Appendix B-1: Nebraska Guidelines for State and Regional Disaster Behavioral Health Coordinators

PRE-DISASTER ACTIVITIES

These activities fall within the responsibility of Disaster Behavioral Health Coordinators. They apply to both State Division of Behavioral Health and Regional Behavioral Health Authority Coordinators.

- **Complete FEMA Incident Command System trainings (100, 200, 700, and 800, minimum)**
  - **Available at:** http://training.fema.gov/IS/crslist.asp
- **Update Contact Lists** to ensure accurate phone and email addresses are available in an emergency
- **Review Plan** and appendices
  - **Include in your Plan a template for a service delivery plan for the FEMA Crisis Counseling Program** that can be modified and inserted into applications
    - Include Regional designation of potential providers
    - Regional Coordinators may wish to pre-identify potential workers if a CCP grant is pursued
  - **Put in place tentative plans for:**
    - Access to cell phones, calling cards, or access to a ham radio operator for emergency communication from the field
    - Tetanus shots and Hepatitis B shots for responders, if needed
    - Location and procedure for responders to access Personal Protective Equipment (PPE) if required
  - **Make Plan Revisions as needed** to reflect changing technologies and realities of disaster preparedness. Involve stakeholders in plan review to ensure broad-based input and buy-in to planning process, and to build and maintain relationships that are crucial during disaster response.
    - **Update Census information** in the plan to insure there is up-to-date information available about the people affected by the event.
- **Test Links and Computer File**s to ensure they are working properly.
- **Download and Review FEMA CCP Forms** as they are updated to become familiar with the information required.
- **Test Plans** by engaging in drills and exercises that test contact information and procedures. Note any relevant experiences that may need to be incorporated in the revision of plans and procedures.

- **Work with designated Volunteer Processing Centers** to ensure there are support staff volunteers available to the behavioral health disaster response. This will be especially helpful in data entry or compilation of tracking forms.
- **Prearrange for site supervisors** who can report to the volunteer processing center or work alongside the American Red Cross (ARC) disaster mental health function to coordinate deployment of non-ARC behavioral health volunteers. These site supervisors should be licensed mental health professionals when possible. They should be able to orient responders to the current disaster and the types of information that should be tracked throughout the response.

- **Review Supply Lists** to insure that up to date information and supplies are available and in the hands of personnel who will assume the role of disaster coordinator for behavioral health – for the State and the Regions.
  - **Supplies:** Disaster behavioral health personnel should have the following items ready in case of a disaster:
    - A current list of designated disaster contacts
    - Master copy of forms including:
      - Brochure providing information about typical survivor responses to a disaster or critical incident
      - Current CCP forms
      - Time and mileage tracking form
    - A copy of the Nebraska Behavioral Health All-Hazards Disaster Response and Recovery Plan
    - Local resource directories
- **Create and advertise Training opportunitie**s for new and experienced behavioral health disaster responders to build their skills.
  - P**sychological First Aid** training should be held periodically not only to potential behavioral health responders, but also to other disaster volunteers or workers.
  - **ARC and CISM Training** can be arranged periodically in conjunction with the American Red Cross and the State's Critical Incident Stress Management Program.
  - Advertise other training opportunities that may enhance response capabilities. Include training as a regular agenda item in meetings with response partners and encourage cross-training opportunities in disciplines other than behavioral health.
  - Additional **Incident Command System** training through emergency management is highly encouraged for all responders and coordinators.

IMMEDIATE RESPONSE ACTIVITIES

If a disaster occurs, these guidelines should be referenced by disaster coordinators. The deployment, coordination and tracking of resources are key concerns for the behavioral health disaster coordinators. Refer to the checklists which follow this section for quick reminders of what to do immediately following a disaster. **Always track coordinator time and costs incurred using a cost tracking log (see Appendix B-3 for example), beginning with the immediate response**. All behavioral health personnel deployed outside of the American Red Cross (ARC) should be tracked using this form.

In some locations the American Red Cross will be the first behavioral health responder agency on scene. Any deployment of behavioral health responders should involve close coordination with ARC. CISM is typically not immediately deployed, but should also factor into the coordination of the overall response. Activation of CISM is currently dependent upon the response agency initiating contact with the State Patrol. Notification of activation to disaster coordinators is not currently built into the system. The coordinator may wish to establish contact with the State or Regional CISM Clinical Director to ensure coordination of activities takes place.

