



California Disaster Behavioral Health Plan



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1. INTRODUCTION

Mental/behavioral health is an essential component of California’s health and medical system. During emergencies, mental/behavioral health services fall under California Emergency Support Function 8 (CA-ESF 8).¹ CA-ESF 8 includes:

- Public Health
- Mental/Behavioral Health
- Environmental Health
- Emergency Medical Services

Disasters can lead to high levels of distress among the affected population, including both survivors and disaster workers. For many people, the distress caused by the disaster is transitory and resolves over time. In some cases, it may exacerbate pre-existing behavioral health disorders or lead to new disorders. The immediate and long-term impacts to behavioral health are less visible than impacts to physical health and are more likely to affect disadvantaged groups within the community. Initial behavioral health impacts are often compounded by continuing secondary stresses in communities that sustain significant damage, and may lead to substantial personal, economic, and societal consequences.

Throughout this document, the term *behavioral health* will be used to encompass the full range of mental health and behavioral health issues, including psychiatric disorders and substance use issues.

Key terms used in this plan include:

Table 1. Key Terms

Term	Definition
Behavioral Health	Behavioral health refers to a state of mental/emotional being and choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. This includes a range of problems from unhealthy stress to diagnosable and treatable diseases like serious mental illnesses and substance use disorders, which are often chronic in nature but from which people can and do recover. The term is also used to describe the service systems encompassing the promotion of emotional health, the prevention of mental and substance use disorders, substance use, and related problems, treatments and services for mental and substance use disorders, and recovery support. ²

¹ [State of California Emergency Plan \(2017\)](#)

² National Framework for Quality Improvement in Behavioral Health Care, SAMHSA, June 2011, <https://www.nasmhpd.org/sites/default/files/SAMHSA%20Quality%20Improvement%20Initiative.pdf>

Term	Definition
Disaster Behavioral Health	<p><i>Disaster behavioral health (DBH)</i> is the provision of mental health, substance abuse, and stress management services to disaster survivors and responders.³</p> <p>DBH aims to provide a continuum of services and activities — including communication/public information, education, basic psychological support such as Psychological First Aid (PFA), crisis intervention, as well as referrals for clinical services when needed — in order to promote resiliency and mitigate the progression of adverse reactions into more serious physical and behavioral health conditions.</p>
Substance Use Disorder	<p><i>Substance Use Disorder</i> means substance-related and addictive disorder as described in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Arlington, VA, American Psychiatric Association.²</p>
Behavioral Health Provider	<p><i>Behavioral health providers</i> are specially trained to work with people experiencing behavioral health problems. They work in hospitals, community mental health clinics, substance use treatment centers, primary care clinics, school-based health centers, college counseling centers, and private practices.⁴</p>
Resilience (Individual)	<p><i>Individual resilience</i> involves behaviors, thoughts, and actions that promote personal well-being and mental health. People can develop the ability to withstand, adapt to, and recover from stress and adversity — and maintain or return to a state of mental well-being — by using effective coping strategies.⁵</p>
Resilience (Community)	<p><i>Community resilience</i> refers to the sustained ability of communities to withstand and recover from adversity. Resilient communities include healthy individuals, families, and communities with access to health care, both physical and psychological, and with the knowledge and resources to know what to do to care for themselves and others in both routine and emergency situations. Enhanced resilience is considered critical to mitigating vulnerabilities, reducing negative health consequences, and rapidly restoring community functioning.⁶</p>

³ Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services, <https://www.phe.gov/Preparedness/planning/abc/Pages/behavioralhealth.aspx>

⁴ A Roadmap to Behavioral Health: A Guide to Using Mental Health and Substance Use Disorder Services, CMS and SAMHSA, August 2019 <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Roadmap-to-Behavioral-Health-508-Updated-2018.pdf>

⁵ Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services, <https://www.phe.gov/Preparedness/planning/abc/Pages/individual-resilience.aspx>

⁶ Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services, <https://www.phe.gov/Preparedness/planning/abc/Pages/community.aspx>

Term	Definition
Emergency	Any incident(s), whether natural or human-caused, that requires responsive action to protect life or property. Under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, an emergency means any occasion or instance for which, in the determination of the President, federal assistance is needed to supplement state and local efforts and capabilities to save lives, protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the United States. ¹
Disaster	A sudden calamitous emergency event bringing great damage, loss, or destruction. ¹
Response	<i>Response</i> includes immediate actions to save lives, protect property, and meet basic human needs. ¹
Recovery	The development, coordination, and execution of service and site restoration plans; the reconstitution of government operations and services; individual, private-sector, non-governmental, 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. ¹

The California Health and Human Services Agency (CHHS) oversees departments and offices that provide a wide range of services in the areas of health care, public health, mental health, alcohol and drug treatment, income assistance, social services, and assistance to people with disabilities. CHHS serves as the lead administrative agency for CA-ESF 8 (Public Health and Medical) and CA-ESF 6 (Mass Care and Shelter). The department within CHHS responsible for state-level DBH activities is the Department of Health Care Services (DHCS), with support from the Department of Public Health (CDPH) and the Emergency Medical Services Authority (EMSA) in their role as designated co-leads for implementation of CA-ESF 8, and the California Department of Social Services (CDSS) in its role as designated lead for implementation of CA-ESF 6. The California Governor’s Office of Emergency Services (Cal OES) leads the state’s overall emergency management activities.

1.1. Purpose

The purpose of the **California Disaster Behavioral Health Plan** is to provide an organizational framework for California’s behavioral health response to disasters. This plan seeks to increase understanding of DBH — what it is and how it can help individuals, families, and communities heal following disasters. This is particularly challenging because the providers of public mental health services in California (county MH/BH departments and/or contracted providers), in addition to private providers, have not historically focused on disaster response and

associated DBH services. Similarly, emergency managers are typically unfamiliar with DBH impacts and the value of integrating DBH into emergency operations.⁷

Effective DBH response can help restore the psychological and social functioning of individuals, families, and communities through a continuum of services and activities — including communication/public information, education, basic psychological support such as Psychological First Aid (PFA), crisis intervention, as well as referrals for clinical services when needed — in order to promote resiliency and mitigate the progression of adverse reactions into more serious physical and behavioral health conditions.

DBH addresses two major areas of need for both disaster survivors and responders:

- 1) Resilience-based psychoeducation and psychosocial interventions to reduce emotional distress and social problems; and**
- 2) Referral and treatment for psychiatric and other behavioral health disorders, e.g., substance use disorder**

1.2. Audience

The intended audience includes California’s behavioral health community, emergency management agencies, and related CA-ESF 8 disciplines, including public health and emergency medical services. Targeted groups include:

Local Community

- County Mental Health/Behavioral Health (MH/BH) Department
- Contract Providers to County MH/BH Department
- Local Public Health Department
- Local Emergency Management Agency
- Local School Districts
- Licensed Behavioral Health Providers
- Community-Based Spiritual Care Providers
- Community-Based Non-Profit Organizations

Operational Area (consists of county and all political subdivisions)

- Medical Health Operational Area Coordination (MHOAC) Program

⁷ Flynn B, Sherman R. Integrating Emergency Management and Disaster Behavioral Health, One Picture Through Two Lenses. Butterworth-Heinemann; 2017.

Region

- Regional Disaster Medical and Health Coordination (RDMHC) Program
- Cal OES Regional Emergency Operations Center (REOC)

State Government

- Department of Health Care Services (DHCS)
- California Department of Public Health (CDPH)
- Emergency Medical Services Authority (EMSA)
- California Department of Social Services (CDSS)
- California Governor’s Office of Emergency Services (Cal OES)
- California Health and Human Services Agency (CHHS)

Tribal Government

- Tribal Councils
- Tribal Clinic Board of Directors

Federal Government

- Substance Abuse and Mental Health Service Administration (SAMHSA), US Department of Health and Human Services (HHS)
- Assistant Secretary of Preparedness and Response (ASPR), US HHS

Non-Governmental Response Partners

- American Red Cross (Disaster Mental Health Services)
- Voluntary Organizations Active in Disasters (VOADs)

1.3. Situation

All emergencies and disasters have the potential to cause psychological, emotional, and behavioral impacts to survivors, disaster workers, and the community. Unlike physical injuries, behavioral health impacts are often less obvious and may manifest weeks or months later. The situation is more challenging due to the stigma associated with recognizing and seeking assistance with behavioral health issues.

It is common for disaster survivors and responders to experience distress and anxiety about safety, health, and recovery. The majority of people who experience a disaster are likely to recover without formal behavioral health intervention. Many people have access to pre-existing support systems that contribute to their own and their community’s resilience. However, these protective factors vary at the individual and community levels. Some people

may experience more severe reactions that hinder their recovery or lead to long term impairment.

A disaster can disrupt the normal provision of care to existing clients in addition to creating a community-wide need for behavioral health support services.^{8,9} Providing behavioral health care in disaster situations differs from traditional services. California's county-based behavioral health system is designed to diagnose, treat, and monitor community members with behavioral health issues, including those with serious mental illness (SMI) and/or substance use disorders (SUD) or children with serious emotional disturbances (SED). County behavioral health systems are frequently functioning at or beyond capacity on a day-to-day basis and have limited capacity to expand or redirect their level of service after a disaster.

Specific training in DBH is rare for most healthcare professionals, including training in early intervention strategies such as Psychological First Aid, non-clinical interventions such as basic and specialized crisis counseling and bereavement support, risk and crisis communication strategies to assist the public, identification of at-risk populations, etc.

The primary goal of DBH is to support the impacted community by providing resilience-based psychoeducation and psychosocial interventions to reduce emotional distress and social problems; a second goal is to provide access to trauma-focused treatment for behavioral health disorders.

A series of DBH-specific appendices are included in this plan:

Appendix B (Disaster Behavioral Health Considerations) provides an overview of current considerations that may be useful to the disaster planning process. This material is meant to be informational, not prescriptive, recognizing that California communities have varying needs, resources, and priorities.

Appendix C (Mental/Behavioral Health and Spiritual Care Resources) provides information on the types of personnel that may provide DBH services, along with suggested staffing configurations for specific disaster missions.

Appendix D (Key Organizations and Services) provides information relevant to DBH developed by national organizations.

Appendix E (Population Support Tools) provides information on freely-available DBH support tools, e.g., Psychological First Aid (PFA), developed for specific populations.

⁸ Lebowitz AJ. Community collaboration as a disaster mental health competency: a systematic literature review. *Community Ment Health J.* 2015;51(2):125-31.

⁹ King RV, Burkle FM, Walsh LE, North CS. Competencies for disaster mental health. *Curr Psychiatry Rep.* 2015;17(3):548.

Appendix F (Crisis Counseling Assistance and Training Program) describes an important federal DBH support program that may be available to disaster-impacted communities under specified conditions.

Appendix G (Curriculum Recommendations) provides guidance on recommended DBH curriculum topics for training disaster health professionals.

Appendix H (Suggested Activities by Emergency Management Phase) provides examples of DBH-related activities during the planning, mitigation, response, and recovery phases of emergencies.

Appendix I (Action Planning) provides basic information on how county MH/BH departments can approach action planning when responding to a disaster.

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2. CALIFORNIA'S SYSTEM OF BEHAVIORAL HEALTH CARE

2.1. County Mental Health/Behavioral Health Departments

In California, counties are the providers of publicly funded mental health services. County boards of supervisors are required to oversee local mental health programs with input from local mental health advisory boards. Within state and federal parameters, counties have broad discretion in how they fund and provide mental health services to target populations and deliver services either directly through physicians and staff employed at county-owned and operated facilities or by contracting with outside hospitals, clinics, community-based organizations, and private practitioners. California counties vary in the proportion of services that are provided by contractors versus the county directly.

The Los Angeles County Department of Mental Health is the nation's largest public mental health system and serves about one-third of all people receiving public mental health services in California. In contrast, the 15 smallest rural California counties combined served about 1% of all people who received public mental health services in 2011.¹⁰

2.2. Department of Health Care Services (DHCS)

The Department of Health Care Services (DHCS) is the lead state agency for behavioral health. The mission of DHCS is to provide Californians with access to affordable, integrated, high-quality health care, including medical, dental, mental health, substance use treatment services, and long-term care. DHCS is the backbone of California's health care safety net, helping millions of low-income and disabled Californians. DHCS funds health care services for about 13.5 million Medi-Cal beneficiaries.

DHCS is the state Medicaid agency and liaison with the Centers for Medicaid and Medicare Services (CMS) for mental health services in California. DHCS administers California's Medicaid (Medi-Cal) program. The Medi-Cal Specialty Mental Health Services (SMHS) program is "carved-out" of the broader Medi-Cal program and operates under the authority of a waiver approved by CMS under Section 1915(b) of the Social Security Act. DHCS is responsible for administering the Medi-Cal SMHS Waiver Program which provides SMHS to Medi-Cal beneficiaries through County Mental Health Plans.

DHCS provides mental health program subject matter expertise and technical assistance to other state departments and agencies, mental health plans and other local mental health programs, and managed care health plans. DHCS facilitates county and federal reimbursement

¹⁰ APS Health Care, *California External Quality Review Organization Summary Tables of Approved Medi-Cal Claims for 2011*. Includes claims processed through the following dates: Short Doyle Medi-Cal, December 10, 2012; Inpatient Consolidation, August 21, 2012; and Monthly Medi-Cal Extract File eligibility data, April 02, 2012 (last modified March 2013).

processes, establishes program and fiscal policies, administers and distributes federal grants, and oversees the state's fiscal and outcome responsibilities for SMHS and the Mental Health Services Act.

DHCS supports DBH activities through its Behavioral Health — Licensing and Certification Division (LCD). During an unusual event or emergency involving behavioral health, DHCS supports affected county MH/BH departments and other local response agencies if requested. DHCS also prepares applications to the Crisis Counseling Assistance and Training Program (CCP) when the CCP is authorized under the Stafford Act, in coordination with Cal OES. See Appendix F for more detailed information on the CCP.

Within DHCS, the Primary, Rural, and Indian Health Division (PRIHD) includes several programs that operate to improve the health status of special, targeted population groups living in medically underserved urban and rural areas in California. The PRIHD Tribal Emergency Preparedness and Response Program assists tribal partners to prepare for and respond to disasters by assisting in the development of Emergency Operations Plans, providing recommendations for community level preparation, and providing on-site training.

2.3. Tribes and Tribal Health Programs

California is home to 109 federally recognized American Indian tribes and the largest population of American Indians in the United States. As legally recognized sovereign governments, federally recognized tribes have “government-to-government” relationships with federal, state, and local governments. The federal Indian Health Service (IHS) provides funding for tribes to administer local tribal primary care clinics. These clinics support a variety of behavioral health services. Additionally, some tribes operate tribal behavioral health programs separate from the clinics. Therefore, tribal community members can access disaster behavioral health services through:

- Tribal Behavioral Health Programs and Tribal Health Clinics
- County operated Mental Health and Behavioral Health programs or contract providers
- State and Federal agencies that provide emergency disaster assistance, including the Federal Emergency Management Agency (FEMA), Substance Abuse and Mental Health Services Administration (SAMHSA), and the Health Resources and Services Administration (HRSA).

3. CALIFORNIA'S EMERGENCY MANAGEMENT SYSTEM

3.1. State Emergency Plan (SEP)

The State of California Emergency Plan (SEP) is maintained by the California Governor's Office of Emergency Services (Cal OES) and describes the methods for conducting emergency operations, process for rendering mutual aid, 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.¹¹ The SEP outlines the activities of all California jurisdictions and emphasizes the integration of capabilities and resources from the broader emergency management community that includes non-governmental organizations, tribal governments, other states, federal government, and others.

The SEP identifies the following operational priorities that govern response strategies, including resource allocation, for the State of California and its political subdivisions. The operational priorities are:

- 1) **Save Lives** – The preservation and sustainment of life is the top priority of emergency managers and first responders and takes precedence over all other considerations.
- 2) **Protect Health and Safety** – Measures should be taken to mitigate the emergency's impact on public health and safety.
- 3) **Protect Property** – All feasible efforts must be made to protect public and private property and resources, including critical infrastructure, from damage during and after an emergency.
- 4) **Preserve the Environment** – All possible efforts must be made to preserve California's environment and protect it from damage during an emergency.

3.2. California Emergency Support Functions (CA-ESFs)

The SEP identifies a series of California Emergency Support Functions (CA-ESFs) that organize numerous response elements into primary disciplines that are considered essential to addressing the emergency management needs of communities. California has 16 Emergency Support Functions. Each CA-ESF is an alliance of state agencies, departments, and other public and private stakeholders with similar functional responsibilities who have a duty to collaboratively prepare for, respond to, mitigate, and recover from an emergency. In addition to governmental agencies, each CA-ESF includes non-governmental entities that contribute functional capabilities in support of the CA-ESF. For example, CA-ESF 8 resources include both governmental entities (e.g., county MH/BH departments) in addition to private, non-governmental resources (e.g., healthcare systems, private healthcare providers).

¹¹ [State of California Emergency Plan](#)

DBH falls primarily under the Public Health and Medical Emergency Support Function (CA-ESF 8), although DBH activities may also be a component of the Mass Care and Shelter Emergency Support Function (CA-ESF 6). The SEP identifies the California Health and Human Services Agency (CHHS) as the lead administrative agency responsible for CA-ESF 8, and CHHS designated the California Department of Public Health (CDPH) and Emergency Medical Services Authority (EMSA) as departmental co-leads responsible for the implementation of CA-ESF 8. CHHS designated the California Department of Social Services (CDSS) as the lead state agency responsible for the implementation of CA-ESF 6.

CA-ESFs exist for organizational purposes – no new legal authorities are associated with CA-ESFs. CA-ESF members focus on planning aspects that support the ability of members to collaboratively respond during emergencies based on their legal authorities, policies, and capabilities.

3.3. Standardized Emergency Management System (SEMS)

In accordance with the California Emergency Services Act (ESA), the Standardized Emergency Management System (SEMS) establishes how state and local government agencies respond to emergencies that involve multiple agencies and/or jurisdictions.¹² State agencies are required to use SEMS and local governments must use SEMS in order to be eligible for reimbursement of response-related costs under the state’s disaster assistance programs.

SEMS incorporates the use of the Incident Command System (ICS), Operational Area (OA) concept,¹³ California Disaster and Civil Defense Master Mutual Aid Agreement (MMAA), and Multi-Agency Coordination (MAC) process.¹⁴

3.3.1 SEMS Levels

SEMS includes five levels of organizational response:

- Field** – The Field level is where emergency response personnel and resources, under the command of responsible officials, carry out tactical activities in direct response to an incident or threat.
- Local Government** – The Local Government level includes cities, counties, and special districts. Local governments manage and coordinate the overall emergency response and recovery activities within their jurisdiction.
- Operational Area (OA)** – An OA is the intermediate level of the state's emergency

¹² Government Code Section 8607(a)

¹³ The Operational Area concept is defined by the Emergency Services Act as an intermediate level of the state’s emergency management organization that encompasses the county and all political subdivisions within the county, e.g., cities and special districts.

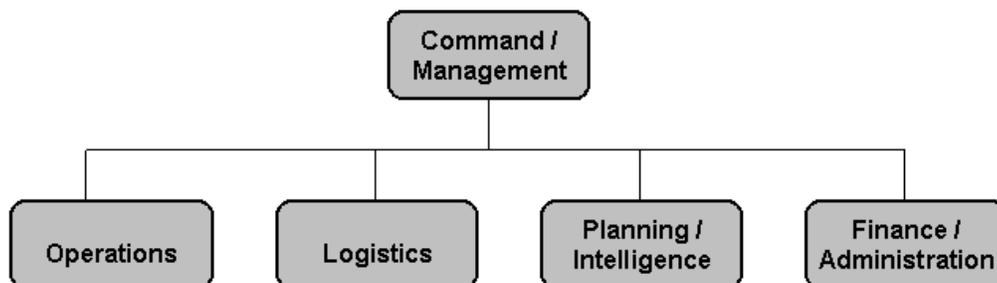
¹⁴ Cal OES’ [California Statewide Multi-Agency Coordination Guide](#) describes the process for multi-agency coordination and decision-making, including the allocation of scarce resources.

management organization which encompasses a county's boundaries and all political subdivisions located within that county, including special districts. The OA facilitates and/or coordinates information, resources, and decisions regarding priorities among local governments within the OA. The OA serves as the coordination and communication link between the Local Government level and Region level. Each of California's 58 OAs have a Medical Health Operational Area Coordination (MHOAC) Program that coordinates health-related emergency management activities during emergencies.

- ❑ **Region** – There are six mutual aid regions in California. Coordinators within each mutual aid region coordinate information and resources among the OAs within the mutual aid region and also between the OAs and the state. Cal OES operates three Regional Emergency Operations Centers (REOCs) – Inland, Coastal, and Southern – for administrative purposes.
- ❑ **State** – The State level of SEMS coordinates state resources in response to requests from the Region level and coordinates mutual aid among the mutual aid regions and between the Region and State levels. The State level also serves as the coordination and communication link between the state and the federal emergency management systems. The state may request assistance from other state governments through the Emergency Management Assistance Compact (EMAC) and similar interstate compacts/agreements and coordinates with FEMA when federal assistance is requested. The State level operates out of the Cal OES-managed State Operations Center (SOC).

3.3.2 SEMS Functions

SEMS includes five major functions based on the Incident Command System (ICS). These five functions should be represented at every emergency coordination facility, including Department Operations Centers (DOCs) and multi-agency Emergency Operations Centers (EOCs).



- ❑ **Command / Management** — A key concept in emergency planning is to establish command and tactical control at the lowest level that can effectively perform that role in the organization. **Command** is responsible for directing, ordering, and/or controlling resources at the Field response level (i.e., Incident Command or Unified Command). The Incident Commander (IC), with appropriate policy direction and authority from the responding agency, sets the objectives to be accomplished and approves the strategy

and tactics to meet those objectives. The IC must respond to higher authority. Depending upon the incident's size and scope, the higher authority could be the next ranking level in the organization up to the agency or department executive.

Management is responsible for overall emergency policy and coordination at DOC and EOC levels above the Field level. An EOC serves as a central location from which multiple agencies or organizations coordinate information collection and evaluation, priority setting, and resource management. Within the EOC, the Management function:

- Facilitates multiagency coordination and executive decision-making in support of the incident response
 - Implements policies established by the governing bodies
 - Facilitates the activities of the Multi-Agency Coordination (MAC) Group
- ☐ **Operations** — At the Field level, the Operations Section is responsible for the coordinated tactical response directly applicable to, or in support of the objectives identified in the Incident Action Plan (IAP). At SEMS levels above the Field level, the Operations Section Coordinator manages functional coordinators who share information and decisions about discipline-specific operations. (Note that the term “Incident Action Plan” is used at the Field level and “Action Plan” is used at higher SEMS levels.)
- ☐ **Logistics** — Responsible for providing facilities, services, personnel, equipment and materials in support of the emergency. Unified ordering takes place through the Logistics Section Supply Unit to ensure controls and accountability over resource requests. As needed, Unit Leaders are appointed to address needs for communications, food, medical, supplies, facilities, and ground support.
- ☐ **Planning/Intelligence** — Responsible for the collection, evaluation, and dissemination of operational information related to the incident for the preparation and documentation of the IAP at the Field level or the AP at a DOC/EOC. Planning/Intelligence also maintains information on the current and forecasted situation and on the status of resources assigned to the emergency or the DOC/EOC. As needed, Unit Leaders are appointed to collect and analyze data, prepare situation reports, develop action plans, compile and maintain documentation, conduct advance planning, manage technical specialists, and coordinate demobilization.
- ☐ **Finance/Administration** — Responsible for all financial and cost analysis aspects of the emergency and for any administrative aspects not handled by the other functions. As needed, Unit Leaders are appointed to record time for incident or DOC/EOC personnel and hired equipment, coordinate procurement activities, process claims, and track costs.

The table below differentiates between field-level emergency response (at the Incident Command Post or Unified Command Post) and other SEMS levels (at DOCs and EOCs):

Table 2. SEMS Functions (Field Level versus other SEMS Levels)

SEMS Function	Field Level (Incident Command or Unified Command)	Other SEMS Levels (DOCs or EOCs)
Command / Management	Command is responsible for directing, ordering, and/or controlling incident resources.	Management is responsible for facilitation of overall policy and providing support and coordination to the incident.
Operations	The coordinated tactical response of all field operations, executed in accordance with the Incident Action Plan (IAP).	The coordination of operations to support emergency response, executed in accordance with the DOC/EOC Action Plan (AP). The county MH/BH department may support operations at its own DOC and should also provide representation to the OA’s EOC in coordination with the MHOAC Program (usually at the Medical Health Branch).
Planning / Intelligence	The collection, evaluation, documentation, and use of intelligence related to the incident.	The collection, evaluation, documentation, and dissemination of information relative to response activities.
Logistics	The provision of facilities, services, personnel, equipment, and materials in support of the incident.	The provision of facilities, services, personnel, equipment, and materials in support of response activities.
Finance / Administration	Financial and cost analysis and administrative aspects not handled by the other functions.	The coordination and support of administrative and fiscal matters related to the incident.

