Jennifer Yasumoto
Health and Human Services Director

Jim Diel
Acting Mental Health Director

2751 Napa Valley Corporate Drive
Napa, California 94558

A Tradition of Stewardship
A Commitment to Service

| MENTAL HEALTH DIVISION | **Mental Health Disaster Response Plan** |

NAPA COUNTY HEALTH AND HUMAN SERVICES AGENCY (HHSA)

This Page Left Intentionally Blank

Napa County Mental Health Disaster Plan

Overview

The Napa County Mental Health Disaster Plan provides a comprehensive concept of operations and guidance document to the disaster mental and behavior health community in the County of Napa.

Record of Changes

Revision			

Table of Contents

Contents

1. Introduction

The Napa County Mental Health Disaster Plan (Plan) is intended to provide a county approach to the mental health disaster function. It serves as a foundational document to ensure coordination of efforts prior to, during and after an emergency.

The Plan recognizes mental health as a component of public health and medical services and promotes the integration of these functions to better facilitate the effective and efficient provision of disaster services.

2. Purpose, Scope, Situation, Assumptions

2.1. Purpose

The Napa County Mental Health Disaster Response Plan addresses the continuum of mental health care before, during, and after a disaster by identifying specific emergency operations activities for each phase of a disaster. The Plan guides the county response to and recovery from the mental health impacts of a disaster. The Plan provides a structure for coordination of county response and recovery efforts.

2.2. Scope

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

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

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

2.3. Relationship to Other Plans

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

2.4. Situation Overview

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

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

---

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

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

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

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

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

[7] Disaster Mental Health Concept of Operations for Public Health of Seattle and King County, 2012.

- Loss of credibility for public health, other government authorities, and societal structures. These reactions include lack of adherence with mandatory quarantine measures and massive price inflation and complete supply chain depletion due to panic buying of critical supplies, such as N-95 respirators, pharmaceuticals, hand sanitizer, and disposable gloves;
- Concerned citizens can overload healthcare systems and inundate hospitals. Patients with "multiple unexplained physical symptoms" or "disaster somatic reaction" have ratios above normal patient census that range from 75:1 to 1700:1. For example, presentation patients with physical symptoms of SARS, radiation exposure, or other causative factors, despite no evidence of exposure and failure to meet case definitions.
- Job defection rates among health care workers and first responders in infectious disease scenarios; and,
- Increased risk of death from natural and "unnatural" causes (e.g. among parents who lose their children traumatically)[8].

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

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

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

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

---

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

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

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

- Utilization of a mental health triage, screening and assessment model[10].
- Disaster Crisis Intervention by mental health professionals;
- Psychological First Aid programs for use by a wide range of mental health professionals, disaster responders and community members;
- Publicizing enhanced coping techniques for the general public via social media, risk communication, and other messaging;
- Development and support of social support systems pre- and post-event to support personal and population-level efforts to continue routine daily activities;
- Access to existing open source available treatments (e.g., internet based, etc.) for specific subpopulations at risk for depression and PTSD;
- The Substance Abuse and Mental Health Services Administration (SAMHSA) /Federal Emergency Management Agency Crisis Counseling Program, including specialized crisis counseling interventions, which relies on paraprofessionals and professionals;
- Immediate crisis intervention by mental health professionals, including a range of modalities;
- Brief support by health care workers and providers;
- Tele-health capacities such as the National Disaster Distress Call Line;
- Acute, evidence based interventions; and
- Resiliency toolkits designed for specific populations such as health care worker.

2.5. Plan Focus, Guiding Principles and Assumptions

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

Principles

- Disaster mental health activities across the mitigation, preparedness, response, and recovery phases of a disaster represent mandates for public health and emergency medical service agencies. Therefore, the disaster mental health function is part of the Medical/Health Operational Area Coordination (MHOAC) program, and mental health function competencies should also be required of the Regional Disaster Medical Health Coordinator (RDMHC). It should also be noted that mental health impacts exist after acute medical needs and last well into the recovery phases.

- Disaster mental health should not be an isolated, siloed activity in response to a disaster, but rather as an ongoing effort that spans all phases of a disaster that is routinely represented in emergency management systems, response planning, and disaster exercises.

- Interventions during disaster response and recovery should be delivered by licensed mental health professionals, trained volunteers, and paraprofessionals.

- Disaster mental health workers will triage, assess, provide early psychological first aid, crisis counseling and make referrals, consistent with their level of training and scope of practice.

- The provision of disaster mental health services should be based on current evidence informed, best practices and widely accepted national guidelines such as the SAMHSA National Registry of Evidence Based Practices or Institute of Medicine. (See references and resources in Appendix F)

- Disaster mental health is not limited to crisis-oriented individual interventions, but also must address a continuum of risk, needs, and available resources.

- Local jurisdictions maintain primary responsibility to coordinate emergency response in the impacted area. The State carries out response activities in support of and in coordination with local response activities.

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

- Implementation of this Plan is dependent on its release and training.

Assumptions

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

---

[11] State of California Emergency Plan, July 2009, pg. 28 – 29.

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

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

3 Mitigation and Preparedness

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

3.1 Mitigation

For the purpose of this Plan, mental health mitigation actions refer to activities that (1) support individual and community resiliency and (2) have the potential to reduce the need for disaster mental health interventions.

MITIGATION ACTIONS INCLUDE:

☐ Implementing resiliency improvement strategies such as disseminating mental health first aid training in the community pre-event.

☐ Provision of prevention and early intervention activities that strengthen community resilience such as those provided through the Mental Health Services Act.

☐ Provision of resiliency training for emergency responders and staff (such as the *Anticipate Plan and Deter* Responder Resilience Program developed for the US Public Health Service and Los Angeles County Emergency Medical Services Agency).

☐ Educating the public on expected reactions to unusual stressors as well as coping strategies to respond to such reactions in order to lessen the possibility of a more serious or continuing psychological response.

3.2 Preparedness

Preparedness involves activities undertaken in advance of an emergency to develop and enhance operational capacity to respond to and recover from an emergency.

3.2.1. Planning

Napa County continually reviews and develops plans that will facilitate and support the disaster mental health function. Below are examples:

PLANNING ACTIONS:

☐ Review Napa County's emergency plan to ensure that mental issues or function are adequately integrated and addressed.

☐ Meet with stakeholders. Review after action reports and relevant publications to identify common mental health issues in emergencies and the potential for impact of these issues in Napa County. Establish preparedness priorities for your area.

☐ Reach out to organizations, practitioners and other jurisdictions that can assist you in initiating or further developing disaster mental health preparedness initiatives identified in the previous task.

☐ Participate in local and regional coordination to assist with planning and preparedness efforts for disaster mental health in your jurisdiction.

☐ Prepare for disaster mental health response by adopting, promulgating, and integrating into established emergency management systems methods for obtaining disaster mental health situation reporting, priority setting, resource allocation and mutual aid management for disaster mental health.

☐ Identify the need for establishing or integrating mental health priorities into sources of funding for preparedness grant funding, including establishing methods for gathering the necessary elements to support post-disaster grant applications.

☐ Develop memoranda of understanding (MOU) or statements of understanding (SOU) with key partners, including contractors and other private and non-profit partners that can assist in carrying out the post-disaster mental health mission.

☐ Work with stakeholders and lead jurisdictional and mental health partners to develop operational area based Family Assistance Center Plans[14] for provision of non-intrusive, culturally sensitive mental health support services to family
members of the deceased, incident survivors, and responders, if requested following a mass fatality disaster.

☐ Meet with the hospital/healthcare partners (who have a role in coordinating disaster response to hospitals and clinics in your area) to develop processes for healthcare organizations to request mental health support during healthcare surge incidents for healthcare providers, responders, survivors, and families.

☐ Develop pre-scripted messages to assist with the mental health mission for use   in an emergency. Establish a method to store, coordinate and share pre-scripted messages prior to and during disasters.

☐ Clarify and include the appropriate tasks to maintain continuity of operations as an important element for disaster mental health during mitigation, preparedness, response and recovery.

☐ Develop guidelines for use of evidence based rapid mental health triage at the Operational Area level.

☐ Conduct baseline mental health surveillance to be used to identify the adverse health effects of a disaster. Baseline surveillance data can be used to design, target and implement interventions during response as well as to inform the development of programs to improve community resilience prior to an incident. The analysis of data collected identifies special populations and community characteristics that will be relevant to recovery efforts.

---

[14] Los Angeles County Operational Area Family Assistance Center Plan, March 16, 2010, version 16

[15] http://www.cdcradiationconference.com/presentation/PlanningPsychosocialBehavioralHealthRadiationEmergency-Yin.ppt

[16]   http://www.cdms.uci.edu/PDF/PsySTART-cdms02142012.pdf

3.2.2. Training and Exercises

Training, tests and exercises are essential to ensure mental health personnel, public officials, emergency response personnel and the public are operationally ready. Disaster Mental Health Core Competencies have been developed for use in California (see Appendix D). Training courses and exercises address these competencies. The disaster mental health function is integrated into the exercise plans for all agencies and organizations with emergency management responsibilities. Napa County includes a surge of psychological casualties and mental health issues (for patients, community members, response staff, etc.) as a regular and expected part of their existing exercise program.

TRAINING AND EXERCISE ACTIONS:

☐ Review training and exercise plan/program from a disaster mental health perspective. Work with stakeholder groups to facilitate inclusion of all appropriate mental health partners. Ensure that a variety of disaster mental health issues, mental health causality estimates etc., are included as a regular and expected part of your exercise program – including post-exercise improvement plans. Determine if additional exercises should be planned in your jurisdiction to offer greater opportunities to test preparedness, response, and recovery initiatives for disaster mental health.

☐ Work with stakeholders to facilitate the availability of disaster mental health training. The type, source, and frequency of trainings should match the variety of evidence-based practices identified by the stakeholder group, potential impacted populations, as well as core competencies for both licensed and non-licensed mental health responders and volunteers. The training plan should also address training for spiritual care partners, if appropriate.

☐ Work with stakeholders to promote and advertise disaster mental health training for all practitioners including state, tribal, county, and city government and volunteers.

3.2.3. Developing Disaster Mental Health Resources

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

RESOURCE ACTIONS:

☐ Meet with emergency manager to review current resource management process for mental health staff and materials.

☐ Work with stakeholders to identify resources programs, personnel, and equipment that are currently available to support disaster mental health tasks following disasters.

☐ Work in coordination with internal and external partners to determine if there are significant gaps in resources based on anticipated disaster mental health needs and identify potential sources to fill those gaps.

☐ Ensure that Napa County has standardized terms, request forms, procedures, mutual aid and deployment plans to facilitate the effective requesting, identification, credentialing, assigning, identification, mobilization, management, and deployment of disaster mental health staff to needed locations following disasters. Plans should also include the deployment and management of volunteers, as well as pre and post-deployment mental health support for both paid and volunteer staff.

☐ Determine what resource databases are currently available, including SAMHSA, CCP Forms and toolkit, government, private and non-governmental mental health resources.

☐ Encourage potential mental health responders to pre-register as a disaster volunteer. Examples include the Disaster Healthcare Volunteers of California. https://www.healthcarevolunteers.ca.gov/

☐ Ensure that mental health resources, including private sector assets, operate in accordance with EF-8. Develop procedures to request mental health resources in accordance with EF-8/EF-6 guidance and the EOM. Identify vendors for resource purchasing during a disaster and the procedures to obtain fiscal authorization to pay for resources during a disaster.

☐ Continue to work with stakeholders to integrate and practice the mechanisms used in the preparedness step to gather realistic, near-real time assessments of mental health risks and needs, available resources, gaps and how resources will be used to fill those gaps.

4 Response and Recovery

4.1 Disaster Mental Health Function

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

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

Disaster mental health responders are typically assigned to:
- Emergency Operation Centers (as a part of the SEMS/NIMS structure as well as for staff support)
- Shelters
- Natural gathering sites and open spaces unique to each local community; parks; fields; empty lots
- Casualty collection points
- Family Assistance Centers
- Public Information
- Call-in centers

---

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

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

RESPONSE ACTIONS:

☐ Work with stakeholders to review recovery plans and procedures to ensure that mental health issues are adequately addressed, including enough available resources to support the potential deployment locations for mental health staff (see above).

☐ Facilitate the participation of all stakeholders in any exercises where recovery functions are practiced. Participate in the after action and improvement planning process including using stakeholders to address plan improvements.

