including mental and behavioral health support, especially low income populations. These Centers are frequently contracted through municipal organizations to assist with the delivery of mental/behavioral health services during emergencies.

Nationally, community Health Centers serve the primary health care needs of more than 20 million patients in over 8,000 locations across the United States. Health centers play a crucial role providing affordable health services for millions of uninsured and newly jobless Americans. Health centers provide a unique and comprehensive approach to health care that addresses patient health and creates local jobs in the communities that they serve. Each health center takes a unique approach to meet the needs of the people in the surrounding community.

## Appendix D - Disaster Mental Health Core Competencies



### Disaster Mental Health Core Competencies

The development of disaster mental health competencies enables California to identify training strategies and California Disaster Healthcare Volunteer registration strategies. This complies with federal requirements and leads the nation into the next iteration of disaster mental health best practices.

The five core competencies are prefaced by a seven-point preamble that serves as a platform for understanding the competencies themselves.

#### Preamble

- Adherence to performance within one's scope of practice (e.g., functional role; knowledge, skill, authority; continuing education; ethics; confidentiality, licensure, certification) with respect to individuals, families, groups, organizations, and/or at the population level;
- Consideration of the context of the situation (e.g., event type, population served, geography, sensitivity for unique subgroup needs) in applying these competencies;
- Recognition of the distinction between public health initiatives and clinical practice with respect to the population, temporal acuity, and disaster phase; and a further distinction between crisis intervention and traditional mental health treatment;
- Sensitivity to diversity and cultural competence;
- Acceptance by management/leadership so as to recognize and embrace disaster behavioral health principles;
- Recognition of the desire to reduce the risk of any harm that may come from intervention; and
- Recognition of the importance of teamwork and adherence to the incident command system

#### Core Competencies

- 1. Understand and describe the following key terms and concepts related to disaster mental/psychosocial/behavioral health preparedness and response:**

- A. The National Incident Management System (NIMS)/Standardized Emergency Management System (SEMS)/Incident Command System (ICS); and the role of disaster mental health in a multidisciplinary disaster response;
- B. The nature, biopsychosocial, and cultural manifestations of human stress and typical stress reactions;
- C. The phases of psychosocial disaster and recovery reactions at the individual and community levels;
- D. The psychosocial effects of psychological trauma and disaster-related losses and hardships on individuals and communities;
- E. Disaster mental health intervention principles and phase-appropriate interventions;
- F. Crisis intervention(s) with disaster-affected individuals and (sub) populations; and
- G. Individual and population-based responses before, during, and after a disaster (e.g., evacuation, shelter in place).

**2. Communicate effectively as demonstrated by one’s ability to:**

- A. Establish a connection and rapport;
- B. Employ active/reflective listening skills;
- C. Utilize effective nonverbal communications;
- D. Establish realistic boundaries and expectations for the interaction; and
- E. Employ principles and strategies for culturally competent and developmentally appropriate communications.

**3. Assess the need for and type of intervention (if any) as demonstrated by, but not limited to, the ability to:**

- A. Perform rapid triage to identify “at risk” individuals and populations;
- B. Gather information by employing such methods as observation, self-report, other reports, and other assessments;
- C. Identify immediate medical needs, if any;
- D. Identify basic human needs (e.g., food, clothing, shelter);
- E. Identify social and emotional needs;
- F. Determine level of functionality (e.g., the ability to care for self and others, follow medical advice and safety orders);
- G. Recognize mild psychological and behavioral distress reactions and distinguish them from potentially incapacitating reactions; and
- H. Synthesize assessment information.

**4. Formulate and implement an action plan (based upon one’s knowledge, skill, authority, and functional role) to meet those needs identified through assessment and as demonstrated by, but not limited to, the activities listed below:**

- A. Develop an action plan that:
  - 1. Identifies available resources (e.g., food, shelter, medical, transportation, crisis intervention services, local counseling services, financial resources);

2. Identifies appropriate stress management interventions; and
  3. Formulates sequential steps.
- B. Initiate an action plan to include, but not be limited to, the ability to:
1. Provide appropriate stress management, if indicated;
  2. Connect to available resources (e.g., food, shelter, medical, transportation, crisis intervention services, local counseling services, financial resources);
  3. Connect to natural support systems (e.g., family, friends, co-worker, spiritual support); and
  4. Implement other interventions as appropriate.
- C. Evaluate the effectiveness of an action plan considering changes in situation or disaster phase through methods such as observation, self-report, other reports, and other assessments.
- D. Revise an action plan as needed (e.g., track progress and outcomes).
- 5. Demonstrate knowledge of responder peer-care and self-care techniques to:**
- A. Describe peer-care techniques (e.g., “buddy” system, informal “town meetings”);
- B. Describe self-care techniques (e.g., stress management, journaling, communication with significant others, proper exercise, proper nutrition, programmed “down time,” sufficient quality sleep); and
- C. Describe organizational interventions that reduce job stress (e.g., organizational briefings, adjustment of shift work, job rotations, location rotations, effective and empathic leadership, work/rest/nourishment cycles, support services, as indicated).

## Recommended Disaster Mental Health Curricula

The following resources have been identified as opportunities to obtain training related to the identified disaster mental health core competencies.