3.4. Sequence of Activities

During emergencies, the SEP establishes a sequence of activities to save lives, protect property, and preserve the environment. Activities include:

- ❑ **Alert and Notification:** Incident recognition is the point in time when a response agency becomes aware that a significant event (i.e., one requiring emergency response beyond baseline operational capability) is imminent or occurring. Response agencies may be informed about an incident by the public through 9-1-1, Duty Officer programs, California State Warning Center, or other means.
- ❑ **Resource Mobilization:** Response agencies activate personnel and mobilize to support the incident response. Activation and mobilization continue for the duration of the emergency, as additional resources are needed to support the response. This includes resources from within the affected jurisdiction, or, when resources are exhausted, from unaffected jurisdictions.
- ❑ **Incident Response:** Immediate response within the affected area is provided by local jurisdictional response agencies and elements of the private sector.
- ❑ **Incident Command:** Under the Incident Command System (ICS) and SEMS, Incident Command is established to direct, order, or control resources by virtue of some explicit legal, agency, or delegated authority. Initial actions are coordinated through the on-scene Incident Commander (IC). The IC oversees an initial Incident Action Plan (IAP), which sets priorities for the incident, assigns resources, and includes a common communications plan. Note: If multiple jurisdictions and/or agencies have responsibility over aspects of the tactical response, **Unified Command** is established to provide a forum for integrated decision making and to enable a coordinated approach to incident response.
- ❑ **Local EOC Activation:** Local jurisdictions activate their EOCs based on the need to coordinate and support response activities. Individual agencies may organize a Department Operations Center (DOC) whose focus is internal agency response and management. For example, a county MH/BH department may activate a DOC to assist with the additional burdens created by the incident on the agency. The lead emergency management agency for the OA should be notified whenever a local DOC or other EOC has been activated.
- ❑ **Operational Area EOC Activation:** The OA EOC activates under specified conditions, including the proclamation of emergencies and activation of local government EOCs. The OA EOC communicates resource requests from an affected jurisdiction to an unaffected jurisdiction, or if resources are not available within the OA, forwards the resource request to the regional level.

The EOC established by the local emergency management agency for the OA should include a Medical Health Branch within Operations (sometimes called an ESF 8 Branch). For incidents that involve behavioral health response, it is important that the county MH/BH department be connected to the OA EOC, either via the department's DOC or by

direct representation at the OA EOC (depending on local policies and procedures). The county MH/BH department should coordinate closely with the MHOAC Program.

- ❑ **Regional Emergency Operations Center (REOC) Activation:** When an OA EOC is activated, the Cal OES Regional Administrator notifies the REOC within the affected region and Cal OES Headquarters. The REOC will then coordinate resource requests from the affected OA to unaffected OAs within the affected region, or if resources are not available within the affected region, forwards resource requests to the SOC for coordination.
- ❑ **State Operations Center (SOC) Activation:** The SOC activates at the discretion of Cal OES in order to:
 - Monitor the situation and provide situation reports to brief state officials
 - Process resource requests between the affected regions, unaffected regions, and state agencies
 - Process requests for federal assistance and coordinate with Federal Incident Management Assistance Teams, when established
 - Coordinate interstate resource requests as part of the Emergency Management Assistance Compact (EMAC) or Interstate Disaster and Civil Defense Compact

Recovery begins on the day of the disaster. As the initial and sustained operational priorities are met, emergency management officials consider the recovery phase needs. Short-term recovery activities include returning vital life-support systems to minimum operating standards. Long-term recovery aims to restore communities to pre-disaster functioning.

During the recovery phase, Local Assistance Centers (LACs) may be opened by local government to assist communities by providing a centralized location for services and resource referrals for unmet needs following a disaster or significant emergency. The LAC provides a venue at which individuals, families, and businesses can access available disaster assistance programs and services. The LACs need to be physically accessible and information needs to be provided in accessible formats for all community members.

If federal resources are authorized, a state-federal Disaster Recovery Center (DRC) may be co-located with the LAC. Since disaster survivors are the customers of government assistance centers, it may be helpful to provide emotional support at these locations.

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4. RESPONSE CONCEPT OF OPERATIONS

4.1. Assumptions

- ❑ Behavioral health impacts to individuals and communities are an unavoidable aspect of every disaster, whether recognized or not.
- ❑ Disaster behavioral health (DBH) is the provision of mental health, substance abuse, and stress management services to disaster survivors and responders.¹⁵ The goal of DBH is to provide services that promote the resiliency of individuals and the community and mitigate the progression of adverse reactions into more serious physical and behavioral health conditions.
- ❑ The early goal of DBH interventions is to stabilize the psychosocial reactions of survivors; the later goal is to restore and rebuild the social and emotional resiliency of individuals, families, and the community. Long term DBH interventions include strategies to offer outreach and support those at higher risk for more severe behavioral health reactions.
- ❑ Systemic DBH interventions may reach greater numbers of affected individuals. An example of a systemic intervention is a mental health clinician who trains teachers to screen children in their classrooms for disaster stress while the teacher provides education about coping with stress.
- ❑ Public messaging, risk communication, and educational materials that specifically address behavioral health issues are essential components of the overall public health messaging strategy following a disaster. Messages should be made available in accessible, culturally-informed, and age-appropriate formats.
- ❑ Disaster response is a local responsibility — local planners and responders understand the cultural, social, language, and behavioral health needs of people in their area.
- ❑ During emergencies, information and resource needs should be coordinated through established coordination functions that exist under CA-ESF 8, including the Medical Health Operational Area Coordination (MHOAC) Program for the OA and the Regional Disaster Medical and Health Coordination (RDMHC) Program for the mutual aid region. The Regional Disaster Medical and Health Specialist (RDMHS) is the staff contact for each of six regional RDMHC Programs. All county MH/BH departments should be integrated into the MHOAC Program, and during emergencies, county MH/BH departments should consider providing representation to the Medical Health Branch of the OA EOC.
- ❑ The availability of DBH resources (i.e., licensed and disaster response trained providers) is limited in most jurisdictions. This adversely impacts the availability of counties to

¹⁵ Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services, <https://www.phe.gov/Preparedness/planning/abc/Pages/behavioralhealth.aspx>

provide mutual aid resources from unaffected areas during emergencies.

- ❑ Many MH/BH departments do not have staff with a background in emergency management and/or DBH who have the dedicated responsibility for disaster preparedness and response.
- ❑ Spiritual care contributes to the promotion of resilience before and after a disaster; spiritual care providers with disaster response training should be identified prior to a disaster as resources who can support individual and community recovery.
- ❑ Some individuals or populations may be at higher risk for more severe behavioral health reactions; for example, individuals with pre-existing behavioral health conditions, past trauma exposures, or access or functional needs.
- ❑ DBH services must be appropriately delivered and adjusted as necessary to be gender and culturally sensitive, linguistically and developmentally appropriate, and suitable for the type, scope, and phase of the disaster.
- ❑ Children can be vulnerable as they may lack the experience, skills, and resources to independently meet their own behavioral health needs, coupled with their reactivity to stress reactions or behavioral health conditions of their caregivers. This vulnerability requires special planning considerations for parents in addition to the caregivers, educators, and professionals working with these children.
- ❑ Primary care providers, emergency responders, early care and school age providers, educators, and others delivering behavioral health support in the affected community benefit from training, technical assistance, support, and referral points for DBH services.
- ❑ Certain incidents may be especially triggering of behavioral health responses (e.g., chemical/biological/radiological/nuclear incidents (including pandemics), mass violence, or acts of terrorism) and lead healthcare facilities to experience an influx of patients with psychologically-based complaints or unexplained physical symptoms that may be related to the psychological stress reactions they are experiencing.

4.2. Health and Medical Emergency Coordination

The table below identifies the major functional entities within California’s health and medical system that have a role in coordinating emergency response:

Table 3. Major Response Partners in California’s Health and Medical System

SEMS Level	Entity with Health and Medical Role
State	State agencies with a health and medical role, including but not limited to: <ul style="list-style-type: none"> • California Department of Health Care Services (DHCS) • California Department of Public Health (CDPH), including the Duty Officer Program or the Medical and Health Operations Center (MHCC), if activated • Emergency Medical Services Authority (EMSA), including the Duty Officer Program or MHCC, if activated

SEMS Level	Entity with Health and Medical Role
	<ul style="list-style-type: none"> • California Governor’s Office of Emergency Services (Cal OES) State Warning Center (CSWC) or State Operations Center (SOC) if activated (SOC functions may transition to a Joint Field Office for a catastrophic event) • California Health and Human Services Agency (CHHS), departments under CHHS, and other state agencies that support CA-ESF 8
Region	<ul style="list-style-type: none"> • Regional Disaster Medical and Health Coordination (RDMHC) Program (includes Regional Disaster Medical and Health Specialist in each Mutual Aid Region) • Cal OES Regional Duty Officer or Regional Emergency Operations Center (REOC) if activated
Operational Area	<ul style="list-style-type: none"> • Medical Health Operational Area Coordination (MHOAC) Program • Operational Area Emergency Operations Center (EOC), if activated
Local	<ul style="list-style-type: none"> • Local MH/BH department • Local Public Health Department • Local Emergency Medical Services Agency (LEMSA) • Local Emergency Management Agency • Local DOCs and EOCs if activated
Field	<ul style="list-style-type: none"> • Numerous organizations/entities, including but not limited to clinics, contracted behavioral health providers, private behavioral health providers, hospitals, licensed community facilities, etc.

A basic tenant of emergency response is “all emergencies are local”. The governing bodies of local jurisdictions are responsible for protecting the life and safety of citizens. The organization and resources of local government vary throughout California. If local government is overwhelmed by the impact of the disaster, the local government may request emergency assistance through SEMS.

County MH/BH departments should be integrated into their county’s Medical Health Operational Area Coordination (MHOAC) Program to enable more effective support during emergencies.

4.2.1 Medical Health Operational Area Coordination (MHOAC) Program

The MHOAC Program is based on the functional activities described in Health and Safety Code §1797.153. Within each OA, the Health and Safety Code authorizes the county health officer and local emergency medical services administrator to jointly act as the MHOAC or appoint another individual to fulfill the responsibilities.

The Health and Safety Code directs the appointed MHOAC as follows: *“The MHOAC shall recommend to the operational area coordinator of the Office of Emergency Services a medical and health disaster plan for the provision of medical and health mutual aid within the*

operational area.” Furthermore, “... the medical and health disaster plan shall include preparedness, response, recovery and mitigation functions in accordance with the State Emergency Plan, as established under Sections 8559 and 8560 of the Government Code, and at a minimum, the medical and health disaster plan, policy and procedures shall include all of the following:

- Assessment of immediate medical needs
- Coordination of disaster medical and health resources
- Coordination of patient distribution and medical evaluation
- Coordination with inpatient and emergency care providers
- Coordination of out-of-hospital medical care providers
- Coordination and integration with fire agency personnel, resources, and emergency fire pre-hospital medical services
- Coordination of providers of non-fire based pre-hospital emergency medical services
- Coordination of the establishment of temporary field treatment sites
- Health surveillance and epidemiological analyses of community health status
- Assurance of food safety
- Management of exposure to hazardous agents
- Provision or coordination of mental health services
- Provision of medical and health public information protective action recommendations
- Provision or coordination of vector control services
- Assurance of drinking water safety
- Assurance of the safe management of liquid, solid, and hazardous wastes
- Investigation and control of communicable disease”

Health and Safety Code §1797.153 specifies that the appointed MHOAC is responsible for ensuring the development of the medical and health disaster plan in cooperation with the:

- County office of emergency services
- Local health department
- Local health officer
- Local environmental health department
- Local department of mental health
- Local emergency medical services agency
- Local fire department
- Regional Disaster Medical and Health Coordinator

- Regional office of Cal OES

Duties of the MHOAC Program include:¹⁶

- Maintain a 24 hour-per-day, 365 day-per-year single point-of-contact for the MHOAC Program and provide this contact information to all of the relevant agencies within the Operational Area, including the county MH/BH department and other health and medical system participants within the Operational Area.
- Produce and share relevant situation reports.
- Maintain a directory of behavioral health, public health, environmental health, and EMS resources within the Operational Area, including equipment, supplies, personnel and facilities.
- Coordinate the identification, acquisition and delivery of health and medical mutual aid and assistance within the Operational Area.
- Utilize resource requesting and management procedures in accordance with the processes identified in the California Public Health and Medical Emergency Operations Manual (EOM) and this plan.
- Support the Medical Health Branch of the Operational Area EOC if activated.

In accordance with the preparedness, response, recovery and mitigation functions outlined in Health and Safety Code §1797.153, the MHOAC Program in each Operational Area should develop policies and procedures so that basic operational processes, e.g., situation reporting and resource requesting, are well understood and practiced.

4.2.2 Regional Disaster Medical and Health Coordination (RDMHC) Program

The Regional Disaster Medical and Health Coordinator (RDMHC) is an appointed position in each of the six mutual aid regions established by Health and Safety Code §1797.152. The RDMHC coordinates disaster information and medical and health mutual aid and assistance within the mutual aid region or in support of other affected mutual aid region(s). The RDMHC may be a county health officer, county coordinator of emergency services, local emergency medical services administrator, or local emergency medical services medical director. Appointees are nominated by a plurality of the votes of local health officers in the mutual aid region and jointly appointed by the Directors of CDPH and EMSA.

The Regional Disaster Medical and Health Specialist (RDMHS) is the staff person associated with the RDMHC Program who directly supports regional preparedness, response, mitigation and recovery activities within the health and medical system. In order to accomplish the functions specified in statute, a comprehensive RDMHC Program will:

¹⁶ More information on the MHOAC Program and RDMHC Program can be found in the [California Public Health and Medical Emergency Operations Manual \(EOM\)](#).

- ❑ Coordinate with MHOAC Programs in the mutual aid region to ensure that all 17 MHOAC Program functions are met.
- ❑ Ensure that relevant situational information is shared
- ❑ Coordinate with MHOAC Programs in the mutual aid region to maintain directories of public health, behavioral health, environmental health, and EMS resources, including equipment, supplies, personnel and facilities, within each Operational Area.
- ❑ Coordinate the identification, acquisition and delivery of health and medical mutual aid and assistance to affected Operational Areas within the mutual aid region, or if necessary, to affected Operational Areas in other mutual aid regions.
- ❑ Utilize resource requesting and management procedures in accordance with the processes identified in the EOM.
- ❑ Coordinate with CDPH and EMSA to support the Medical Health (or CA-ESF 8) Branch of a REOC, if activated.

4.2.3 CDPH and EMSA Duty Officer Programs

CDPH and EMSA operate Duty Officer Programs on a 24 hour-per-day, 365 day-per-year basis. The CDPH and EMSA Duty Officer Programs receive notifications from internal and external sources regarding public health, behavioral health, environmental health, and medical events and notify appropriate state agencies and local partners to increase awareness of an incident or impending threat. When unusual events occur that require additional coordination and communication, the CDPH and EMSA Duty Officer Programs notify internal management and programs, local partners, and other state agencies in accordance with established policies and procedures. When behavioral health impacts are identified, the CDPH Duty Officer Program notifies the designated DHCS representative.

4.2.4 Medical and Health Coordination Center (MHCC)

The Medical and Health Coordination Center (MHCC) is activated as needed to provide support and coordination for an emergency that has health and/or medical impacts. The MHCC serves two functions: 1) it is the Emergency Operations Center (EOC) shared by the California Department of Public Health (CDPH), California Emergency Medical Services Authority (EMSA) and the Department of Health Care Services (DHCS); and 2) it is the Coordination Center for state-level public health and medical (CA-ESF 8) activities involving other departments within the California Health and Human Services Agency (CHHS) and other CA-ESF 8 stakeholders with an incident-specific public health and medical role.

The MHCC collects situational information from local jurisdictions and other state agencies involved in CA-ESF 8 response and prepares summary reports that are shared with Cal OES, CHHS, state agencies, and stakeholders. Likewise, the MHCC serves as a coordination point for resource requests received from local jurisdictions or mission assignments received from Cal OES.

4.3. Integrating Disaster Behavioral Health and Emergency Management

County MH/BH departments should actively coordinate with the Medical Health Operational Area Coordination (MHOAC) Program. This coordination is best achieved by actively participating in community-wide planning so that relationships are established prior to the need to execute response and recovery activities. There is a learning curve involved — emergency management professionals may not be familiar with DBH impacts and population-based interventions to reduce distress and normalize responses — and behavioral health professionals may not be familiar with standard emergency management practices.⁷ The best time for relationship-building and collaboration is prior to the harsh realities of an unanticipated disaster. See Appendix H for an overview of suggested activities by emergency management phase and Appendix I for more information on Action Planning.

The manner in which DBH services are coordinated during emergencies varies by county. Some county MH/BH departments may establish a Department Operations Center (DOC) to coordinate agency activities during an emergency. Whenever an emergency leads to the activation of the OA EOC (a decision usually made by the local emergency management agency with input from elected and appointed leaders), the county MH/BH department should coordinate with the MHOAC Program and evaluate the need to send representative(s) to the Medical Health Branch of the OA EOC.

The following examples illustrate how DBH representatives can integrate into emergency operations:

Command/Management (Public Information Function): A county MH/BH department representative familiar with public messaging and risk communication should collaborate with the designated Public Information Officer (PIO) to address the emotional and behavioral aspects of messages. In large activations, a Joint Information Center (JIC) may be activated at the OA EOC (or other location) to coordinate consistent messaging among governmental entities and other response partners. When possible, county MH/BH departments should participate in JIC activities.

Communication activities may include:

- Assess the need for, and help to prepare, messages containing DBH content (i.e., coping with the stress of emergency evacuation, etc.)
- Coordinate information releases with PIO staff from other agencies and jurisdictions
- Provide requested information about DBH issues related to the incident
- If a new community hotline is set up (or an existing behavioral health hotline is used or expanded), provide education to hotline personnel and assist in monitoring hotline trends related to DBH
- Provide copies of all news releases, bulletins, and summaries pertaining to DBH to the PIO

Command/Management (Liaison Function): If Incident Command/Unified Command (IC/UC) is established, a DBH liaison to the IC/UC may be warranted. The DBH liaison should:

- Monitor DOC/EOC information to help structure the DBH response
- Monitor the current DBH response and available resources
- Include relevant objectives in the Action Plan

Command/Management (Safety Function): To assist with ensuring safety, DBH should:

- Identify psychological hazards associated with the incident
- Assess whether a location is safe for deploying DBH service delivery
- Identify corrective actions and ensure implementation
- Develop a plan for responder stress management (set up shifts if needed; enforce breaks/mealtimes/sleep times; provide education on worker stress and self-care)
- Coordinate post-deployment strategies including providing relevant handouts on post-deployment stressors, contact numbers for behavioral health follow up if needed (for county employees this may be the Employee Assistance Program), and provision of individual and/or group post-deployment support
- Develop an exit plan for workers leaving operations (e.g., re-entry to normal life, recognition of response efforts)

Planning: One of the chief responsibilities of the Planning Section is to create an Action Plan (AP). DBH should:

- Assemble information for a DBH needs assessment, if warranted
- Determine resource availability, situation status, and DBH objectives and strategy for the Action Plan
- Activate additional personnel to assist with planning, if necessary
- Gather information from operations and field staff on DBH services provided by deployment location; this can include the numbers of adults, children, and disaster responders where DBH services (e.g., PFA, crisis counseling, education, etc.) were provided, the number of referrals for additional services, etc.
- Advise Planning Section staff of any significant changes in incident status

Operations: This is the primary DBH function within a response. If possible, a DBH Coordinator or designee should be responsible for the direct management of all incident-related operational activities. The person who leads DBH Operations (who may be positioned as a Branch Director, Division or Group Supervisor, or Unit Leader) should:

- Direct DBH operations to meet the DBH objectives identified in the Action Plan, including DBH objectives for disaster survivors as well as responders

- Ensure that logistical support activities are adequate to support the proposed operations
- Coordinate with the Planning section
- Develop a response schedule of activities and tactical assignments
- Review responder activities and modify them based on effectiveness/needs assessment
- Monitor current operations and their effectiveness
- Estimate immediate and long-range resource and logistical requirements
- Supervise and coordinate all DBH response activities

Logistics:

- Receive requests for, and locate, DBH resources including staff, equipment, and supplies. For health emergencies such as an emerging infectious disease, obtain and maintain an adequate supply of PPE for DBH staff and contract providers deployed to the incident
- Complete resource requests to obtain DBH staff from other counties if DBH resources are needed in the OA (refer to Appendix C for Resource Typing information by specific resource type and disaster mission)
- Identify and maintain warehouse space needed for equipment and supplies; provide logistical support for DBH response locations and field teams

Finance/Administration: The Finance/Administration function for DBH primarily involves tracking and reporting response activities. The representative serving in this role typically carries out the following duties:

- Obtain information on the required fiscal process and tracking forms
- Prepare cost estimates
- Ensure completeness of documentation needed to support claims for emergency funds
- Ensure all personnel time records reflect incident activity
- Ensure that all documents initiated by the incident are properly completed

4.4. Mutual Aid/Emergency Assistance

An essential cornerstone of good planning is establishing emergency assistance agreements before disaster strikes. Establishing such agreements in advance typically leads to faster delivery of needed resources under mutually agreed-upon, pre-negotiated terms.

When impacted jurisdictions exhaust or anticipate exhausting their available resources (e.g., personnel, equipment, or supplies), mutual aid or other forms of emergency assistance may be needed. It's important to understand the distinction between "mutual aid" as expressed in

California's Master Mutual Aid Agreement (MMAA)¹⁷ and "emergency assistance" which is a more expansive term that includes additional forms of assistance.

California's statewide mutual aid system was designed to provide additional resources to the state's political subdivisions whenever their own resources are overwhelmed or inadequate. The MMAA is entered into by and between the State of California, its departments and agencies, and the various political subdivisions, municipal corporations, and public agencies that may assist each other by providing resources during an emergency.

The MMAA obligates each signatory entity to provide aid to the other during an emergency without expectation of reimbursement. In addition, the MMAA does not require the providing jurisdiction to unreasonably deplete its own resources.

"Each party agrees to furnish resources and facilities and to render services to each and every other party to this agreement to prevent and combat any type of disaster in accordance with duly adopted mutual aid operational plans, whether heretofore or hereafter adopted, detailing the method and manner by which such resources, facilities, and services are to be made available and furnished, which operational plans may include provisions for training and testing to make such mutual aid effective; provided, however, that no party shall be required to deplete unreasonably its own resources, facilities, and services in furnishing such mutual aid."

Under specific conditions, federal and state funding may be appropriated to reimburse public agencies who render aid to other jurisdictions. If other agreements, memoranda, or contracts are used to provide assistance for consideration, the terms of those documents may affect disaster assistance eligibility and local entities may only be reimbursed if funds are available.

4.4.1 Mutual Aid Coordination

Formal mutual aid requests follow established procedures and are processed through pre-identified mutual aid coordinators. Mutual aid requests follow discipline-specific chains from one level of government to the next. For CA-ESF 8, the mutual aid coordination function at the OA level is managed by the MHOAC Program and the mutual aid coordination function at the regional level is managed by the RDMHC Program. The mutual aid coordinator receives the mutual aid request and coordinates the provision of resources from within the coordinator's geographic area of responsibility. In the event resources are unavailable at one level of government, the request is forwarded to the next higher level of government to be filled.

- ❑ **Field Level Requests:** Requests for MMAA resources originate from the Field Level and are managed by the Incident Commander (IC). If the IC is unable to obtain the resource through local channels, the request is elevated to the next level until obtained or cancelled.

¹⁷ <https://www.caloes.ca.gov/PlanningPreparednessSite/Documents/CAMasterMutAidAgreement.pdf>

- Local Government Requests:** Local jurisdictions are responsible for the protection of life and property within their jurisdiction. The local jurisdiction where the incident occurred should assess its resource inventory and existing local agreements to determine if the requested resource is available. When locally committed resources are exhausted and mutual aid is needed, the local official should request assistance from the MHOAC Program for health and medical resources.
- Operational Area Requests:** The OA includes the county and all the political subdivisions within the county (cities, special districts, etc.). The MHOAC Program assesses the availability of resources within the OA and fulfills the resource request based upon that assessment. In the event resources are not available within the OA, the request is forwarded to the RDMHC Program.
- Region Level Requests:** The state is geographically divided into six mutual aid regions. Each mutual aid region is comprised of multiple OAs and has a Regional Disaster Medical and Health Specialist (RDMHS) who is the operational arm of the RDMHC Program. The RDMHS coordinates the mutual aid response of discipline-specific resources within the Region to support a mutual aid request by a jurisdiction also within the Region. In the event resources are unavailable at the Region level, the request is forwarded to the state to be filled within another mutual aid region. This involves coordination by other RDMHSs and state agencies.
- State Level Requests:** On behalf of the Governor, Cal OES coordinates state mutual aid resources during emergencies. Cal OES may forward an unfilled request to an unaffected mutual aid region or task an appropriate state agency to fill the need.