4.2   Disaster Mental Health and Identification of Stakeholders

4.2.2   Private Sector Stakeholders

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

---

[18] FEMA, National Disaster Recovery Framework (September 2011).

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

Figure 1 - Disaster Mental Health Organizational Levels

Organizational Level	Lead for Disaster Mental Health Function
Federal	Health and Human Services (HHS) Agency - ESF 8
State	CA Health and Human Services Agency (CHHS) -
Regional	CHHS - EF
Operational Area	OA Disaster Mental Health Function (Determined by the Operational Area)
Local	Local Government Disaster Mental Health Function (Determined by City/County Jurisdictional Authority)
Field	Field Disaster Mental Health Function (Determined by Jurisdictional Authority or Incident

SEMS LEVEL

4.3 Disaster Mental Health Programs and Services

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

---

[20] Tennessee Disaster Mental Health Response, 2012, pg. 9.

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

[22] http://www.nctsn.org/content/psychological-first-aid

[23] http://www.ready.gov/sites/default/files/documents/files/LPC_Booklet.pdf

4.3.1 Crisis Counseling Assistance and Training Program (CCP)

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

<div style="border:1px solid black; padding:10px;">

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

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

</div>

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

---

[25] Federal Emergency Management Agency Crisis Counseling Assistance and Training Program Guidance CCP Application Toolkit, Version 3.4 May 2012 , Pg. 8

CCP ACTIONS:

☐ To prepare for FEMA/SAMHSA's strict deadline for the submission of a CCP grant application, familiarize yourself with SAMHSA's guidance materials (see Appendix F – Disaster Mental Health Programs and Services).

☐ Identify key staff that will become familiar with the process used to apply for the CCP grant programs, including specialized crisis counseling. CalOES will submit the application to the federal government on behalf of Napa County and direct staff to State subject matter experts that can assist them in completing the application.

☐ Ensure that key staff are very familiar with how to access federal resources available from Substance Abuse and Mental Health Services Administration (SAMHSA)/ Disaster Technical Assistance Center (DTAC), including the nationwide Distress hotline for crisis counseling and support (www.disasterdistress.samhsa.gov).

☐ If possible, pre-identify providers that could be used as contractors to provide crisis counseling services in a CCP.

☐ Ensure that systems are in place to document initial disaster behavioral health response efforts.

☐ If there is sufficient time during a pre-notification of an event, begin collecting information and writing applicable portions of a grant application in anticipation of a Presidential Disaster Declaration.

☐ Ensure stakeholders are also educated on federal disaster mental health resources, grants (including fiscal requirements and oversight by the grant administrators - Cal EMA and FEMA), and hotline and to determine how to integrate these resources.

☐ Consider working with Departments of Mental Health statewide to sponsor a training or exercise to practice procedures to apply for CCP funds prior to the next disaster.

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

order to transition from CCP services to existing community resources upon the phase down of the program. [26]

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

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

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

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

---

[26] Information in this section is from the Tennessee Disaster Mental Health Response, 2012, pgs. 11-12.

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

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

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

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

4.3.1.2 CCP Primary and Secondary Services

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

Primary CCP Services

Individual Crisis Counseling

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

Brief Educational or Supportive Contact

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

Group Crisis Counseling

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

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

Public Education

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

Assessment, Referral, and Resource Linkage

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

Community Networking and Support

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

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

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

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

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

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

4.3.2.1   SAMHSA Disaster Distress Helpline
The Disaster Distress Helpline (DDH) is the national hotline dedicated to providing year-round immediate disaster crisis counseling. This toll-free, multilingual, crisis support service is available 24/7 via telephone (1-800-985-5990) and SMS (text 'TalkWithUs' to 66746). to residents in the U.S. and its territories who are experiencing emotional distress related to natural or man-made disasters. Callers and texters are

connected to trained and caring professionals from the closest crisis counseling center in the network. Helpline staff provides counseling and support, including information on common stress reactions and healthy coping, as well as referrals to local disaster-related resources for follow-up care and support.

https://www.samhsa.gov/find-help/disaster-distress-helpline

5   Concept of Operations

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

5.1 Operational Goals and Priorities

The operational goals of the Plan are to:

- Lessen the psychological impact of disasters by promoting community, responder, and public psychological resiliency before and during a disaster
- Provide long-term mitigation of mental health vulnerabilities following recovery activities through evidence based mental health interventions;

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

5.1.1 Emergency Activation Levels

Activation of the disaster mental health function is scaled to the nature and scope of the emergency and allows the activating authority to appropriately staff incident positions. Emergency activations may occur during the pre-event phase or after an event has occurred.

---

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

Level I Emergency Activation

Definition	Level I activation represents a minor to moderate incident where <u>local resources are adequate and available</u>. A local emergency may be proclaimed. Emergency Operations Centers (EOC) may be activated.
Examples	o A minor disaster that does not result in major personal loss such as death, destruction, economic or personal losses; o A seemingly manageable earthquake or public health threat; o A mass casualty event such as a crime event or sizeable transportation accident high in injuries or loss of life (airliner, train, severe traffic accident).
Mental Health Response	A disaster mental health response based on casualties, injuries and other losses is generally within the capacity of the County Mental Health Department. Typically, a California Department of Healthcare Services (DHCS) jurisdiction may handle this event from the Disaster Coordinator's office when the EOC has not been activated. Alert the Public Health On-Call Manager (Medical Health Operational Area Coordination

Level II Emergency Activation

Definition	Level II activation represents a moderate to severe emergency where <u>local resources may not be adequate and mutual aid is required </u>on a regional or even statewide basis. A local emergency will be proclaimed and a State of Emergency will likely be proclaimed. The Governor proclaims a STATE OF EMERGENCY when a disaster requires extraordinary action by the State in order to protect the lives, property and environment of its citizens. EOCs are activated to the extent necessary at the local government, tribal government, operational area, regional and state levels.
Examples	o A moderate disaster with escalating degrees of loss (death, destruction, economic and personal losses) and potential for crisis and trauma; o A disaster situation that is escalating slowly or on a continuum and has the potential to expand as more time goes passes; o A public health threat that is challenging to manage and has potential for transmission to other areas or raising public fear and anxiety.
Mental	Depending on the mental health resources, a disaster mental health response may be within the capacity of the County

Level II Emergency Activation

Health Response	Mental Health Department. The Mental Health Department Operations Center will usually be activated for a short period of time; the timeframe will depend upon the needs of the incident and coordination with the EOC. The jurisdiction may require additional resources from within the Mutual Aid Region to support an increasing and/or protracted response. Alert the Public Health On-Call Manager (Medical Health Operational Area
	Coordination (MHOAC)) at 707-246-0979.

Level III Emergency Activation

Definition	Level III activation represents a major disaster wherein <u>resources in or near the impacted areas are overwhelmed and needs are extensive. State and or Federal resources are required</u>. The Governor proclaims a STATE OF EMERGENCY first and then requests a PRESIDENTIAL DISASTER DECLARATION on behalf of the affected local governments. EOCs and DOCs are activated at the local government, tribal government, operational area, regional and state levels and by the federal government.
Examples	o A natural disaster with catastrophic impact (earthquake); o A human-caused incident involving weapons of mass destruction (chemical, biological, radiological, nuclear, explosive) with catastrophic impact; o A public health emergency with implications of wide-scale illness, contagion, transmission, death and public fear, anxiety and potential for panic; o A large-scale disaster with extensive economic impacts (e.g., high numbers of unemployed due to a freeze or drought)
Mental Health Response	A disaster mental health response will exceed the capacity of the County Mental Health Departments and will require resources from other Mutual Aid Regions, the State, federal government and/or other states. Coordinate with EOC.

5.1.2   Sequence of Events - Disaster Mental Health Entities and the Community

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

reactions of communities is illustrated in Figure 2 and describes, together with the disaster mental health and emergency management in this section.

FIGURE 2 - PHASES OF DISASTER: COLLECTIVE REACTIONS

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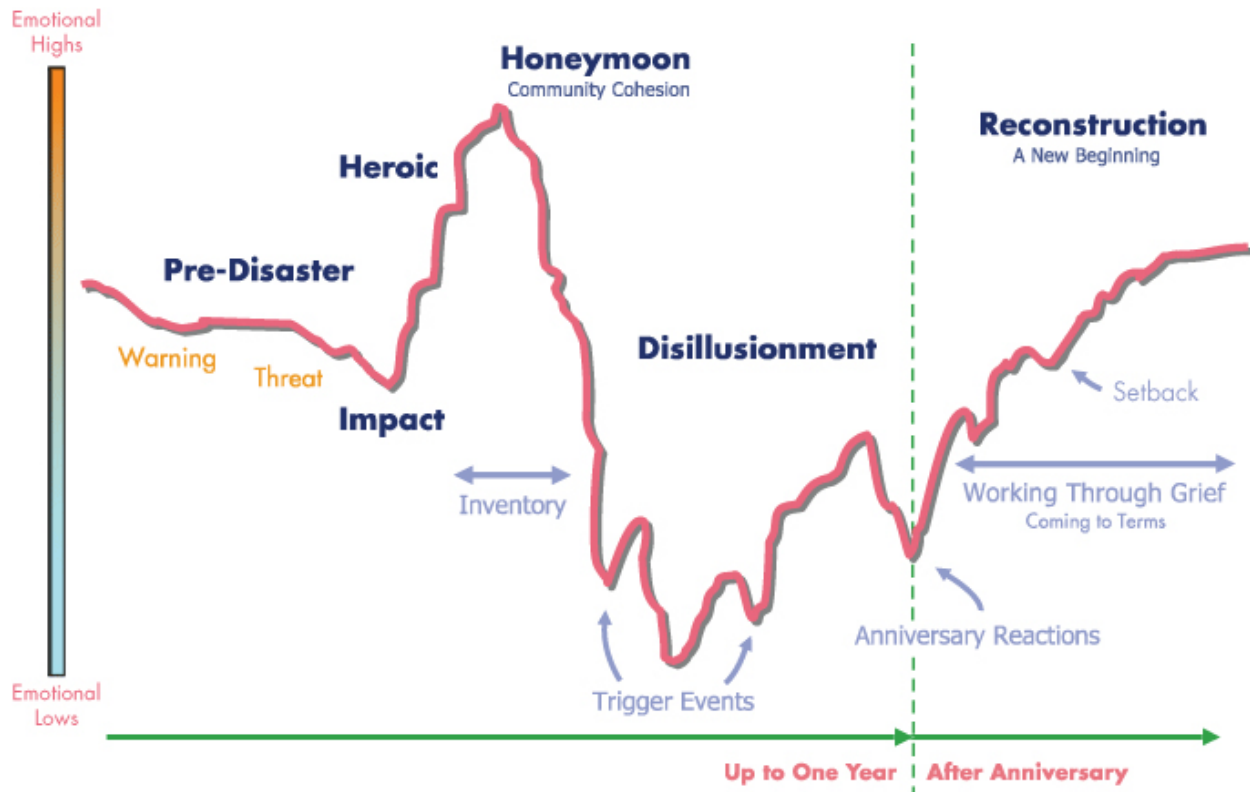
5.1.3 Response

Pre-Event

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

Sufficient warning provides the opportunity to increase readiness and to effectively respond once the emergency occurs and to ensure the community is warned. This includes, but is not limited to:

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

Event

During this phase, emphasis is placed on control of the situation, saving lives and minimizing the effects of the disaster, including adverse mental health impacts. The impact phase of a disaster can vary from the slow, low-threat buildup associated with some types o f floods to earthquakes and other rapid, dangerous disasters with destructive outcomes.

The greater the scope, community destruction, and personal losses associated with the disaster, the greater the psychosocial expected effects. In the immediate aftermath of a disaster event, survival, rescuing others, and promoting safety are priorities (the "heroic" phase). Evacuation to shelters, motels, or other homes may be necessary. The conditions associated with evacuation and relocation have psychological significance. When there are physical hazards or family separations during the evacuation process, survivors often experience post-trauma reactions.

For large county led responses, the following model used to triage/refer disaster victims, "Napa County Mental Health Disaster Response", see Appendix I.

For less severe events that still affect the community (e.g., youth suicide, school lockdown refer to the "Community Event Response Plan" see Appendix J.