- **Assess the situation**
  - Assist local government in the assessment of disaster-related behavioral health needs.
- Begin assembling information about the disaster.
- Get damage assessment information from Emergency Management as soon as it is available. The easiest way to do this is to ask for emergency management's assistance in completing the FEMA Crisis Counseling Program initial needs assessment form.
- Note any high risk groups or special populations affected by the disaster to estimate the size and extent of the behavioral health response needed.
  - Contact the ARC to determine their level of deployment – ask for daily updates from the ARC disaster mental health officer.
  - Determine the number and type of first responders deployed and level of initial involvement of Nebraska CISM team members
  - Employ assessment & tracking protocols recommended by the SAMHSA Center for Mental Health Services. Refer to the FEMA Crisis Counseling Program Data Collection Toolkit, online at: http://www. samhsa.gov/dtac/proguide.asp
    - Within this toolkit various tools are available to record contacts, track materials (e.g. brochures, fact sheets, FAQ's), and assess behavioral, emotional, physical and cognitive reactions to critical incidents.
    - Make forms available at the site that behavioral health responders will be deployed from. Ensure they are available to those who will be orienting and deploying responders from this site.
    - Arrange for contacts to be tallied with summaries sent daily to the

Regional Coordinator. Original cost tracking forms should be sent directly to the Regional Coordinator along with any master tally.

- Regional Coordinators should retain original cost tracking forms and send summaries to the State Coordinator. Frequency of reporting to the State Coordinator may be negotiated and highly dependent upon the size, type, and scope of the disaster.

- **Coordinate resources relevant to the behavioral health disaster response**
  - Build on local organization and requests – disaster coordinators should refer to local plans prior to deployment of additional resources. Coordination may include liaison work with groups such as:
    - American Red Cross
    - Emergency Management Agency
    - Public Health Departments
    - Hospitals and Medical Facilities
    - Educational institutions
    - VOAD (Voluntary Organizations Active in Disaster)
    - Private behavioral health and substance abuse providers
    - Public behavioral health and substance abuse providers
    - First responder groups
    - Utility companies deployed in clean-up efforts
    - Federal resources that may be responding
  - Regional and State Coordinators form a linked network that works to ensure resources are adequate to meet the behavioral health needs of people in Nebraska following disaster. The State Coordinator is highly dependent upon Regional Coordinators for information and local networking. The role of the State Coordinator is to work within State-level response structures and serve as a link to Federal Resources. The Regional Coordinators work with local responders and serve as a link from the Region to State resources. The State Coordinator also serves as a primary link between Regional Coordinators and resources.
  - Coordinate services with other responding agencies to provide behavioral health services to emergency responders, if needed
    - The Nebraska Critical Incident Stress Management Program may be activated to provide these services to many first-response agencies. See Appendix A-6 for information about activating CISM.
  - Coordinate with the designated Public Information Officer (PIO).
    - Use the specialized skills of the behavioral health professionals identified as having expertise in the area of risk communication and/or threat assessment. The State Coordinator will work closely with one of these professionals to ensure that PIO needs are quickly met with accurate, timely information related to behavioral health.

        - Work with Public Information Officer to ensure behavioral health professionals are available at hot line sites.
        - The State Coordinator should consider activating and publicizing the Rural Response Hotline to triage crisis counseling needs. Regional Coordinators may ask the State Coordinator to do so or the State Coordinator may initiate it without request.
            - The State Coordinator may wish to request periodic updates from the Rural Response Hotline about calling trends and level of use.
    - Coordinate with Federal response agencies as applicable. This is particularly important when a Presidential Declaration of Disaster is made.
        - **An Immediate Services Application must be submitted** by the Nebraska Emergency Management Agency and Nebraska Dept of Health and Human Services **within 14 days of a Presidential Declaration of Disaster eligible for individual assistance**. See Appendix C for further information on the application process.
- Arrange access to specialized resources
    - Build on local response capabilities, requests, and organization.
        - Access closest and most appropriate resources.
            - Work with NEMA if Governor declared disaster to determine level of response that can be supported.
            - Work with NEMA/Public Health/other State agencies to determine if state resources need to be accessed.
            - Consider activation of State employees. (This is particularly pertinent if a State facility has been involved in the disaster.)
        - Be cognizant of the importance of cultural competence in the delivery of service. Mobilize those with special skills as needed. (i.e., language, children, older adults, death notification, etc.).
    - **Accessing Out-of-State Resources:**
        - If a disaster is deemed to have overwhelmed State resources, the State Coordinator should notify the NEMA ESF-8 Coordinator to initiate a request for additional resources from outside Nebraska.
            - The ESF-8 Coordinator works with the Nebraska Emergency Management Agency (NEMA) to contact interstate resources.
            - NEMA is responsible for obtaining a list from cooperating States of individuals with appropriate skills and experience.
            - NEMA is responsible for the logistical support of out-of-state relief personnel brought into Nebraska as a result of the request.