4.5. Disaster Behavioral Health Resources

DBH may be considered a sub-specialization within behavioral health. DBH focuses on population-based interventions (psychosocial and psychoeducation models) to reduce distress among the affected population, normalize reactions, and monitor for more serious impacts. A second component is the care of those more seriously impacted by disaster trauma, which may involve the delivery of trauma-specific behavioral health services.

DBH assistance may come from the following behavioral health professionals:

- Psychiatrist – assessment, medication orders, and care coordination
- Licensed Psychiatric Registered Nurse – assessment, medication management, monitoring, crisis counseling, and care coordination
- Licensed Psychologists – psychosocial assessment, diagnosis, crisis counseling, and care coordination
- Credentialed School Counselors, School Social Workers, and School Psychologists – psychological assessment, crisis counseling, and care coordination in a school setting
- Licensed Marriage and Family Therapist (LMFT) – psychosocial assessment, crisis counseling, and care coordination

- ❑ Licensed Clinical Social Workers (LCSW) – psychosocial assessment, crisis counseling, and care coordination
- ❑ Licensed Professional Clinical Counselor (LPCC) – psychosocial assessment, crisis counseling and care coordination.

Other Types of behavioral health practitioners that county MH/BH departments may deploy:

- ❑ Licensed Psychiatric Technicians (LPT) – medication monitoring and administration
- ❑ Certified Drug and Alcohol Counselors – provide education for disaster survivors and response staff on the impact of disasters on addiction and recovery
- ❑ Registered Interns – deployed under supervision to provide behavioral health services in shelters and assistance centers:
 - Psychological Assistants
 - Associate Clinical Social Worker (ACSW)
 - Associate Marriage and Family Therapist (AMFT)
 - Associate Professional Clinical Counselor (APCC)

Appendix C provides detailed information about different types of potential DBH responders in California. Appendix C also includes information on suggested staff assignments for specific disaster missions, e.g., providing support to a Local Assistance Center (LAC).

Religious Leaders and Faith-Based Communities

Religious leaders and faith-based communities often support behavioral health after disasters. Faith-based communities include places of worship, religious organizations, congregations, and the spiritual leaders who represent them. Faith-based communities are often interwoven into the fabric of local communities and are among the first to respond in disasters; they also play a major role in facilitating long term recovery.

Faith-based communities provide informal and formal services related to disaster response. Informally, faith-based communities rally around community members, offer spiritual care support, and assist in fulfilling unmet needs. In some cases, faith-based organizations enter into mutual aid agreements with local, tribal, state, and federal partners in disaster response and recovery efforts. Those working in partnership with DBH providers to provide support to disaster survivors and responders should be trained in disaster spiritual care and community disaster response systems prior to deploying to a disaster.

The National Disaster Interfaiths Network (NDIN) has created a series of tip sheets that can be found at <http://www.n-din.org/>.¹⁸

¹⁸ [Disaster Tips Sheets for U.S. Religious Leaders](http://www.n-din.org/), National Disaster Interfaiths Network

4.5.1 Sources of Disaster Behavioral Health Personnel

Potential sources of personnel that may assist in mitigating the impact of a disaster on behavioral health include:

- County MH/BH department staff and contract providers
- Local public health department staff
- Licensed behavioral health care providers that have volunteered through the Disaster Healthcare Volunteers (DHV) registry maintained by EMSA. These personnel resources are typically requested by local Medical Reserve Corps (MRCs) and/or local DHV Coordinators
- Local certified chaplain chapters through local law/fire departments and hospitals
- Local city/law/fire department's behavioral health and/or peer support personnel
- American Red Cross Disaster Mental Health (DMH) volunteers
- Community Emergency Response Team (CERT) volunteers trained in Psychological First Aid (PFA) in community settings
- State-to-state behavioral health resources available through the Emergency Management Assistance Compact (EMAC)
- Federal Mental Health Teams comprised of a scalable number of U.S. Public Health Service commissioned officers (maximum of 26 individuals per team on 5 teams) that provide a range of DBH services
- Federal Applied Public Health Teams (APHT), U.S. Public Health Service (a component of which may aid in disaster behavioral services and may assist with DBH epidemiology)
- U.S. Centers for Disease Control and Prevention:
 - Community Assessment for Public Health Emergency Response (CASPER) Program: DBH risk and epidemiology
 - Office of Public Health Preparedness and Response (OPHPR) Branch: specialized, focused population assessments in addition to CASPER

4.6. Response Actions

The response actions below identify activities undertaken when an emergency or unusual event adversely impacts the behavioral health of those in the affected communities. An **unusual event** is defined in the California Public Health and Medical Emergency Operations Manual (EOM) as an incident that significantly impacts or threatens public health, behavioral health, environmental health, or emergency medical services. An unusual event may be self-limiting or a precursor to emergency system activation. The specific criteria (triggers) for an unusual event include any of the following:

- The incident significantly impacts or is anticipated to impact public health or safety;

- The incident disrupts or is anticipated to disrupt the health and medical system, including MH/BH services;
- Resources are needed or anticipated to be needed beyond the capabilities of the OA, including those resources available through existing agreements (day-to-day agreements, memoranda of understanding, or other emergency assistance agreements);
- The incident produces media attention or is politically sensitive;
- The incident leads to a regional or state request for information; and/or
- Whenever increased information flow from the OA to the state will assist in the management or mitigation of the incident's impact.

4.6.1 Affected Field-Level Entities

Affected field-level entities, (e.g., behavioral health programs and services) should:

- Notify local and state agencies in accordance with statutory and regulatory requirements and local policies and procedures
- Cooperate with guidance issued by the county MH/BH department and state agencies such as the DHCS and Cal OES
- If behavioral health resources are needed that cannot be obtained through local policies and procedures, including emergency assistance agreements, request needed resources through the county MH/BH department in accordance with local policies and procedures

4.6.2 County Mental Health/Behavioral Health Department

In California, county MH/BH departments are responsible for local disaster response activities involving behavioral health. Since behavioral health is a vital component of California's health and medical system, each county's MH/BH department should be integrated into the county's Medical Health Operational Area Coordination (MHOAC) Program, which serves as the coordination point for all health and medical emergency needs.

Prior to an emergency, the county MH/BH department should engage behavioral health professionals, including contract behavioral health agencies and private sector resources, to build a resource directory of response personnel and conduct training in coordination with the MHOAC Program. Ideally, county MH/BH departments should pre-identify behavioral health responders and their DBH qualifications or skillsets. Counties can also encourage private sector providers to join the California Disaster Healthcare Volunteers (DHV) system (go to <https://www.healthcarevolunteers.ca.gov/>).

During an unusual event or emergency involving behavioral health, the county MH/BH department should:

- Notify:

- Local and state agencies in accordance with statutory and regulatory requirements and local policies and procedures
- MHOAC Program
- Local emergency management agency
- Activate Department Operations Center (DOC), if warranted
- Coordinate with the MHOAC Program on DBH issues and any resource needs
- Provide essential information on DBH impacts and response activities to the MHOAC Program for incorporation into the overall Health and Medical Situation Report prepared by the MHOAC Program. Providing this information informs response partners and decision makers, and should include the following at a minimum:
 - Succinct description of behavioral health impacts, including number of people affected (if known)
 - Threats or interruptions to key behavioral health services
 - Priority concerns and/or activities
 - Potential need for assistance
 - Report to the OA EOC if activated and participate in incident-related conference calls to coordinate DBH needs
 - Provide behavioral health public messaging to the affected community, including sending the appropriate representatives to be a part of the Joint Information Center (JIC) operations.
 - As needed, deploy DBH emergency response staff that have received disaster response training, including providing “just in time” disaster training and staff orientation appropriate to the type of disaster
 - Maintain situational awareness of the disaster’s DBH impact on community members, disaster responders, and other government agency staff, and provide this information to the MHOAC Program, DOC, and EOC in accordance with local policies and procedures on a regular basis
 - If DBH resources (personnel, equipment, or supplies) are needed that cannot be obtained within the local jurisdiction or through existing agreements, request resources through the MHOAC Program in accordance with local policies and procedures.
 - If the President issues a major disaster declaration under the Stafford Act, or if the Secretary of HHS declares a public health emergency, coordinate with the Department of Health Care Services (DHCS) and the MHOAC Program to pursue an application for the federally-funded Crisis Counseling Assistance and Training

Program (CCP) administered by SAMHSA¹⁹, including the options of the 60-day Immediate Services Program (ISP) or 9-month Regular Services Program (RSP).

- Coordinate with affected field-level entities, MHOAC Program, Incident Command, and DOCs/EOCs in accordance with local policies and procedures regarding situational status, response activities, and resource needs

4.6.3 MHOAC Program

Each of California's 58 counties has an appointed Medical Health Operational Area Coordinator (MHOAC) who oversees a multi-faceted MHOAC Program that encompasses the county and all political jurisdictions within the county (e.g., cities, special districts, etc.). The MHOAC Program's responsibilities include the following:

- Notify:
 - RDMHC Program
 - CDPH and EMSA Duty Officer Programs (either directly or via the RDMHC Program), or the MHCC if activated for the incident
- Prepare a Medical Health Flash Report or Situation Report containing the minimum data elements, including significant behavioral health impact and response information. The initial Health and Medical Situation Report may be provided verbally to the RDMHC Program under pressing circumstances
- Within two hours of incident recognition, submit the initial Health and Medical Situation Report, including relevant DBH information, to the:
 - RDMHC Program
 - CDPH and EMSA Duty Officer Programs (or MHCC if activated)
 - Emergency management agency for the OA (or OA EOC if activated)
- Provide updated Health and Medical Situation Reports including behavioral health information as follows:
 - Once during each operational period at agreed upon times
 - When significant changes in status, prognosis, or actions are taken
 - In response to State/Regional agency request as communicated by the RDMHC Program
- Coordinate with the affected field-level entities, county MH/BH department, and CDPH and EMSA Duty Officer Programs (or MHCC if activated) to share situational information
- Attempt to fill resource requests within the OA or by utilizing existing agreements

¹⁹ Federally recognized Tribes may apply directly for the Crisis Counseling Assistance and Training Program through the Region IX Health and Human Services Regional Emergency Coordinator (REC) in consultation with the Region IX SAMHSA Administrator.

- (including day-to-day agreements, memoranda of understanding, or other emergency assistance agreements)
- If requested resources, e.g., DBH response personnel, cannot be met within the OA or through existing agreements, prepare a Resource Request that includes the number, type, and qualifications of requested personnel; description of the “disaster mission” (e.g., backfill county MH/BH department personnel, support a Family Assistance Center); and need for logistical support (“wrap around services”) such as food and lodging. Submit the resource request to the:
 - RDMHC Program via the RDMHS, which will begin to coordinate the resource acquisition process; confirm receipt
 - Emergency management agency for the OA (or OA EOC if activated). Confirm receipt and entry into Cal EOC or other resource tracking system used by your jurisdiction
 - Ensure that situational information is provided to the RDMHC Program, emergency management agency for the OA (or OA EOC if activated), CDPH and EMSA Duty Officers (or MHCC if activated) to support the requested resources. A Health and Medical Situation Report including behavioral health information should be submitted with the resource request or as soon as possible
 - Notify the requestor of the outcome of the request and delivery details if the request is filled
 - Support the Medical Health (or ESF 8) Branch of the OA EOC (if activated)

4.6.4 RDMHC Program

Each of California’s six mutual aid regions has an appointed Regional Disaster Medical and Health Coordinator (RDMHC) who oversees a comprehensive RDMHC Program. Each RDMHC Program has an assigned Regional Disaster Medical and Health Specialist (RDMHS) who operationally supports medical and health operations in that region. The RDMHC Program’s responsibilities include the following:

- Notify and coordinate with CDPH and EMSA Duty Officer Programs (or MHCC if activated)
- Notify and coordinate with emergency management agencies in accordance with established policies and procedures, including the Cal OES Regional Duty Officer (or REOC if activated)
- Confirm that the MHOAC Program submitted the Health and Medical Situation Report including behavioral health information to the CDPH and EMSA Duty Officer Programs (or MHCC if activated); if not, submit immediately
- Confirm that the Cal OES Regional Duty Officer (or REOC if activated) received the information contained in the Health and Medical Situation Report including behavioral health information; if not, submit immediately
- If resources are requested, immediately begin the process of filling the resource request by coordinating with unaffected OAs within the mutual aid region

- Coordinate with the Cal OES Regional Duty Officer (or REOC if activated) to ensure proper tracking and fulfillment of the resource request
- Notify the DHCS, CDPH and/or EMSA Duty Officers (or MHCC if activated) that a resource request is being processed
- Notify the requesting MHOAC Program, DHCS, CDPH and/or EMSA Duty Officers (or MHCC if activated), and Cal OES Regional Duty Officer (or REOC if activated) of the outcome of the request and delivery details if the request is filled within the Mutual Aid Region
- Coordinate with the MHCC to ensure that information, policy-level decisions for response activities, and guidance developed by State-level programs are distributed to the MHOAC Program(s)
- Coordinate with DHCS, CDPH and EMSA to support the Medical Health Branch of the REOC if activated

4.6.5 DHCS

DHCS supports DBH activities through its Behavioral Health - Licensing and Certification Division (LCD). During an unusual event or emergency involving behavioral health, DHCS works with affected county MH/BH departments and other local response agencies if requested. DHCS supports state-level response activities in coordination with the MHCC. Upon learning of a disaster-related behavioral health issue, DHCS will:

- Notify:
 - Appropriate DHCS programs and partner agencies
 - CDPH Duty Officer Program (or MHCC if activated)
 - SAMHSA Regional Administrator
- If the President issues a major disaster declaration (Stafford Act) and authorizes the Crisis Counseling Assistance and Training Program (CCP), coordinate with affected counties and their MHOAC Programs to prepare an CCP application in conjunction with Cal OES
- Provide DBH support to county MH/BH departments, which may include conference calls to share situational information, response priorities, potential resource needs, etc.
- Coordinate with other states and federal agencies and programs to provide access to subject matter expertise in DBH

4.6.6 CDPH Duty Officer Program

- Notify:
 - DHCS Point-of-Contact
 - EMSA Duty Officer Program
 - MHOAC Program

4.7. Roles and Responsibilities

The following table outlines major roles and responsibilities of response partners at different SEMS levels.

Table 4. Common Roles and Responsibilities of Response Partners

Local	
Local Mental/Behavioral Health Department	<ul style="list-style-type: none"> • Activate local DBH plan. • Integrate into the emergency management structure in accordance with local plans and procedures (e.g., via physical or virtual presence at Unified Command, EOC, etc.) • Continue to provide behavioral health services to existing clients (if this activity is considered an essential function and is threatened, consider activating the organization’s continuity plan). • Provide DBH support to responders and survivors. • Provide situational information regarding behavioral health impacts and activities to the MHOAC Program for inclusion in the Health and Medical Situation Report for the OA. • If additional resources are needed, submit requests to the MHOAC Program, who will inform the emergency management agency (or OA EOC if activated) that a request has been submitted for health and medical resources. This allows the MHOAC to begin the process of obtaining the needed resource(s) in coordination with the emergency management agency.
Medical Reserve Corps	<ul style="list-style-type: none"> • Medical Reserve Corps (MRC) units are community-based organizations of volunteers. • MRCs work closely with local agencies, first responders, and support organizations including the American Red Cross to supplement existing emergency and health resources. • MRC volunteers may include physicians, nurses, behavioral health professionals, pharmacists, dentists, veterinarians, epidemiologists, interpreters, chaplains, office workers, legal advisors, and others.
Disaster Healthcare Volunteers	<ul style="list-style-type: none"> • Disaster Healthcare Volunteers (DHV) is a federally funded program that establishes a cadre of pre-identified and credentialed disaster volunteers; DHV is administered at the state level by the Emergency Medical Services Authority (EMSA). • By registering through DHV, the licenses, credentials, accreditations, and hospital privileges of volunteers are verified in advance. • Local DHV Coordinators may access DHV volunteer resources as needed. MRC units are often included in DHV.

State	
Department of Health Care Services	<ul style="list-style-type: none"> • Administer the Medi-Cal Program, including the Specialty Mental Health Services Program. • Identify and mobilize available departmental resources to support county MH/BH departments in assessing mental health risks to survivors and response personnel. • If authorized, coordinate Crisis Counseling Assistance and Training Program applications in coordination with Cal OES. • When the Medical and Health Coordination Center (MHCC) is activated, DHCS will assist CDPH and EMSA in providing appropriate program coordination and information management.
California Department of Public Health	<ul style="list-style-type: none"> • Operate a 24/7/365 Duty Officer Program for all public health functions, including behavioral health. • In coordination with EMSA, activate and support the Medical and Health Coordination Center (MHCC) that coordinates information flow and resource management for health and medical emergency response.
Emergency Medical Services Authority	<ul style="list-style-type: none"> • Operate a 24/7/365 Duty Officer Program for disaster medical services, including behavioral health. • In coordination with CDPH, activate and support the MHCC that coordinates information flow and resource management for health and medical emergency response.
California Governor's Office of Emergency Services	<ul style="list-style-type: none"> • Coordinate the state's emergency management organization in compliance with SEMS, the Emergency Services Act, relevant regulations, and Executive Orders. • Serve as the lead agency for coordinating emergency activities related to communications, fire and rescue, management, law enforcement, recovery, public information, and cybersecurity. • Manage state disaster recovery programs when authorized. The California Disaster Assistance Act (CDAA) authorizes the Director of Cal OES to administer a disaster assistance program, which provides disaster-related state financial assistance for some or all of the following: emergency protective measures, debris removal, permanent restoration of public facilities and infrastructure, and certain mitigation measures. • Coordinate with DHCS on submission of Crisis Counseling Assistance and Training Program (CCP) applications, if authorized.

State	
Department of Social Services	<ul style="list-style-type: none"> • Administer the Functional Assessment Service Team (FAST) and the Volunteer Emergency Services Team (VEST) Programs. 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, shelters that are opened throughout the state may include clients that have mental health conditions. DSS coordinates with the American Red Cross to support these needs.
Department of State Hospitals	<ul style="list-style-type: none"> • DSH’s primary response role during emergencies is to assist California’s state hospitals and psychiatric programs. • DSH may deploy FAST or VEST members with mental health treatment experience to shelters in coordination with state response.
Department of Developmental Services	<ul style="list-style-type: none"> • DDS Regional Centers and state-operated hospitals/community facilities provide psychological, behavioral, and emotional support to the clients, staff and volunteers at state-operated hospitals/facilities. • DDS may deploy eligible 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.
California Victim Compensation Board	<ul style="list-style-type: none"> • The California Victim Compensation Board is a state program dedicated to providing reimbursement for many crime-related expenses to eligible victims who suffer physical injury or the threat of physical injury as a direct result of a violent crime. • The Victim/Witness Assistance Program is designed to provide comprehensive services to victims/witnesses of all types of violent crime pursuant to California Penal Code §13835. These services include 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, and restitution.
Department of Aging	<ul style="list-style-type: none"> • Communicate with its network of local partner agencies so that the needs of older at-risk individuals and persons with disabilities are included in health and medical emergency preparedness, response and recovery activities. • CDA may deploy FAST or VEST teams with expertise in serving older adults and persons with disabilities (including those with behavioral health issues) to shelters as requested by CDSS during disaster events.

Tribal	
Tribal Governments	<ul style="list-style-type: none"> • Coordinate with response agencies and request assistance as needed.

Federal or National	
Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Health and Human Services Agency	<ul style="list-style-type: none"> • If a disaster leads to a Stafford Act declaration that includes Individual Assistance, SAMHSA supports the acquisition of FEMA Crisis Counseling Assistance and Training Program (CCP) grants that provide community-based outreach, counseling, and other mental health services to disaster survivors. CCP provides supplemental funding to state, territory, or tribal mental health authorities through two grant programs: <ul style="list-style-type: none"> ○ The Immediate Services Program (ISP) grant provides funding for up to 60 days after a presidential disaster declaration. ○ The Regular Services Program (RSP) grant provides funding for up to nine months after a presidential disaster declaration. • Through an interagency agreement between FEMA and SAMHSA’s Center for Mental Health Services (CMHS), CMHS is responsible for CCP grant administration and program oversight. • SAMHSA’s Disaster Distress Helpline is a confidential, multilingual, 24/7 crisis support service offered via telephone (1-800-985-5990) and SMS/Text (‘TalkWithUs’ to 66746), that is available to those 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. • SAMHSA’s Disaster Technical Assistance Center (DTAC) provides technical assistance and consultation to eligible states, territories, and federally recognized tribes.

Federal or National	
Office of the Assistant Secretary for Preparedness and Response (ASPR), U.S. Health and Human Services Agency	<ul style="list-style-type: none"> • Provide federal support, including deployment of medical professionals through the National Disaster Medical System, to augment state and local capabilities if needed during disasters. • Coordinate the federal health and medical services support functions during a public health emergency. • Maintain Regional Emergency Coordinators (ASPR-RECs) in each of the country’s 10 disaster planning regions. ASPR-RECs monitor emerging public health concerns, including behavioral health, and provide consultation and technical assistance to states, territories, tribes, local, and private sector authorities. • Administer the Hospital Preparedness Program (HPP), which provides leadership and funding through grants and cooperative agreements to states, territories, and eligible municipalities to improve surge capacity and enhance community and hospital preparedness for public health emergencies. HPP may be used to support behavioral health activities as part of overall hospital preparedness.
American Red Cross	<ul style="list-style-type: none"> • The American Red Cross has approximately 8,000 licensed mental health providers 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 others to utilize members of all of the major professional mental health associations for service as American Red Cross disaster mental health volunteers. In concert with government partners and other healthcare providers, the American Red Cross provides services at shelters, service centers, aid stations and temporary evacuation points. • Local jurisdictions are encouraged to establish a partnership with the local chapter of the American Red Cross prior to disaster. Jurisdictions may include the American Red Cross in their DBH stakeholder group and confer with the American Red Cross on their disaster role, disaster mental health related training, deployment of mental health volunteer personnel, and collaboration on the best methods to assist the public with complex mental health needs.
FEMA	<ul style="list-style-type: none"> • Administer the Crisis Counseling Assistance and Training Program (CCP) consisting of the following: Immediate Services Program (ISP; 60 days in duration), Regular Services Program (RSP; 9 months in duration), and Specialized Crisis Counseling Services (SCCS) Program.

Federal or National	
Indian Health Service (IHS), U.S. Health and Human Services Agency	<ul style="list-style-type: none"> • Direct response partner for emergencies and disasters across the tribal communities it serves. • Assist tribal partners by providing emergency and disaster services in contracted or compacted tribal programs, reservations, and communities.
Department of Defense (DOD) and Veterans Administration (VA) Health Care Systems	<ul style="list-style-type: none"> • The Department of Defense and Veterans Administration Health Care Systems are service providers for active military and veterans in California, including behavioral health assistance.
Administration for Children and Families (ACF), U.S. Health and Human Services Agency	<ul style="list-style-type: none"> • ACF programs fund grantee operations that can provide assistance with behavioral health and other issues arising during and after a disaster.
Centers for Medicare and Medicaid Services (CMS), U.S. Health and Human Services Agency	<ul style="list-style-type: none"> • Administer all aspects of the Medicare, Medicaid and Children’s Health Insurance programs (CHIP), including behavioral health.
Office on Disability, U.S. Health and Human Services Agency	<ul style="list-style-type: none"> • Collaborate with national and local disability rights leaders and other agencies across HHS to ensure that rights and safeguards are met during a response.
National Voluntary Organizations Active in Disaster (NVOAD)	<ul style="list-style-type: none"> • National Voluntary Organizations Active in Disaster (NVOAD) is a nonprofit membership organization that serves as a forum where organizations share knowledge and resources 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 disasters. • California has a two statewide VOADs that can provide a link to local chapters throughout the state.

Federal or National	
Salvation Army	<ul style="list-style-type: none">• The Salvation Army provides relief services to communities impacted by 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, including survivors and disaster workers. The Salvation Army's primary goals are to offer:<ul style="list-style-type: none">○ Material comfort○ Physical comfort○ Spiritual and emotional comfort• 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 responders and emergency management personnel. Disaster relief and recovery services are provided to all in need without discrimination.