For the operational response direction and guidance based on type of disaster refer to the "Mental Health Disaster Response Plan Matrix", see Appendix K

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

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

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

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

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

FIGURE 3 – Phases of Disaster[30]
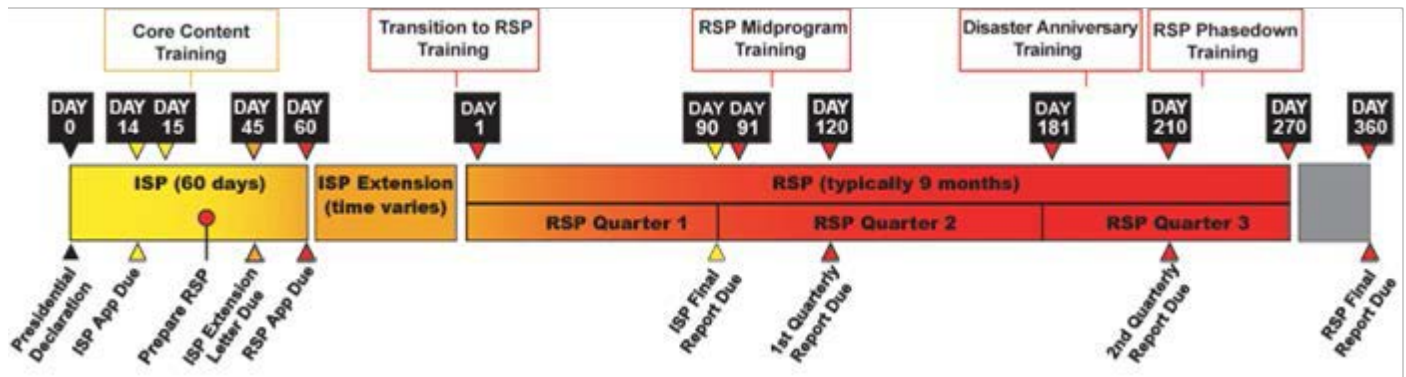
Short Term Sustained Operations

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

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

Disaster mental health assistance during sustained operations may include:

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

---

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

5.1.4 Recovery

Recovery is coordinated by the Mental Health Division and has three phases - short, intermediate, and long-term[31]. Short-term recovery begins concurrently with or shortly before the commencement of response operations and may last for days. This phase addresses health and safety needs beyond rescue, assessment of the scope of damages and needs, restoration of basic infrastructure and mobilization of recovery organizations and resources.

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

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

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

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

RECOVERY ACTIONS:

☐ At this point in time, the local jurisdiction should have submitted their application for the FEMA CCP Immediate Service Program.

☐ Implementation of approved FEMA CCP Immediate Services Program Grant activities.

☐ The local jurisdiction may apply for the FEMA funded Regular Services Grant Program. This grant may continue for approximately nine months.

☐ Mental Health Division coordinates recovery efforts including but not limited to outreach to affected populations, data informed support services, and brief crisis response through existing resources.

☐ Provision of licensed mental health clinicians to all affected schools for 1-2 days following resumption of regular student attendance as requested.

☐ Provide behavioral support for operations of the Local Assistance Center during hours of operation, with more limited ad hoc support provided for community provider sites assisting with recovery efforts.

☐ Coordination of mental health service provision for individuals experiencing a mental health need following the disaster through the Central Access call line and targeted activities based on data , linking to the SAMHSA CCP services provided through the MHP (by a plan provider, Mentis), county staff for brief intervention, mobile crisis response, and brief therapy services regardless of ability to pay. These activities remain ongoing and will scale down as community needs are met, with Central Access coordination concluding with the close of the Local Assistance Center.

☐ Data review and mapping from shelter operations to refine outreach, targeting of service provision and likely community needs from interviews conducted during disaster event.

☐ Participation in community forums, coordination with the Community Organizations Active in Disasters (COAD), and after action reporting as well as regional Public Health Emergency Preparedness (PHEP) system improvement activities.

---

[31] FEMA National Disaster Recovery Plan (September 2011). A Southern California Recovery Guide is also in final stages of development through efforts of the Urban Area Security Initiatives (UASI)

5.2 Alert and Notification

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

5.2.1   Notification Methods

Notification methods may include email, telephone or a combination of these types. The method utilized typically reflects the urgency associated with the specific incident.

NOTIFICATION ACTION:

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

---

5.2.2 Field

When field-level mental health entities become aware of an incident that may impact mental health, they should notify their supervisor in accordance with statutory and regulatory requirements and policies and procedures.

5.2.3 Local Government

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

5.2.4 Operational Area

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

---

[32] The California Health Alert Network (CAHAN) is the State of California's web-based information and communications system available on a 24/7/365 basis for distribution of health alerts, dissemination of prevention guidelines, coordination of disease investigation efforts, preparedness planning, and other initiatives that strengthen state and local preparedness.
http://www.bepreparedcalifornia.ca.gov/cdphprograms/publichealthprograms/emergencyPreparednessOffice

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

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

5.2.5 Region/State

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

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

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

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

5.2.6 Federal

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

5.3   Direction, Control, and Coordination

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

5.3.1 Field Operations

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

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

5.3.2 Local Emergency Operations Centers

EOCs are activated to support significant emergency responses, including disaster mental health issues. Napa County Mental Health is responsible for coordinating mental health services in Napa. Disaster mental health resources are typically drawn from county or city staff, contracted services, and pre-screened and registered volunteers (e.g., from the Napa County Medical Reserve Corp).

5.3.3 Operational Area Emergency Operations Centers

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

It is anticipated that an event requiring a significant disaster mental health response will also require OA EOC activation. The disaster mental health function will be coordinated through the Medical/Health Branch in the EOC as part of the Medical and Health Operational Area Coordinator (MHOAC) Program, and will serve as liaison to the Napa County Mental Health Division. For additional information about types of resources to request, please see Appendix G - Resources.

5.3.4 Regional Emergency Operations Centers

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

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

5.3.5 State Operations Center

The State manages state resources in response to the emergency needs of the other SEMS levels, manages and coordinates mutual aid among the regions and between the regional level

and state level, and serves as the coordination and communication link with the federal disaster response system. Cal EMA maintains the State Operations Center (SOC) at its headquarters.

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

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

5.3.6 EF 8 Multi-Agency Coordination (MAC) Group
An EF 8 MAC Group may be convened at the regional or state level with participation across the spectrum of public health and medical entities, including mental health, depending on the scope and magnitude of the emergency. EF 8 MAC Group activities may include

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

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

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

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

5.4 Information Collection, Analysis, and Dissemination

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

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

5.41 Disaster Mental Health Information and Intelligence

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

Disaster mental health information should be integrated through the MOAHC Program with public health and medical information as described in the California Public Health and Medical Emergency Operations Manual. Information needs will change over time as the incident progresses. However, information gathering and analysis should be streamlined as much as possible and used for different purposes, as applicable, e.g. situation reports and needs assessments.

In an emergency Napa County Mental Health will gather the following, where applicable:
- Any population based assessment of mental health impacts and needs
- Maintain contact with official sources of fatality, casualty, and other statistics (such as the Coroner, Department of Health, etc.) to obtain ongoing information on numbers of people dead, injured, hospitalized, numbers of homes destroyed/damaged, disaster-related unemployment data, etc. Use this information to determine post-disaster mental health impact and to develop the appropriate community-wide mental health response and recovery plans.
- Information from the CCP application, specifically the CCP Tool Kit database.
- High-risk groups or populations of special concern.
- Potential for psychological harm (acute and long-term).
- Status of mental health infrastructure (facility evacuation; status of outpatient providers).
- Patterns of large scale convergence of concerned citizens (worried and well) on health facilities.
- Behavioral/mental health needs of responders.

- Resources for mental health care (short term and long term).
- Capabilities for providing disaster mental health and emergency behavioral health care (personnel, medications, etc.), including specific capacity among licensed health care facilities (psychiatric bed counts, pediatric psych bed counts), as well as licensed responders and non-licensed individuals trained in psychological first aid, psychological triage, and other response skills.
- Disaster mental health support being provided at shelters, reception and service centers, schools, businesses, places of worship, natural gathering sites and open spaces unique to each local community, parks, fields, empty lots, casualty collection points, mental health facilities, hospitals and other medical treatment sites, isolation and quarantine sites, points of distribution and dispensing, Family Assistance Centers, Local Assistance Centers/Disaster Recovery Centers, call-in centers and other facilities.
- Resources requested.

5.4.2 Field

Disaster mental health information and intelligence will be transmitted from field sites to the appropriate personnel in accordance with established policies and procedures.

Information and intelligence will be coordinated through the field site's planning element and disseminated through the command function.

5.4.3 Local Government

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

5.4.4 Operational Area

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

Information is entered into the OA's specified reporting system and shared within the OA; information is forwarded to the Regional Disaster Mental Health Coordinator (RDMHC) Program as outlined in the California Public Health and Medical Emergency Operations Manual. Information sources for the OA disaster mental health function may include:
- Appropriate City Agencies/EOCs
- Mental Health Department
- Public Health Department
- Department of Social Services
- American Red Cross
- Contracted service agencies
- Community-based organizations
- Health care facilities

5.4.5   Region

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

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

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

5.4.6   State

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

Information sources for the state disaster mental health function may include:
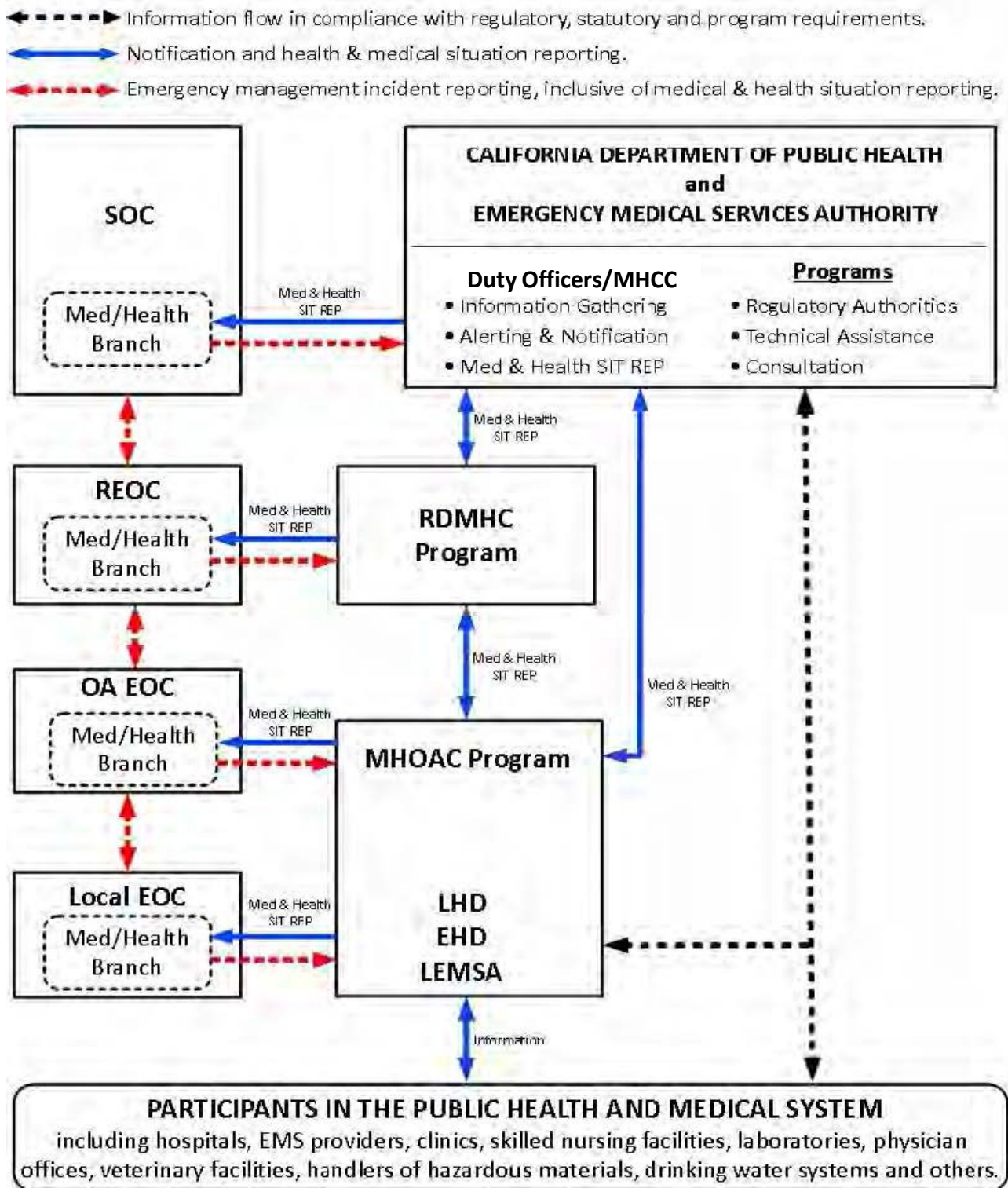
- REOCs
- MHCC
- Agencies and organizations represented in the SOC

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

5.4.7   Federal

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

Figure 3 - Information Flow during Emergency System Activation[33]

Information flow in compliance with regulatory, statutory and program requirements.