LONG-TERM RESPONSE ACTIVITIES – RECOVERY/RESTORATION PHASE

Regional/Local Coordinators:

- **Coordinate activities/liaison with other responding agencies.**
  - **Behavioral health should seek membership on long term needs groups that form in affected communities.**
- **Gather and disseminate information** that can help providers in their work with affected individuals and communities.
  - Information that can illustrate the impact on individuals and communities may include emergency management needs assessment data, FEMA statistics, Hotline trends, and ongoing data collection from providers.
- **If awarded, work with State coordinators to establish a FEMA Crisis Counseling Program.** (*See Appendix C for additional information.*) The following is an abbreviated list of some of the most pressing issues to be addressed in setting up this program.
  - Staffing
  - State service contracts
  - Program implementation
  - Service facilities
  - Equipment & supplies procurement
  - Service announcements (coordinate with State Public Information Officer)
  - Obtaining specialized training for staff and in-services staff
  - Documentation of process and service provision
  - Program evaluation
  - After-Action Reports

- **Coordinate local outreach and clinical services.** These services may be needed, though not funded.

  Without the appropriate Presidential Declaration there will be a need to give providers information and support in their efforts to work within affected communities and areas.
  - Assist local behavioral health providers in identifying additional resources to meet their current clients' needs. Provide information to providers about phases of recovery, normal reactions to stress and disaster, and planning for commemorative events.

Appendix B-2: Checklist For Disaster Behavioral Health Coordinators

PREPAREDNESS BEFORE A DISASTER OCCURS

Have these things with you …. Just in case!

- ☐ Your own Credentials/Badges for disaster response

Key Contact Lists

List or way to access responders (including contact information):

- ☐ Area behavioral health response leadership
- ☐ Licensed and community responders with disaster behavioral health training
- ☐ Behavioral Health Agencies with trained responders
- ☐ Substance Abuse Professionals
- ☐ Clergy or Pastors

Phone numbers for key disaster response contacts in the area

- ☐ Emergency Management
- ☐ American Red Cross
- ☐ Public Health
- ☐ State Patrol
- ☐ Other area Voluntary Organizations Active in Disaster Response

_____

_____

_____

State Agency Contacts

_____

_____

_____

Forms and Manuals

- ☐ Copy of the State Plan and Appendices (hard copy and electronic)
- ☐ Copy of the Regional Plan and Appendices & Checklists
- ☐ Master copies of forms and normal reactions to disaster brochure

Training and orientation material

- ☐ Training Manual for Mental Health and Human Service Workers in Major Disasters:
  https://store.samhsa.gov/product/Training-Manual-for-Mental-Health-and-Human-Service-Workers-in-Major-Disasters/SMA96-0538

- ☐ Field Manual for Mental Health and Human Service Workers in Major Disasters: *https://store.samhsa.gov/shin/content/DK-APP/ADM90-0537-small.pdf*

Once a disaster occurs….. Start recording your actions!

Date(s) of Event: _____

Type of Disaster: _____

Geographic Area Affected: _____

Remember to fill out the cost tracking form for your time!

- What's already been done in the local area? (Start making notes of what you know)

  Is the ARC responding?
  - ☐ Yes → record name of DMH contact for ARC
  - ☐ No

- Has the **Governor declared** this a State Disaster?
  - ☐ Yes → State & Regional Disaster Coordinators should be in contact
  - ☐ No (Update your information periodically through Emergency Management)

Make and retain notes of other behavioral health activity:
(who has been deployed, where, how many, when, etc.)