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APPENDIX A: ACRONYMS

AP	Action Plan
APHT	Applied Public Health Team
ASPR	Assistant Secretary for Preparedness and Response
BH	Behavioral Health
CA-ESF	California Emergency Support Function
CA-ESF 6	California Mass Care and Shelter Emergency Support Function 6
CA-ESF 8	California Public Health and Medical Emergency Support Function 8
Cal OES	California Governor's Office of Emergency Services
CASPER	Community Assessment for Public Health Emergency Response
CCP	Crisis Counseling Assistance and Training Program
CDA	California Department of Aging
CDPH	California Department of Public Health
CDSS	California Department of Social Services
CHHS	California Health and Human Services Agency
CMHS	Center for Mental Health Services
CMS	Center for Medicaid and Medicare Services
CSWC	California State Warning System
DBH	Disaster Behavioral Health
DHCS	Department of Health Care Services
DHV	Disaster Healthcare Volunteers
DOC	Department Operations Center
DRC	Disaster Recovery Center
DSC	Disaster Spiritual Care
DSH	Department of State Hospitals
DTAC	Disaster Technical Assistance Center (SAMHSA)
EMAC	Emergency Management Assistance Compact
EMSA	Emergency Medical Services Authority
EOC	Emergency Operations Center
ESA	Emergency Services Act
FAC	Family Assistance Center
FAST	Functional Assessment Service Team
FEMA	Federal Emergency Management Agency
HHS	US Health and Human Services Agency

CALIFORNIA DISASTER BEHAVIORAL HEALTH PLAN (2020)

IAP	Incident Action Plan
ICS	Incident Command System
ISP	Immediate Services Program
LAC	Local Assistance Center
LEMSA	Local Emergency Medical Services Agency
MAC	Multi-Agency Coordination
MH	Mental Health
MHCC	Medical and Health Coordination Center
MHOAC	Medical Health Operational Area Coordination Program
MHP	Mental Health Plan
MHSA	Mental Health Services Act
MMAA	Master Mutual Aid Agreement
MRC	Medical Reserve Corps
NIMS	National Incident Management System
OA	Operational Area
PFA	Psychological First Aid
PHI	Protected Health Information
PTSD	Post-Traumatic Stress Disorder
RDMHC	Regional Disaster Medical and Health Coordination Program
RDMHS	Regional Disaster Medical and Health Specialist
REOC	Regional Emergency Operations Center
SAMHSA	Substance Abuse and Mental Health Services Administration
SEMS	Standardized Emergency Management System
SEP	State Emergency Plan
SMHS	Specialty Mental Health Services
SOC	State Operations Center
SPR	Skills for Personal Recovery
VEST	Volunteer Emergency Services Team
VOAD	Voluntary Organizations Active in Disaster

APPENDIX B: DISASTER BEHAVIORAL HEALTH CONSIDERATIONS

Introduction

This section focuses on a phased, whole community approach to DBH. This material is meant to be informational, not prescriptive, recognizing that California communities and the county mental health/behavioral health departments that serve them will have varying needs, resources, and priorities.

Whole Community Approach

Disasters affect both individuals and the community itself. Secondary stresses experienced during post-disaster recovery may further compound the initial impacts of the disaster on the behavioral health of individuals and the resilience of the community.

Disaster behavioral health (DBH) services should encompass the **entire community** affected by the disaster. In addition to the individuals directly affected (including survivors and disaster workers), their spouses/partners, children, and other family members are also likely to be affected. An informed and comprehensive community-based response is warranted to protect the health of the affected population.

Difference between Typical Behavioral Health Care and DBH Services

There is a difference between day-to-day behavioral health care and how it is addressed in disasters. Understanding this distinction is critical to effective disaster planning, mitigation, response, and recovery.

California's county-based behavioral health system is designed to diagnose, treat, and monitor community members with behavioral health issues, typically those with serious mental illness (SMI) and/or substance use disorders (SUD) as well as children with serious emotional disturbances (SED). Local behavioral health systems are frequently functioning at or beyond capacity on a day-to-day basis and have limited ability to expand or redirect their level of service after a disaster.

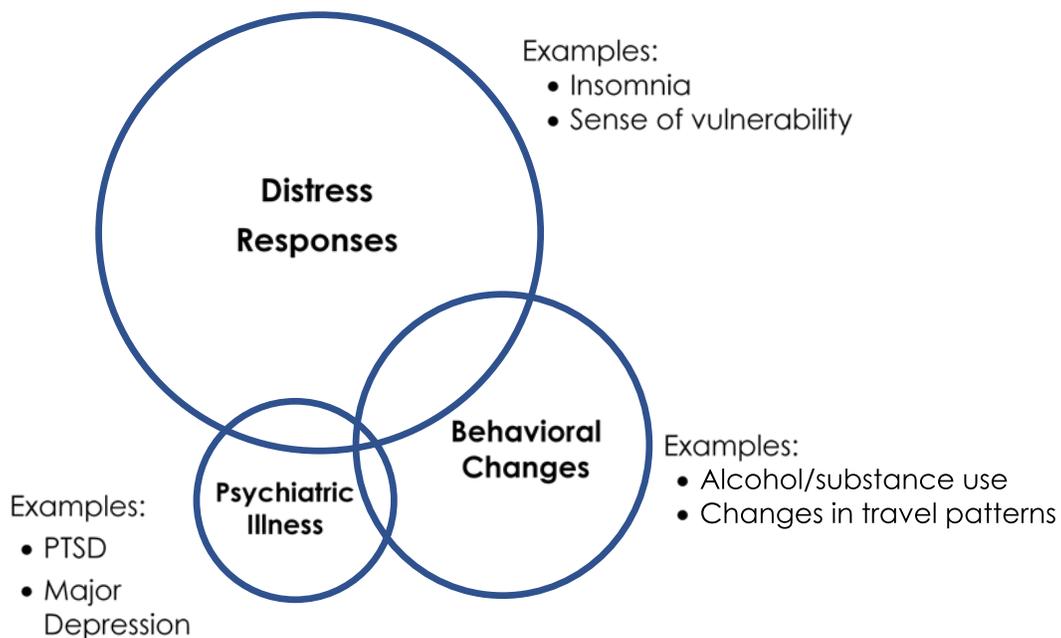
DBH relies on a strengths-based model which encourages the survivor to access their support system and preexisting coping skills and strategies.⁷ Providing DBH services requires specific knowledge and skill sets that are not generally found in behavioral health professionals in private practice or county-based behavioral health systems.²⁰

²⁰ King RV, Burkle FM, Walsh LE, North CS. Competencies for disaster mental health. *Curr Psychiatry Rep.* 2015;17(3):548.

DBH Consequences

Individuals vary in their response to disasters. This variability is due many factors, including incident specifics, level of exposure, individual characteristics, and community factors. It is common for those affected by a disaster to experience distress that is transitory and resolves over time. On the other end of the spectrum is a smaller proportion of individuals who may develop new clinical disorders (or experience exacerbation of pre-existing disorders) due to their disaster experience.

DBH consequences may manifest in the domains of *distress responses*, *behavioral changes*, and *psychiatric illness*.²¹



The National Center for PTSD identifies numerous factors that may contribute to the development of serious or lasting psychological problems following disaster or mass violence.²² These factors include the severity of exposure (especially injury, threat to life, and extreme loss), post-event stress and adversity, weak psychosocial support, female gender, minority group membership, poverty, low socioeconomic status, prior exposure to trauma, and prior history of mental disorders. Community-level factors that have been shown to create additional risk include displacement and low social cohesion.

²¹ Institute of Medicine Committee on Responding to the Psychological Consequences of Terrorism, Stith Butler A, Panzer AM, Goldfrank LR, eds. *Preparing for the Psychological Consequences of Terrorism: A Public Health Strategy*. Washington (DC): National Academies Press (US); 2003.

²² https://www.ptsd.va.gov/professional/treat/type/disaster_risk_resilience.asp

Protective factors have been identified at the individual, social, and community levels that can be used to inform and promote adaptive responses. Examples include having the ability to reframe what happened in a more positive, energizing, or helpful way; the capacity to seek support from others when needed; the ability to use distraction when appropriate to reduce distress; the use of positive religious strategies; the capacity to adapt coping strategies in a flexible way; and the ability to make meaning of the situation based on personal values. Social support has been shown to facilitate well-being and limit psychological distress. DBH interventions such as Skills for Psychological Recovery focus on fostering many of these adaptive skills.

Two Categories of Need

DBH addresses two major areas of need:

- 1) Resilience-based psychoeducation and psychosocial interventions to reduce emotional distress and social problems; and
- 2) Referral and treatment for psychiatric and other behavioral health disorders, e.g., substance use disorder

Relative to the first need — the majority of people exposed to disasters will experience distress for a period of time but do not develop psychiatric disorders. DBH emphasizes the normalization of reactions experienced by survivors and responders. Early psychoeducation and psychosocial interventions are indicated for the majority of survivors and responders to reduce distress, provide emotional support, educate, and normalize emotional responses.²³

The second need relates to the smaller proportion of people who go on to develop, or experience a worsening of, a behavioral health disorder. For those individuals, referral to appropriate clinical services and access to brief or longer term care is warranted.

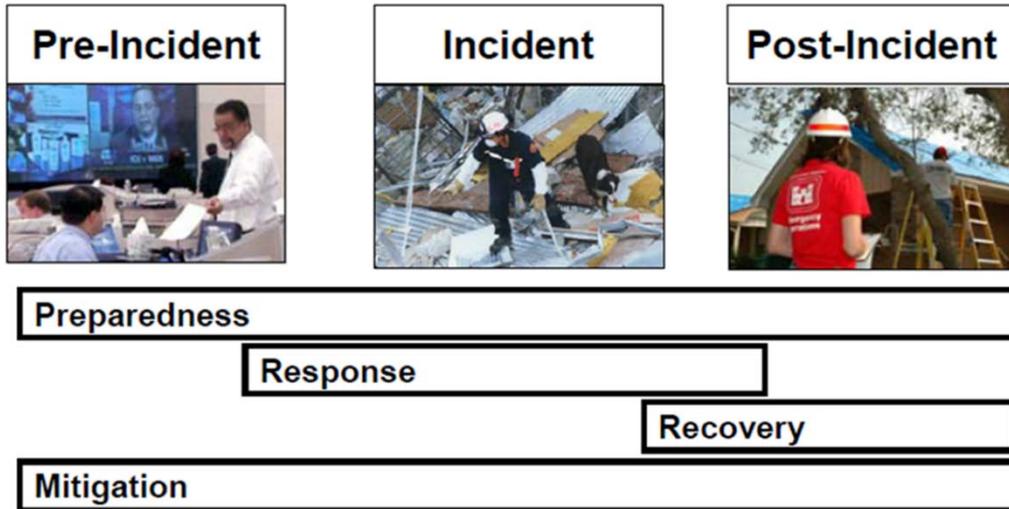
DBH aims to provide a continuum of services and activities — including communication/public information, education, basic psychological support such as Psychological First Aid (PFA), crisis intervention, as well as referrals for clinical services when needed — in order to promote resiliency and mitigate the progression of adverse reactions into more serious physical and behavioral health conditions.

Phases of Emergency Management

Emergencies are often managed in the context of four phases — preparedness, mitigation, response and recovery. While preparedness and mitigation activities are constantly underway, the response phase is the most robust in terms of life-saving and life-preserving activities. The State of California Emergency Plan defines response as “*Activities that address the short-term,*

²³ North CS, Pfefferbaum B. Mental health response to community disasters: a systematic review. JAMA. 2013;310(5):507-18.

direct effects of an incident. Response includes immediate actions to save lives, protect property, and meet basic human needs” while the recovery phase includes the “... long-term care and treatment of affected persons” with a focus on “community restoration”.



Inaccurate Assumptions about DBH

Some of the more common misunderstandings about DBH include:

- DBH is only needed in the *response* phase
- DBH is only needed in the *recovery* phase
- DBH is only needed when there have been mass casualties or acts of terror
- All behavioral health professionals are trained to practice DBH

Common DBH Interventions

The most common DBH interventions include:

- 1) Psychological First Aid (PFA)
- 2) Psychological Debriefing
- 3) Crisis Counseling

These psychosocial interventions are not considered formal treatment for psychiatric disorders, although they may sometimes be used in addition to treatment or before treatment can be initiated.

Psychological First Aid

Psychological First Aid (PFA) describes a set of practical early interventions and principles administered by clinicians or non-clinicians to reduce emotional distress and foster short and long term adaptive functioning. PFA is akin to physical first aid, with parallel goals — to stabilize psychological and behavioral functioning by meeting basic physical needs and then addressing psychological needs; reduce distress and dysfunction; facilitate return to adaptive functioning; and promote access to further care.

PFA is delivered to affected individuals by behavioral health professionals and other first responders. PFA has been broadly endorsed and promulgated by disaster mental health experts^{24,25,26,27} and numerous organizations, including the Substance Abuse and Mental Health Services Administration (SAMHSA), National Center for PTSD, National Child Traumatic Stress Network (NCTSN), American Psychological Association (APA), U.S. Centers for Disease Control and Prevention (CDC), and World Health Organization (WHO).

The PFA model is based on five empirically supported principles to guide post-disaster interventions: promoting a sense of safety; promoting calming; promoting a sense of self and community efficacy; promoting connectedness; and instilling hope.²⁸ PFA can be delivered in diverse settings including homes as well as shelters, medical triage areas, disaster assistance centers, family reception and assistance centers, workplaces, schools, and other community settings.

PFA includes eight core helping actions: contact and engagement, safety and comfort, stabilization, information gathering, practical assistance, connection with social supports, information on coping support, and linkage with collaborative services.

²⁴ Johns Hopkins Center for Public Health Preparedness. Psychological First Aid Competencies for Public Health Workers. Johns Hopkins University, Baltimore, MD. 2006. Available at <https://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-center-for-public-health-preparedness/training/PFA.html>.

²⁵ Forbes D, Lewis V, Varker T, et al. Psychological first aid following trauma: implementation and evaluation framework for high-risk organizations. *Psychiatry*. 2011;74(3):224-39.

²⁶ National Institute of Mental Health. Mental Health and Mass Violence: Evidence-based Early Psychological Intervention for Victims/Survivors of Mass Violence: A Workshop to Reach Consensus on Best Practices. NIH Publication No. 02-5138, Washington DC: US Government Printing Office. 2002.

²⁷ Inter-Agency Standing Committee (IASC). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. IASC. 2007. Available at https://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf.

²⁸ Hobfoll, S. E., Watson, P., Bell, C. C., Bryant, R. A., Brymer, M. J., Friedman, M. J., & Ursano, R. J. (2007). Five essential elements of immediate and mid-term mass trauma intervention: Empirical evidence. *Psychiatry*, 70, 283–315.

A number of PFA models are available and the county MH/BH department should use a PFA model that works best for their mission. Staff who may be deployed for DBH activities should be trained in the PFA model that is adopted. See Appendix E for examples of Population Support Tools, including various PFA models. Appendix D provides information and resources provided by national organizations

Psychological Debriefing

Psychological debriefing consists of one or more individual or group sessions provided hours or days after a traumatic event. The main elements are emotional ventilation, trauma processing, and psychoeducation. A review of 11 randomized controlled trials of single-session debriefing found the intervention to be ineffective for PTSD prevention or treatment.²⁹ Two longer-term follow-up studies documented significantly worse post-traumatic symptom outcomes in individuals who received debriefing, but only in those at most risk for PTSD. The National Institute for Clinical Excellence concluded that psychological debriefing should not be used to prevent or treat PTSD.³⁰ Critical Incident Stress Debriefing (CISD) and Critical Incident Stress Management (CISM) evolved from psychological debriefing.

Disasters may lead to different levels of trauma exposure and an additional concern pertaining to group debriefing is that persons with high levels of trauma exposure may further traumatize those who had lower levels of trauma exposure (emotional contagion effect). Many county MH/BH departments no longer use the CISD model for debriefing or have developed a modified approach that avoids the pitfall of re-traumatization that may occur when conducting debriefings with groups of people with differing levels of trauma exposure.

Crisis Counseling

Crisis counseling refers to brief mental health intervention delivered by trained, experienced DBH professionals and paraprofessionals in crisis disaster settings. This strengths-based approach reaches out to provide support to individuals in non-traditional community settings such as shelters, faith-based organizations, and homes. Crisis counseling takes different forms but shares many fundamental elements with PFA. It can be delivered to individuals or groups to help survivors understand their reactions, enhance coping, consider options, and connect with other services.

Although crisis counseling can be broadly helpful for post-disaster distress, it is not sufficient for the needs of some individuals who will require formal assessment and treatment for psychiatric illness. Such assessment requires clinical evaluation by licensed providers to direct individuals to services appropriately targeted to their needs.

²⁹ Rose S, Bisson J, Churchill R, Wessely S. Psychological debriefing for preventing post traumatic stress disorder (PTSD). *Cochrane Database Syst Rev.* 2002;(2):CD000560.

³⁰ <https://www.nice.org.uk/guidance/ng116/resources/posttraumatic-stress-disorder-pdf-66141601777861>

Enhanced crisis counseling programs have been developed to provide more intensive mental health services after severe disasters or for those most at risk and typically occur in office settings. *Skills for Psychological Recovery* (SPR)³¹ and *Skills for Life Adjustment and Resilience* (SOLAR; formerly *International Program for Promoting Adjustment and Resilience* [interPAR])³² are examples of interventions comprised of CBT elements that have been developed specifically for disaster counseling and are typically delivered by licensed behavioral health professionals in an office or telehealth setting following the disaster.

SPR was developed by the National Center for PTSD and the National Child Traumatic Stress Network and is consistent with empirically supported principles following disaster. It focuses on an evidence-based set of interventions that include a brief needs assessment, problem-solving, activities scheduling, helpful thinking, social support facilitation, and distress management. These interventions are provided over one to five sessions in a flexible manner tailored to need. SPR can be provided in a variety of community settings.

The goals of SPR are to:

- Protect the mental health of disaster survivors
- Enhance their own ability to address their needs and concerns
- Teach skills to promote the recovery of individuals and families
- Prevent maladaptive behaviors while identifying and supporting adaptive behaviors

Each county MH/BH department should determine which crisis counseling method works best for their circumstances, include the chosen method(s) in their disaster plan, and train staff in advance.

See Appendix F for more information on the Crisis Counseling Assistance and Training Program (CCP), a specialized program provided by FEMA and administered by SAMHSA that provides crisis counseling services and training.

Identifying Those at Greatest Risk

In the immediate aftermath of disaster, it is important to determine those who may need immediate or delayed care for behavioral health issues. The terms *triage*, *screening*, and *assessment* may be used in this context.

Triage: A triage system supports the sorting of patients according to established criteria. In mass casualty situations, triage is used to identify those most in need of medical care. Typical sorting categories include those needing *immediate lifesaving interventions (red)*; those who

³¹ Berkowitz, Steve, et al. Skills for psychological recovery: field operations guide. The National Center for PTSD and National Child Traumatic Stress Network (2010).

³² Forbes, D., O'Donnell, M., & Bryant, R. A. (2017). Psychosocial recovery following community disasters: An international collaboration. *Australian & New Zealand Journal of Psychiatry*, 51, 660-662.

need *significant intervention that can be delayed (yellow)*, and those needing *little or no treatment (green)*.

The State of Colorado Crisis Education and Response Network has adopted a 3-level triage system for DBH:³³

Red – Immediate, take to advanced care
<ul style="list-style-type: none">✓ Suicidal or homicidal ideation or action✓ Dangerous aggression✓ Conscious but non-responsive✓ Unable to care for self or children
Yellow – Delayed, needs intervention
<ul style="list-style-type: none">✓ Anxious behavior impacting those around them or impacting the response community✓ Difficulty understanding and following directions✓ Strong stress reaction interfering with functioning✓ Disruptive and aggressive behaviors✓ Difficulties caring for self or children
Green – Give coping information

Another potential application of triage focuses on determining who, among those who experience a disaster, are most likely to develop a clinical disorder such as PTSD, depression, or anxiety. Research indicates that individuals follow different trajectories after disaster exposure, with the majority following a “resilience pathway”, i.e., they may develop transitory distress that resolves over time without any mental health intervention. At the other end of the continuum, a smaller subset of those exposed to disaster may go on to develop a clinical disorder. If that subset can be accurately predicted, it may be possible to reduce the subsequent development of clinical disorders through early referral to evidence-based interventions (e.g., prolonged exposure CBT for adults or trauma-focused CBT for children). Shalev et al examined whether early therapeutic interventions can prevent the development of PTSD after acute trauma.³⁴ They found that 12 weeks of prolonged exposure or cognitive therapy begun within 1 month of a traumatic event reduced PTSD and PTSD symptoms at 5 months, but at 3 years there were no significant differences between groups for any outcome measure.

³³ Colorado Crisis Education and Response Network: A Disaster Behavioral Health Partnership, Protocols and Guidelines, Colorado Department of Human Services, Division of Behavioral Health and Cooperating and Assisting Partners, 2018.

³⁴ Shalev AY, Ankri Y, Gilad M, et al. Long-term outcome of early interventions to prevent posttraumatic stress disorder. *J Clin Psychiatry*. 2016;77(5):e580-7.

Screening: Screening is a “wide-net” process that seeks to identify those who may have specific behavioral health needs and benefit from more comprehensive assessment.³⁵ The National Child and Traumatic Stress Network (NCTSN) recommends that screening tools/instruments be reliable, valid, and have adequate sensitivity and specificity.

Brewin³⁶ noted population-based screening instruments should meet these criteria:

- Include items that successfully predict the criterion diagnosis;
- Short and easy-to-administer (e.g., self-report questionnaires); and
- Effective at ruling in respondents who are legitimate cases (high sensitivity) and ruling out those who are not (high specificity).³⁷

Assessment: A more comprehensive assessment conducted by a licensed behavioral health professional.

Community Services: A Phased Approach

This section provides information on a phased approach to providing DBH services. It is not meant to be prescriptive, recognizing that California communities and the county MH/BH departments that serve them will have varying needs, resources, and priorities.

Community-based intervention programs should target a range of potentially negative outcomes. Guidelines for psychosocial disaster response emphasize the need for multi-level support strategies that are in alignment with the needs of the affected population. These strategies include the provision of accurate information, practical help, low-intensity support such as Psychological First Aid (PFA), community-based interventions, and specialized behavioral health treatment for the minority of individuals who go on to develop more severe behavioral health issues. Community-based intervention programs should include strategies that provide support to disaster workers.

It’s important to consider that problems are likely to extend beyond the individual disaster survivor or disaster worker/first responder to those close to him or her. As community-based early intervention systems are developed, they should encompass family members to harness familial resources in the recovery of the traumatized individual and to prevent or reduce emotional and behavioral problems in affected spouses/partners, children, and other family members.

³⁵ https://www.nctsn.org/sites/default/files/resources/fact-sheet/screening_and_assessment_considerations_for_implementation.pdf

³⁶ Brewin CR. Systematic review of screening instruments for adults at risk of PTSD. *J Trauma Stress*. 2005;18(1):53-62.

³⁷ *Sensitivity* reflects the probability that someone with a clinical diagnosis (e.g., PTSD) will have a positive test result and *specificity* reflects the probability that someone who does not have the clinical diagnosis will have a negative test result.

There is widespread agreement about the importance of **communication** in strengthening community recovery and resilience. Providing community-wide information and coping advice, including information tailored to the needs of disaster workers, should be a routine part of any community's disaster response. Information should include useful, relevant advice provided by trusted sources – the challenge is to avoid creating unnecessary anxiety while presenting facts about risks and guidance about what these risks mean for day-to-day living.³⁸ The receipt of accurate information about the event, the nature of adaptive coping, and available support services can reduce uncertainty and calm survivors.³⁹ Examples of informational materials prepared by national organizations are provided in Appendix D.

Care must be taken in the design of survivor education information because it is possible that certain educational approaches (e.g., the presentation of “shopping lists” of psychological symptoms) may in fact worsen reactions by labeling common reactions negatively and encouraging selective attention to sensations and symptoms following trauma.⁴⁰

In addition to traditional communications channels, the heavy use of social media during and after disasters requires its effective incorporation into risk communication materials.

Consider the following 3-phase approach to providing DBH services:

Phase	Primary Goal	Timeline
Level 1	Provide Immediate Support	First hours and days
Level 2	Improve Coping and Strength-Based Skills	Days, Weeks, Months
Level 3	Continue to Provide Care to Those Affected	Long-Term

In this 3-level framework, Level 1 refers to the earliest stage of response following the disaster and includes providing information and support to the affected population. This level is consistent with Psychological First Aid (PFA).