Notification and health & medical situation reporting.

Emergency management incident reporting, inclusive of medical & health situation reporting.

SOC
- Med/Health Branch

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH and EMERGENCY MEDICAL SERVICES AUTHORITY

Duty Officers/MHCC
- Information Gathering
- Alerting & Notification
- Med & Health SIT REP

Programs
- Regulatory Authorities
- Technical Assistance
- Consultation

Med & Health SIT REP

REOC
- Med/Health Branch

Med & Health SIT REP

RDMHC Program

Med & Health SIT REP

OA EOC
- Med/Health Branch

Med & Health SIT REP

Med & Health SIT REP

MHOAC Program

Local EOC
- Med/Health Branch

Med & Health SIT REP

LHD EHD LEMSA

Information

PARTICIPANTS IN THE PUBLIC HEALTH AND MEDICAL SYSTEM
including hospitals, EMS providers, clinics, skilled nursing facilities, laboratories, physician offices, veterinary facilities, handlers of hazardous materials, drinking water systems and others.

[33] California Public Health and Medical Emergency Operations Manual (July 2011).

5.5   Public Information

.

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

5.5.1 Disaster Mental Health Emergency Public Information

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

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

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

5.5.2 Operational Area

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

5.5.3 Region/State

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

5.5.4 Federal

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

5.6 Resource Management

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

5.6.1 Disaster Mental Health Programs and Services

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

5.6.2 Disaster Mental Health Resources

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

5.6.3 Resource Agreements

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

5.6.3.1 Mutual Aid

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

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

5.6.3.2 Agreements

Contracts

Napa County Mental Health has agreements with the following organizations to provide disaster response services:

- Aldea Children & Family Services
- Buckelew Programs
- Mentis
- Progress Foundation
- Exodus

Payment for Service

Reimbursement occurs through the existing terms and provisions of contracts with these providers or through the mutual aid reimbursement process, where the county has requested these services. Existing avenues of payment include: Medi-Cal billing, SAMHSA block grant funding, AB109 funding, Mental Health Services Act (MHSA), and other local/state/federal grants and payment arrangements.

5.6.4 Flow of Requests and Resources

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

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

Figure 4. Flow of Resource Requests and Assistance during Emergencies[34].
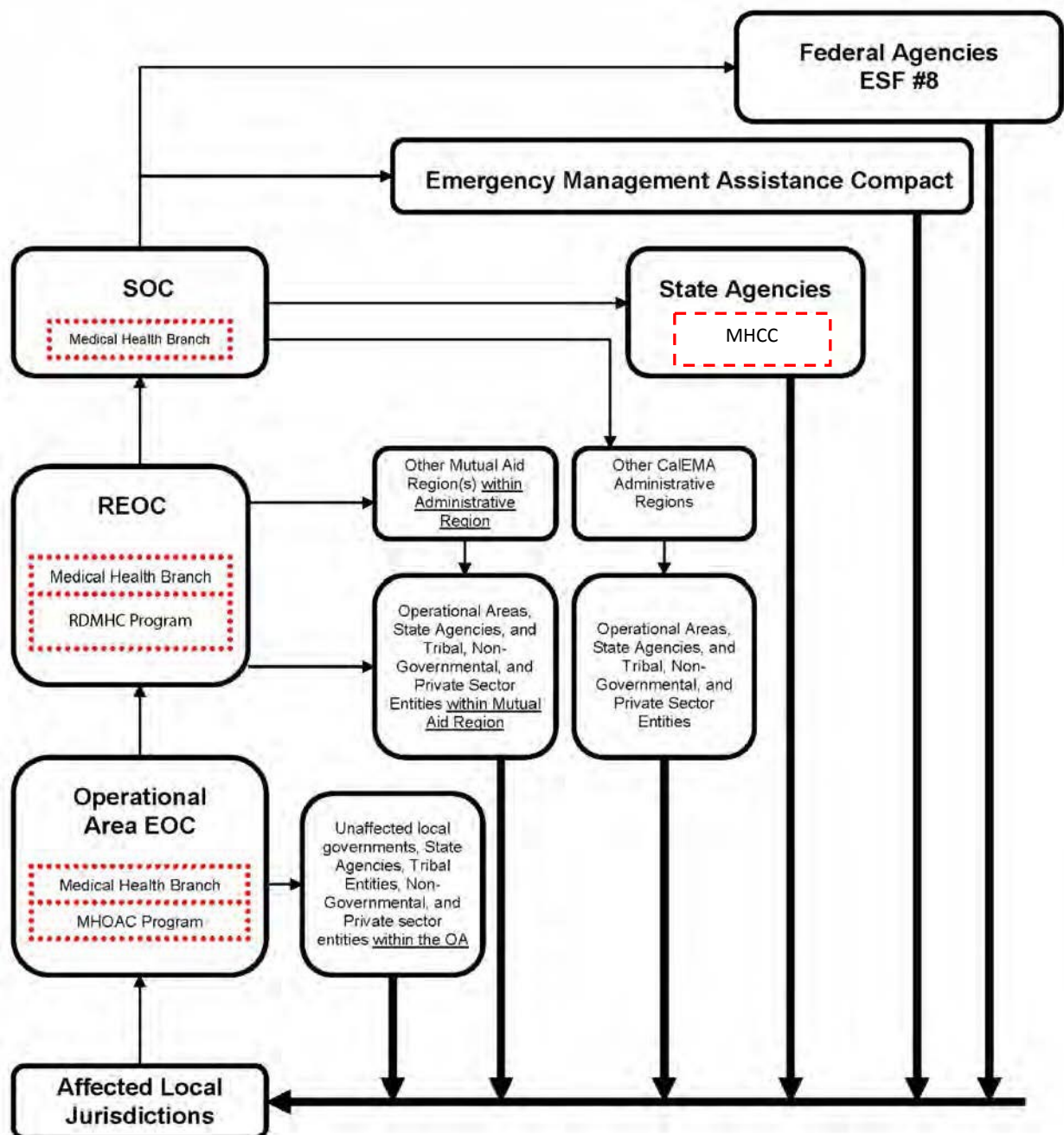
6   Administration, Finance, and Logistics

6.1 Administration

6.1.2   Documentation

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

6.1.3 After Action Reports

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

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

6.2 Finance

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

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

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

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

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

6.2.1 Victim Advocacy Programs

6.2.1.1 Project SERV
CFDA Number: 84.184S
Program Type: Discretionary/Competitive Grants
www.ed.gov/programs/dvppserv/index.html

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

6.2.2 State Programs

6.2.2.1 Office of Justice Programs
Victims of Crime

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

www.ojp.gov/programs/victims.htm

6.2.3 Federal Programs
Health and Human Services (HHS)/Substance Abuse and Mental Health Administration (SAMHSA)
- **CSAP/CSAT Discretionary Funds**
- Center for Substance Abuse Prevention (CSAP)
- Center for Substance Abuse Treatment (CSAT)
  http://www.samhsa.gov/Budget/FY2012/SAMHSA- FY11CJ.pdf

6.3 Logistics

During emergency response and recovery, disaster mental health resources are acquired pursuant to the incident objectives through the established emergency management channels.

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

7   Training and Exercises

Napa County Mental Health with lead and participate in trainings and exercises.

8   Plan Maintenance

Napa County Mental Health coordinates and facilitates the Plan review and maintenance process, which includes coordination with lead and supporting agencies and other key stakeholders.

9   Authorities and References

9.1   Executive Authority Documents and Agreements

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

9.2   State Law

- California Emergency Services Act, Government Code §8550
- California Disaster Assistance Act, Government Code §8680
- Welfare and Institutions Code
- Health and Safety Code
- Penal Code
- California Code of Regulations
- California Code of Regulations (CCR)
- Disaster Service Worker Regulations
- State of California Emergency Plan (SEP)
- California Public Health and Medical Emergency Operations Manual (EOM)
- Other Relevant State Plans

9.3   Federal Law

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

Appendices

Appendix A – Acronyms

Appendix B - Glossary

Appendix C – Organizational Roles and Assignment of Responsibilities

Appendix D - Disaster Mental Health Core Competencies

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

Appendix F - Disaster Mental Health Programs and Services

Appendix G - Disaster Mental Health Resources

Appendix H – References

Appendix I _ Napa County Mental Health Disaster Response

Appendix J – Community Event Response Plan

Appendix K - Mental Health Disaster Response Matrix

Appendix A - Acronyms

AAR: After Action Report
ACF-OHSEPR: Administration of Children and Family Office of Human Services Emergency Preparedness and Response
AoA: Administration on Aging
ARC: American Red Cross
ASPR: Assistant Secretary for Preparedness and Response
ASPR: Association of Staff Physician Recruiters ASPR-ABC: ASPR's Response At-Risk Behavior
ASPR-NDMS: ASPR's National Disaster Medical System
ASPR-REC's: ASPR's Regional Emergency Coordinators
CAHAN: California Health Alert Network
Cal EMA: California Emergency Management Agency
CDC: Center for Disease Control
CDPH: California Department of Public Health
CHHS: California Health and Human Services Agency
CMS: Centers for Medicare and Medicaid Services
CONOPS: Concept of Operations
CSWC: California State Warning Center
DDH: Disaster Distress Helpline
DHCS: California Department of Healthcare Services
DOC: Department Operations Centers
DoD: Department of Defense
DTAC: Disaster Technical Assistance Center
EDO: Cal EMA Executive Duty Officer
EF-8: California Emergency Function 8
EMAC: Emergency Management Agreement
EMS: Emergency Medical Services
EOC: Emergency Operations Center
EOM: Emergency Operations Manual
EPCO: Office of Emergency Preparedness and Continuity of Operations
ESAR-VP: Emergency System for Advance Registration of Volunteer Health Professionals
Framework: State of California Mental/Behavior Health Disaster Response Framework
FEMA CCP: Federal Emergency Management Agency Crisis Counseling Program
FEMA: Federal Emergency Management Agency

HHS: Health and Human Services Agency
IHEs: Institutions of higher education
IHS: Indian Health Services
HPP: Hospital Preparedness Program
HRSA: Health Resources and Services Administration
IC: Incident Command
IOM: Institute of Medicine
IPs: Improvement Plans
ISP: Immediate Services Program
JFO: Joint Field Office
JIC: Joint Information Center
LEAs: Local Education Agencies
MAC: Multiagency Coordination
MHCC: Medical Health Coordination Center
MHOAC: Medical Health Operational Area Coordinator
MMAA: California Disaster and Civil Defense Master Mutual Aid Agreement
MOU: Memorandum of Understanding
NCPTSD: National Center for Post-Traumatic Stress Disorder
NIH: National Institutes of Health
NIMS: National Incident Management System
NOVA: National Organization for Victim Assistance
NRF: National Response Framework
NVOAD: National Voluntary Agencies Active in Disaster
OA: Operational Area
OD: Office on Disability
OFRD: Office of Force Readiness and Development
OTF: Opioid Treatment Facility
PFA: Psychological First Aid
PIO: Public Information Officials
PTSD: Post-traumatic Stress Disorder
RDMHC: Regional Disaster Medical and Health Coordinator
REOC: Regional Emergency Operations Center
RSP: Regular Service Program
SAMHSA: Substance Abuse and Mental Health Services Administration
SARS: Severe Acute Respiratory Syndrome
SCCS: Specialized Crisis Counseling