- California Responds

Module One – Mental Health Response System and Federal Funding Overview

Module Two – Basic Clinical Principals

Module Three – Weapons of Mass Destruction

Module Four – Anxiety and Related Topics

Module Five – Coping Among Survivors

Module Six – Delivering Bad News: Families, Victims, Agencies

Module Seven – Risk Management, Isolation and Quarantine Issues

Offered online: <http://www.dmh.ca.gov/Disaster/Publications.asp>

- Core Competencies On-line Training

Course objectives:

All Hazards systems, plans, and key concepts

Community-wide assessment models

Rapid assessment and triage

Disaster related stress reactions: survivors, responders, colleagues, & self

Evidence-based disaster mental health risk factors

Crisis intervention

Psychological first aid

Psycho education

Cross-cultural considerations

Traumatic grief & loss

Problem-solving and conflict resolution

Information & referral process considerations

Advocacy

Evidence-based stress-related treatments

Working in disaster-mental settings/ altered environments (shelters, relief centers, unconventional intervention settings)

Concepts of risk communication

Field safety considerations

Management of substance abuse

Provider self-care issues

<http://disastermentalhealth.com/>

- Disaster Services: An Overview

This course provides basic information about disasters and its effect, outlines the role of agencies in disaster relief, and introduces American Red Cross (ARC) Disaster Services to the public. This is a prerequisite to take any disaster class through ARC.

Contact local Red Cross office; go to <http://www.redcross.org/find-your-local-chapter>

- Foundations of Disaster Mental Health  
This course is to prepare licensed mental health professionals to provide for and respond to the psychological needs of people across the continuum of disaster preparedness, response and recovery.  
Contact local Red Cross office; go to <http://www.redcross.org/find-your-local-chapter>
- Psychological First Aid  
The course provides a framework for understanding the factors that affect stress responses in disaster relief workers and the clients they serve. In addition, it provides practical suggestions about what you can say and do as you practice the principles of Psychological First Aid.  
Contact local Red Cross office; go to <http://www.redcross.org/find-your-local-chapter>
- ICS-100, ICS-200, ICS-700a, ICS-800  
Courses through FEMA that teach about the Incident Command System (ICS) that meet the requirements specified in the National Incident Management System (NIMS).  
Offered online: <http://training.fema.gov/IS/NIMS.asp>

## Appendix E

# Guidelines for Developing a Disaster Mental/Behavioral Health Training Plan for Your Jurisdiction

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Recommended actions when using this tool:

- Review section 3.2.2 Training and Exercises section of the *State of CA Disaster Mental-Behavioral Health Disaster Response Plan* including the “recommended actions”; reference the following appendix F *Disaster Mental/Behavioral Health Programs and Services*; also reference the 2010 ‘Core Competencies’ document in appendix D; and also review the *Disaster Mental/Behavioral Health Training and Development Guidelines* in this appendix, below. These resources are complimentary and will assist your jurisdiction in assessing training needs and approaches.
- Work with your jurisdiction’s/organization’s stakeholder group to develop a customized Disaster Mental/Behavioral Health training plan for your jurisdiction. As suggested in the guidance below, the plan should address core competencies, type of staff to be trained, and source and type of evidence-based mental health interventions needed for each phase of the disaster and that address the expected continuum of risk, needs, and available resources.

## Introduction to the Guidelines

This document sets forth training and development guidelines for multiple groups that may be involved in mental/behavioral health response to disasters within California. These guidelines reflect the stakeholder input gathered during the development of the State of California Mental/Behavioral Health Disaster Response Plan in 2012, provided by the Core Working Group. As such, these guidelines represent recommendations for many audiences:

- clinicians and professionals who may or may have disaster-focused practices;
- disaster responders and paraprofessionals who may or may not have mental/behavioral training,
- volunteers who may or may not be clinicians;
- government personnel who may or may not routinely work with mental/behavioral health (or disasters); and,
- community members, who through training and development may increase the levels of resiliency at the individual, family, and neighborhood level.

These guidelines offer a robust set of guidance from government- and non-government-based individuals with considerable experience in the practice of disaster mental/behavioral health preparedness and response. However, these guidelines do not represent compliance metrics or benchmark capabilities. These guidelines were set forth in response to questions of “What guidelines should exist?” rather than “What guidelines are realistic in light of current funding constraints and compliance enforcement mechanisms?” Multiple Core Work Group members noted that specific training needs should be locally determined, rather than dictated in a State of California document. Additionally, many guidelines were suggested regarding the type of training (such as psychological first

aid) without stipulating specific courses, content, or providers. These guidelines will require planning input from local stakeholder groups (as noted in the “Recommended Actions” above) and implementation in order to be effectively adopted.

## Core Competencies

The most important point of reference for these guidelines is the California Department of Mental Health Disaster Mental Health Core Competencies, last updated in May 2010 and based on consensus stakeholder input. (See Appendix D *Disaster Mental Health Core Competencies*.) Members of the 2012 Core Working Group, (constituted to guide development of the State of California Mental/Behavioral Health Disaster Framework), reviewed and addressed the existing Core Competencies document during the June 12, 2012 planning session. The consensus in June 2012 was that the Core Competencies document is comprehensive and widely supported; as such, it appears unmodified in Appendix D. However, the following recommendations to change the Core Competencies were made:

- A. It is recommended that only government-provided training opportunities should be listed in the Core Competencies, (eliminating references to commercial sites offering trainings). However, local jurisdictions should review other training resources (such as found in Appendix F) to develop a program that fits their needs.
- B. The competencies should focus on the provision of disaster mental/behavioral health services based on evidence informed/best practices (for children as well as adults) and widely accepted national guidelines such as the SAMHSA National Registry of Evidence Based Practices or Institute of Medicine. (See section 2.5 Plan Focus, Guiding Principles and Assumptions of the *State of CA Disaster Mental-Behavioral Health Disaster Framework*).
- C. The Core Competencies (Appendix D) and Disaster Mental/Behavioral Health Programs and Services (Appendix F) should be reviewed and customized by each jurisdiction to determine what best meets the goals of their training plan.