In Level 2, those individuals who continue to experience mild to moderate distress, despite the provision of Level 1 support, may benefit from learning strength-based skills to improve coping and promote recovery, consistent with Skills for Psychological Recovery (SPR).

Those individuals who display persistent and/or moderate-to-severe distress may require more intensive mental health treatment (e.g., trauma-focused therapies or pharmacological interventions) provided by licensed behavioral health professionals. It is important to note that individuals presenting with extreme levels of distress or other features, e.g., suicidality,

³⁸ Rogers MB, Amlôt R, Rubin GJ, Wessely S, Krieger K. Mediating the social and psychological impacts of terrorist attacks: the role of risk perception and risk communication. *Int Rev Psychiatry*. 2007;19(3):279-88.

³⁹ Vaughan E, Tinker T. Effective health risk communication about pandemic influenza for vulnerable populations. *Am J Public Health*. 2009;99 Suppl 2:S324-32.

⁴⁰ Wessely S, Bryant RA, Greenberg N, Earnshaw M, Sharpley J, Hughes JH. Does psychoeducation help prevent post traumatic psychological distress? *Psychiatry*. 2008;71(4):287-302.

should be referred to professional behavioral health care immediately, regardless of time since trauma or disaster.

Level 1 (Immediate Support)

Level 1 represents the early response following a disaster. It includes meeting basic needs, providing immediate assistance to calm survivors and their families, and mobilizing social support and coping skills.

PFA is recommended for assisting people in the hours, days, and weeks following disaster.⁴¹ PFA is an initial disaster response intervention with the goal to promote safety, stabilize survivors, and connect individuals to help and resources. PFA is typically delivered to affected individuals by behavioral health professionals, first responders, and others trained in PFA. The purpose of PFA is to assess the immediate concerns and needs of an individual in the aftermath of a disaster. PFA is supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), National Center for PTSD, National Child Traumatic Stress Network (NCTSN), American Psychological Association (APA), U.S. Centers for Disease Control and Prevention (CDC), and World Health Organization (WHO).

Different versions of PFA are available that target different audiences. See Appendix E for a list of available PFA resources and trainings, along with other population support resources. Online PFA is available that can be accessed by entire communities. A PFA mobile phone app has been designed to assist providers in delivering PFA.

Level 2 (Improve Coping and Strengths-Based Skills)

The stress-related education, interpersonal support, and normalization of acute stress responses that take place under PFA are unlikely to address the full range of survivor needs, particularly if the disaster produced higher-intensity traumatic impacts.

A second level of post-disaster support involves crisis counseling services and early therapeutic interventions. Brief counseling services that focus on the psychological impact of the event and the reduction of continuing stress reactions can be helpful to the affected community in the following weeks and months.

Skills for Psychological Recovery (SPR), developed by the National Center for PTSD and the National Child Traumatic Stress Network (NCTSN), focuses on an evidence-based set of interventions that include a brief needs assessment, problem-solving, activities scheduling, helpful thinking, social support facilitation, and distress management. These interventions are provided over one to five sessions in a flexible manner tailored to need. SPR can be provided in a variety of community settings by health and community practitioners with varying levels of expertise.

⁴¹ <https://www.nctsn.org/resources/psychological-first-aid-pfa-field-operations-guide-2nd-edition>.

Level 3 (Referral and Treatment)

At any point in time, individuals who display persistent and moderate-to-severe stress may require more intensive care. Disasters may lead to anxiety, depression, post-traumatic stress disorder (PTSD), and substance use disorder (SUD).

Practice guidelines for the treatment of PTSD have been issued by the American Psychological Association (2017)⁴² and the U.S. Department of Veterans Affairs/Department of Defense (2017)⁴³, among other groups. In a review of relevant practice guidelines, Hamblen et al⁴⁴ concluded that *“All of the guidelines gave the highest overall recommendations to trauma-focused psychotherapies (usually including eye movement desensitization and reprocessing), and all agreed that selective serotonin reuptake inhibitors (either specific ones or the whole class) were the most effective medications. All of the clinical practice guidelines made strong recommendations for Prolonged Exposure therapy (PE), Cognitive Processing Therapy (CPT), and trauma-focused Cognitive Behavioral Therapy (CBT-T). The majority of clinical practice guidelines also gave Eye Movement Desensitization and Reprocessing (EMDR) a strong recommendation.”*

At present, a relatively small proportion of behavioral health professionals are trained in the trauma-focused practices recommended in current clinical practice guidelines.⁴⁵ Trauma-focused interventions require specialized training and point to the need for capacity-building among the clinical behavioral health workforce.

Engaging the Affected Population

Because disaster survivors and responders may not seek (or decline) professional help, it can be a major challenge to engage them in early post-trauma interventions.⁴⁶ Individuals may be reluctant to engage in traditional mental health support due to logistical barriers, perceptions of social stigma, and/or a desire to self-manage their responses.

The challenge is to create intervention strategies that maximize reach and impact while remaining cost-effective and feasible for system-wide delivery. One way to accomplish this is to implement low intensity treatments that include relatively simple and brief interventions that can be readily delivered to large populations of disaster survivors (as part of disaster

⁴² <https://www.apa.org/ptsd-guideline/ptsd.pdf>

⁴³ <https://www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGFinal.pdf>

⁴⁴ Hamblen JL, Norman SB, Sonis JH, et al. A guide to guidelines for the treatment of posttraumatic stress disorder in adults: An update. *Psychotherapy (Chic)*. 2019;56(3):359-373. See <https://www.ptsd.va.gov/professional/articles/article-pdf/id52066.pdf>

⁴⁵ Mchugh RK, Barlow DH. The dissemination and implementation of evidence-based psychological treatments. A review of current efforts. *Am Psychol*. 2010;65(2):73-84.

⁴⁶ Kantor V, Knefel M, Lueger-Schuster B. Perceived barriers and facilitators of mental health service utilization in adult trauma survivors: A systematic review. *Clin Psychol Rev*. 2017;52:52-68.

response or in hospital centers). In this model, more intensive interventions would be reserved for subpopulations with greater needs or who do not benefit from brief intervention.

Ruggiero et al⁴⁷ used a randomized controlled trial design to test the efficacy of a modular, web-based intervention for disaster-affected adolescents and their parents. Nearly half of the 2,000 disaster-affected families accessed the intervention, suggesting that a web-based approach has potential for meaningful penetration after disasters. The adolescents that received the web-based intervention showed greater benefit relative to PTSD and depressive symptoms.

Internet and mobile technologies could greatly increase deployment of low-intensity interventions that can be accessed by large numbers of trauma-affected individuals. They could also enable cost-effective online screening of large numbers of individuals across geographic areas. In principle, a population-based approach could enable a simultaneous focus on effectiveness, engagement, and reach. During the 2020 COVID response, examples of strategies that extended outreach include the expansion of telehealth, 24/7 Access Center Hotline, and secure chat solutions.

Community Activities

There is growing evidence that participation in community activities intended to support those affected by a particular trauma may be helpful. Such activities, often initiated by community agencies and self-help organizations for survivors and their families, include ceremonies (e.g., memorial events, parades), fund-raising projects, and establishing legal and financial support services. Participation in services and activities that help address social disruption (e.g., family tracing and reunification services, re-initiation of schooling, establishment of safe play spaces) may be especially important in the context of extreme stressors. County MH/BH departments should consider the inclusion of appropriate community engagement strategies as part of their disaster planning efforts.

Involvement in mutual support and social activities may help reduce the negative psychological impact of traumas via several possible mechanisms. First, they may conserve or increase resources available to survivors. The *Conservation of Resources* theory of stress holds that stress occurs when resources — important possessions, conditions of living, personal characteristics, and tools to acquire other resources — are threatened, and research has indicated that resource loss is correlated with symptom severity in disaster survivors. Activities that reduce resource loss or bring significant new resources to survivors may reduce perceived stress and accompanying psychological symptoms.⁴⁸

⁴⁷ Ruggiero KJ, Price M, Adams Z, et al. Web Intervention for Adolescents Affected by Disaster: Population-Based Randomized Controlled Trial. *J Am Acad Child Adolesc Psychiatry*. 2015;54(9):709-17.

⁴⁸ Freedy, J. R., Shaw, D., Jarrell, M., & Masters, C. (1992). Towards an understanding of the psychological impact of natural disasters: An application of the conservation resources stress model. *Journal of Traumatic Stress*, 5, 441–454.

Following disasters, individuals often experience deterioration in social support due to disruptions of support availability.⁴⁹ Support may be disrupted by the death of loved ones, displacement of communities, or loss of access to routine daily activities. Lower perceived social support is associated with PTSD symptoms in trauma survivors.⁵⁰ Community activities can provide opportunities for the exchange of social support and may increase perceptions that support is available.

Another way in which participation in community activities may reduce problems is by influencing trauma-related appraisals. For example, traumatic stressors are by definition associated with perceptions of helplessness; joining a self-help group, participating in legal proceedings, or working toward legislative reform may sometimes increase perceptions of control among individuals and groups.

The development and evaluation of larger community-focused interventions that can be feasibly and reliably delivered in affected communities represents a priority for innovation and research in an era in which climate change is expected to increase exposure to disasters and other forms of social stress.

Resilience

There has been an increasing emphasis on **resilience** as an important DBH concept for both individuals and communities. The American Psychological Association defines resilience as the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress.⁵¹ Increasingly, DBH researchers and professionals are considering the opportunities for post-traumatic growth following disasters.

Strengthening *community resilience* represents an important aspect of a comprehensive approach. Community resilience is the sustained ability of a community to withstand and recover from adversity and is grounded in strong behavioral health foundations such as coping skills and social support.⁵² Community resilience is influenced by the community's pre-event vulnerability to disaster and its adaptive capacity to recover – which includes factors such as the physical and psychological health of the population; social and economic well-being; individual, family, and community knowledge and attitudes about self-reliance and self-help; effective risk communication; level of social integration of government and non-governmental organizations in planning, response, and recovery; and the social connectedness of community members.

⁴⁹ Kaniasty, K., & Norris, F. (1993). A test of the social support deterioration model in the context of natural disaster. *Journal of Personality and Social Psychology*, 64, 395–408.

⁵⁰ Brewin, C. R., Andrews, B., & Valentine, J. D. (2000). Meta-analysis of risk factors for post-traumatic stress disorder in trauma-exposed adults. *Journal of Consulting and Clinical Psychology*, 68, 748-766.

⁵¹ <https://www.apa.org/topics/resilience>

⁵² Chandra A, Acosta J, Howard S, et al. Building Community Resilience to Disasters: A Way Forward to Enhance National Health Security. *Rand Health Q.* 2011;1(1):6.

Such resilience goes beyond individual preparedness to establish a supportive community-wide social context and collective self-efficacy that may limit the adverse health impact of disasters.⁵³ Some research suggests that that social support and perceptions of collective efficacy might help buffer psychological distress under conditions of high resource loss following a disaster.

Tools have been developed to help communities with enhancing aspects of resilience, including the Communities Advancing Resilience Toolkit^{54,55} and work by the Community and Regional Resilience Institute.⁵⁶ An example of how communities can use a participatory public health approach to build community resilience is provided by the Los Angeles County Community Disaster Resilience Project.⁵⁷

Community activities that promote resilience directly benefit disaster response and also help to manage other kinds of threats, such as severe weather or hazardous exposures, in part by considering how impacts may be exacerbated by community vulnerabilities, such as the number of at-risk individuals or low social connectedness.

Each county MH/BH department should determine which resiliency-promoting strategies work best for their circumstances and mission (including resiliency-promoting strategies for disaster workers) and incorporate these approaches into their disaster planning.

Identifying DBH Resources

The best time to identify DBH resources is before disaster strikes. County MH/BH departments and their community disaster response partners should identify sources of DBH staff as an important component of their preparedness efforts and written disaster plans.

Psychologists, social workers, and others who have been trained to treat clinical conditions such as PTSD, depression, and anxiety generally do so through the administration of a series of therapeutic sessions. In contrast, DBH response involves a strengths-based model which encourages the survivor or responder to access their support system and their pre-existing coping skills. Trained DBH professionals may come from county MH/BH departments and their

⁵³ Ursano, R. J., McKibben, J. B. A., Reissman, D. B., Liu, X., Wang, L., et al. (2014). Post-traumatic stress disorder and community collective efficacy following the 2004 Florida hurricanes. *PLoS ONE*, 9, e88467.

⁵⁴ Chandra A, Acosta J, Stern S, Uscher-Pines L, Williams MV, Yeung D, Garnett J, Meredith LS. Building community resilience to disasters. A way forward to enhance national health security. Santa Monica (CA): RAND Corporation 2011. Available from: https://www.rand.org/pubs/technical_reports/TR915.html

⁵⁵ Pfefferbaum RL, Pfefferbaum B, Zhao YD, Van Horn RL, McCarter GSM, Leonard MB. Assessing community resilience: A CART survey application in an impoverished urban community. *Disaster Health*. 2016;3(2):45-56.

⁵⁶ <https://merid.org/case-study/community-and-regional-resilience-institute/>

⁵⁷ Bromley E, Eisenman DP, Magana A, et al. How Do Communities Use a Participatory Public Health Approach to Build Resilience? The Los Angeles County Community Disaster Resilience Project. *Int J Environ Res Public Health*. 2017;14(10)

contracted providers, American Red Cross, Medical Reserve Corps, retired professionals, and other sources. Paraprofessionals, spiritual care providers, and lay persons may also be trained and experienced in DBH response.

In California, Disaster Healthcare Volunteers (DHV) is an online registration system for medical and healthcare volunteers, including healthcare providers with an active license, public health professionals, and members of a medical disaster response team.⁵⁸ The DHV system validates the credentials of volunteers, enabling them to be deployed during an emergency. At this time, a relatively small number of behavioral health providers are registered in the DHV system. Encouraging DBH professionals to enroll in DHV increases the opportunity to utilize these skilled resources when needed.

Provider Training

An urgent need exists to expand the workforce of professionals and paraprofessionals skilled in providing DBH services. Provider training is a frequently overlooked element of community response to a disaster.⁵⁹ After a county MH/BH department identifies the models and intervention strategies they wish to employ, response staff should receive training in these approaches.

In 2020, the *Center for the Study of Traumatic Stress* and the *National Center for Disaster Medicine and Public Health*⁶⁰ expanded and updated the curriculum guidance for DBH initially released in 2014. The updated curriculum guidance can be found at:

https://www.cstsonline.org/assets/media/documents/CSTS_Curriculum_Recommendations_2nd_ed.pdf

Ideally, provider training should include formal instruction in the intervention via interactive “hands-on” workshops in which all participants practice key elements of the intervention, including demonstration of skills, behavior rehearsal, active participation, performance feedback, and group planning, followed by regular supervision from instructors as they deliver the interventions in real-world settings.

One strategy to consider is the training of community workers to fulfill a paraprofessional role with the satisfaction of agreed-upon core competencies. Such training could be provided by groups such as the American Red Cross, Medical Reserve Corps (MRC), or Community Emergency Response Teams (CERT).

⁵⁸ The Disaster Healthcare Volunteer (DHV) system is administered by the Emergency Medical Services Authority. See <https://healthcarevolunteers.ca.gov/>.

⁵⁹ Young, B. H., & Ruzek, J. I. (2012). Disaster mental health services: Implementation, training, and sustainability. In J. L. Framingham & M. L. Teasley (Eds.), *Behavioral health response to disasters* (pp. 351-369). Boca Raton, FL: CRC Press, Taylor & Francis Group.

⁶⁰ The *Center for the Study of Traumatic Stress* and the *National Center for Disaster Medicine and Public Health* are located within the *Uniformed Services University of the Health Sciences*.

APPENDIX C: MENTAL/BEHAVIORAL HEALTH AND SPIRITUAL CARE RESOURCES (BY TYPE AND MISSION)⁶¹

The two tables that follow support the ability of an impacted jurisdiction to assess its needs relative to disaster behavioral health, identify resource shortfalls, and request the appropriate types and numbers of assisting personnel. These tables include both Behavioral Health and Disaster Spiritual Care professionals.

The first table identifies specific **Resource Types**, including identification of the appropriate California Licensing Board or Association for each type.

The second table provides approximate staffing recommendations according to **Disaster Mission**, e.g., supporting a Family Assistance Center. This information is meant to be tailored to the needs of the local jurisdiction based on local circumstances.

Note that deployed MH/BH or DSC staff are expected to meet the vetting and training requirements of the *sending* organization (vs. the *requesting* organization).

We recommend the following for all disaster missions:

- The *requesting* jurisdiction should specify the qualifications (e.g., licensing/certification, training, experience, deployment duration) of needed behavioral health and DSC staff.
- The *sending* jurisdiction should match the request to the qualifications of staff offered for deployment.
- Consider a minimum 7-day disaster assignment (5 days working + 2 days travel).
- Statewide training/credentialing standards for disaster behavioral health and DSC staff have not been established. Therefore, staff offered for disaster deployment should be vetted and trained in behavioral health or DSC response per the requirements of the *sending* organization. Prior to actual disaster deployment, the *requesting* jurisdiction and *sending* jurisdiction should confirm that available staff are acceptable to the *requesting* jurisdiction.

⁶¹ These tables were developed by Sandra Shields LMFT, LPCC, ATR-BC, Los Angeles County Department of Mental Health, Disaster Services Unit, in her role as a member of the California Public Health and Medical Emergency Operations Manual (EOM) Workgroup.

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Resource Typing for Mental/Behavioral Health and Spiritual Care

By Resource Type

Behavioral Health = BH

Mental Health = MH

Disaster Spiritual Care = DSC

Behavioral Health (BH) Mission Support Team			
Eligibility Category	CA Licensing Board or Association	Source	Mission or Task
<ul style="list-style-type: none"> BH Unit Leader or Employee Health and Well Being Unit Leader – partnered with an Emergency Manager This team could also include a third member – a Disaster Spiritual Care (DSC) Unit Leader to assist with DSC operations 	<ul style="list-style-type: none"> Licensing for eligible team members is included under single resource descriptions below. 	<ul style="list-style-type: none"> County MH/BH Department staff and contract providers County Department of Health including Emergency Medical Services and Public Health Disaster Healthcare Volunteers (DHV) including Medical Reserve Corps (MRC) US Public Health Service (USPHS) 	<ul style="list-style-type: none"> BH Mission Support This is a leadership-level team that can be ordered to partner with a local jurisdiction to support a major BH response. The team would not “manage” the disaster response for the jurisdiction but would act as a support – particularly to help with needs assessments, mission tasking, and resource requests This team can also assist with Employee Health and Well Being operations

Behavioral Health (BH) Crisis Response Team			
Eligibility Category	CA Licensing Board or Association	Source	Mission or Task
<ul style="list-style-type: none"> • BH Specialist - Supervisor • BH Specialists – Licensed • This team could also include a DSC Specialist - Professional Chaplain as one of the four members and/or a trained “Peer Support” member (usually a Fire or Police First Responder from the sending organization or provided by the local receiving jurisdiction.) 	<ul style="list-style-type: none"> • BH Specialist - Supervisor • Licensing for eligible team members is included under single resource descriptions below. 	<ul style="list-style-type: none"> • County MH/BH Department staff and contract providers • County Department of Health including Emergency Medical Services and Public Health • Disaster Healthcare Volunteers (DHV) including Medical Reserve Corps (MRC) • US Public Health Service (USPHS) • See Source for DSC Specialist - Professional Chaplain under “Specific Resource Types”. 	<ul style="list-style-type: none"> • BH Crisis Response • This is an expert-level team with extensive training and experience in providing crisis disaster MH/BH support to impacted disaster responders. • This team may be referred to as the “Debriefing” or “CISM” team, however each team can use whatever staff crisis intervention model that is standard practice in their own (sending) organization. • This team can provide education, group crisis meetings, staff support, or set up staff “drop in” centers. • This team could partner with the Employee Assistance Program (EAP) in the local jurisdiction to facilitate referrals for staff needing additional support. • For disasters where there are multiple impacted organizations requesting crisis assistance for their staff, large geographic areas, etc. - consider ordering more than one team.

BH Specialist - Licensed			
Eligibility Category	CA Licensing Board or Association	Source	Mission or Task
Psychiatrist (MD)	Medical Board of CA https://search.dca.ca.gov/	<ul style="list-style-type: none"> • County MH/BH Department staff and contract providers • County Departments of Health and Public Health • California Disaster Healthcare Volunteers (DHV) including Medical Reserve Corps (MRC) • American Red Cross Disaster Mental Health and other VOADs with qualified BH/MH staff resources • US Public Health Service (USPHS) • Professional Organizations for each license type 	<ul style="list-style-type: none"> • Backfill for county or state BH staff • Community education – outreach • Crisis teams • Employee/staff mental health • Disaster Shelters and Disaster Medical Shelters • Local Assistance Center (LAC) • Disaster Recovery Center (DRC) • Family Assistance Center (FAC) • Points of Distribution / Dispensing • Hospital surge • Recovery – BH/MH follow-up evaluation and trauma focused treatment
Psychologist (PhD, PsyD)	Dept of Consumer Affairs, Board of Psychology https://search.dca.ca.gov/		
Licensed Clinical Social Worker (LCSW)	Dept of Consumer Affairs, Board of Behavioral Sciences https://search.dca.ca.gov/		
Licensed Marriage and Family Therapist (LMFT)	Dept of Consumer Affairs, Board of Behavioral Sciences https://search.dca.ca.gov/		
Licensed Professional Counselor (LPCC)	Dept of Consumer Affairs, Board of Behavioral Sciences https://search.dca.ca.gov/		
Licensed Educational Psychologist (LEP)	Dept of Consumer Affairs, Board of Behavioral Sciences https://search.dca.ca.gov/		

BH Specialist – Registered Associate (Intern)			
Eligibility Category	CA Licensing Board or Association	Source	Mission or Task
<ul style="list-style-type: none"> • Psychological Assistant (PSB) • Associate Clinical Social Worker (ACSW) • Associate Marriage and Family Therapist (AMFT) • Associate Professional Clinical Counselor (APCC) 	<ul style="list-style-type: none"> • For all: https://search.dca.ca.gov/ 	<ul style="list-style-type: none"> • Same as specified for “BH Specialist – Licensed” 	<ul style="list-style-type: none"> • Same as specified for “BH Specialist – Licensed”
BH Specialist – School Psychologist and School Counselor			
Eligibility Category	CA Licensing Board or Association	Source	Mission or Task
<ul style="list-style-type: none"> • School Counselor with a Pupil Personnel Services (PPS) Credential and a specialization in School Counseling • School Psychologist with a Pupil Personnel Services (PPS) Credential with a specialization in School Psychology 	<ul style="list-style-type: none"> • California Commission on Teacher Credentialing: https://www.ctc.ca.gov/commission/lookup 	<ul style="list-style-type: none"> • Schools/school-based crisis response teams • County MH/BH department staff and contract providers 	<ul style="list-style-type: none"> • School-based crisis response • Community outreach • Teacher and school staff mental health support • Disaster Shelters and Family Assistance Centers with a high population of school-aged children

BH Specialist – Psychiatric Nurse and Nurse Practitioner			
Eligibility Category	CA Licensing Board or Association	Source	Mission or Task
<ul style="list-style-type: none"> Registered Nurse (RN with psych experience or specialty) <p><u>Note:</u> For a school-based disaster response, consider BH Specialist – Psychiatric Nurse and Nurse Practitioner with school nursing specialty/ experience or current RN - School Nurses.</p>	<ul style="list-style-type: none"> Department of Consumer Affairs Board of Registered Nursing https://search.dca.ca.gov/ 	<ul style="list-style-type: none"> County MH/BH Department staff and contract providers County Departments of Health and Public Health California Disaster Healthcare Volunteers (DHV) including Medical Reserve Corps (MRC) American Red Cross Disaster Mental Health and other VOADs with qualified BH/MH staff resources Professional Organizations for each license type US Public Health Services (USPHS) 	<ul style="list-style-type: none"> Back fill staff in psychiatric care facilities or disaster field psychiatric hospital Community Education – Outreach Crisis Teams Employee/Staff Mental Health Disaster Shelters and Disaster Medical Shelters Local Assistance Centers Family Assistance Centers (FAC) Hospital Surge Points of Distribution / Dispensing

BH Specialist – Other			
Eligibility Category	CA Licensing Board or Association	Source	Mission or Task
<ul style="list-style-type: none"> Depends on the BH-related profession requested. 	<ul style="list-style-type: none"> Staff in this category may/may not have a state license or licensing board but may be qualified through their job title and duties in a County MH/BH Department. Licensing Boards that may qualify under this category include: <ul style="list-style-type: none"> Vocational Nurses and Psychiatric Technicians: https://www.bvnpt.ca.gov/consumers/license_verification.shtml Occupational Therapists: https://www.bot.ca.gov/licenses/index.shtml 	<ul style="list-style-type: none"> County MH/BH Department staff and contract providers County Departments of Health and Public Health California Disaster Healthcare Volunteers (DHV) including Medical Reserve Corps (MRC) 	<ul style="list-style-type: none"> This is a general category that counties may use to specify other BH Specialists that they may wish to “Resource Type” to deploy within their Operational Area. Typically, the BH Specialist - Other would <i>not</i> be included in a Mutual Assistance/Mutual Aid Request. Examples of BH Specialist - Other might be a Psychiatric Technician, Occupational Therapist, Community Worker, Caseworker/Navigator, etc.