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

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

Appendix B - Glossary

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

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

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

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

California Health Alert Network - The California Health Alert Network (CAHAN) is the State of California's web-based information and communications system available on a 24/7/365 basis for distribution of health alerts, dissemination of prevention guidelines, coordination of disease investigation efforts, preparedness planning, and other initiatives that strengthen state and local preparedness. CAHAN participants have the ability to receive alerts and notifications via alphanumeric pager, e-mail, fax, and phone (cellular and landline). http://cdphready.org/california-health-alert-network-cahan/

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

Casualty collection point - A site for the congregation, triage (sorting), preliminary treatment, and evacuation of casualties following a disaster. Emergency Medical Services Authority, EMS System Standards and Guidelines (June 1993 – EMS #101) https://emsa.ca.gov/wp-content/uploads/sites/71/2017/07/emsa101.pdf

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Healthcare surge - A healthcare surge is proclaimed in a local jurisdiction when an authorized local official, such as a local health officer or other appropriate designee, using professional judgment determines, subsequent to a significant emergency or circumstances, that the healthcare delivery system has been impacted, resulting in an excess in demand over capacity in hospitals, long-term care facilities, community care clinics, public health departments, other primary and secondary care providers, resources and/or emergency medical services. The local health official uses the situation assessment information provided from the healthcare delivery system partners to determine overall local jurisdiction/Operational Area medical and health status. CA Department of Public Health Standards and Guidelines for Healthcare Surge During Emergencies – Foundational Knowledge. http://cdphready.org/wp-content/uploads/2015/10/CAHAN-1st-Time-User-Guide.pdf

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mental health assessment - Mental health assessment is provided by mental health professionals and is systematic approach to understanding the mental status, needs and diagnoses of individuals including children. Part of the disaster "seamless triage to care" model. [36]

Mental health triage - Process of sorting individuals based on evidence based risk markers for acute mental health emergencies and/or long term risk for disorder. The first component of the "seamless triage to care model". [37]

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

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

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

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

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

---

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix C – Organizational Roles and Assignment of Responsibilities

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

1 State Agencies

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

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

1.2 Supporting State Agencies/Departments/Offices

1.2.1 California Office of Emergency Services

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

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

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

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

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

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

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

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

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

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

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

1.2.3   Department of Alcohol and Drug Programs

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

1.2.4   Department of Developmental Services

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

Coordination with local emergency response and shelter staff to provide and/or obtain mental health resources.

Adjusting employee work schedules to avoid strenuous assignments that may result in stress and fatigue.

- DDS regional centers will initiate contact with their community emergency preparedness networks to identify resources for assisting impacted individuals with accessing needed services.
- DDS regional centers will initiate contact with service providers and clients who live independently to provide them with information about precautionary measures to protect their health and safety, identification of resources, and other pertinent information.

1.2.5 Department of Education

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

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

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

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

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

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

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

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

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

1.2.6 Department of Public Health

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

- Care and Shelter: Ensures the safety of food, drugs, medical devices and other consumer products in the disaster area. Regulates bottled drinking water plants and distributors and drinking water haulers to ensure the safety of bottled or hauled water used as emergency supplies of drinking water. Provides support to local health departments for infectious disease surveillance and outbreak response and food safety and sanitation standards in shelters. Analyzes impacted areas for safe return of displaced populations.
- Construction and Engineering: Provides technical assistance with the

construction, operation and inspection of public drinking water treatment facilities and assesses the extent of damage to public drinking water systems in disaster areas. In conjunction with the Office of Statewide Health Planning and Development (OSHPD), inspects healthcare facilities to determine their ability to provide patient care following an emergency.

- Evacuation: Supports local jurisdictions in safe evacuation of patients from healthcare facilities due to disaster. Provides assistance/coordination in identifying facilities needing evacuation, setting evacuation prioritizations and in facility re-population. Provides support for infant transport from neonatal intensive care units in coordination with the Emergency Medical Services Authority (EMSA). Provides assessments on radiation levels that require evacuation in a radiological incident.

- Fire and Rescue: Provides radiation safety services to responding fire and hazardous materials organizations for large radiological incidents. Provides assessment of health risks to both first responders and the public due to contaminants generated by fires and smoke.

- Food and Agriculture: Acts as technical resource on disease-carrying insects and animals and food safety in a disaster area. Provides laboratory and assessment services related to chemical, microbial and radiological contaminants. Identifies and assesses hazards to human health posed by pesticides used to combat agricultural pests.

- Hazardous Materials: Coordinates with appropriate agencies to investigate chemical exposures and determine appropriate protective actions. Coordinates emergency medical waste and shellfish protection programs with responsible state and local agencies. Augments local radiological monitoring and decontamination programs in the event of a nuclear power plant or other radiological disaster. Provides laboratory services related to food, drug, hazardous materials, drinking water contamination and testing of environmental samples.

- Law Enforcement: Provides guidance to law enforcement organizations on radiation safety. Works with fire and law to determine patient safety within licensed healthcare facilities.

- Long Term Recovery: Supports the restoration of healthcare facilities, drinking water systems and safe food supplies. Is the lead department for coordinating recovery activities due to radiological contamination.

- Management: Prepares messages to inform the public on appropriate actions to protect their health and safety. Maintains the California Health Alert Network (CAHAN) to notify appropriate response personnel of significant health/medical related events and/or the need to respond. Prepares public health and medical reports in concert with the Emergency Medical Services Authority and other CHHSA departments. Provides technical assistance related to public drinking water systems, communicable disease, hazardous materials, biohazards and radioactive materials and other public and environmental health concerns.

- Public Health and Medical: Administers and coordinates disaster-related public health programs and assesses hazards to the public's health. Provides statewide policies on environmental health. Coordinates with local health departments to conduct surveillance of infectious diseases in a disaster area and determines appropriate actions to be taken to prevent

and control disease outbreaks. Implements pandemic influenza response plans in coordination with local health departments and other state agencies. Provides epidemiological and laboratory support through state and local public health and clinical laboratories, cooperating federal

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

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

1.2.7 *Department of Social Services*

The California Department of Social Services is responsible for supporting local agencies in mass care and shelter activities and programs throughout the state—and mental health will be addressed under this responsibility area. The department assists in networking with Operational governmental organizations and federal organizations to track resources needed for care and shelter. The department coordinates with the American Red Cross to assist in training for shelter operations. Once activated by Cal EMA the Disaster Services Section staff assists in the mass care and shelter functions by:

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

The department also oversees the federal grant recovery program for individuals and households, and the Emergency Repatriation for California. These responsibilities are delegated to the department through an administrative order from the California Emergency Management Agency. The Health and Human

Services Agency has also tasked the department with the development and implementation of the California Emergency Function 6 (Mass Care and Shelter) Annex to the State Emergency Plan (CA-EF 6).

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

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

1.2.8 Department of State Hospitals

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

1.2.9 Department of Veterans Affairs

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

1.2.10 Emergency Medical Services Authority

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

- EMSA is the lead agency responsible for coordinating California's medical response to disasters.

- EMSA Disaster Medical Services Division (DMSD) develops and maintains disaster readiness medical response plans, policies and procedures.
- EMSA DMSD On-Call Duty Officer provides 24 hour coverage for emergency events throughout California.

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

2 Local Government Agencies

2.1 Lead Agency – Department of Mental Health

In Napa County, the Mental Health Group operates under the Medical/Health Branch of the Operations Section in the Emergency Operations Center. The functions include:
- Provide Behavioral Health Services, as needed, up to and including provide assessments/triage of community members and survivors
- Act as a gatekeeper and fiscal reimbursement to inpatient services for indigent and Medi-Cal beneficiaries.
- Provide and participate in local community educational events in Mental Health disaster preparedness

2.2 Medical Reserve Corps (MRC)

Napa County operate a local MRC Unit that is comprised of a wide variety of medical and non-medical professionals, including mental and behavioral health professionals, who volunteer to assist in disasters and other events.

3   Federal Agencies

3.1 1 Lead Federal Agency - Health and Human Services/Office of the Assistant Secretary for Preparedness and Response (ASPR)

- Created to lead the nation in preventing, preparing for, and responding to the adverse health effects of public health emergencies and disasters.
- During an emergency or disaster, provides federal support, including deployment of medical professionals through ASPR's National Disaster Medical System (ASPR-NDMS), to augment state and local capabilities.
- Serves as the principal advisor to the Secretary of HHS on all matters related to federal public health and medical preparedness and response for public health emergencies.
- Coordinates the federal health and medical services support functions during a public health emergency.
- Maintains Regional Emergency Coordinators (ASPR-RECs) in each of the country's 10 disaster planning regions. ASPR-RECs monitor emerging public health concerns, including mental health, and provide consultation and technical assistance to states, territories, tribes, local, and private sector authorities.
- Administers the Hospital Preparedness Program (HPP), which provides leadership and funding through grants and cooperative agreements to states, territories, and eligible municipalities to improve surge capacity and enhance community and hospital preparedness for public health emergencies. HPP may be used to support mental health activities as part of overall hospital preparedness.

3.2 Supporting Federal Agencies

3.2.1   *FEMA*

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

3.2.2   *HHS/Administration for Children and Families*

- ACF programs fund grantee operations that can provide assistance with mental health and other issues arising during and after a disaster.
- Conducts surveillance through its Family Violence Prevention and Services Program, which monitors the National Domestic Violence Hotline and maintains contact with family violence service agencies, to identify increases in domestic violence behaviors caused by disasters and public health emergencies.

3.2.3   *HHS/Administration on Aging (AoA)*

- Develops a comprehensive, coordinated and cost-effective system of home and community-based services that helps elderly individuals maintain their health and independence in their homes and communities.
- Works with ACF-OHSEPR (Administration of Children and Family Office of Human Services Emergency Preparedness and Response) and ASPR-ABC (Assistant Secretary for Preparedness and Response-At-Risk, Behavioral health & Community Resilience) to develop and review state, territory, tribal and local emergency response plans and coordinate ESF #8 and ESF #6 activities and assists HHS entities to help ensure that the mental health and functional needs of at-risk individuals, particularly senior citizens and persons with disabilities, are being addressed.

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

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

3.2.5   HHS/Centers for Medicare and Medicaid Services (CMS)
- Administers all aspects of the Medicare, Medicaid and Children's Health Insurance programs (CHIP), including mental and mental health.
- Supports emergency preparedness and response by helping to ensure that strategies are in place for the delivery of safe and high quality health care during disasters, pandemics and other emergencies.

3.2.6   HHS/Health Resources and Services Administration (HRSA)
- Primary federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable.
- Grant programs support community-based mental health care provision, which contributes to community resiliency.
- Office of Emergency Preparedness and Continuity of Operations (EPCO) leads HRSA's efforts in preparing for, responding to, and recovering from emergent and public health events.
    - Maintains situational awareness regarding the effect of emergent and public health events on grantees who deliver mental health services and coordinates information exchange among HRSA (Health Resources and Services Administration), ASPR (Association of Staff Physician Recruiters), and other stakeholders.
    - Provides technical assistance to grantees regarding federal disaster assistance programs.
- HRSA's network of community-based service delivery grantees and nongovernmental organizations is capable of exchanging information that contributes to the community's resilience and mental health response and recovery.

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

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

3.2.9 HHS/National Institutes of Health (NIH)

- The National Institute of Mental Health and several other NIH Institutes participate in a number of HHS and interagency coordination activities, such as the White House Pandemic Psychological Support Working Group, ASPR-NBSB, HHS Disaster Behavioral Health Concept of Operations Working Group, VA National Center for Post-Traumatic Stress Disorder (NCPTSD) Scientific Advisory Board, and the VANCPTSD Educational Advisory Board.
- Periodically engage service components of the federal government (e.g., SAMHSA, DHS-FEMA), state government agencies, professional organizations, scientific organizations and others to refine NIH research priorities in this area.