## Beyond Disaster Mental/Behavioral Health Responders

The Core Competencies and other earlier work have focused on training for disaster mental health responders at various levels of government. These guidelines recognize that training and development is needed beyond government, and beyond the construct of “disaster mental health responders.” All of the training suggested below should be seen as on-going, regular, and institutionalized under the aegis of a specific department (such as the county mental health department).

### First Responders

Local first responders are not necessarily trained or practiced in disaster mental/behavioral health response. Local responders should receive some form of Psychological First Aid training. (See Appendix F - Disaster Mental/Behavioral Health Programs and Services.)

### Community

Training to promote resiliency is needed at the individual, family (and children), and community levels. Proactive community training represents tangible mitigation and preparedness phase activities, and can be accomplished using community based psychological first aid and preparedness training. (See Appendix E- Disaster Mental/Behavioral Health Programs and Services.)

Additionally, training on the behavioral response to disasters (including mental self-care and family mental health care) should be provided to media, county public relations departments, and major

integrated disaster drills where disaster mental/behavioral health post disaster impact and recovery issues are/can be included and practiced.

### **Clinicians and Mental/Behavioral Health Professionals**

Clinicians and mental/behavioral health professionals are not necessarily trained or versed in disaster response. All mental health providers working for state, county, or city government must have additional training in disaster mental health. Similar training should apply to volunteers likely to be deployed to large-scale incidents.

As such, training and development is needed in the following areas:

- How to function in a responder mode, including such skills as psychological first aid and victim prioritization.
- How to perform immediate assessments and to triage/determine immediate client/victim needs, including how to recognize individuals in need of mental health care.
- How to coordinate with paraprofessionals and other responders in a disaster. How to perform secondary assessment, education, referral and treatment that addresses the expected continuum of risk, needs, and available resources. ((See Appendix F- Disaster Mental/Behavioral Health Programs and Services.)
- This training could occur at the local or state level, or be provided through professional clinician communities. Such training could receive continuing education units (CEUs) as an incentive, and could potentially be a requirement of the various state licensing boards.

### **Preparation for Federal Assistance**

Key staff at the county and state level should be trained in accessing federal disaster mental/behavioral health resources. These include training regarding available resources, the application process for grants under the Stafford Act Crisis Counseling Program and Specialized Crisis Counseling Services program, and related documentation requirements. Each jurisdiction will need to identify which staff should be trained.

## Appendix F - Disaster Mental/Behavioral Health Programs and Services

### Psychological First Aid (PFA)

- ***Listen, Protect, Connect: Family-to-Family, Neighbor-to-Neighbor (Psychological First Aid for the Community Helping Each Other)***  
<http://www.cdms.uci.edu/protect.pdf>
- ***Listen, Protect, Connect: Model and Teach (Psychological First Aid for the Students and Teachers)***  
[http://www.ready.gov/sites/default/files/documents/files/PFA\\_SchoolCrisis.pdf](http://www.ready.gov/sites/default/files/documents/files/PFA_SchoolCrisis.pdf)  
  
***National Center for PTSD Psychological First Aid Model:***  
[http://www.nctsn.org/nctsn\\_assets/pdfs/PFA\\_InfoBrief\\_FINAL.pdf](http://www.nctsn.org/nctsn_assets/pdfs/PFA_InfoBrief_FINAL.pdf)
- ***American Red Cross - Psychological First Aid: Helping Others in Times of Stress, February 2012*** Contact your local chapter to request the class or find your local chapter at: <http://www.redcross.org/> (This PFA model also includes training on the PsySTART Rapid Mental Health Triage System.)
- ***Psychological First Aid World Health Organization Model :***  
[http://whqlibdoc.who.int/publications/2011/9789241548205\\_eng.pdf](http://whqlibdoc.who.int/publications/2011/9789241548205_eng.pdf)
- ***Psychological First Aid Video***  
In support of developing prevention principles and educating and informing communities please click on link below of a YouTube presentation on “Psychological First Aid” (PFA). It incorporates concepts and strategies to help yourself and others during critical incidents and emergencies. This presentation was developed as a project by the California Disaster Mental Health Coalition (CHHSC) and its 2009-2011 chair, Diane Bridgeman, Ph.D. Shawn Talbot and CAMFT provided time and funding for this public service project. <http://youtu.be/yUnkukCx3s>

### American Red Cross Training and Guidance for Licensed Mental Health Professionals:

- **Foundations of Disaster Mental Health Training – August 27, 2011** (Contact your local chapter of the American Red Cross for the training. The purpose of this training is to prepare independently-licensed Disaster Mental Health worker to deploy to an American Red Cross disaster relief assignment. This course also includes training on the PsySTART Rapid Mental Health Triage System.)
- **American Red Cross Disaster Mental Health Handbook, October 2012:** This is the handbook used to manage the American Red Cross Disaster Mental Health function/activity during disasters. This handbook can be obtained from your local chapter of the American Red Cross and is also available (with permission from American Red Cross NHQ) at: <http://www.cdms.uci.edu/PDF/Disaster-Mental-Health-Handbook-Oct-2012.pdf>

## Evidence Informed Trauma Interventions – Guidance

### Using Your Jurisdictions Existing Prevention and Early Intervention (PEI) Plans

- California Department of Mental Health- Mental Health Services Action, Prevention and Early Intervention (PEI)  
[http://www.dmh.ca.gov/Prop\\_63/MHSA/Prevention\\_and\\_Early\\_Intervention/default.asp](http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp)
- Los Angeles County Department of Mental Health PEI Plan Highlights:  
<http://dmh.lacounty.gov/wps/portal/dmh/home/> (Look up Mental Health Services Act, Prevention and Early Intervention (PEI) to obtain the PDF.