Certified Drug and Alcohol Counselor			
Eligibility Category	CA Licensing Board or Association	Source	Mission or Task
<ul style="list-style-type: none"> • Certification from a National Commission for Certifying Agencies (NCCA) organization 	<ul style="list-style-type: none"> • Addiction Counselor Certification Board of California: https://www.accbc.org/certification-board/ • California Association of DUI Treatment Programs (CADTP): https://www.cadtp.org/ • California Consortium of Addiction Programs and Professionals (CCAPP): https://www.ccapp.us/ 	<ul style="list-style-type: none"> • County MH/BH Department staff and contract providers 	<ul style="list-style-type: none"> • Education on addictions • Employee/staff mental health (addictions only) • Disaster Shelters (addiction counseling only)
BH Specialist – Supervisor			
Eligibility Category	CA Licensing Board or Association	Source	Mission or Task
<ul style="list-style-type: none"> • BH Specialist – Licensed • BH Specialist – School Psychologist and School Counselor • BH Specialist – Psychiatric Nurse and Nurse Practitioner MH 	<ul style="list-style-type: none"> • Same as specified for “BH Specialist - Licensed” • Previous disaster deployment. • FEMA IS 100 and 700 (minimum) • Endorsed by sending organization as a supervisor capable of supervising the BH response in the field. 	<ul style="list-style-type: none"> • Same as specified for “BH Specialist - Licensed” 	<ul style="list-style-type: none"> • Same as specified for “BH Specialist – Licensed”, but at the Supervisory level. • Recommended ratio of BH Specialist - Supervisor to BH staff is 1:7

BH Unit Leader			
Eligibility Category	CA Licensing Board or Association	Source	Mission or Task
<ul style="list-style-type: none"> • BH Specialist – Licensed • BH Specialist – School Psychologist and School Counselor • BH Specialist – Psychiatric Nurse and Nurse Practitioner MH 	<ul style="list-style-type: none"> • Licensed as specified under “BH Specialist-Licensed” above. • Disaster Mental Health Subject Matter Expert (SME) • Previous disaster deployment as a BH Specialist - Supervisor • MH/BH Tactics and Incident Action Planning expertise • FEMA IS 100 and 700 (minimum) • Endorsed by sending organization as a BH Unit Leader capable of managing the BH Unit at the EOC/DOC level and/or capable of functioning as part of “BH Mission Support Team” 	<ul style="list-style-type: none"> • Same as specified for “BH Specialist - Licensed” 	<ul style="list-style-type: none"> • This is an EOC/DOC Unit Leader assigned under Operations with the mission to oversee the BH response for people in the impacted community • A BH Unit leader can also be deployed with an Emergency Management partner as a part of a “BH Mission Support Team”

Employee Health and Well Being Unit Leader			
Eligibility Category	CA Licensing Board or Association	Source	Mission or Task
<ul style="list-style-type: none"> • BH Specialist – Licensed • BH Specialist – School Psychologist and School Counselor • BH Specialist – Psychiatric Nurse and Nurse Practitioner MH 	<ul style="list-style-type: none"> • Licensed as specified under “BH Specialist-Licensed” • Previous disaster deployment as a BH Specialist - Supervisor • FEMA IS 100 and 700 (minimum) • Disaster Mental Health subject matter expert (SME); background/experience in Employee Assistance Programs (EAP) and/or Victim’s Witness programs is helpful for this position. • MH/BH tactics and Incident Action Planning expertise • Endorsed by sending organization as a BH Unit Leader capable of managing the Employee Health and Well Being Unit at the EOC level 	<ul style="list-style-type: none"> • Same as specified for “BH Specialist - Licensed” 	<ul style="list-style-type: none"> • This is an EOC/DOC Unit Leader assigned under Operations or Logistics with the mission to oversee the BH response of employees (staff) impacted by the disaster as well as staff assigned to the disaster response operation.

DSC Specialist – Professional Chaplain			
Eligibility Category	CA Licensing Board or Association	Source	Mission or Task
<ul style="list-style-type: none"> Professional Board Certified Chaplain – (Police, Fire, Law, Military, Hospitals, Mental Health, etc.) 	<ul style="list-style-type: none"> Association of Professional Chaplains: http://www.professionalchaplains.org/ National Association of Catholic Chaplains: https://www.nacc.org/ Neshama, Association of Jewish Chaplains: http://jewishchaplain.net/ College of Pastoral Supervision and Psychotherapy: https://cpsp.org/ Also see Chaplaincy organizations for specific faith traditions Vetted and trained for DSC response by the sending organization. 	<ul style="list-style-type: none"> County MH/BH Department staff and contract providers Police, Fire, Law, Hospital, Military Chaplains and vetted Chaplain teams California Disaster Healthcare Volunteers (DHV) - including MRCs American Red Cross DSC Team and other VOADs with qualified DSC staff resources 	<ul style="list-style-type: none"> Memorial Services Condolence Teams Crisis teams Community Education – Outreach Employee/Staff MH Disaster Shelters and Disaster Medical Shelters Family Assistance Center (FAC) Hospital Surge Points of Distribution / Dispensing

DSC Specialist – Endorsed DSC Provider			
Eligibility Category	CA Licensing Board or Association	Source	Mission or Task
<ul style="list-style-type: none"> Community faith leader previously vetted, trained, affiliated, and endorsed by the sending organization. Note: Spontaneous Unaffiliated Volunteer (SUV) DSC providers cannot be deployed through the mutual aid system. 	<ul style="list-style-type: none"> Affiliated with a government-based DSC team (such as a community-based chaplain’s team) or organization affiliated with a recognized non-government disaster response organization such as National Voluntary Organizations Active in Disaster (NVOAD) or Community-based VOAD (COAD) DSC Provider is previously vetted and trained in DSC, has met the basic requirements of their faith group and standard of excellence of the deploying agency 	<ul style="list-style-type: none"> Vetted volunteer or paid staff DSC team members associated with a government-based agency or non-government disaster response organization (NVOAD), or Community-based VOAD group (COAD) American Red Cross DSC Team and other VOADs with DSC resources 	<ul style="list-style-type: none"> Same as above.
DSC Specialist – Supervisor			
Eligibility Category	CA Licensing Board or Association	Source	Mission or Task
<ul style="list-style-type: none"> DSC Specialist – Professional Chaplain DSC Specialist – Endorsed DSC Provider 	<ul style="list-style-type: none"> Professional Chaplain or Endorsed DSC Provider as specified above Previous disaster deployment(s) FEMA IS 100 and 700 (minimum) Endorsed by sending organization as a supervisor capable of overseeing the DSC response in the field 	<ul style="list-style-type: none"> Same as above 	<ul style="list-style-type: none"> Same as above but at the Supervisory level Recommended ratio for DSC Supervisors to DSC staff is 1:7

DSC Specialist – Unit Leader			
Eligibility Category	CA Licensing Board or Association	Source	Mission or Task
<ul style="list-style-type: none"> • DSC Specialist – Professional Chaplain • DSC Specialist – Endorsed DSC Provider 	<ul style="list-style-type: none"> • Certified Chaplain or Community Faith Leader as specified above. • Previous disaster deployment as a DSC Supervisor • FEMA IS 100 and 700 (minimum) • DSC Subject Matter Expert (SME) • DSC Tactics and Incident Action Planning expertise • Endorsed by sending organization as a supervisor capable of managing the DSC Unit at the EOC/DOC level 	<ul style="list-style-type: none"> • Same as above. 	<ul style="list-style-type: none"> • This is an EOC/DOC-level Unit Leader assigned under Operations with the mission to oversee the DSC Health response for people in the impacted community.

Resource Typing for Mental/Behavioral Health and Spiritual Care

By Disaster Mission

Behavioral Health = BH

Mental Health = MH

Disaster Spiritual Care = DSC

Backfill MH/BH Department Staff			
Resource Type	Suggested Staffing Ratio	Source	Notes
<ul style="list-style-type: none"> BH Specialist – Licensed BH Specialist – Psychiatric Nurse and Nurse Practitioner Mental Health Other Resource types as requested. 	<ul style="list-style-type: none"> 1 staff per position needed to backfill County MH/BH Department staff for a multi-day disaster assignment. 	<ul style="list-style-type: none"> County MH/BH Department staff and contract providers County Department of Health including Emergency Medical Services and Public Health California Disaster Healthcare Volunteers (DHV) including Medical Reserve Corps (MRC) US Public Health Service (USPHS) 	<ul style="list-style-type: none"> Specify licensed “eligibility category” needed to backfill staff on the resource request. (See California Resource Typing for Mental/Behavioral Health and Spiritual Care – Specific Resource Types) Specify Resource Types for MH/BH and DSC Also specify the BH specialty needed (children (pre-K; K-6, teens), adults, older adults, etc.) in the resource request. See 4 requirements for all disaster missions for BH or DSC staff (listed at beginning of table)

Community Outreach and Community Meetings			
Resource Type	Suggested Staffing Ratio	Source	Notes
<ul style="list-style-type: none"> • BH Specialist – Licensed • BH Specialist – Registered Associate (Intern) • BH Specialist – Psychiatric Nurse and Nurse Practitioner • Also consider: DSC Endorsed Spiritual Provider and Certified Drug and Alcohol Counselor 	<ul style="list-style-type: none"> • 1 “mutual aid” staff paired with 1 or 2 local BH staff to provide support to community disaster recovery meetings and mobile outreach teams • For a large Community Outreach mission, consider ordering 1 BH – Supervisor per each outreach region/community or 1 BH-Supervisor per 7 team members. 	<ul style="list-style-type: none"> • County MH/BH Department staff and contract providers • County Departments of Health including Emergency Medical Services and Public Health • American Red Cross Disaster Mental Health and other VOADs with qualified BH/MH and DSC staff. • California Disaster Healthcare Volunteers (DHV) including Medical Reserve Corps (MRC) 	<ul style="list-style-type: none"> • See 4 requirements for all disaster missions for BH or DSC staff (listed at beginning of table)

Family Assistance Center (FAC)			
Resource Type	Suggested Staffing Ratio	Source	Notes
<ul style="list-style-type: none"> BH Specialist – Licensed BH Specialist – Psychiatric Nurse and Nurse Practitioner BH Specialist - Supervisor DSC Specialist – Professional Chaplain DSC Supervisor 	<ul style="list-style-type: none"> Behavioral Health: <ul style="list-style-type: none"> <50 Victims and 400 family and friends = 1 BH Specialist - Supervisor and 5 BH Specialists and 1 BH Specialist – Psychiatric Nurse and Nurse Practitioner 51-300 Victims and 401-2400 family and friends = 3 BH Specialist - Supervisors and 20 BH Specialists and 2 BH Specialist – Psychiatric Nurse and NP per day total. Disaster Spiritual Care: <ul style="list-style-type: none"> 301-1000 Victims and 2401-8000 family and friends = 10 DSC Supervisors and 65 DSC Specialist – Professional Chaplains per day total. The staffing ratio varies based on the needs of people utilizing the FAC. <u>Note:</u> Suggested staffing ratios borrowed from LA County Op Area Family Assistance Center Plan, page 25, table 4 and page 80 on Staffing Guidelines, (January 31, 2014, v2) 	<ul style="list-style-type: none"> Behavioral Health: <ul style="list-style-type: none"> County MH/BH Department staff and contract providers County Department of Health including Emergency Medical Services and Public Health American Red Cross Disaster Mental Health and other VOADs with qualified BH/MH and DSC staff. California Disaster Healthcare Volunteers (DHV) including Medical Reserve Corps (MRC) US Public Health Service (USPHS) Disaster Spiritual Care: <ul style="list-style-type: none"> County MH/BH Department staff and contract providers Police, Fire, Law, Hospital, Military Chaplains and vetted Chaplain teams American Red Cross Disaster Mental Health and other VOADs with qualified DSC staff resources California Disaster Healthcare Volunteers (DHV) - including Medical Reserve Corps (MRC) 	<ul style="list-style-type: none"> Due to the level of trauma expertise needed for a FAC, BH Specialists – Registered Interns and untrained BH or DSC staff should <u>NOT</u> be included in the resource requests for FAC/FFRC operations Pair local BH and DSC staff with requested “mutual aid” staff It is advisable to specify “previous disaster experience” or FAC/FFRC training preferred” on the resource request Consider language and cultural competencies needed for the FAC/FFRC; specify language(s) needed in the resource request If the population in the FAC is from a specific population such as LGBTQ-2S, specify cultural competency requirements needed in the resource request For American Red Cross FAC/FFRC ops, resource request for BH or DSC resources should be coordinated with Red Cross Disaster Mental Health leadership Plan to staff BH and DSC at a reduced level at night for FACs located in hotels where family are staying to assist with crisis BH needs See 4 requirements for all disaster missions for BH or DSC staff (listed at beginning of table)

Employee / Disaster Responder MH Support			
Resource Type	Suggested Staffing Ratio	Source	Notes
<ul style="list-style-type: none"> Employee Health and Well Being Unit Leader BH Specialist - Supervisor BH Specialist – Licensed (Also consider DSC Specialist - Professional Chaplains or Endorsed Spiritual Providers and Certified Drug and Alcohol Counselors) 	<ul style="list-style-type: none"> 1 Employee Health and Well Being Unit Leader to oversee Employee Disaster BH support. For large operations, the Employee Health and Well Being Unit Leader function can be broken up into a Family Support Branch and Employee Support Branch. Staffing ratio depends on the strategy used: <u>Staff Helpline:</u> 1 BH Specialist - Supervisor and 2–7 BH Specialists per shift depending on call volume. <u>Staff Stress Education and Drop-In Centers:</u> minimum 1 BH Specialist-Licensed and 1 DSC Chaplain or Endorsed Spiritual Provider <u>Family Support/Condolence Teams:</u> minimum 1 BH Specialist - Supervisor condolence operations, 1 BH Specialist-Licensed, 1 DSC Chaplain or Endorsed Provider per outreach team. <u>Employee Funerals:</u> minimum 2 BH Specialists – Licensed and 2 DSC Professional Chaplains or Endorsed DSC Providers 	<ul style="list-style-type: none"> Employee Assistance Program (EAP) County MH/BH Department staff and contract providers Police, Fire, Law, Hospital, Military Chaplains and vetted Chaplain teams 	<ul style="list-style-type: none"> This mission is likely to be handled locally, however, in a large-scale disaster, particularly with large numbers of employee injuries and deaths, local BH Departments may not have the resources to provide disaster MH support to staff and family members. Counties typically contact Employee Assistance Program (EAP) services. However, the EAP provider may not have any “surge capacity” or disaster MH/BH expertise to accommodate employee disaster BH response services following a disaster. See 4 requirements for all disaster missions for BH or DSC staff (listed at beginning of table)

Hospital Surge			
Resource Type	Suggested Staffing Ratio	Source	Notes
<ul style="list-style-type: none"> • BH Specialist – Licensed Clinical Social Worker • BH Specialist – Psychiatric Nurse and Nurse Practitioner MH • BH Specialist - Supervisor • Also consider DSC Specialist - Professional Chaplains 	<ul style="list-style-type: none"> • Behavioral Health: • 1 BH Specialist - Supervisor, and 2–7 BH Specialists – Licensed Clinical Social Workers total (local plus mutual aid) per shift based on the numbers of family members of those injured or killed, surge of concerned community members, and/or number of impacted hospital staff (for each impacted hospital) • Disaster Spiritual Care: • Consider a minimum of one DSC Supervisor and 2–7 Professional (Hospital) Chaplains total per shift to pair with BH Specialists. 	<ul style="list-style-type: none"> • Hospital Social Work staff from county hospitals or other healthcare partners in county • County MH/BH Department staff and contract providers • County Department of Health including Emergency Medical Services and Public Health • California Disaster Healthcare Volunteers (DHV) including Medical Reserve Corps (MRC) • <u>Note:</u> For guidance on Hospital-based Family Assistance Centers, see: Los Angeles County Family Information Center Planning Guide for Healthcare Entities – June 28, 2013 (LA County Emergency Medical Services Agency website, Disaster Programs, Resource Documents http://dhs.lacounty.gov/wps/portal/dhs/ems/). 	<ul style="list-style-type: none"> • A surge of psychological casualties can occur for CBRNE or mass casualty incidents. The surge may include family members of the missing, injured, deceased in addition to concerned community members who fear they may have been injured by the event. The surge in BH and DSC needs may include: • Local BH agencies may get requests from hospital partners for BH and DSC staff to assist with a surge of people with post-disaster BH needs, including staff for hospital-based FACs and for hospitalized patients injured in the disaster who need psychological support • Hospital staff: Hospitals may need assistance with the BH care of staff in a large-scale event. Hospitals may not have Employee Assistance Program staff, Social Work and/or DSC staff to meet this demand. • Resource Request should specify that BH and DSC resources should have current hospital employment and/or experience. • See 4 requirements for all disaster missions for BH or DSC staff (listed at beginning of table)

Local Assistance Center (LAC) / Disaster Recovery Center (DRC)			
Resource Type	Suggested Staffing Ratio	Source	Notes
<ul style="list-style-type: none"> • BH Specialist – Licensed • BH Specialist – Registered Associate (Intern) 	<ul style="list-style-type: none"> • Minimum 2 BH per LAC or DRC per shift. • If FEMA is also sending Outreach Teams into the impacted area, add 1 BH per Outreach team per shift. 	<ul style="list-style-type: none"> • County MH/BH Department staff and contract providers 	<ul style="list-style-type: none"> • LACs and FEMA DRCs are generally covered with BH staff from the county MH/BH department. However, in a large-scale disaster, a jurisdiction may need to request assistance if multiple LACs and/or DRCs are open. • See 4 requirements for all disaster missions for BH or DSC staff (listed at beginning of table)
School Disaster MH Response			
Resource Type	Suggested Staffing Ratio	Source	Notes
<ul style="list-style-type: none"> • BH Specialist – School Psychologist and School Counselor • BH Specialist – Psychiatric Nurse and Nurse Practitioner (particularly with school nursing experience) or RN – School Nurses. • BH Specialist - Supervisor • (Also consider DSC Specialist - Professional Chaplains or Endorsed Spiritual Providers.) 	<ul style="list-style-type: none"> • Staffing level is based on the scope of the disaster. • Pair local responders with “mutual aid” staff. • Plan for crisis counseling for students, staff, parents; community meetings; hospital visits, funerals, and referrals for local BH trauma treatment. • Consider adding DSC staff; if appropriate. Pair DSC with BH staff. • Add 1 BH Specialist - Supervisor per shift for every 7 responders • A “School MH Branch” position can be added under BH Unit Leader to manage the school-based BH mission. 	<ul style="list-style-type: none"> • Schools/school-based crisis response teams • County MH/BH Department staff and contract providers • American Red Cross Disaster Mental Health and DSC teams and other VOADs with qualified BH and DSC staff 	<ul style="list-style-type: none"> • BH response to schools is usually staffed by school-based MH/BH staff. However, in a large-scale disaster, schools may request BH staff to assist. • Local BH departments may need to request mutual aid if they do not have enough staff to cover the needs. • Specify child/teen trauma specialty and/or school-based BH experience on the resource request. • Due to the traumatic nature of school-based disasters as well as the high visibility of these events, BH and DSC staff with previous disaster and/or school crisis response experience are preferred. • See 4 requirements for all disaster missions for BH or DSC staff (listed at beginning of table)

Disaster Shelters and Disaster Medical Shelters			
Resource Type	Suggested Staffing Ratio	Source	Notes
<ul style="list-style-type: none"> • BH Specialist – Licensed • BH Specialist – Registered Associate (Intern) • BH Specialist - Supervisor • Consider Certified Drug and Alcohol Counselor (s) as appropriate. • (Also consider DSC Specialist - Professional Chaplains or Endorsed DSC Providers.) 	<ul style="list-style-type: none"> • The ratio for BH staffing in shelters is 2 BH staff for every 50-100 shelter residents per shift. This ratio can be adjusted based on the needs of shelter clients • 1 BH Specialist - Supervisor for every 7 BH Specialists – Licensed (BH Specialist - Supervisor can be on site or supervise activities at several smaller shelters) • BH Specialist - Supervisor or BH Specialist • Licensed is REQUIRED if Registered Associates are deployed to shelters. • Pair DSC with BH, if DSC staff are deployed. • Pair local BH staff with “mutual aid” staff. • Add Certified Drug and Alcohol Counselor(s) as needed. • Consider “Shelter BH Response Branch” and/or “Shelter DSC Response Branch” positions under BH Unit Leader to manage the BH response for large “mega shelters” or multiple large shelters 	<ul style="list-style-type: none"> • County MH/BH Department staff and contract providers • County Department of Health including Emergency Medical Services and Public Health • California Disaster Healthcare Volunteers (DHV) including Medical Reserve Corps (MRC) • US Public Health Services (USPHS) • American Red Cross Disaster Mental Health and DSC teams and other VOADs with qualified BH and DSC staff 	<ul style="list-style-type: none"> • Large numbers of disaster shelters, particularly “mega shelters” with 500 or more shelter residents can exceed the staffing capabilities of a county MH/BH department. • For American Red Cross shelters, resource requests for BH or DSC staff should be coordinated with Red Cross leadership though the CEOC. • BH department mission in shelters includes linking disaster clients to regular local BH resources for longer term crisis counseling, trauma treatment, and other follow-up services. • Add specific information about language needs and other expertise such as chronic mental illness, homeless services, or LGBTQ-2S in the resource request so that staff request meets the need of the shelter. • Staff Housing Shelters should have separate BH and DSC staff specifically assigned to the Staff Housing Shelter to address the BH and DSC needs of disaster staff, particularly in the evenings when staff are returning to the Staff Housing Shelter at the end of their disaster response shift. • See 4 requirements for all disaster missions for BH or DSC staff (listed at beginning of table)

Disaster Field Psychiatric Hospital			
Resource Type	Suggested Staffing Ratio	Source	Notes
<ul style="list-style-type: none"> • BH Specialist – Licensed Psychiatrist • BH Specialist – Psychiatric Nurse and Nurse Practitioner MH • BH Specialist – Licensed Clinical Social Worker • BH Unit Leader • BH Specialist - Supervisor • (Also consider DSC needs) 	<ul style="list-style-type: none"> • Staffing ratios would follow existing staffing guidelines as much as possible. • Example: American Academy of Child and Adolescent Psychiatry (December 1990) suggests: <ul style="list-style-type: none"> ○ 1 Psychiatrist ○ 1 Psychiatric Nurse per 12 pts per shift ○ 1 Social Worker per 10 pts per shift 	<ul style="list-style-type: none"> • Staffing the Field Psychiatric Hospital with existing local staff from the damaged/ destroyed facilities should be considered first. • Hospital/Clinic and other County health agency partners per Operational Area agreements can also be considered. • Federal Disaster Medical Assistance Teams (DMAT) • US Public Health Service (USPHS) • County MH/BH Department staff and contract providers • County Department of Health including Emergency Medical Services and Public Health 	<ul style="list-style-type: none"> • Disaster Field Psychiatric Hospital(s) may be needed for a catastrophic disaster when local psychiatric facilities are damaged or destroyed. • Resource requests should specify inpatient hospital or psychiatric facility-specific current employment and/or specific specialty, including inpatient child, adolescent or adult expertise. • It is advisable to specify “previous disaster experience and training preferred” on the resource request. • Consider language and cultural groups needed for the hospitals and specify language type needed in the resource request. • See 4 requirements for all disaster missions for BH or DSC staff (listed at beginning of table)

Public Health Points of Distribution / Dispensing (PODS)			
Resource Type	Suggested Staffing Ratio	Source	Notes
<ul style="list-style-type: none"> • BH Specialist – Licensed • BH Specialist- Registered Associate (Intern) • BH Specialist – Psychiatric Nurse and Nurse Practitioner • (Also consider DSC Specialist - Professional Chaplains or Endorsed Spiritual Providers) 	<ul style="list-style-type: none"> • Staffing depends on the County Public Health POD plan and role specified in the plan for BH and DSC. For example, the LA County POD plan assigns BH to regular POD roles or has 1-2 BH and 1-2 DSC stationed in POD registration or at the “questions” table. • Pair local BH and DSC responders with “mutual aid” staff. • Also make sure to plan for the BH and DSC needs of POD staff. 	<ul style="list-style-type: none"> • County MH/BH Department staff and contract providers • County Department of Health including Emergency Medical Services and Public Health • California Disaster Healthcare Volunteers (DHV) including Medical Reserve Corps (MRC) • American Red Cross Disaster Mental Health and DSC teams and other VOADs with qualified BH and DSC staff. 	<ul style="list-style-type: none"> • County POD operations are generally staffed with local responders; however, in a large response, County BH Departments may get requests for BH and DSC staff that exceed local resources. • Specify POD training or experience, if needed. • POD operations for CBRNE events and terrorist attacks will require more BH and DSC staff with “management of fear”, trauma response, and/or public health experience. Specify these requirements if needed in the resource request.