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

- When an incident occurs with the potential to overwhelm state, territory and tribal mental health resources, SAMHSA Emergency Operations utilizes ICS to coordinate SAMHSA resources and steady state programming (e.g., National Child Traumatic Stress Network, Suicide Prevention Lifeline) to meet requests for assistance.
- Maintains close linkages with state, territory and tribal mental health partners and engages in preliminary needs assessments throughout the response period.
- Communication and information dissemination with the public, responders and professional communities is accomplished through multiple mechanisms, including SAMHSA's website and materials warehouse.
- Technical Assistance and Consultation is supplemented with the efforts of the SAMHSA Disaster Technical Assistance Center (DTAC).
- When Stafford Act declarations with Individual Assistance are approved, SAMHSA's roles are exercised through DHS-FEMA CCP grants designed to support local efforts in mitigating the mental health impact of disasters. SAMHSA works with DHS-FEMA to ensure that crisis counseling services are available to affected communities in a timely and responsible way, ensuring a culturally competent and locally driven program.
- When disaster related mental health needs overwhelm state, territory and tribal mental health response systems and no other resources are available, SAMHSA has authority to redirect discretionary program funding to provide, under very strict guidelines, SAMHSA's Emergency Response Grants (SERG). SERGs are designed to meet local emergency substance use and mental health needs for primary victims and their families. The SERG program does not have a specific appropriation. Instead, funds are tapped from existing discretionary programs but cannot exceed 2.5 percent of all amounts appropriated in a fiscal year, no matter the level of response. SERG monies are considered "funds of last resort" and cannot supplant or replace other existing funds. As the transition to recovery unfolds, SAMHSA provides technical assistance and ongoing programmatic support.
- SAMHSA's Disaster Distress Helpline (DDH) is a confidential and multilingual, 24/7 crisis support service offered via telephone (1-800-985-5990) and SMS/Text ('TalkWithUs' to 66746), and is available to U.S. residents who are

experiencing psychological distress as a result of a disaster. This toll-free line and SMS service is answered by trained crisis counselors who connect callers with local resources related to or specific to any natural or man-made disaster, incident of mass violence, or any other Federally-declared or non-declared disasters within the United States and its territories.

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

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

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

- Provides its partners, stakeholders, and response assets with subject matter expertise, education, and coordination to ensure that mental health issues and the needs of at-risk individuals (including children) are integrated into public health and medical emergency preparedness, response, and recovery activities.
- During a response, is part of the ASPR EMG and supports the ESF #8 mission by maintaining situational awareness and analysis, identifying emerging trends, vetting action requests and mission assignments, responding to requests for information, and providing input to ESF #8 situation reports and IAPs.

3.2.13 HHS/Office on Disability (OD)

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

4 Non-Governmental Organizations

Such as:

4.1 1 American Red Cross

The Red Cross works in concert with government partners, other health care providers, and mental health workers provide services at shelters, service centers, bulk distribution routes, aid stations and temporary evacuation points. In Napa County, the Red Cross typically works in a supportive role rather than directly operating as primary service coordination for these areas of need. They may also, at the discretion of the Napa County EOC, take on more direct responsibility for the delivery of services up to and including mental health delivery at specified sites. The American Red Cross of the California Northwest region serves Napa County. It provides relief to those affected by disasters. https://www.redcross.org/local/california/northern-california-coastal/about-us/locations/california-northwest.html

4.2 **Napa County Community Organizations Active in Disaster (COAD)**

- Napa Valley COAD develops and enhances partnerships for communication, coordination and collaboration amongst the whole community including non-profit and faith-based organizations, government agencies and the private sector during all phases of disaster.

4.3 **Salvation Army**

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

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

5   Private Organizations

5.1 1 Community Health Centers

OLE Health provides assistance for a range of community needs, including mental and behavioral health support, especially low income populations. During disaster operations, Ole Health may operate clinic services in shelter settings, coordinate primary care through their network of distributed medical sites, and acts in partnership with Napa County to meet health needs for effected populations.

Appendix D - Disaster Mental Health Core Competencies

Disaster Mental Health Core Competencies

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

<u>Preamble</u>

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

<u>Core Competencies</u>

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

    A. The National Incident Management System (NIMS)/Standardized Emergency Management System (SEMS)/Incident Command System (ICS); and the role of disaster mental health in a multidisciplinary disaster response;

    B. The nature, biopsychosocial, and cultural manifestations of human stress and typical stress reactions;

    C. The phases of psychosocial disaster and recovery reactions at the individual and community levels;

    D. The psychosocial effects of psychological trauma and disaster-related losses and hardships on individuals and communities;

    E. Disaster mental health intervention principles and phase-appropriate interventions;

    F. Crisis intervention(s) with disaster-affected individuals and (sub) populations; and

    G. Individual and population-based responses before, during, and after a disaster (e.g., evacuation, shelter in place).

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

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

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

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

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

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

2. Identifies appropriate stress management interventions; and
3. Formulates sequential steps.

B. Initiate an action plan to include, but not be limited to, the ability to:
1. Provide appropriate stress management, if indicated;
2. Connect to available resources (e.g., food, shelter, medical, transportation, crisis intervention services, local counseling services, financial resources);
3. Connect to natural support systems (e.g., family, friends, co-worker, spiritual support); and
4. Implement other interventions as appropriate.

C. Evaluate the effectiveness of an action plan considering changes in situation or disaster phase through methods such as observation, self-report, other reports, and other assessments.

D. Revise an action plan as needed (e.g., track progress and outcomes).

5. Demonstrate knowledge of responder peer-care and self-care techniques to:

A. Describe peer-care techniques (e.g., "buddy" system, informal "town meetings");

B. Describe self-care techniques (e.g., stress management, journaling, communication with significant others, proper exercise, proper nutrition, programmed "down time," sufficient quality sleep); and

C. Describe organizational interventions that reduce job stress (e.g., organizational briefings, adjustment of shift work, job rotations, location rotations, effective and empathic leadership, work/rest/nourishment cycles, support services, as indicated).

Recommended Disaster Mental Health Curricula

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

- Core Competencies On-line Training Course
  objectives:
  All Hazards systems, plans, and key concepts
  Community-wide assessment models
  Rapid assessment and triage
  Disaster related stress reactions: survivors, responders, colleagues, & self Evidence-based disaster mental health risk factors
  Crisis intervention Psychological
  first aid Psycho education
  Cross-cultural considerations Traumatic
  grief & loss
  Problem-solving and conflict resolution Information &
  referral process considerations Advocacy
  Evidence-based stress-related treatments
  Working in disaster-mental settings/ altered environments (shelters, relief centers, unconventional intervention settings)
  Concepts of risk communication Field
  safety considerations Management of
  substance abuse Provider self-care issues
  http://disastermentalhealth.com/

- Disaster Services: An Overview
  This course provides basic information about disasters and its effect, outlines the role of agencies in disaster relief, and introduces American Red Cross (ARC) Disaster Services to the public. This is a prerequisite to take any disaster class through ARC.
  Contact local Red Cross office; go to http://www.redcross.org/find-your-local- chapter

- Foundations of Disaster Mental Health
  This course is to prepare licensed mental health professionals to provide for and respond to the psychological needs of people across the continuum of disaster preparedness, response and recovery.
  Contact local Red Cross office; go to http://www.redcross.org/find-your-local- chapter

- Psychological First Aid
  The course provides a framework for understanding the factors that affect stress responses in disaster relief workers and the clients they serve. In addition, it provides practical suggestions about what you can say and do as you practice the principles of Psychological First Aid.
  Contact local Red Cross office; go to http://www.redcross.org/find-your-local- chapter

- ICS-100, ICS-200, ICS-700a, ICS-800
  Courses through FEMA that teach about the Incident Command System (ICS) that meet the requirements specified in the National Incident Management System (NIMS).
  Offered online: http://training.fema.gov/IS/NIMS.asp

Appendix E - Napa County Disaster Mental Health Training Plan

Introduction to the Guidelines

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

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

These guidelines offer a robust set of guidance from government- and non-government-based individuals with considerable experience in the practice of disaster mental health preparedness and response. However, these guidelines do not represent compliance metrics or benchmark capabilities. These guidelines were set forth in response to questions of "What guidelines should exist?" rather than "What guidelines are realistic in light of current funding constraints and compliance enforcement mechanisms?" Multiple Core Work Group members noted that specific training needs should be locally determined, rather than dictated in a State of California document. Additionally, many guidelines were suggested regarding the type of training (such as psychological first aid) without stipulating specific courses, content, or providers.

Core Competencies

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

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

Beyond Disaster Mental Health Responders

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

First Responders

Local first responders receive training through regional Crisis Intervention Training in partnership with their local Mental Health Plan (Napa County Mental Health). Disaster Response coordination and responding to mental health needs in a Disaster will be included in future cycles of CIT training provided to First Responders.

Community

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

Clinicians and Mental Health Professionals

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

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

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

Preparation for Federal Assistance

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

Appendix F - Disaster Mental Health Programs and Services

Psychological First Aid (PFA)

- ***Listen, Protect, Connect: Family-to-Family, Neighbor-to-Neighbor (Psychological First Aid for the Community Helping Each Other)***
  https://www.ready.gov/sites/default/files/documents/files/LPC_Booklet.pdf

- ***Listen, Protect, Connect: Model and Teach (Psychological First Aid for the Students and Teachers)*** http://www.ready.gov/sites/default/files/documents/files/PFA_SchoolCrisis.pdf

- ***National Center for PTSD Psychological First Aid Model***:
  https://www.ptsd.va.gov/professional/continuing_ed/psych_firstaid_training.asp

- ***American Red Cross - Psychological First Aid: Helping Others in Times of Stress, February 2012*** Contact your local chapter to request the class or find your local chapter at:
  http://www.redcross.org/ (This PFA model also includes training on the PsySTART Rapid Mental Health Triage System.)

- ***Psychological First Aid World Health Organization Model*** :
  http://whqlibdoc.who.int/publications/2011/9789241548205_eng.pdf

- ***Psychological First Aid Video***
  In support of developing prevention principles and educating and informing communities please click on link below of a YouTube presentation on "Psychological First Aid" (PFA). It incorporates concepts and strategies to help yourself and others during critical incidents and emergencies. This presentation was developed as a project by the California Disaster Mental Health Coalition (CHHSC) and its 2009-2011 chair, Diane Bridgeman, Ph.D. Shawn Talbot and CAMFT provided time and funding for this public service project.
  http://youtu.be/yUnkukCxF3s

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

- **Foundations of Disaster Mental Health Training – August 27, 2011** (Contact your local chapter of the American Red Cross for the training. The purpose of this training is to prepare independently-licensed Disaster Mental Health worker to deploy to an American Red Cross disaster relief assignment. This course also includes training on the PsySTART Rapid Mental Health Triage System.)

- **American Red Cross Disaster Mental Health Handbook, October 2012:** This is the handbook used to manage the American Red Cross Disaster Mental Health function/activity during disasters. This handbook can be obtained from your local chapter of the American Red Cross and is also available (with permission from American Red Cross NHQ) at: http://www2.cuny.edu/wp content/uploads/sites/4/page-assets/about/administration/offices/ovsa/disaster-relief/hurricanes-harvey-irma/Disaster-Mental-Health-Handbook.pdf

Evidence Informed Trauma Interventions – Guidance

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

- California Department of Mental Health- Mental Health Services Action, Prevention and Early Intervention (PEI)
  http://www.mhsoac.ca.gov/components

- Los Angeles County Department of Mental Health PEI Plan Highlights:
  http://dmh.lacounty.gov/wps/portal/dmh/home/ (Look up Mental Health Services Act, Prevention and Early Intervention (PEI) to obtain the PDF.