- Has the **President declared** this a Disaster?
  - ☐ Yes → If Declaration = Individual Assistance → start FEMA CCP grant
    If Declaration = **only Public Assistance** → Track Network Provider Time
  - ☐ No (Update your information periodically through Emergency Management)

- Was a State-operated facility involved in the disaster?
  - ☐ Yes → Refer to facility emergency plans – Consider mobilizing BHERT
  - ☐ No

- Is the State DHHS Emergency Coordination Center being activated?
  - ☐ Yes → State Disaster Coordinator & Risk Communication Consultant report to ECC
  - ☐ No

- Is an Emergency Operations Center being activated?
  - □ Yes → Follow LEOP or SEOP and consider activating Behavioral Health Plan
  - □ No

Things to do within the first 72 hours of a disaster

(Check off as you complete each one and date each item to help with documentation later)

□ Ask Emergency Management for assistance compiling the information needed to fill out the CCP Needs Assessment Table (see Appendix C). *Make sure you get it back if you hand it off for completion*!

□ Determine if responders need to be mobilized

- Designate a Site Supervisor in the field if needed
- Get forms to the Site
- The first or primary disaster coordinator on duty will arrange for notification and development of shifts for other disaster coordinators to ensure continuity of response coordination and to guard against burn out or compassion fatigue.
- Start notification or call out of non-affected responders as appropriate

□ Gather information from the field about conditions, stories, and needs

- Designate someone to compile forms/data, if needed
- Visit the affected area if possible
- Designate someone to collect news stories about the event
- Get field reports from the ARC
- Determine if providers in the area are affected by the event

□ Make contact with State Disaster BH Coordinator to relay information about conditions and needs

□ Consider need for Rural Response Hotline involvement

- Link with CISM to relay possible support needs of emergency workers

Remember...
Disaster Behavioral Health Responders do not have to be the first on scene! Take your time and thoughtfully deploy resources.

□ Start gathering information about the people in the affected areas and estimate the number of individuals within populations of special concern

(One source for this information is the U.S. Census Bureau; other good sources are emergency management, and service providers.)

- Children (under age 18)
- Developmentally Disabled
- People in active Substance Abuse Treatment
- College Students in dorms/away from home
- Families/individuals relocated
- People in poverty
- Emergency responders involved in rescue/recovery
- Frail Elderly
- Physically Disabled
- Severe Mental Illness
- People in Correctional Institutions
- People with high traumatic exposure
- Women/girls in the area
- Other? List and estimate number

□ Make risk messages with behavioral health content available to public information officers

Special Situations

Air Transportation Incidents

□ Contact the American Red Cross as they are the designated responder

□ Consider ways to support the affected community through the response network

Agricultural Emergency

□ Contact the Livestock Emergency Disease Response System (LEDRS) representative (Department of Agriculture Veterinarian)

□ Consider deploying culturally competent responders as indicated

Terrorism

□ Contact law enforcement/determine level of security clearance required by responders

□ Release risk communication messages to quell fear/panic

Quarantine

□ Activate hotline

□ Consider phone outreach to quarantined areas

Mass Vaccination/Dispensing Clinics

□ Coordinate with Public Health and deploy responders to each clinic site

□ Responders should use Disaster Behavioral Health outreach methods and work throughout the clinic setting (**Do not** designate one area in the clinic as the “mental health” area)

□ Coordinate activities with Public Health Officials

NOTE: *This is not an exhaustive checklist - just something to get you started.* **Remember that every disaster is different. Use this checklist in conjunction with the guidelines**. *To make the best decisions, be calm and model responsible behavior for others. When in doubt —– ask questions and consult with experienced disaster responders, coordinators, or those with the most direct knowledge of the area.*

Appendix B-3: Cost and Personnel Tracking Forms for Disaster Behavioral Health Activities

(Use to fill out current State or Federal Expense Reimbursement Form – Request Form from State DBH Coordinator)

AGENCY: _____

Date Submitted: _____

Contact Person (Name & Phone Number):

_____

Date	Name/position of Staff Deployed	City/Location of Deployment	Number of Hours in Field	General Description of Work Activities	Agency Cost[1]			
					Personnel	Travel for Deployment		
						Mileage for Personal Vehicle[2]	Meals[3]	Lodging
Total Agency Cost								

[1] Reimbursement cannot be considered for lost revenue as a result of deployment. Please figure agency cost using per hour wage and benefits cost of personnel.