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APPENDIX D: KEY ORGANIZATIONS AND RESOURCES

Several national organizations and academic institutions contribute resources and offer tools to assist disaster behavioral health programs. Key organizations include:

Substance Abuse and Mental Health Services Association (SAMHSA)

The Substance Abuse and Mental Health Services Association (SAMHSA) is an agency within the U.S. Department of Health and Human Services (HHS) that leads efforts to advance behavioral health. Its mission is to reduce the impact of substance abuse and mental illness on America's communities. SAMHSA's Disaster Technical Assistance Center (DTAC) offers tools to help prepare counties for behavioral health response and needs after a disaster.

The Disaster Response Template Toolkit published by SAMHSA DTAC is a resource for disaster behavioral health programs which includes print materials, website and social media content, and multimedia materials that can be used during outreach and recovery efforts. The templates can be adapted for use in any community's program. It features a program administration section for managers and supervisors, as well as public education materials that can be customized for your disaster behavioral health response needs.

SAMHSA operates toll-free crisis counseling through the Disaster Distress Helpline at 1-800-985-5990 and technical support through DTAC staff at dtac@samhsa.hhs.gov.

- SAMHSA Disaster Technical Assistance Center: <https://www.samhsa.gov/dtac>
- Crisis Counseling Assistance and Training Program: <https://www.samhsa.gov/dtac/ccp>
- CCP Toolkit: <https://www.samhsa.gov/dtac/ccp-toolkit>

ASPR TRACIE

The Technical Resources, Assistance Center, and Information Exchange (TRACIE) provides information and technical assistance to healthcare providers, emergency managers, public health practitioners, and others working in disaster medicine, healthcare system preparedness, and public health emergency preparedness.

- All ASPR TRACIE resources: <https://asprtracie.hhs.gov/>
- DBH library: <https://asprtracie.hhs.gov/dbh-resources>
- COVID-19 library: <https://asprtracie.hhs.gov/COVID-19>
- Mental/behavioral health (non-responders): <https://asprtracie.hhs.gov/technical-resources/68/mental-behavioral-health-non-responders>
- Responder health and safety: <https://asprtracie.hhs.gov/technical-resources/72/responder-safety-and-health>

Center for the Study of Traumatic Stress

The mission of the Center for the Study of Traumatic Stress (CSTS) at the Uniformed Services University is to advance scientific and academic knowledge, interventions, educational resources and outreach to mitigate the impact of trauma from exposure to war, disasters, terrorism, community violence and public health threats. Center scientists, educators and clinicians continue to bring scholarly and research-oriented problem solving to the mental and behavioral health problems of those exposed to war, disaster and traumatic events. All CSTS fact sheets can be found here: <https://www.cstsonline.org/fact-sheet-menu/fact-sheet-list>

Resources for Communities and Families

- [Helping Communities After Disasters](#)
- [How Families Can Help Children](#)
- [How Schools Can Help Children](#)
- [First Responders, Emergency Workers & Volunteers and Exposure to Human Remains](#)

Resources for Disaster Responders and Healthcare Personnel

- [Supporting Those with Pre-Existing Mental Health Conditions](#)
- [Maintaining the Well-Being of Healthcare Providers](#)
- [Psychological and Behavioral Issues Healthcare Providers Need to Know about CBRN Events](#)

Resources for Leaders

- [Leadership in Disasters](#)
- [Grief Leadership in the Wake of Tragedy](#)
- [Risk and Crisis Communication for Leaders](#)
- [Workplace and Organization Management After Disaster](#)

National Center for PTSD

The Veterans Affairs National Center for PTSD is a world leader in research and education programs focusing on PTSD and other psychological and medical consequences of traumatic stress. Mandated by Congress in 1989, the Center is a consortium of seven academic centers of excellence providing research, education, and consultation in the field of traumatic stress.

The Center offers resources for families, providers, support for veterans, and resources for self-help and coping for individuals with PTSD. Provider resources include assessment, trauma, PTSD and treatment, continuing education, consultation and patient education.

The Center operates at Veterans Crisis Line at 1-800-8255, text 8338255, or a Confidential Veterans chat available at https://www.ptsd.va.gov/gethelp/crisis_help.asp

- PTSD Coach: https://www.ptsd.va.gov/appvid/mobile/ptsdcoach_app.asp
- PTSD Family Coach: https://www.ptsd.va.gov/appvid/mobile/familycoach_app.asp
- Trauma Exposure Measures: <https://www.ptsd.va.gov/professional/assessment/te-measures/index.asp>

The National Child Traumatic Stress Network (NCTSN)

The National Child Traumatic Stress Network (NCTSN), established by Congress in 2000, is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma informed services, and public and professional education.

The NCTSN (jointly with the National Center for PTSD, and funded by SAMHSA, US HHS) provides training material and resources for Psychological First Aid (PFA) and Skills for Psychological Recovery (SPR) for behavioral health providers and disaster response workers.

- PFA: <https://www.nctsn.org/resources/psychological-first-aid-pfa-field-operations-guide-2nd-edition>
- SPR: <https://www.nctsn.org/resources/skills-for-psychological-recovery>

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APPENDIX E: POPULATION SUPPORT TOOLS

The table below includes examples of DBH population support tools, including *Psychological First Aid (PFA)* and *Skills for Personal Recovery (SPR)*. Different versions of these tools target different groups and applications.

Name of Resource	Personnel Trained	Beneficiaries	Reference
Psychological First Aid (PFA) Field Operations Guide ⁶²	Professional behavioral health Providers, Disaster Response Workers	Children, adolescents, adults and families in the immediate aftermath of a disaster	http://www.nctsn.org/content/psychological-first-aid (PFA is available in multiple languages)
Psychological First Aid (PFA) Online Training	Professional behavioral health Providers, Disaster Response Workers	Children, adolescents, adults and families in the immediate aftermath of a disaster	http://learn.nctsn.org/enrol/index.php?id=38
Psychological First Aid (PFA) Mobile Application	Professional behavioral health Providers, Disaster Response Workers	Children, adolescents, adults and families in the immediate aftermath of a disaster	http://www.nctsn.org/content/pfa-mobile
Listen, Protect, Connect: Psychological First Aid (PFA) Mobile Application (in conjunction with SAMHSA Mobile Application)	Community Members	Neighbor to Neighbor, Family to Family” and Children, Parents, and Schools.	SAMHSA Disaster Application: Available at the Apple App Store and Google Play Store

⁶² National Child Traumatic Stress Network www.nctsn.org

CALIFORNIA DISASTER BEHAVIORAL HEALTH PLAN (2020)

Name of Resource	Personnel Trained	Beneficiaries	Reference
Listen, Protect and Connect: Family to Family, Neighbor to Neighbor. Psychological First Aid for the Community Helping Each Other	Adult Family Members, Co-Workers, Responders, Neighbors	All Ages, Family Members, Co-workers, Responders, Neighbors	https://www.fema.gov/media-library-data/1499092051917-115ad4c12a44f04a93b4a37c17e99211/PFA(1).pdf
Listen, Protect and Connect: Psychological First Aid for Children and Parents	Parents and Caregivers of Children	Children, Parents and Caregivers	www.ready.gov/sites/default/files/documents/files/PFA_Parents.pdf https://www.fema.gov/media-library-data/1499091995177-9ff6b07a88db5d422062efa4fdca9cfe/pfa_parents_and_children.pdf
Listen, Protect and Connect: Psychological First Aid for Teachers and Schools	Teachers, School Staff	Students and School Staff Members	www.ready.gov/sites/default/files/documents/files/PFA_SchoolCrisis.pdf Guidelines for Schools by U.S. Department of Education: https://rems.ed.gov/docs/HH_Vol3Issue3.pdf
Coping in Today's World, Psychological First Aid and Resilience for Families, Friends and Neighbors	Professional behavioral health Providers, Community Members, Families, and Parents	Children, Adolescents, Adults and Families	American Red Cross chapters nationwide (available in multiple languages)
Skills for Psychological Recovery (SPR) Online Training	BH Providers, Disaster Response Workers	Survivors of disasters and traumatic events (recovery phase)	http://learn.nctsn.org/enrol/index.php?id=113
Disaster Mental Health Training by American Red Cross	Red Cross Volunteers, Partner Agencies, behavioral health Providers	Children, Adolescents, Adults and Families	American Red Cross chapters nationwide (available in multiple languages) and online

APPENDIX F: CRISIS COUNSELING ASSISTANCE AND TRAINING PROGRAM (CCP)

FEMA/SAMHSA Crisis Counseling Assistance and Training Program

The Crisis Counseling Assistance and Training Program (CCP) is authorized under the Robert T. Stafford Disaster Relief and Emergency Assistance Act:⁶³

“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 responders, to victims of major disasters in order to relieve mental health problems caused or aggravated by such major disaster or its aftermath.”

The CCP is administered by FEMA through the Substance Abuse and Mental Health Services Administration (SAMHSA). The State Mental Health Authority (SMHA) applies for CCP grants in compliance with program guidance provided by SAMHSA.⁶⁴ In California, DHCS is the SMHA and prepares CCP application requests, which are developed in cooperation with requesting counties, through Cal OES.

CCP sub-recipients usually are community behavioral health organizations that have an existing relationship with the state, territory or tribe. The CCP requires training of paraprofessional staff who understand the cultures of the community and reflect the ethnic groups they serve, which is critical for effective implementation.

Mental health treatment, as typically defined within the professional community, implies the provision of assistance to individuals for a diagnosable disorder. In contrast, crisis counseling seeks to prevent the onset of diagnosable disorders by helping the majority of survivors understand that they are experiencing common reactions to extraordinarily uncommon events. With the help of psychoeducation, emotional support, skills building, and linkage to services, most survivors will exhibit resilience and recovery.

While a mental health professional typically will provide services in an office or clinical setting, the crisis counselor supports people in their communities. Typical settings for crisis counseling may include a disaster survivor’s home, workplace, school, community center, shelter, or even a coffee shop.

The CCP supports short-term interventions that involve:

- Assisting disaster survivors in understanding their current situation and reactions

⁶³ Crisis Counseling Assistance and Training (42 U.S.C. 5183), Section 416.

⁶⁴ <https://www.samhsa.gov/sites/default/files/dtac/ccptoolkit/fema-ccp-guidance.pdf>

- Mitigating stress
- Assisting survivors in reviewing their disaster recovery options
- Promoting the use or development of coping strategies
- Providing emotional support
- Encouraging linkages with other individuals and agencies who may help survivors in their recovery process (recover to their pre-disaster level of functioning)

Supplemental funding for crisis counseling is available to State Mental Health Authorities through two grant mechanisms: (1) **Immediate Services Program (ISP)** which provides funds for up to 60 days of services immediately following a disaster declaration; and (2) **Regular Services Program (RSP)** which provides funds for up to nine months following a disaster declaration. While SAMHSA provides technical assistance for an ISP, the monitoring responsibility remains with FEMA. FEMA has designated SAMHSA as the authority responsible for monitoring all RSP programs.

County MH/BH departments should become familiar with CCP strategies and activities prior to a disaster.

CCP Principles

- **Strengths Based.** CCP services promote resilience, empowerment, and recovery. The program encourages people to recall other times when they coped well with difficulties so they can draw upon these strengths.
- **Outreach Oriented.** Crisis counselors deliver services in the communities rather than wait for survivors to seek their assistance.
- **Conducted in Nontraditional Settings.** Crisis counselors make contact in homes and communities, not in clinical or office settings.
- **Anonymous.** Crisis counselors do not classify, label, or diagnose people; no records or case files are kept.
- **Culturally Aware.** The CCP model embraces cultural and spiritual diversity as reflected in culturally relevant outreach activities that represent the communities served.
- **Designed to Strengthen Existing Community Support Systems.** The CCP supplements, but does not supplant or replace, existing community systems.

CCP Services

- **Individual Crisis Counseling.** Helps survivors understand their reactions, improve coping strategies, review their options, and connect with other individuals and agencies that may assist them.
- **Basic Supportive or Educational Contact.** General support and information on resources and services available to disaster survivors.

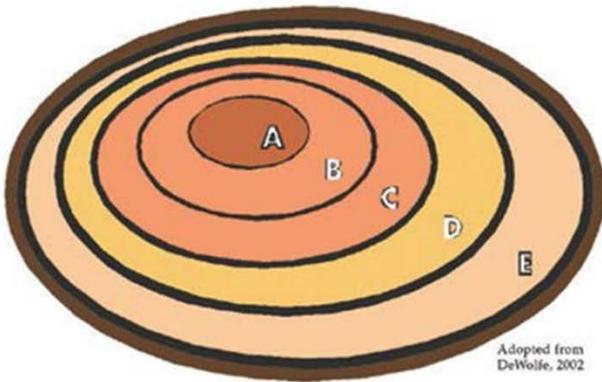
- **Group Crisis Counseling.** Group sessions led by trained crisis counselors who offer skills to help survivors cope with their situations and reactions.
- **Public Education.** Information and education about typical reactions, helpful coping strategies, and available disaster-related resources.
- **Community Networking and Support.** Relationship building and training of community providers regarding available resources and how to access these resources.
- **Assessment, Referral, and Resource Linkage.** Adult and child needs assessment and referral to additional disaster relief services or mental health or substance abuse treatment. Ideally, all county behavioral health providers should be trained in current consensus-based disaster behavioral health strategies.
- **Development and Distribution of Educational Materials.** Flyers, brochures, tip sheets, educational materials, and web site information developed and distributed by CCP staff.
- **Media and Public Service Announcements.** Media activities and public messaging in partnership with local media outlets, State and local governments, charitable organizations, or other community brokers. Social media can be utilized to prepare and support the public through PSAs, which encourage the public to comply with public health guidance.

Community Needs Assessment

Disaster response agencies such as FEMA typically estimate the amount of assistance that a community may need based on the amount of damage sustained by the community. Usually this is determined by assessing the number of homes and other structures that have been damaged or destroyed and damage to key infrastructure elements such as roads, utilities, hospitals, and schools. Unfortunately, the level of structural physical damage may not correlate with the psychological impact of an event on survivors, responders, and the community.

If the Crisis Counseling Assistance and Training Program (CCP) is authorized, applicants must include a community needs assessment. An initial needs assessment provides the rationale and justification for the CCP and identifies at-risk populations who will be targeted for outreach. The CCP uses a *Population Exposure Model* (see figure below) to help identify and prioritize groups who could benefit from crisis counseling services.

Population Exposure Model



- A. Injured survivors, bereaved family members
- B. Survivors with high exposure to disaster trauma, or evacuated from disaster zones
- C. Bereaved extended family and friends, first responders
- D. People who lost homes, jobs, and possessions; people with preexisting trauma exposure or mental health problems; at-risk groups (e.g., unsheltered population); and other disaster responders
- E. Affected people from the larger community

■ Addressed by the CCP

This model mirrors a “ripple effect,” illustrating how the effects of a disaster expand to wider segments of the community. The injured and bereaved represented in “A” are those with the highest level of exposure to the disaster and those most likely to benefit from CCP services that are delivered face-to-face and are of higher intensity. Those represented in each subsequent ring have a lesser degree or intensity of exposure. Those in ring “E” have experienced little to no direct exposure to the disaster and, thus, may be targeted for the lowest intensity of service such as public education and information.

SAMHSA provides the following guidance on needs assessment:⁶⁵

- Determine the need for crisis counseling, mental health and/or substance misuse treatment, public education, and information dissemination
- Assess risk factors and reactions in relation to:
 - Safety
 - Level of exposure to the traumatic event
 - Prior trauma or physical or behavioral health concerns
 - Presence of severe reactions
 - Current functioning
 - Alcohol and drug use and misuse
- Identify at-risk groups⁶⁶
- Emphasize techniques that facilitate grouping and mobilizing people to work together

⁶⁵ <https://www.samhsa.gov/dtac/dbhis-collections/disaster-response-template-toolkit/needs-assessment>

⁶⁶ Include consideration of the DBH needs of disaster workers, including first responders and first receivers.

- Foster collective activities
- Facilitate leadership development
- Is an ongoing process and should be updated as needed throughout the response
- Identify the community's role in influencing and affecting the general well-being of the population
- Involve residents in the entire process
- Look at quantitative data, including demographic records, official statistics, and the damage assessment report provided by the locality or in the case of a presidentially declared disaster, may include information from the FEMA Preliminary Damage Assessment as well as qualitative data from individual social indicators and contacts with the community. These often take the form of:
 - Observations
 - Community surveys and group forums
 - Key informant interviews
 - Community impressions
 - Behavioral census

SAMHSA provides a CCP template that can be used to estimate needs; states can modify the template as necessary (see next page). In addition, DHCS provides support to county MH/BH departments relative to the CCP program, including assistance with conducting a community needs assessment.

Needs Assessment Table⁶⁷

While many survivors will fit into more than one *Loss Category*, they should only be counted once on the Needs Assessment. Please determine which Loss Category they best fit into based on where they are at greatest risk for suffering a negative mental health outcome.

Loss Category	# of Persons	Average Number of Persons per Household (ANH)	Range Estimate	# of Persons per Loss Category
Type of Loss	Number	Multiply by ANH	At Risk Multiplier	Number of Persons Targeted per Loss Category
Missing or Dead		2.62		
Hospitalized		2.62		
Non-Hospitalized Injured		2.62		
Homes Destroyed		2.62		
Homes - Major Damage		2.62		
Homes - Minor Damage		2.62		
Displaced*				
Evacuees*				
Disaster Workers*				
Children*				
Elderly*				
People With Prior Mental Illness*				
Racial and Ethnic Minority Groups*				
Non-English-Speaking Groups*				
LGBTQ Population*				

* Note: The categories listed above can be tailored to reflect the demographics and needs of the impacted community.

⁶⁷ <https://www.samhsa.gov/dtac/dbhis-collections/disaster-response-template-toolkit/needs-assessment>

APPENDIX G: CURRICULUM RECOMMENDATIONS

In 2020, the *Center for the Study of Traumatic Stress* and the *National Center for Disaster Medicine and Public Health*⁶⁸ expanded and updated the curriculum guidance for Disaster Behavioral Health (DBH) initially released in 2014. The 2020 guidance includes ten key DBH topics, literature searches relevant to each topic, and web-based resources.

The full publication, including references, can be found at https://www.cstsonline.org/assets/media/documents/CSTS_Curriculum_Recommendations_2nd_ed.pdf

For the reader's convenience, the ten DBH topics identified in the curriculum recommendations are included on the following pages.

⁶⁸ The *Center for the Study of Traumatic Stress* and the *National Center for Disaster Medicine and Public Health* are located within the *Uniformed Services University of the Health Sciences*.

Disaster Behavioral Health Topics

1. Defining Disaster Behavioral Health

- a. *Primary Concept:* Understand key terminology used in the field.
 - i. Disasters compared to emergencies and crises—Understand how disasters (when needs exceed resources and external assistance is needed) are different than emergencies (can be handled within existing resources), crisis (where existing resources are at capacity but still functional).
 - ii. Defining Behavioral Health (BH)—Understand the history and current use of terms such as mental health, behavioral health, substance use/abuse, stress, resilience, etc. Behavioral health is a newer and more inclusive term that has increasingly replaced the term mental health when referring to topics that go beyond more limited issues of mental illness and health. There is not worldwide consensus on the best terminology.
 - iii. Compare and contrast BH factors in disaster and non-disaster situations—Understand how psychosocial, family, and community characteristics are similar and different in normal circumstances as compared with during and following disasters.

2. The Disaster Environment

- a. *Primary Concept:* During and following disasters, normal governance, system function, and the nature of behavioral health services typically operate differently than in “blue sky” times. Disaster management is becoming increasingly formal and based on legal and operational requirements and relationships. It is important for the learner to understand these different processes, roles, and functions in order to

participate in any roles before, during, and following disasters.

- i. Understanding the fundamental needs vs. resources analysis for disaster declaration (e.g. the federal Stafford Act) related to defining disaster behavioral health above.
- ii. Governmental determination/declaration process/meaning—Understand who has what authority and requirements at various stages in the event process.
- iii. Key governmental structures and guidance such as the National Response Framework (especially Emergency Support Function [ESF] 6 & 8, Department of Health and Human Services [DHHS] Concept of Operations [CONOPS], National Biodefense Strategy, and state and local emergency response plans)
- iv. Working within the Incident Command System (ICS)—Understand that authority is modified from usual practice under the ICS. Behavioral health and other healthcare providers are typically unfamiliar with the ICS.
- v. The context of BH interventions in disaster—Understand how providing behavioral health assistance in disaster situations is different than usual practice process and environments. For example, rapid triage, short time to intervene, little background information, initiating contact with people, providing service in atypical settings such as shelters.
- vi. System impact/overlap (medical care, emergency response, and public health)
— Understand how various systems operate differently in disaster situations, ways to effectively develop entrée into a community, and methods

by which to initiate and integrate behavioral health services into these changing systems.

3. Key Partners

- a. *Primary Concept:* Addressing the behavioral health needs of both victims/survivors and workers requires valued and functional partnerships among many elements of the community. It is important to know these various partners, what roles they play, and how to establish and maintain these partnerships.
 - i. Roles of health care providers and workers (e.g., hospitals, outpatient services, emergency medical services, emergency medical services, nursing homes, assisted living).
 - ii. Integrating with other human services organizations and professions (e.g., social services, protective services, public health).
 - iii. Integrating with other stakeholders (e.g., faith community, schools, employers, governmental entities, non-governmental organizations (NGOs)).
 - iv. Integrating with Emergency Management structures and functions.

4. Individual and Collective Responses to Disaster

- a. *Primary Concept:* Disasters create a broad range of psychological and behavioral responses for individuals and communities across a broad range of domains. Various cultural and contextual factors influence the experience and expression of response to disasters. It is important to understand various responses and the factors influencing them to effectively develop public mental health assessment and intervention strategies
 - i. Domain impacts
 - Physical
 - Psychological
 - Emotional
 - Cognitive
 - Social
 - ii. Assessing the nature and scope of BH needs following an event

- Community Phases of Disaster
 - Disaster Ecology Model
 - Haddon Matrix
 - The forces of harm
- iii. Individual and collective adjustment patterns over time
 - iv. Risk and protective factors
 - v. Cultural competence (awareness, knowledge, and skills)
 - vi. Notes on panic (panic is widely misunderstood phenomenon in disasters and typically occurs in only very specialized situations)
 - vii. Role of Leadership in shaping community/ organizational response

5. Behavioral Health as a Function of Event Type

- a. *Primary Concept:* BH factors are significantly impacted by the types of events people experience. Key factors include causality, duration, impact, and familiarity. Understanding these factors and the roles they play in individual and community experiences of disasters can help optimize preparedness and response efforts. Threats posed by certain events, including emerging infectious diseases, cyber events, and climate-related disasters, are increasingly important to consider.
 - i. Impact characteristics
 - ii. Causality
 - iii. Duration
 - iv. Geographic scope
 - v. Extent of injury/illness/death
 - vi. Mass fatalities and handling of human remains
 - vii. Familiarity
 - viii. Dislocation
 - ix. Destruction of community/regional/ national fabric
 - x. Criminal involvement
- b. Emerging Issues
 - i. Pandemics / Outbreaks
 - ii. Cyber-terrorism
 - iii. Global climate change/rising sea levels

6. Considerations for Special Populations

- a. *Primary Concept:* Some individuals and groups often need specialized or tailored preparedness measures in advance of disasters as well as interventions following a disaster. Some may be at increased risk of negative outcomes and some may simply need nontraditional approaches. Learners will understand what specialized needs may be present or emerge at different stages in the event cycle.
 - i. Defining special needs
 - ii. Special needs by pre-event demographics (e.g., children, frail elderly, people with serious mental illness, physical and/or developmental disabilities, the homeless)
 - iii. Special needs created by disaster impact (e.g., injured, bereaved, in shelters)
 - iv. Special needs by recovery impact (e.g., relocated, unemployed)

7. Providing Care

- a. *Primary Concept:* Providing behavioral health care in disaster situations differs from more traditional services in many ways. While a solid grounding in the behavioral sciences is important, optimal function can only be achieved through understanding the unique aspects of: needs of people following disasters, service environments during and after disasters, and manner in which services are provided.
 - i. Legal and ethical issues on providing disaster behavioral health services
 - ii. Early intervention strategies
 - Selecting intervention strategies
 - Psychological First Aid (various models and foci)
 - Notes on controversial disaster interventions such as Critical Incident Stress Debriefing (CISD) and use of Mental Health First Aid in disasters
 - iii. Non-clinical interventions (e.g., basic and specialized crisis counseling,

bereavement support)

- iv. Diagnosis and treatment of BH disorders
 - Diagnostic challenges
 - Use of pharmaceuticals
 - Treatment options
- v. Grief and bereavement
 - Critical factors (including diagnostic criteria)
 - Support factors and strategies
- vi. Risk and crisis communication
 - Fundamentals of communicating in a crisis
 - Identifying existing and emerging key stakeholders with whom to communicate
 - Communication as a BH intervention
 - BH's role with public information efforts

8. Additional Important Roles

- a. *Primary Concept:* In addition to direct services, behavioral health professionals, as well as other healthcare professionals, can perform other roles to help in disasters.
 - i. Consultation
 - Types of consultation (e.g., case, systems, program, formal, informal)
 - Recipients of consultation (formal and informal leaders, risk/crisis communicators, healthcare colleagues, other professionals and stakeholders)
 - ii. Planning and preparedness (including fostering public/private partnerships)
 - iii. Education/information
 - iv. Assessing changing needs
 - v. Program design/implementation/evaluation
 - vi. Support non-BH responders in caring for themselves, victims, and survivors

9. Impact on Workers/Responders

- a. *Primary Concept:* Those who work in and respond to disasters experience unique stresses as well as rewards. Reducing stress and promoting resilience in these groups requires understanding these stresses and rewards, the concept of post traumatic growth, and the interactions among

workers, as well as their families, their coworkers and the organizations that employ them.