### National Guidance

- National Institute of Health (2002) *Mental Health and Mass Violence: Evidence-Based Early Psychological Interventions for Victims/Survivors of Mass Violence, a Workshop to Reach Consensus of Best Practices*:  
[www.nimh.nih.gov/health/publication/massviolence.pdf](http://www.nimh.nih.gov/health/publication/massviolence.pdf)
- Substance Abuse and Mental Health Services Administration (SAMHSA), Training and Technical Assistance: <http://www.samhsa.gov/nctic/training.asp> *National Center for Trauma Informed Care (NCTIC) – Trauma -Informed Care and Trauma Services*:  
<http://www.samhsa.gov/nctic/training.asp>

### Evidence Informed Trauma Interventions - Training

- **Cognitive Behavioral Intervention for Trauma in Schools (CBITS)** The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) program is a school-based group and individual intervention designed to reduce symptoms of posttraumatic stress disorder (PTSD), depression, and behavioral problems; improve peer and parent support; and enhance coping skills among students exposed to traumatic life events, such as community and school violence, physical abuse, domestic violence, accidents, and natural disasters. CBITS has been tested primarily with children in grades 3 through 8, as in the three studies reviewed in this summary. It also has been implemented with high school students. Students who have participated in CBITS evaluations have been individually screened for trauma and/or were exposed to a catastrophic weather event such as Hurricane Katrina. CBITS relies on cognitive and behavioral theories of adjustment to traumatic events and uses cognitive-behavioral techniques such as psycho-education, relaxation, social problem solving, cognitive restructuring, imaginable exposure, exposure to trauma reminders, and development of a trauma narrative. The program includes 10 group sessions and 1-3 individual sessions for students, 2 parent psycho-educational sessions, and a teacher educational session. It is designed for delivery in the school setting by mental health professionals working in close collaboration with school personnel. <http://cbitsprogram.org/>
- **Prolonged Exposure Therapy for Posttraumatic Stress Disorders Prolonged Exposure (PE) Therapy for Posttraumatic Stress Disorders** is a cognitive-behavioral treatment program for adult men and women (ages 18-65+) who have experienced single or multiple/continuous traumas and have posttraumatic stress disorder (PTSD). The program consists of a course of individual therapy designed to help clients process traumatic events and reduce their PTSD symptoms as well as depression, anger, and

general anxiety. PE has three components: (1) psycho-education about common reactions to trauma and the cause of chronic post trauma difficulties, (2) imaginal exposure (also called revisiting the trauma memory in imagination), repeated recounting of the traumatic memory, and (3) in vivo exposure, gradually approaching trauma reminders (e.g., situations, objects) that are feared and avoided despite being safe. Treatment is individualized and is conducted by social workers, psychologists, psychiatrists, and other therapists trained to use the PE manual, which specifies the agenda and treatment procedures for each session. Standard treatment consists of 8-15 sessions conducted once or twice weekly for 90 minutes each. The duration of treatment can be shortened or lengthened depending on the needs of the client and his or her rate of progress. [http://www.med.upenn.edu/ctsa/workshops\\_pet.html](http://www.med.upenn.edu/ctsa/workshops_pet.html)

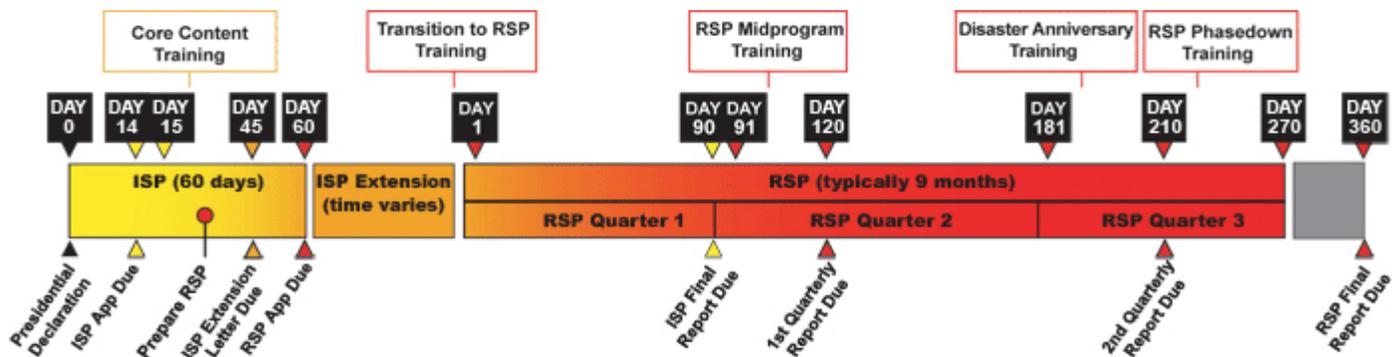
- **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)** Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a psychosocial treatment model designed to treat posttraumatic stress and related emotional and behavioral problems in children and adolescents. Initially developed to address the psychological trauma associated with child sexual abuse, the model has been adapted for use with children who have a wide array of traumatic experiences, including domestic violence, traumatic loss, and the often multiple psychological traumas experienced by children prior to foster care placement. The treatment model is designed to be delivered by trained therapists who initially provide parallel individual sessions with children and their parents (or guardians), with conjoint parent-child sessions increasingly incorporated over the course of treatment. The acronym PRACTICE reflects the components of the treatment model: Psycho-education and parenting skills, Relaxation skills, Affect expression and regulation skills, Cognitive coping skills and processing, Trauma narrative, In vivo exposure (when needed), Conjoint parent-child sessions, and Enhancing safety and future development. Although TF-CBT is generally delivered in 12-16 sessions of individual and parent-child therapy, it also may be provided in the context of a longer-term treatment process or in a group therapy format.
  - [www.musc.edu/tfcbt](http://www.musc.edu/tfcbt)
  - [www.musc.edu/tfcbtconsult](http://www.musc.edu/tfcbtconsult)
  - [www.musc.edu/ctg](http://www.musc.edu/ctg) (child traumatic grief treatment)
  