[2] Mileage will only be paid for personnel using their own vehicle. Use of agency vehicles is considered an in-kind cost and will not be reimbursed under the FEMA Crisis Counseling Program. Use of rental cars is generally not reimbursed.

[3] Meal receipts must be kept and submitted within 60 days of the end of deployment, and are subject to the Federal M&I allowance for the location of deployment.

ICS-Form 214 Daily Unit Activity Log

UNIT LOG	1. Incident Name	2. Date Prepared	3. Time Prepared
4. Unit Name/Designators	5. Unit Leader (Name and Position)		6. Operational Period

7. Personnel Roster Assigned		
Name	ICS Position	Home Base

8. Activity Log	
Time	Major Events

9. Prepared by (Name and Position)

Appendix B-4: Estimating the Number of Counselors Needed for Crisis Counseling Response

These guidelines can be used to estimate the number of counselors needed to serve a population, or to serve a location when the number of people at that location is known.

Estimating the Number of Clients[1]

- Estimate that 25% of the affected population will require crisis counseling. However, this could vary with the type of disaster.
- Plan for a maximum of two crisis-counseling sessions per individual.
- Plan for each initial counseling session to last an average of 20 minutes.
- Plan to conduct second counseling sessions for approximately half of the clients who received an initial counseling session.

Example of Calculating the Number of Initial Clients and Counselors

- Estimate of affected population—50,000 citizens
- Segment of the population requiring initial crisis counseling = 50,000 x .25 = 12,500 (Reminder—25% equals .25)
- Segment affected population that are special needs clients = Segment of the initial population requiring initial counseling multiplied by .1 =.12,500 x .1 = 1,250 (Reminder—10% equals .1)
- Add segment of the initial population requiring initial counseling and the segment of the special needs population to get the total number of initial clients = 12,500 + 1,250 = 13,750
- Length of initial counseling session = 20 minutes (Reminder—20 minutes equals .33 hour)
- 168 = Initial number of hours to see clients. (7 days x 24 hours = 168 hours)
- Solving the calculation
    - Add segment of population requiring crisis counseling (12,500) and segment of population that are of special concern (1,250) = (12,500 + 1,250) =13,750
    - Estimate time needed for initial crisis counseling sessions = number of

[1] Guidelines are taken from an algorithm in the Delaware Mental Health Response Plan and does not necessarily reflect the FEMA Crisis Counseling Needs Assessment estimation methods.

sessions needed (13,750) x time for each session (20 minutes, or. 33 hours) = 13,750 x 0.33 = 4537.5

- Divide total time needed for initial crisis counseling sessions by the time frame for services (in this example, one week working 24 hours/7 days a week, or 168 hours) = 4537.5/168 = 27 counselors.

Estimating Number of Counselors for Ongoing Services

- Ongoing services (second session or beyond) may be provided up to a year after the event, or even further depending on the nature of the disaster.
- Approximately half of the clients who were initially counseled will require a second session.
- Approximately 50% of total number of initial counselors will be needed for follow up counseling for seven days (168 hours) following the initial sessions.
- Example of Performing a Calculation
  - 27 initial counselors (From example estimating initial clients and counselors)
  - 50 % need for second session (Reminder—50% equals .5)
  - Solving the calculation:

    27 x .5 = 13 to 14 counselors needed for second sessions

Appendix B-5: Incident Command Overview

What is the Incident Command System?

The Incident Command System (ICS) is a management strategy designed to bring multiple responding agencies, including those from different jurisdictions, together under a single overall command structure. Before the use of the ICS became commonplace, various agencies responding to a disaster often fought for control, duplicated efforts, missed critical needs, and generally reduced the potential effectiveness of the response. Under ICS, each agency recognizes one “lead” coordinating agency and person, handles one or more tasks that are part of a single over-all plan, and interacts with other agencies in defined ways.