National Guidance

- National Institute of Health (2002) *Mental Health and Mass Violence: Evidence-Based Early Psychological Interventions for Victims/Survivors of Mass Violence, a Workshop to Reach Consensus of Best Practices*: https://files.eric.ed.gov/fulltext/ED469199.pdf

- Substance Abuse and Mental Health Services Administration (SAMHSA), Training and Technical Assistance: https://www.samhsa.gov/tribal-ttac/tribal-training-technical-assistance

Evidence Informed Trauma Interventions - Training

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

- **Prolonged Exposure Therapy for Posttraumatic Stress Disorders Prolonged Exposure (PE) Therapy for Posttraumatic Stress Disorders** is a cognitive-behavioral treatment program for adult men and women (ages 18-65+) who have experienced single or multiple/continuous traumas and have posttraumatic stress disorder (PTSD). The program consists of a course of individual therapy designed to help clients process traumatic events and reduce their PTSD symptoms as well as depression, anger, and

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

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

- **PsySTART Disaster Mental Health Triage and Incident Management System:** (See also above *American Red Cross - Psychological First Aid: Helping Others in Times of Stress, February 2012* and *Foundations of Disaster Mental Health.)* https://www.myctb.org/wst/HELPERS/Emergency%20Preparedness%20Documents/PsySTART_Overview.pdf
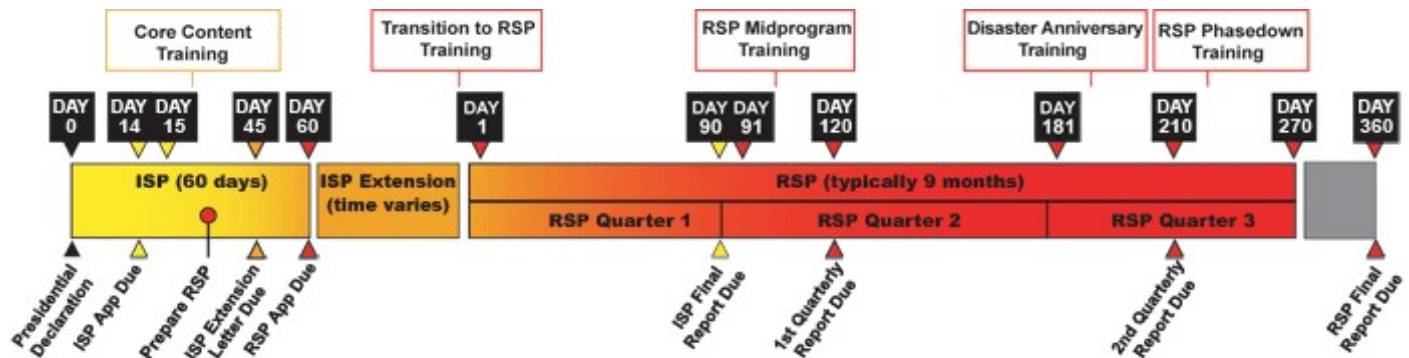
Crisis Counseling Program

Crisis Counseling Timeline and Related Tasks
https://www.samhsa.gov/dtac/ccp-toolkit

 *does not include Specialized Crisis Counseling Services timelines which are individualized to response.

CCP Typical Timeline

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

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

Day 0: Presidential Declaration of Disaster

- **Review the main ISP documents.** These include
  ISP Application,
  Application for Federal Assistance Standard Form SF-424
  Budget Information for Non-Construction Programs SF-424A
  Assurances for Non-Construction Programs SF-424B
  Budget Worksheet (XLS | 81 KB)
  ISP Cost Extension Budget Worksheet (XLS | 56 KB)

- **Communicate with State Mental Health Authority (SMHA) leadership, the Governor's Authorized Representative (GAR) or designee, and State fiscal staff to determine if an ISP application will be submitted.** The GAR usually is located within the State Emergency Management Agency (SEMA). Ensure that leadership

staff understand the basic programmatic, regulatory, and fiscal requirements of the CCP, as well as the SMHA staff time that will be needed to administer the program.

▪ **Contact your designated FEMA Regional Individual Assistance Coordinator or Disaster Field Office to request Preliminary Damage Assessment information.** This will be needed to complete the needs assessment section of the ISP application. Supplement this with information obtained from local contacts, media reports, or other disasters.

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

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

▪ **With SMHA leadership, identify the team that will write the ISP application.** Ensure   the team has enough time to complete the task by identifying additional staff to take on other essential duties, if necessary. Identify the team leader responsible for managing the application process. It is essential that a fiscal staff person be a member of the team, as fiscal mechanisms will need to be quickly established to process ISP funds.

▪ **Develop an ISP application that meets FEMA and SAMHSA requirements within the 14-day timeframe.** An actual meeting of team members may not be possible or necessary at this time. ISP application development is a process that goes on for several days.   Communication among team members regarding their responsibilities for developing the application should be managed by the team leader. The activities listed below are not necessarily sequential steps, but they are important and must be completed within the 14- day timeframe.
- • Create a timeline for the application writing process and assign responsibilities to team members to ensure that the ISP application will be completed within the 14-day timeframe.
- • Ensure that the timeline accommodates completing standard grant forms and obtaining signatures of the GAR and SMHA leadership staff.
- • Conduct needs assessment evaluating the disaster situation, State and local resources and capabilities, and response activities to date.
- • Use the available ISP documents. These include the ISP Application, ISP Supplemental Instructions, CCP Quarterly and Final Report Format, CCP Guidance, and required data collection forms.
- • Identify potential providers; determine how the program will be staffed; and decide how staff will be hired in a timely manner.
- • Develop a plan of services including a staffing plan, training, and budget.
- • Provide an orientation to the participating local providers on the scope and purview of the CCP model outlining allowable versus nonallowable services and costs.
- • Determine how and where program staff will receive required 2-day CCP Core Content Training. Contact the SAMHSA CMHS Project Officer or SAMHSA DTAC

for technical assistance support for recommended qualified instructors.
- Ensure that State fiscal mechanisms will be in place to process FEMA funds so that service providers will be able to efficiently access funding.
- As needed, contact the SAMHSA CMHS Project Officer and SAMHSA DTAC for TA.

- **Continue to carry out initial disaster behavioral health response and crisis counseling activities according to your organization's all-hazards disaster plan and the needs of the disaster event.** Document all response efforts.

Day 10: Draft Application Due (optional)

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

Day 13: Revision of Draft Application (optional)

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

Day 14: Final Application Due

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

Days 15–60: Program Implementation and Service Delivery

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

- **Collect and analyze program data.** Using the required CCP data collection tools, collect   data and use the information to target outreach and service delivery, as well as determine   and justify the need for an RSP.

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

- **Review the main RSP documents.** These include RSP Application Form (DOCX | 94 KB), SF-424 Family Forms on Grants.gov, SF-424 Family Forms on Grants.gov, Project/Performance Site Locations (PDF | 190 KB), Department of Health and Human Services (HHS) Checklist (PDF | 219 KB), Disclosure of Lobbying Activities SF-LLL (PDF | 30 KB), Budget Worksheet (XLSX | 79 KB)

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

Day 40: Confirm Intent to Submit RSP Application

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

Day 40–59: Write RSP Application

- **Write the RSP application.** Put together a team to write the RSP application. Identify a team leader, and assign tasks to team members. The RSP application is similar in format to the ISP application, but the State is expected to develop a more thorough response appropriate for the longer (9-month) program. Grant reviewers will expect a more detailed needs assessment based on current information on and selection of service providers, and targeting of services related to the identified need. As a separate grant, the RSP application must **justify** services for the 9-month program and should not be viewed as just a continuation of the ISP. Technical assistance is available from your SAMHSA CMHS Project Officer and SAMHSA DTAC.

- **Please note that the ISP Midprogram Report is contained within the RSP application.** By completing the RSP application, you also will be meeting the requirement for the ISP Midprogram Report. A State is required to submit an ISP Midprogram Report only if it is applying for an RSP. Additionally, the State is required to submit two copies of the program data on CD-ROMs to SAMSHA CMHS.

- **RSP Application Without an ISP**
  Typically, a State applying for an RSP grant has also had an ISP in response to the disaster. In the case that a State is seeking an RSP without having had an ISP, the State must take particular care completing the needs assessment and response activities from date of incident sections of the RSP application. The State will be expected to provide a detailed justification of need for RSP services.

Day 45: Letter for ISP Extension Due

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

Day 60: RSP Application Due

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

Cal EMA/CHHS - CCP Coordination Process
CRISIS COUNSELING IMMEDIATE SERVICE PROGRAM (ISP) AND REGULAR SERVICES PROGRAM (RSP)

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

ISP GRANT APPLICATION

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

- FEMA and SAMHSA - Reviews the grant application. If changes are needed, FEMA will notify Cal EMA IA and include deadline for changes. If approved, FEMA will notify Cal EMA of approval
- Cal EMA IA – Notify CHHS of changes needed and deadline for changes or approval of grant application. Work with CHHS to ensure changes are submitted on time. However, if

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

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

ISP APPEAL

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

ISP FISCAL

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

ISP GRANT MONITORING

- CHHS Disaster Services – Develop consultant contract(s) and manage the contracting

process to obtain approved CCP trainers for every mandated ISP training.

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

ISP FINAL REPORT

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

RSP GRANT APPLICATION

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

RSP APPEAL

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

RSP REPORTING REQUIREMENTS

- CHHS Disaster Services - prepares Quarterly Progress Reports and submits to Cal EMA IA for review. (Report due to FEMA 30-days after the end of each reporting period.)

- Need correct citation Cal EMA IA – reviews the Quarterly Progress Reports and submits to FEMA no later than 30-days after the end of each reporting period.
  - Prepares a cover letter for the SCO's signature addressed to the FEMA Regional Director.
  - Obtains SCO approval on report and signature on cover letter
  - Submits the original and two copies of the report to FEMA.
- CHHS Disaster Services- prepares a final program report (which includes Financial Reporting) and submits to Cal EMA IA for review. (Report due to FEMA 90-days from the end of the program period.)
- Cal EMA IA – reviews the Final Program Report and submits to FEMA no later than 90-days after the end of the program period.
  - Prepares a cover letter for the SCO's signature addressed to the FEMA Regional Director.
  - Obtains SCO approval on report and signature on cover letter
  - Submits the original and two copies of the report to FEMA.

RSP GRANT MONITORING

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

IF CRISIS COUNSELING SERVICES NOT REQUESTED

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

Appendix G - Disaster Mental Health Resources

Personnel

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

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

Teams

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

Facilities

- State Hospitals
- Available Psychiatric Beds

Equipment

TBD

Supplies

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

Appendix H - References

American Psychiatric Nurses Association – California Chapter
https://www.samhsa.gov/dtac/webinars-podcasts

Bonano, et al., Weighing the Costs of Disaster: Consequences, Risks, and Resilience in Individuals, Families, and Communities; Psychological Science in the Public Interest (2010) II I:1-49.

California Department of Public Health and Emergency Medical Services Authority. California Public Health and Medical Emergency Operations Manual, July 2011.
http://www.bepreparedcalifornia.ca.gov/Documents/FinalEOM712011.pdf

California Emergency Management Agency, U.S. Department of Homeland Security, Federal Emergency Management Agency Region IX. Southern California Catastrophic Earthquake Response Plan, December 14, 2010. http://www.calema.ca.gov/PlanningandPreparedness/Pages/Catastrophic-Planning.aspx
California Emergency Management Agency. State of California Emergency Plan, July 2009.
http://www.calema.ca.gov/PlanningandPreparedness/Pages/State-Emergency-Plan.aspx

California Health Alert Network
http://www.bepreparedcalifornia.ca.gov/CDPHPrograms/PublicHealthPrograms/EmergencyPreparednessOffice/CAHAN/Pages/CAHANInformation.aspx

California Native American Heritage Commission http://www.nahc.ca.gov/

DeWolfe, D., *Training Manual for Mental Health and Human Service Workers in Major Disasters*, 2nd ed., 2000

Disaster Mental Health Concept of Operations for Public Health of Seattle and King County
https://www.kingcounty.gov/depts/health.aspx

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

FEMA Planning Resources
http://www.fema.gov/plan-prepare-mitigate

FEMA's Comprehensive Program Guide (CPG) 101: Developing and Maintaining Emergency Operations Plans (Version 2.0, November 2010.) https://www.fema.gov/media-library-data/20130726-1828250450014/cpg_101_comprehensive_preparedness_guide_developing_and_maintaining_emergency_operations_plans_2010.pdf

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

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

HHS Earthquake Incident Plan
www.phe.gov

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

King, M., Schreiber, M., Formanski, S., Fleming, S., Bayleyegn, T., Lemusu, S. Surveillance of Traumatic Experiences and Exposures after the Earthquake-Tsunami in American Samoa. Disaster Medicine and Public Health (2012) 16: 705-707

Li, J., Prechet, D., Mortensen, P., Olsen, J. Mortality in parents after death of a child in Demark; a nationwide follow-up study. Lancet (2003) 361: 363–67. Published online Jan 14, 2003.
http://image.thelancet.com/extras/02art5149web.pdf

Los Angeles County Operational Area Family Assistance Center plan Development Project
http://dp.ccalac.org/Policies/planning%20policies%20procedures/Documents/Family%20Assistance%20Center.pdf

Mental Health and Mass Violence: Evidence-Based Early Psychological Intervention for Victims/Survivors of Mass Violence, NIH Publication No. 02-5138, September 2002
http://www.nimh.nih.gov/health/publications/massviolence.pdf

Myers, D. & Zunin, L. Phases of disaster. In Myers, D. & Wee, D. (2005). *Disaster mental health services: Aprimer for practitioners (pp.18-24).* New York: Brunner-Routledge.