- **PsySTART Disaster Mental Health Triage and Incident Management System:** (See also above *American Red Cross - Psychological First Aid: Helping Others in Times of Stress, February 2012* and *Foundations of Disaster Mental Health*.)  
<http://www.cdms.uci.edu/PDF/PsySTART-cdms02142012.pdf>

## Crisis Counseling Program

### *Crisis Counseling Timeline and Related Tasks*

(From <http://www.samhsa.gov/dtac/CCPtoolkit/ISP.htm> \*does not include Specialized Crisis Counseling Services timelines which are individualized to response.)

### CCP Typical Timeline



Prior to a Presidential Disaster Declaration, activities are underway regarding preparation for the CCP. These include:

- Cal EMA Individual Assistance (IA) - Notifies CDMH Disaster Services of disaster/event that has impacts to people and has the potential to elevate to a Presidential Major Disaster Declaration.
- Disaster Services will make initial contact with the impacted County's Mental Health Disaster Coordinator (DC) to verify status and size of County Mental Health activation and response activities.
- CDMH Disaster Services - Surveys impacted local mental health (via a needs assessment) to identify an interest in applying for the ISP grant.

#### Day 0: Presidential Declaration of Disaster

- **Review the main ISP documents.** These include the [ISP Application](#) [MS Word 1119kb], [Standard Form 424\\*](#) [PDF 474kb], [Standard Form 424a](#) [MS Word 175kb], [ISP Supplemental Instructions](#) [PDF 2471kb], [CCP Guidance](#) [PDF 740kb], and [CCP Quarterly and Final Report Format](#) [MS Word 67kb].
- **Communicate with State Mental Health Authority (SMHA) leadership, the Governor's Authorized Representative (GAR) or designee, and State fiscal staff to determine if an ISP application will be submitted.** The GAR usually is located within the State Emergency Management Agency (SEMA). Ensure that leadership staff understand the basic programmatic, regulatory, and fiscal requirements of the CCP, as well as the SMHA staff time that will be needed to administer the program.
- **Contact your designated FEMA Regional Individual Assistance Coordinator or Disaster Field Office to request Preliminary Damage Assessment information.** This will be needed to complete the needs assessment section of the ISP application. Supplement this with information obtained from local contacts, media reports, or other disaster

response organizations such as the American Red Cross. FEMA registrant data, as they become available, may also be used to inform the needs assessment.

- **Communicate with your SAMHSA CMHS Project Officer.** Typically, your SAMHSA CMHS Project Officer will contact the State Disaster Mental Health Coordinator to do the following:
  - Verify receipt of application and technical assistance materials.
  - Determine if the State intends to apply for an ISP.
  - Offer technical assistance on the application process, scope, and limits of the program.
  - Reinforce application protocols and explain the roles of FEMA, SEMA, SAMHSA CMHS, and SAMHSA DTAC.

## **Days 2–9: Write ISP Application, and Continue Initial Disaster Response Activities**

- **With SMHA leadership, identify the team that will write the ISP application.** Ensure the team has enough time to complete the task by identifying additional staff to take on other essential duties, if necessary. Identify the team leader responsible for managing the application process. It is essential that a fiscal staff person be a member of the team, as fiscal mechanisms will need to be quickly established to process ISP funds.
- **Develop an ISP application that meets FEMA and SAMHSA requirements within the 14-day timeframe.** An actual meeting of team members may not be possible or necessary at this time. ISP application development is a process that goes on for several days. Communication among team members regarding their responsibilities for developing the application should be managed by the team leader. The activities listed below are not necessarily sequential steps, but they are important and must be completed within the 14-day timeframe.
  - Create a timeline for the application writing process and assign responsibilities to team members to ensure that the ISP application will be completed within the 14-day timeframe.
  - Ensure that the timeline accommodates completing standard grant forms and obtaining signatures of the GAR and SMHA leadership staff.
  - Conduct needs assessment evaluating the disaster situation, State and local resources and capabilities, and response activities to date.
  - Use the available ISP documents. These include the ISP Application, ISP Supplemental Instructions, CCP Quarterly and Final Report Format, CCP Guidance, and required data collection forms.
  - Identify potential providers; determine how the program will be staffed; and decide how staff will be hired in a timely manner.
  - Develop a plan of services including a staffing plan, training, and budget.
  - Provide an orientation to the participating local providers on the scope and purview of the CCP model outlining allowable versus nonallowable services and costs.
  - Determine how and where program staff will receive required 2-day CCP Core Content Training. Contact the SAMHSA CMHS Project Officer or SAMHSA DTAC for technical assistance support for recommended qualified instructors.
  - Ensure that State fiscal mechanisms will be in place to process FEMA funds so that service providers will be able to efficiently access funding.
  - As needed, contact the SAMHSA CMHS Project Officer and SAMHSA DTAC for TA.
- **Continue to carry out initial disaster behavioral health response and crisis counseling activities according to your organization's all-hazards disaster plan and the needs of the disaster event.** Document all response efforts.