The Incident Command System is based upon simple and proven business management principles. In a business or government agency, managers and leaders perform the basic daily tasks of planning, directing, organizing, coordinating, communicating, delegating, and evaluating. The same is true for the Incident Command System, but the responsibilities are often shared between several agencies. These tasks, or **functional areas** as they are known in the ICS, are performed under the overall direction of a single Incident Commander (IC) in a coordinated manner, even with multiple agencies and across jurisdictional lines.

What the ICS is *not*.

Many people who have not studied the full details of the Incident Command System have a variety of erroneous perceptions about what the system means to them and their agencies. To set the record straight, the Incident Command System ***is not***:

- A fixed and unchangeable system for managing an incident.
- A means to take control or authority away from agencies or departments that participate in the response.
- A way to subvert the normal chain of command within a department or agency.
- Always managed by the fire department.
- Too big and cumbersome to be used in small, everyday events.
- Restricted to use by government agencies and departments.

Emergency Operations Center

The Emergency Operations Center (EOC) is a central location where government at any level can provide interagency coordination and executive decision-making for managing response and recovery.

Functions of the EOC

- Command and Control
- Situation Assessment
- Coordination
- Priority Establishment
- Resource Management

Components of the ICS

The Incident Command System has two interrelated parts. They are “management by objectives,” and the “organizational structure.”

Management by objectives:

Four essential steps are used in developing the response to every incident, regardless of size or complexity:

- Understand the policies, procedures, and statutes that affect the official response.
- Establish incident objectives (the desired outcome of the agencies’ efforts).
- Select appropriate strategies for cooperation and resource utilization.
- Apply tactics most likely to accomplish objectives (assign the correct resources and monitor the results).

The complexity of the incident will determine how formally the “management by objectives” portion will be handled. If the incident is small and uncomplicated, the process can be handled by verbal communication between appropriate people. As the incident and response become more complex, differences between the individual agencies’ or departments’ goals, objectives, and methods may need to be resolved in writing.

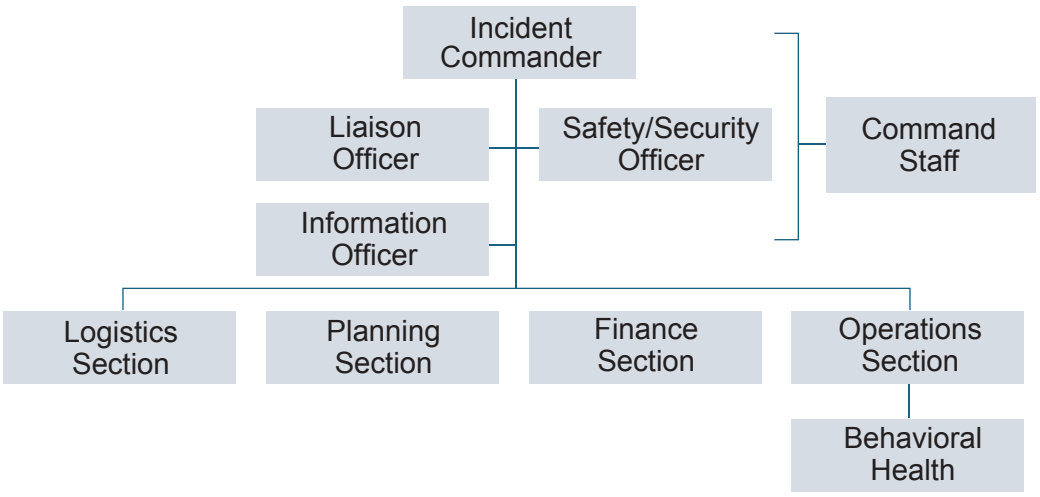
Organizational structure:

The ICS supports the creation of a flexible organizational structure that can be modified to meet changing conditions. Under the ICS, the one person in charge is always called the “Incident Commander” (IC). In large responses, the IC may have a “General Staff ” consisting of the Information, Safety, and Liaison Officers. In a smaller incident, the IC may also handle one, two, or all three of these positions, if they are needed at all.