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

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

SAMHSA Disaster Behavioral Health Information Series (DBHIS) Resources www.samhsa.gov/dtac

SAMHSA DTAC Training Presentations
https://www.samhsa.gov/dtac/webinars-podcasts

Schreiber, M. (2011). National Children's' Disaster Mental Health Concept of Operations. Oklahoma City, OK: Terrorism and Disaster Center at the University of Oklahoma Health Sciences Center. https://www.aap.org/en-us/Documents/disasters_dpac_NPDCCschreiber.pdf

Tennessee Disaster Mental health Response
http://www.state.tn.us/mental/2012TnDisasterMHResponse.pdf

U.S. Department of Health and Human Services, Substance use and Mental Health Services Administration. The Dialogue, 2012 (Volume 8, Issue 4) - The Crisis Counseling and Assistance Program (CCP): Addressing Diverse Needs https://www.samhsa.gov/sites/default/files/images/fema-ccp-guidance.pdf

U.S. Department of Health and Human Services. HHS Disaster Behavioral Health Concept of Operations, December 2011. http://www.phe.gov/Preparedness/planning/abc/Documents/dbh-conops.pdf

U.S. Department of Health and Human Services. Mental Health All-Hazards Disaster Planning Guidance. DHHS Pub. No. SMA 3829. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2003. https://store.samhsa.gov/product/Mental-Health-All-Hazards-Disaster-Planning-Guidance/SMA03-3829

U.S. Department of Homeland Security, Federal Emergency Management Agency Region IX, California Emergency Management Agency. California Catastrophic Incident Base Plan: Concept of Operations, September 23, 2008. http://www.calema.ca.gov/PlanningandPreparedness/Pages/Catastrophic-Planning.aspx
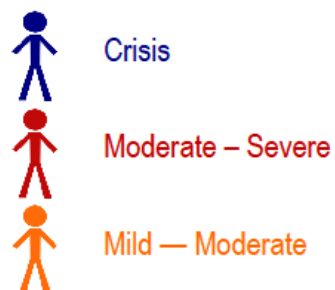
U.S. Department of Homeland Security, Federal Emergency Management Agency Region IX, California Emergency Management Agency. San Francisco Bay Area Earthquake Readiness Response: Concept of Operations Plan, Interim, Public Version, September 23, 2008. http://www.calema.ca.gov/PlanningandPreparedness/Pages/Catastrophic-Planning.aspx
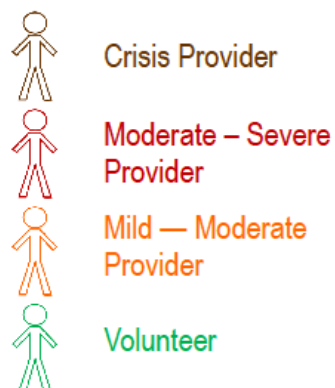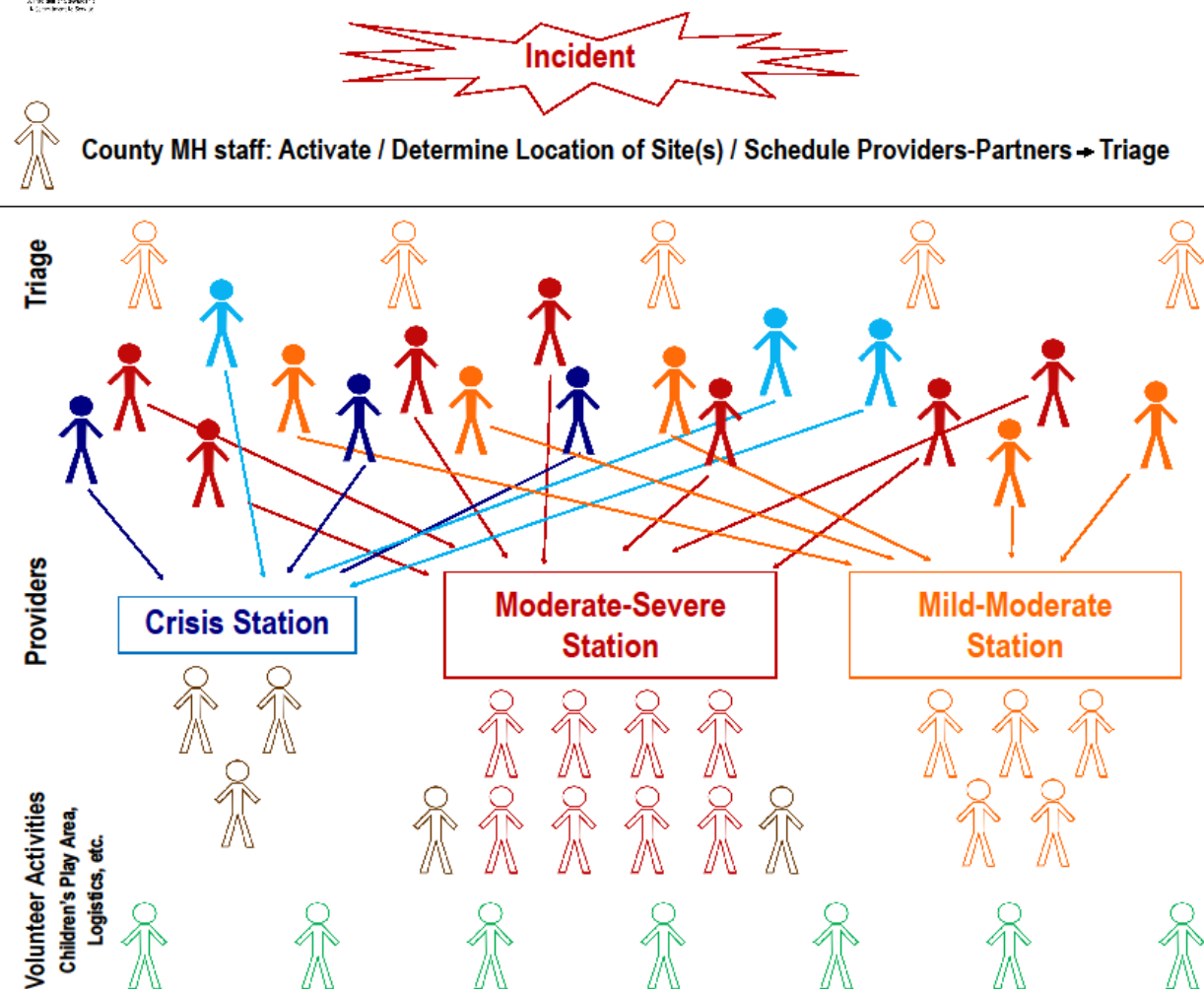
Appendix I – Napa County Mental Health Disaster Response

Napa County Mental Health Disaster Response

Appendix J – Community Event Response Plan

Community Event Response Plan

INCIDENT	School Coordinated	County MH Coordinated
Examples:	Youth suicide School evacuation or lock down Severe traffic accident w/youth	Neighborhood shooting incident Severe traffic accident
Activation / Notification Route	Law ⇨ MH MH ⇦ School MH ⇨ Providers & County PIO Provider ⇨ School	Law ⇨ MH MH ⇨ CBO/FBO in area MH ⇨ Providers & County PIO Provider ⇨ MH
NAPA COUNTY MENTAL HEALTH (NCMH)	• Contact staff to ready for deployment • Offer services to affected family members • Deploy staff into school for outreach • Lead Town Hall Meeting coordination with schools • Brief Providers on situation status and request availability of resources • Request messaging guidelines from County PIO and share with staff and Providers	• Contact staff to ready for deployment • Offer services to affected family members • Deploy staff into neighborhood for outreach • Lead Town Hall Meeting coordination with CBO/FBO • Brief Providers on situation status and request availability of resources • Request messaging guidelines from County PIO and share with staff and Providers • Confer with school point person as appropriate
PROVIDERS	• Respond to resource availability request • Supply resources as needed and provide service • Follow messaging guidelines	• Respond to resource availability request • Supply resources as needed and provide service • Follow messaging guidelines
SCHOOLS	• Provide logistical support to NCMH for Town Hall Meeting • Provide mild-moderate level service interventions	• Request support from NCMH as appropriate
PIO — SCHOOLS	• Collaborate with County PIO to create messaging guideline	
PIO — COUNTY	• Contact local papers and request discretion in reporting as applicable • Collaborate with School PIO to create messaging guidelines • Provide messaging guidelines to NCMH	• Contact local papers and request discretion in reporting as applicable • Provide messaging guidelines to NCMH
LAW	• Inform School / NCMH of event	• Inform NCMH of event
CBO / FBO		• Provide logistical support to NCMH for Town Hall Meeting

7/10/18

Appendix K –Mental Health Disaster Response Matrix

Event		Site(s)	Staffing (response staffing scalable)	Affected population	Services / Actions	Notes / Considerations
Fire	Command	EOC	MH Group Supervisor Triage and Assessment Coordinator Contractor Liaison		Set objectives Activate needed positions Oversee response and brief EOC	Scale based on size of event
	Response	Shelter LAC Community	MH Staff Contractors Triage team members	People who lose life People who lose property People who lose pets Witnesses (Neighbors)/Relatives Dislocated family members First Responders	Assess MH residential system Triage and assess at shelter Provide MH services/medication at shelter Relocate patients who need acute psychiatric services Triage and assess at LAC Provide MH services at LAC	Scalable for smaller events (i.e apartment fire, loss of multiple units, etc). Consider potential of multiple shelter locations
Earthquake	Command	EOC	MH Group Supervisor Triage and Assessment Coordinator Contractor Liaison		Set objectives Activate needed positions Oversee response and brief EOC	
	Response	Shelter LAC Community	MH Staff Contractors Triage team members	People who lose life People who lose property People who lose pets Witnesses (Neighbors)/Relatives Dislocated family members First Responders	Assess MH residential system Triage and assess at shelter Provide MH services/medication at shelter Relocate patients who need acute psychiatric services Triage and assess at LAC Provide MH services at LAC	Work out shelter based service needs: what and how much. Consider potential of multiple shelter locations
Mass Shelter	Command	EOC	MH Group Supervisor Triage and Assessment Coordinator Contractor Liaison		Set objectives Activate needed positions Oversee response and brief EOC	
	Response	Multiple Shelters	MH Staff Contractors Triage team members	People who lose life People who lose property People who lose pets Dislocated family members First Responders	Triage and assess at shelters Provide MH services/medication at shelters Relocate patients who need acute psychiatric services Triage and assess at LAC Provide MH services at LAC	Work out shelter based service needs: what and how much
Pandemic	Command	MH Division EOC	MH Group Supervisor Triage and Assessment Coordinator Contractor Liaison		Set objectives Activate needed positions Oversee response and brief EOC	
	Response	Healthcare facilities with significant loss Schools Other	MH Staff Contractors Triage team members MH or other first responders in medical sites (i.e. QVH, etc)	People who lose life or have been exposed Dislocated (or healthy but isolated) family members Healthcare providers (including Agency staff)	Supply messaging to PIO for public information Triage and assess for mental health need Provide MH services at medical health or other sites, as needed	Work out logistics of providing MH services at medical sites.

5150

Flood	Command	EOC	MH Group Supervisor Outreach Coordinator Triage and Assessment Coordinator Contractor Liaison		Set objectives Activate needed positions Oversee response and brief EOC	
	Response	Shelter LAC Community	MH Staff Contractors Triage team members	People who lose life People who lose property or businesses People who lose pets Dislocated family members	Triage and assess at shelters and/or elsewhere in community. Provide MH services/medication at shelters and/or elsewhere in the community. Relocate patients who need acute psychiatric services Triage and assess at LAC Provide MH services at LAC	Work out shelter based service needs: what and how much. Consider potential of multiple shelter locations
MCI	Command	EOC	MH Group Supervisor Triage and Assessment Coordinator		Set objectives Activate needed positions Oversee response and brief EOC	
	Response	Community	MH Staff Contractors Triage team members	Family members of injured or dead Witnesses First responders Other impacted individuals in the community.	Triage and assess mental health needs. Provide MH services Coordinate with other responders	
Other	Command					
	Response					