### Day 10: Draft Application Due (optional)

- **Submit a draft ISP application.** The SMHA may opt to submit a draft ISP application to the SAMHSA CMHS Project Officer for review. Submission of a draft application can help to identify issues early, identify the appropriate size of the program, and avoid formal conditions being placed on the ISP grant award. The SMHA must inform the SAMHSA CMHS Project Officer that it intends to submit a draft as early as possible, so that Federal staff can ensure adequate time is scheduled for review.

### Day 13: Revision of Draft Application (optional)

- **Incorporate SAMHSA CMHS Project Officer feedback into a final draft for formal submission.** If the State submits a draft ISP application to the SAMHSA CMHS Project Officer for review, the Project Officer will return written or verbal comments within 24 hours of receipt of the draft.

### Day 14: Final Application Due

- **Submit the original, signed, final ISP application to the FEMA Regional Office.** Send an electronic and a hardcopy version of the application to the SAMHSA CMHS Project Officer.

### Days 15–60: Program Implementation and Service Delivery

- **Address any grant conditions in writing according to the due date indicated in the award conditions letter.** FEMA and SAMSHA CMHS make every effort to review ISP applications as quickly as possible. Following review, the ISP grant may be awarded as written (without conditions), awarded with conditions attached, or denied.
- **Conduct a Core Content Training.** The Core Content Training is necessary to ensure that staff understand the CCP model, are competent with crisis counseling interventions, are able to identify severe reactions to disaster and refer people appropriately, and are able to collect program data.
- **Formalize State fiscal mechanisms to process ISP funds.** Execute contractual agreements with service providers. Ensure that mechanisms used have the capacity to address ISP continuation funding, which often occurs following day 60 of the ISP up to the award of the RSP grant (should the State choose to apply for an RSP).
- **Establish clear program branding to ensure that disaster survivors and impacted people can access services.** A program name and logo, outreach or psycho-educational materials, and use of media or hotlines are typical mechanisms for program branding and promulgation.
- **Implement the plan of services described in the ISP application, and conduct crisis counseling.**
- **Collect and analyze program data.** Using the required CCP data collection tools, collect data and use the information to target outreach and service delivery, as well as determine and justify the need for an RSP.

### Day 25–40: Determine if RSP Application Will Be Submitted

- **Review the main RSP documents.** These include the RSP Application [MS Word 1286kb], Health and Human Services 5161-1, revised 8-07 [MS Word 755kb], RSP Supplemental

[Instructions](#) [PDF 3354kb], [CCP Guidance](#) [PDF 740kb], [CCP Quarterly and Final Report Format](#) [MS Word 67kb], and the [Project/Performance Location\(s\)](#) [MS Word 123kb].

- **Within this time period, meet with SMHA leadership to review ongoing needs assessment data, and determine if an RSP application will be submitted.** Ensure that leadership staff understand the basic programmatic, regulatory, and fiscal requirements of the RSP; how it differs from the ISP; and the SMHA staff time that will be needed to administer the program. Be aware that ISP and RSP funds are separate grant awards; therefore, ISP funding does not "roll over" into the RSP grant.

#### Day 40: Confirm Intent to Submit RSP Application

- **Inform the SAMHSA CMHS Project Officer and the FEMA Regional Contact of the State's intent to submit an RSP application.**

#### Day 40–59: Write RSP Application

- **Write the RSP application.** Put together a team to write the RSP application. Identify a team leader, and assign tasks to team members. The RSP application is similar in format to the ISP application, but the State is expected to develop a more thorough response appropriate for the longer (9-month) program. Grant reviewers will expect a more detailed needs assessment based on current information on and selection of service providers, and targeting of services related to the identified need. As a separate grant, the RSP application must **justify** services for the 9-month program and should not be viewed as just a continuation of the ISP. Technical assistance is available from your SAMHSA CMHS Project Officer and SAMHSA DTAC.
- **Please note that the ISP Midprogram Report is contained within the RSP application.** By completing the RSP application, you also will be meeting the requirement for the ISP Midprogram Report. A State is required to submit an ISP Midprogram Report only if it is applying for an RSP. Additionally, the State is required to submit two copies of the program data on CD-ROMs to SAMSHA CMHS.
- **RSP Application Without an ISP**  
Typically, a State applying for an RSP grant has also had an ISP in response to the disaster. In the case that a State is seeking an RSP without having had an ISP, the State must take particular care completing the needs assessment and response activities from date of incident sections of the RSP application. The State will be expected to provide a detailed justification of need for RSP services.

#### Day 45: Letter for ISP Extension Due

- **Submit an ISP extension request letter to the FEMA Regional Contact, with a copy to the SAMHSA CMHS Project Officer.** If the State is submitting an RSP application, it will need an extension of the ISP is needed in order to continue services until the time that the RSP application is reviewed, approved, and awarded. The State may request a no-cost or a funded extension. Contact the SAMHSA CMHS Project Officer for specific requirements.
- **Ensure State fiscal and contracting mechanisms will enable funds to continue to be disbursed to providers throughout the ISP extension period.** The FEMA Region will provide the State with an approval letter of the extension request. If the State has any concerns regarding its inability to continue with uninterrupted services, staff should notify SAMHSA CMHS and the FEMA Region immediately.

## Day 60: RSP Application Due

- **Submit the original, signed, final RSP application to the FEMA Regional Office.** Send an electronic and a hardcopy version of the application to the SAMHSA CMHS Project Officer.