- i. Defining disaster workers/responders
- ii. Types of stress workers experience (including when a worker is also a victim and/or experiences multiple events in a short period)
- iii. Types of rewards and stress mediators for workers/responders
- iv. Protecting and maintaining the healthcare workforce
- v. Workplace/organizational responsibilities and strategies
- vi. Individual responsibilities and strategies such as self- and buddy-care
- vii. Organizational and leadership factors that promote wellness and sustainment

10. Broad-Based/Comprehensive/Classic Resources

a. *Primary Concept:* A limited number of resources has been especially significant in the development of the field of disaster behavioral health and could be considered seminal readings. Some formed the foundations of this developing field. Others, drawn from areas of study, have shaped how the field of disaster behavioral health continues to emerge. These include:

- i. Resources that are foundational to the field of disaster behavioral health
- ii. Resources frequently cited over time and in a variety of places
- iii. Resources on specific types of events (such as war) that have influenced the development of the field of disaster behavioral health
- iv. Resources on more general topics that have influenced the development of the field of disaster behavioral health

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APPENDIX H: SUGGESTED ACTIVITIES BY EMERGENCY MANAGEMENT PHASE

This appendix includes specific activities that county MH/BH departments may wish to consider in each phase of emergency management (planning/preparedness, mitigation, response, and recovery). Ideally, these and other relevant activities should be tailored to the needs, resources, and priorities of the local community and MH/BH department.

Planning and Preparedness

1. Convene DBH Advisory Committee

It is important to involve and collaborate with a broad range of public and private agencies and organizations to create a realistic vision and plan for DBH operations in each county/Operational Area. During the planning process, it may be helpful to consider a list of subcommittee or task groups that focus on specific topics, such as planning considerations for specific hazards, recruitment and training, operational and deployment protocols, legal issues, etc.

Representatives from the following groups should be considered for inclusion:

County/City Stakeholders

- County MH/BH Department, including staff with experience in DBH and the needs of specific groups more likely to suffer adverse impacts caused by the disaster
- Emergency Management Agency
- Public Health Department / Health and Human Services Agency
- Local Victims of Crime Office
- Law Enforcement, Fire, and Emergency Medical Services
- School Districts / Universities / Colleges
- Correctional Facilities
- Legal Affairs / Risk Management

Other Public/Private Organizations

- American Red Cross
- Tribal Nations
- Agencies or associations representing children, elders, individuals with disabilities and/or access and functional needs, and any groups that systemically experience health disparities, regardless of cause

- Faith Communities
- Associations of behavioral health Professionals

2. Review Operational Area's Emergency Operations Plan

California's Emergency Services Act defines an "Operational Area" (OA) as a county and all political subdivisions within a county (e.g., cities, special districts, etc.) Each OA is required to have an emergency operations plan (EOP) for use by all of the political jurisdictions within the OA. The OA EOP is usually maintained by the county's emergency management agency.

An important component of the EOP is the county's DBH plan. The roles and responsibilities of the county MH/BH department, and other DBH response partners, should be incorporated into the OA EOP. OA EOPs typically include information on the following topics:

- Potential hazards and risks facing the OA (often called a "Hazard Vulnerability Analysis")
- Special annexes or plans which identify the specific roles, responsibilities, or procedures related to a specific type of disaster. For example, many OAs have developed special plans for:
 - Hazardous Materials (HazMat) incidents
 - Active Shooter incidents
 - Infectious Disease incidents (e.g., COVID-19, SARS, and other communicable diseases)
 - Aviation or transportation accidents
 - Radiological/Nuclear incidents
- Written policies related to DBH scope of practice, interventions, type of staff available to respond, equipment and supplies needed for disaster response, and training standards for the county MH/BH department
- Review data on the population and groups within the community that may be more vulnerable to the behavioral health impact of a disaster, including:
 - Adults with pre-existing serious mental illness (SMI), substance use disorder (SUD), or other disorder; children with serious emotional disturbance (SED) or other vulnerabilities
 - People in group homes or assisted living facilities
 - People experiencing homelessness or inadequate sustaining resources
 - People experiencing adverse socioeconomic factors
 - People who are isolated or lacking social support
 - Religious communities
 - Children and elderly individuals

- People who are incarcerated
- County staff including disaster service workers, first responders, healthcare workers

3. Review Disaster Plans of Response Agencies

The American Red Cross is involved in meeting the immediate and short-term needs of a community impacted by disaster. Other community organizations are also likely to have disaster-related service missions. During the planning process, identify such organizations and request and review copies of their respective disaster plans. Identify opportunities to collaborate, reduce redundancies in the provision of services, and fill gaps where appropriate.

4. Establish MOUs with Community Partners

Memoranda of Understanding (MOUs) should be established between the county MH/BH department and other public and private response organizations to identify agreed-upon roles. These MOUs should clearly articulate the roles and responsibilities of the partner agencies and the mechanisms and procedures for carrying out such duties. MOUs should be reviewed and cleared by the county's legal affairs / risk management department.

5. Develop a Comprehensive DBH Plan

The needs, resources, and priorities that inform DBH planning vary throughout California communities. Larger, well-resourced communities may have multiple plans related to DBH, while smaller communities may have a single comprehensive plan. The items identified below represent a generic approach to information that should be considered and incorporated into planning documents.

Ideally, a DBH plan should include input from a broad array of public and private stakeholders (see previous section on DBH Advisory Committee). Once the plan is completed, it should be actively shared with and reviewed by a wide audience, especially those who have direct responsibility for carrying out specific roles and tasks identified in the plan in addition to disaster response partners.

The plan elements listed below are based on guidance from the U.S. Department of Health and Human Services (HHS), Substance Abuse and Behavioral Health Services Administration (SAMHSA), Behavioral Health All-Hazards Guidance Document (2003). The DBH plan should be tailored to the county's organizational structure and needs and include the following:

Statement of Purpose

- ◆ A statement that describes the general purpose of the plan.

General Assumptions

- ◆ This information should include an overview of the basic assumptions pertinent to the plan, e.g., high probability scenarios; high impact scenarios; county demographics including vulnerable populations; special facilities; plan limitations.

Concept of Operation

- ◆ Includes the county's overall approach to an emergency that has DBH implications, roles and responsibilities of public and private partners, general sequence of actions, mutual aid/emergency assistance, etc. Planning documents should identify how DBH needs are assessed, response strategies, and interventions.

Legal Authorities

- ◆ Reference the specific legal authorities that enable the county MH/BH department to fulfill the elements of the plan or to maintain existing services. In the event the county MH/BH department mobilizes and deploys paid staff and volunteers to provide DBH services on behalf of the county, reference should be made in the plan as to what legal authority authorizes such deployment and how employee or volunteer liability will be covered in the event of a disaster-related accident or injury.

Organization and Assignment of Responsibilities

- ◆ Identify tasks (within the county MH/BH department, other county departments, etc.) and which organization/position is responsible for carrying out each task. If more than one organization is responsible for a task, identify the lead organization and supporting organization(s).
- ◆ Identify who is responsible for modifying and updating the DBH plan and how often this will occur.

Administration, Logistics, Legal Issues

- ◆ Procedures for record keeping of program activities, expenditures and obligations, human resource utilization, and situational reports.
- ◆ Policies and procedures for activating, deploying, and tracking response personnel.
- ◆ Procedures for the management of volunteers.
- ◆ Procedures for feeding, sheltering, transporting, and supervising personnel.
- ◆ Procedures for the repair/replacement of essential equipment (radios, computers, cell phones).
- ◆ Address issues of licensing, personal, professional and organization liability, patient records management, informed consent, confidentiality, emergency evaluation or commitment laws, and duty to report laws.
- ◆ Written policies and guidance identifying scope of practice for DBH response, intervention standards, identification of DBH staff, position descriptions, training plan, and maintenance of equipment and supplies necessary for DBH response.

- ❑ **Communications**
 - ◆ Procedures and methods for notifying county behavioral health personnel, facilities, services providers, and others as appropriate.
 - ◆ Redundant communication capabilities.
 - ◆ Identify the availability of technical consultation.
- ❑ **Public Information**
 - ◆ Identify policies and responsibilities for the dissemination of public DBH information.
 - ◆ Identify the availability of public information material (fact sheets, guides, multiple languages, access to services, etc.).
 - ◆ Identify populations that may need special warning procedures (e.g., people with disabilities or access and functional needs).
 - ◆ Identify a process for distributing educational and other materials to DBH service sites.
 - ◆ Identify subject matter experts and resources beyond the county MH/BH department that may be utilized as consultants or advisors .
- ❑ **Evacuation**⁶⁹
 - ◆ Develop evacuation procedures for county behavioral health sites.
 - ◆ Identify alternate sites and facilities.
- ❑ **Collaboration with other agencies**
 - ◆ Coordinate with American Red Cross Mental Health Services.
 - ◆ Coordinate with community hospitals and other behavioral health service providers.
- ❑ **Resource Management**
 - ◆ Identify how the county MH/BH department will locate obtain, allocate, and distribute necessary resources (i.e., personnel, transportation, communications equipment, mutual aid, etc.).
- ❑ **Special Response Plans**
 - ◆ Develop special response plans for high risk events .

⁶⁹ Evacuation may be covered within a DBH plan or a separate evacuation plan.

☐ **Continuity of Operations⁷⁰**

- ◆ Describe how the county MH/BH department will maintain or re-establish vital functions.
- ◆ Identify and address procedures for restoring vital records and data management.
- ◆ Establish procedures for the identification of essential personnel, staff notification, staff and family support, and staff transportation.
- ◆ Identify alternate locations for essential operations.

☐ **Other Planning Considerations**

- ◆ Identify a plan to prepare and support county MH/BH department personnel during and following deployment (i.e., physical and emotional health, family support).
- ◆ Highlight the importance of the county MH/BH department's role in disaster training, drills and exercises.
- ◆ Collaborate with county's GIS department to map high risk geographical areas and populations.
- ◆ Develop a list of federal, state and local behavioral health and substance abuse treatment facilities, contacts, and telephone numbers (including alternate modes of contact).

6. Educate and Train DBH staff

The field of DBH services and trauma-focused care is relatively new. Awareness has grown that disasters cause high levels of distress among many in a community and some individuals will go on to develop (or experience a worsening of) psychological or behavioral health disorders.

DBH includes two major categories of service to consider for both disaster survivors and disaster responders:

- 1) Resilience-based psychoeducation and psychosocial interventions to reduce emotional distress and social problems, and
- 2) Referral and treatment for psychiatric and other behavioral health disorders, e.g., substance use disorder

⁷⁰ Continuity of Operations is often covered in a separate continuity plan.

SAMHSA defines trauma-specific services as the “prevention, intervention, or treatment services that address traumatic stress as well as any co-occurring disorders (including substance use and mental disorders) that developed during or after trauma.”⁷¹

Trauma-informed intervention and treatment principles are particularly important to DBH services. Educating and training behavioral health professionals in trauma-specific interventions strengthens their ability to mitigate adverse behavioral health consequences caused by disasters. The American Psychological Association published “A Guide to Guidelines for the Treatment of Posttraumatic Stress Disorder in Adults: An Update” wherein five major guidelines were reviewed for best practices. The strongest recommendations were for trauma-focused therapies, including Trauma-Focused Cognitive Behavioral Therapy, Prolonged Exposure, Cognitive Processing Therapy, and Eye Movement Desensitization and Reprocessing.

All DBH staff should receive training in resilience-based psychoeducation and psychosocial interventions suitable for their communities. Training in trauma-specific treatment for behavioral health disorders will enhance the effectiveness of care provided to clients who suffer more severe impact to their behavioral health.

7. Develop DBH Response Teams

A county DBH Response Team provides a significant resource to the community. Following a disaster, people may experience a range of reactions from transitory distress to more serious functional impairment. Disaster DBH Response Teams provide supportive behavioral health interventions that can mitigate both the acute and long-term psychological consequences of disaster exposure. Consideration must be given to the key issues listed below in the development of a county DBH Response Team:

- Risk Management:** If utilizing county MH/BH department personnel, address how employees will be compensated for time worked as well as limitations on employee number of work hours/days. If utilizing volunteers, address professional liability issues such as malpractice, workplace injury, etc. If utilizing contractor provider agencies, add disaster responsibilities to the provider contract that address risk management issues.
- Selection Criteria:** Team members should meet educational and training standards, ideally including experience in trauma-related support services.
- Recruitment of Partner Organizations in a County DBH Team:** It would be optimal for teams to be representative of the community in which they are deployed. Teams should be comprised of members from various cultural/ethnic backgrounds with a range of clinical and practical experience. Below is a list of potential recruitment sites:

⁷¹ Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

- ◆ Local public/private behavioral health and substance abuse treatment facilities
- ◆ Community-based private practitioners
- ◆ Professional associations
- ❑ Training: The skills required by DBH Response Team members are not typically offered through traditional clinical graduate behavioral health programs. A training protocol highlighting the necessary intervention skills and response protocols should be included in DBH plan and provided to DBH workers joining the team. Team members should be provided with on-going training and education to maintain and enhance their DBH response skills.
- ❑ Position Descriptions: All team members should be provided with a position description clearly outlining their roles and responsibilities.
- ❑ Credentialing: A process for verifying and credentialing DBH Response Team members should be developed. Once verified, team members should be provided with identification badges.
- ❑ Tracking: Methods should be developed for tracking the recruitment and training of team members. It is important to clarify deployment priorities and expectations for those members who do volunteer with multiple relief agencies.
- ❑ Mobilization and Deployment Process: The DBH plan should include a mobilization and deployment process. Team members should only be deployed to safe environments and their activities should be monitored from a risk management perspective.

8. Evaluate and Update DBH Plan

Periodically review the DBH plan to ensure it meets the DBH needs of the county. All disaster plans should include an evaluation component whereby specific protocols and procedures are reviewed, tested, evaluated, and updated as necessary.

This may occur in the context of a larger state or county emergency management exercise or as a stand-alone drill or exercise. Such drills might include a periodic call down of DBH Response Team members to evaluate their availability and response times; tabletop exercises that evaluate the county MH/BH department's ability to coordinate and deploy multiple internal and external DBH resources; and special drills that may involve establishing a Family Assistance Center (FAC) or Point of Dispensing (POD) site. County MH/BH departments can also work with county partners to ensure that DBH injects are included in disaster exercises, e.g., the expected number of psychological casualties produced by a certain type of disaster.

Mitigation

1. Identify Higher Risk Populations

The county MH/BH department should identify populations and areas that may be at higher risk for adverse DBH impact and identify the optimal response strategies and interventions for these

population groups. Prior to a disaster, consider outreach to higher risk groups to provide pre-disaster education and resilience strengthening that may mitigate the acute and long-term psychological consequences of disaster.

The following populations may be at heightened risk for developing significant stress reactions or behavioral health issues following a disaster:

- ◆ Individuals with pre-existing behavioral health disorders or trauma exposure
- ◆ Individuals who are more vulnerable to disaster impacts due to socioeconomic status
- ◆ Children
- ◆ Elderly individuals
- ◆ Individuals with disabilities or access and functional needs
- ◆ First responders

2. Develop Disaster-Related Information

Providing information about disaster preparedness, common emotional and psychological responses, and personal resiliency can mitigate stress reactions when disaster strikes. Informational material should address personal, family, and work-life disaster planning, common stress reactions, and community resources that are available to meet disaster-related needs. These materials should be available in multiple languages that reflect the composition and culture of the community.

Response

1. Activate DBH Plan

Once a disaster occurs that creates a need for DBH services, the DBH plan (or relevant components) should be activated and community response partners should be notified of plan activation. The DBH plan may also be activated in anticipation of an event that may have DBH implications.

2. Participate in EOC Operations

California jurisdictions vary in their organizational structure and approach to emergency operations. In larger counties, the county MH/BH department may operate a department operations center (DOC) where the majority of DBH operations are coordinated during a disaster.

In addition, each OA has an Emergency Operations Center (EOC) that serves as the primary coordination point for the entire OA (which includes the county and all political jurisdictions within the county). The OA EOC is typically run by the county's emergency management agency and should include representation from all sectors involved in the response, including

DBH. DBH would typically be located in the Medical Health Branch (or CA-ESF 8 Branch) of the EOC.

3. Activate Response Protocols (including DBH Response Teams)

The county DBH plan should include clear, concise descriptions of the roles and responsibilities of those involved in the response, including county DBH Response Team(s). The tools provided in Appendix C that describe resource types and disaster missions can be helpful to this process. Team members should be informed about the nature of the event, where they should report for briefing and work assignment, and any issues that may impact their safety and security.

Team members should wear government or other appropriate identification and oriented to what is known about the event at that point in time. Specific information regarding victim demographics, safety and security issues, service delivery plan, and other pertinent details should be provided. Team members should be advised of their administrative (work site) and technical (clinical) supervisors along with clear expectations. Expectations regarding telephone contact and periodic updates with county DBH administrative leaders should also be addressed.

Procedures should be well established to identify, acquire, and deploy resources necessary to support DBH services.

4. Initiate Early Supportive Interventions

In the initial aftermath of a disaster, individuals are primarily focused on immediate disaster-related needs such as obtaining food, water, and shelter; receiving first aid or medical care for injuries; and locating lost or missing family members. Early phase supportive interventions usually involve providing basic comfort care and psychosocial support while assessing individuals for stress reactions that might signal future psychological complications. Pre-disaster training for response team members should include orientation and skill development in well accepted early supportive interventions such as Psychological First Aid (PFA).

5. Assess DBH Needs of the Impacted Population

Information concerning the immediate emotional and psychological impact to members of a community (including disaster responders), along with the potential for long-term behavioral health impacts, should be gathered as soon as possible. This information can be used to guide the prioritization of activities included in the Incident Action Plan and support requests for supplemental funding (e.g., Crisis Counseling Assistance and Training Program if authorized).

6. Collaborate with County Government for Risk Communication

County government officials typically provide information and periodic updates following a disaster. DBH experts should provide input to public communications in an effort to mitigate adverse behavioral health impacts and promote community resilience.

7. Distribute Educational Materials

Educational materials that describe common stress reactions and effective coping mechanisms should be distributed to the public as soon as possible after disaster strikes. Certain national organizations, including SAMHSA, have developed educational materials that are available for this purpose (see Appendix D) or they can be developed by county MH/BH departments. Educational materials should be both culturally and linguistically appropriate for the target population.

8. Provide Supportive Interventions for DBH Response Personnel

Meeting the DBH needs of a community can be considerably stressful to the professionals involved in the response. Protocols should be developed and offered to meet the support needs of DBH Response Team members and others administering care to disaster survivors.

Recovery

1. Assess Intermediate and Long-Term Needs

Assess and evaluate the intermediate and long-term needs of the affected community with an understanding that secondary stresses may contribute to an increased need for behavioral health services. Research indicates that while many members of a disaster-impacted community will experience distress, these reactions are usually mild and transitory. A minority of individuals may develop more moderate to severe psychological reactions that over time, if untreated, may develop into psychiatric disorders such as Acute Stress Disorder, Major Depression, Post-Traumatic Stress Disorder, or Generalized Anxiety Disorder. Pre-disaster substance use disorders may also be worsened by disasters.

Counties may elect to use systematic approaches to prioritize the delivery of more intensive DBH services for those in greatest need. Factors to consider include the ability of the method to accurately identify those who are likely to develop significant behavioral health disorders due to disaster exposure (high sensitivity and specificity); ease of administration/suitability for population screening; and appropriate protection of protected health information (PHI).

2. Engage Community Resources to Provide DBH Services

The DBH plan should include an inventory of local behavioral health treatment facilities and individual providers willing and able to treat disaster survivors. Providers should possess the requisite education and training experience to evaluate and assess the range of psychiatric and substance use disorders in survivors. Training in trauma-specific services is particularly important in providing care to those most severely affected. County behavioral health officials should explore options to obtain financial support to augment DBH response and recovery (e.g., Crisis Counseling Assistance and Training Program).

3. Provide Supportive Interventions for DBH Response Teams and Other Disaster Personnel

Providing support to disaster survivors can be stressful and behavioral health professionals are not immune to stress reactions in the context of their work. On-going support services should be offered to all DBH Response Team members and other disaster responders, especially in the long-term recovery phase of disaster.

APPENDIX I: ACTION PLANNING

In the Incident Command System (ICS), *Incident Action Planning* is the term used at the tactical field level to describe the approach to establishing priorities, objectives, and tasks. At DOC and EOC levels above the tactical field level, e.g., local government or Operational Area, this process is referred to as *Action Planning*. While some jurisdictions may operate physical DOC/EOCs, others may utilize a virtual approach. The Action Planning steps are relevant in either case. In a county MH/BH department, the Planning Section develops the Action Plan in coordination with other DOC section staff and with the approval of DOC management.

Action Planning involves these steps:

1. Understand your department's policy and direction

The Command and General staff must understand the department's policies and priorities in order to develop appropriate response actions. For example, the county may have developed plans to provide specific services during the emergency. This policy should be clearly understood as a component of the county's response.

2. Assess the situation

Situational understanding is critical for developing effective response actions. The department should have access to established mechanisms and systems within the community (city, county, regional, or state) that can provide and/or verify situational information.

3. Establish incident objectives

At the tactical field level, the Incident Commander (or Unified Command if multiple agencies are involved) sets the overall objectives for the response. For DOCs or EOCs above the field level, e.g., a DOC for the county MH/BH department or a county EOC that includes county MH/BH department representation, there is usually a senior policy group that provides input on objectives that are communicated to the DOC/EOC Manager or Coordinator. Incident objectives always follow the SMART format – Specific, Measurable, Actionable, Realistic, and Time-Bound.

4. Determine appropriate strategies to achieve the objectives

Once the objectives have been established, the DOC/EOC Section Chiefs will determine the appropriate strategies and actions to effectuate the response. This leads to an Action Plan for each section that clearly identifies actions and duties. Action Plans can be developed on a daily or weekly basis, depending on the needs of the incident. It is important to track and document objectives and their completion.

5. Give tactical direction and ensure that it is followed

Tactical directions provide operational and response personnel with the actions to be taken and identify the resources needed to complete the task.

6. Provide necessary back-up

When tactical direction is initiated, support may be needed to meet the objectives. This may include revision of the actions taken in the response, the assignment of additional resources (personnel, supplies and equipment), and/or the revision of objectives.

7. Document the Action Plan

The Federal Emergency Management Agency (FEMA) has developed ICS forms that can be utilized in Action Planning. These forms are a documentation tool that directs the response and archives the objectives, strategies, and tactics. It is also used as a method for documenting the personnel, supplies, and equipment used in response and recovery phases. County MH/BH departments can customize ICS forms in a way that best meets their needs.

The completed Action Plan should be copied and shared with all deployed DBH staff so that all team members clearly understand the information most relevant to incident response.