### Cal EMA/CHHS - CCP Coordination Process

#### **CRISIS COUNSELING IMMEDIATE SERVICE PROGRAM (ISP) AND REGULAR SERVICES PROGRAM (RSP)**

**Partners: The California Emergency Management Agency (Cal EMA), the California Department of Mental Health (CHHS), the Federal Emergency Management Agency (FEMA), and the Substance use and Mental Health Services Administration (SAMHSA)**

### ISP GRANT APPLICATION

- Cal EMA Individual Assistance (IA) - Notifies CHHS Disaster Services of disaster/event that has impacts to people and has the potential to elevate to a Presidential Major Disaster Declaration.
  - Disaster Services will make initial contact with the impacted County's Mental Health Disaster Coordinator (DC) to verify status and size of County Mental Health activation and response activities.
  - CHHS Disaster Services - Surveys impacted local mental health (via a needs assessment) to identify an interest in applying for the ISP grant.
  - Cal EMA IA – Notifies CHHS Disaster Services if a Presidential Major Disaster Declaration is approved.
- NOTE: the State has 14 days from the date of Declaration to submit an ISP grant application to the Federal Emergency Management Agency (FEMA).**
- CHHS Disaster Services – Provides hands on assistance to counties on writing their ISP application.
  - CHHS Disaster Services – Completes a state ISP grant application and consolidates all the county grant applications and the state grant application into one complete package.
  - Disaster Services Staff will send the proposed ISP budget to the DMH Budget Officer for review before sending the ISP application package to the DMH Director for approval/signature.
  - CHHS Disaster Services – Submits a completed ISP grant application to Cal EMA no later than 12 days from the Presidential Disaster Declaration date.
  - Cal EMA IA – Prior to CHHS submitting the grant application, provides CHHS information on name of State Coordinating Office (SCO) or Deputy SCO that will be signing/approving the grant application.
  - Cal EMA IA – Reviews the ISP grant application and submits to FEMA no later than 14 days from the Presidential Disaster Declaration date. If changes are needed, works with CHHS to ensure a swift turn around in order to submit the application to FEMA in a timely manner.
    - Prepare cover letter addressed to FEMA
    - Obtain State Coordinating Officer approvals on application and cover letter
    - Submit original and two copies of grant application to FEMA
  - FEMA and SAMHSA - Reviews the grant application. If changes are needed, FEMA will notify Cal EMA IA and include deadline for changes. If approved, FEMA will notify Cal EMA of approval
  - Cal EMA IA – Notify CHHS of changes needed and deadline for changes or approval of grant application. Work with CHHS to ensure changes are submitted on time. However, if

approved, notify CHHS Disaster Services of approval (funded for 60 days; however, may be extended in certain circumstances)

- Cal EMA IA – Submits requested changes to FEMA by specified deadline.
- Cal EMA IA – When grant is approved notifies Cal EMA Accounting of implementation of the ISP.
- Cal EMA Accounting – sets up an account in SMARTLINK in order to process draw down requests from CHHS for funds from the monies approved by FEMA.
- CHHS Disaster Services – Provides Cal EMA IA and Accounting Office information on CHHS's account where funding will be deposited.
- CHHS Disaster Services – No later than 30 days after implementation of ISP, notify Cal EMA if there will be a regular services program grant application.
- CHHS Disaster Services – If there will be a regular service program grant application, begin preparing a mid-program report that will be included in the Regular Services Program grant application.
- CHHS Disaster Services - Prior to 60 days from the date of declaration, and if a regular program grant application is being submitted, CHHS will identify if there is a need for a 30-day program extension and notify Cal EMA IA.
- Cal EMA IA - If an extension is requested, Cal EMA IA prepares a letter for the SCOs signature, addressed to the Federal Coordinating Officer documenting extenuating circumstances, such as a delay in the approval of the regular service program grant application.

### **ISP APPEAL**

- Cal EMA IA - If a grant application is not approved by FEMA, Cal EMA IA can appeal the decision in writing signed by the SCO or Deputy SCO, addressed to the FEMA Regional Director and must be submitted within 60-days of the date of notification of the decision.

### **ISP FISCAL**

- Cal EMA Accounting – Monitors to ensure federal funds for the ISP grant are deposited into Cal EMA's SMARTLINK.
- Need correct citation CHHS Disaster Services – As money is spent by local county mental health offices and CHHS, submits a Request for Advance or Reimbursement (Std Form 270) to Cal EMA IACal EMA IA – Obtains SCO approval on “This space for agency use” section of Form 270 and submits signed Form to Cal EMA Accounting.
- Cal EMA Accounting – Request funds be drawn from SMARTLINK via a “Claim Schedule” (STD 218) for money to be deposited CHHS's account.
- CHHS Accounting sets up PCA codes to reimburse counties for ISP spending.
- Cal EMA Accounting – Provides copy of Claim Schedule (STD 218) to Cal EMA IA.
- Cal EMA IA - files a copy of the Claim Schedule (STD 218) in the disaster's Crisis Counseling ISP Fiscal Report.
- CHHS – Sends allocation letter to County. County requests Board of Supervisors' approval prior to incurring costs.
- CHHS Disaster Services – When the ISP final program report is submitted to Cal EMA, the final STD 270 will be included in this report.

### **ISP GRANT MONITORING**

- CHHS Disaster Services – Develop consultant contract(s) and manage the contracting process to obtain approved CCP trainers for every mandated ISP training.

- CHHS Disaster Services – Conduct weekly conference calls with County Project Managers. Provide technical assistance to counties as necessary.

### **ISP FINAL REPORT**

- CHHS Disaster Services - Prepare and submit an ISP final program report, a financial status report, and a final voucher to Cal EMA IA no later than 80 days after the last day of ISP funding.
- Cal EMA IA – Review and submit the ISP final program report, a financial status report, and a final voucher to FEMA no later than 90 days after the last day of ISP funding.
  - Prepare cover letter addressed to FEMA
  - Obtain State Coordinating Officer signature on cover letter
  - Submit Final Request for Advance or Reimbursement (Std Form 270) to Cal EMA Accounting.

### **RSP GRANT APPLICATION**

- CHHS Disaster Services – Approximately 30 days from the ISP approval date and prior to 60 days from the date of declaration, coordinates the county(s) interest in applying the Crisis Counseling Services Regular Program (RSP) and notifies Cal EMA IA.
- CHHS Disaster Services - When one or more counties/cities are interested in applying for the RSP grant, CHHS will provide assistance to counties on writing their RSP application.
- CHHS Disaster Services – No later than 55 days from the date of declaration, submit the completed RSP grant application to Cal EMA IA for review as well as a copy to SAMHSA.
- Cal EMA IA – Reviews the RSP grant application and submits to FEMA no later than 60 days from the Presidential Disaster Declaration date.
- **NOTE: If SAMHSA or FEMA notifies Cal EMA IA or CHHS Disaster Services that changes are needed, work with CHHS to ensure a swift turn around in order to submit the application to FEMA in a timely manner.**
- Cal EMA IA – Notify CHHS of funding approved for the RSP.
- CHHS Disaster Services – Has fiscal responsibility for the RSP as funding is direct from SAMHSA to CHHS.
- CHHS Disaster Services – In disasters of catastrophic nature, and when additional funding is necessary, prepare a request to Cal EMA explaining extenuating circumstances surrounding the request.
- Cal EMA IA – Prepares and sends a letter from the SCO to FEMA’s Assistant Associate Director.

### **RSP APPEAL**

- Cal EMA IA - If a grant application is not approved by FEMA, Cal EMA IA prepares an appeal letter to be signed by the SCO or Deputy SCO, addressed to FEMA’s Assistant Associate Director within 60-days of written notification of the decision.

### **RSP REPORTING REQUIREMENTS**

- CHHS Disaster Services - prepares Quarterly Progress Reports and submits to Cal EMA IA for review. (Report due to FEMA 30-days after the end of each reporting period.)
- Need correct citation Cal EMA IA – reviews the Quarterly Progress Reports and submits to FEMA no later than 30-days after the end of each reporting period.

- Prepares a cover letter for the SCO's signature addressed to the FEMA Regional Director.
- Obtains SCO approval on report and signature on cover letter
- Submits the original and two copies of the report to FEMA.
- CHHS Disaster Services- prepares a final program report (which includes Financial Reporting) and submits to Cal EMA IA for review. (Report due to FEMA 90-days from the end of the program period.)
- Cal EMA IA – reviews the Final Program Report and submits to FEMA no later than 90-days after the end of the program period.
  - Prepares a cover letter for the SCO's signature addressed to the FEMA Regional Director.
  - Obtains SCO approval on report and signature on cover letter
  - Submits the original and two copies of the report to FEMA.

**RSP GRANT MONITORING**

- CHHS Disaster Services – coordinates site visits with Crisis Counseling RSP providers.
- Cal EMA IA – when able participates in site visits with CHHS Disaster Services.
- CHHS Disaster Services – Develop consultant contract(s) and manage the contracting process to obtain approved CCP trainers for mandated RSP trainings.
- CHHS Disaster Services – Conduct weekly conference calls with County Project Managers. Provide technical assistance to counties as necessary.

**IF CRISIS COUNSELING SERVICES NOT REQUESTED**

- Cal EMA IA - confers with local government officials for their input regarding community mental health issues.
- CHHS Disaster Services – continues to monitor local mental health offices to determine if additional Crisis Counseling is needed.

## Appendix G - Disaster Mental/Behavioral Health Resources

### Personnel

The following list is a consolidation of potential resources from various professions that may be able to assist at various points in the response depending upon their scope of practice and the needs of incident.

- Licensed Health Professionals
  - Psychiatrist-assessment, medication orders, and care coordination
  - Psychiatric RN-assessment (physical and mental/emotional), medication management, monitoring, crisis counseling, and care coordination
  - Licensed Psychologists and Psychological Assistants for psychosocial assessment, crisis counseling, and care coordination
  - Credentialed School Counselors, School Social Workers and School Psychologists
  - LVN - monitoring and medication administration
  - LPT - monitoring and medication administration
  - MFT - psychosocial assessment, crisis counseling, and care coordination
  - IIMF - MFT Interns- psychosocial assessment, crisis counseling, and care coordination
  - LCSW- Licensed Clinical Social Workers - psychosocial assessment, crisis counseling, and care coordination
  - ASW - Associate Clinical Social Workers - psychosocial assessment, crisis counseling, and care coordination
  - LPCC – psychosocial assessment, crisis counseling and care coordination.
  - LPCCI – LPCC Intern – psychosocial assessment, crisis counseling and care coordination
  - EMTs - Emergency Medical Technicians
- State-to-state behavioral health resources available through EMAC
- Credentialed Paraprofessionals
- MRCs
- Trained Volunteers
  - DHV registered
  - American Red Cross volunteers trained in Psychological First Aid and mental health professionals
- Mental/Behavioral health professional associations

### Teams

- Federal Office of the Surgeon General (OASG) - Office of Force Readiness and Deployment (OFRD) OASG-OFRD USPHS disaster response teams Mental Health Teams which provide a wide range of behavioral health services in emergencies and large scale disasters
- Federal Applied Public Health Teams (APHT) and Mental Health Teams (MHT)
- Community and Faith-based organization teams

### Facilities

- State Hospitals
- Available Psychiatric Beds

### Equipment

TBD

### Supplies

Pharmaceuticals – critical psychiatric or substance use treatment medications (e.g. psychotropic medication, methadone, etc.)

## Appendix H - References

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