The Incident Commander:

- Assumes responsibility for the overall management of the incident
- Establishes the Incident Command Post (ICP)
- Determines goals and objectives for the incident
- Supervises Command and General Staff if activated
- Only position staffed during every incident
- Will perform all functions unless delegated

The Incident Command System[1]



Information Officer

- Central point for information dissemination
- Keeps media informed with progress and success of incident objectives
- Releases information only after approved by Incident Commander
- One per incident

Safety Officer

- Anticipates, detects, and corrects unsafe conditions
- Has emergency authority to stop unsafe acts relative to the incident
- Can appoint an assistant
- One per incident

Liaison Officer

- Point of contact for assisting and cooperating agencies at the incident
  - Assisting and Cooperating Agencies provide tactical, support, or service resources to the incident
    - Red Cross, Salvation Army, other volunteer organizations
    - State agencies including Behavioral Health

[1] Adapted from: Northwest Oklahoma Amateur Radio Emergency Services (n.d.). The Incident Command System. Retrieved September 21, 2004 from http://www.qsl.net/nwokares/ICS_1.htm

Various other tasks within the ICS are subdivided into four major operating sections: Planning, Operations, Logistics, and Finance/Administration. Each operating section has its own “chief,” and may have various “task forces” working on specific goals. The Logistics section handles the coordination of all interagency communication infrastructures involved in the response, including Amateur Radio.

These operating sections may be scaled up or down, depending on the needs of the situation. In a small, single agency response, the IC may handle many or all functions. As the size and complexity of a response increase, and as other agencies become involved, the various tasks can be re-assigned and subdivided.

Logistics Section

- Provides service (communication, medical, food) and support (supplies, facilities, ground support) to the incident or event

Planning Section

- Tracks status of resources
- Reports on incident situation and intelligence
- Prepares Incident Action Plan (IAP)
- Provides documentation services
- Prepares demobilization plan
- Locates technical specialists
  - HAZMAT, WMD, Communications, Behavioral Health, etc.

Finance/Administrative Section

- Monitors incident costs
- Maintains financial records
- Administers procurement contracts
- Tracks and records personnel time
- Provides legal representation if required

Operations Section

- Directs and coordinates all tactical operations
- Organization is developed as required; organization can consist of:
  - Single resources, Task Forces, and Strike Teams
  - Staging Areas
  - Air Operations
  - Divisions, Groups, or Branches
    - Divisions are geographical (e.g. counties)
    - Groups are functional – Medical, Search & Rescue, Law Enforcement, Behavioral Health, etc.
    - Combination of Divisions and Groups are common.

Appendix B-6: Best Practices

The National Institute of Mental Health (NIMH) workshop to reach consensus on best practices in early psychological intervention for victims/survivors is excerpted here[1]:

Guidance on Best Practice Based on Current Research Evidence

Thoughtfully designed and carefully executed randomized controlled trials have a critical role in establishing best practices. There are, however, few randomized controlled trials of psychological interventions following mass violence. Existing randomized controlled trial data, often from studies of other types of traumatic events, suggest that:

- Early, brief, and focused psychotherapeutic intervention can reduce distress in bereaved spouses, parents, and children.
- Selected cognitive behavioral approaches may help reduce incidence, duration, and severity of acute stress disorder, post-traumatic stress disorder, and depression in survivors.
- Early interventions in the form of single one-on-one recitals of events and emotions evoked by a traumatic event do not consistently reduce risks of later post-traumatic stress disorder or related adjustment difficulties.
- There is no evidence that eye movement desensitization and reprocessing (EMDR) as an early mental health intervention, following mass violence and disasters, is a treatment of choice over other approaches.

Other practices that may have captured public interest have not been proven effective, and some may do harm.

The Center for Mental Health Services (CMHS) and Office for Victims of Crime, U.S. Department of Justice (OVC), recommend the following key concepts in the practice of disaster mental health:

- Remember people are having normal reactions to an abnormal situation
- Remember that all who witness a disaster are affected
- First, do no harm

[1] National Institute of Mental Health (2002). Mental Health and Mass Violence: Evidence-Based Early Psychological Intervention for Victims/Survivors of Mass Violence. A Workshop to Reach Consensus on Best Practice. NIH Publication No. 02-5138, Washington, D.C.: U.S. Government Printing Office, p.2.

- Avoid “mental health” terms and labels
- Assume competence and capability
- Respect differences in coping
- Offer practical and flexible assistance to meet individual needs
- Focus on strengths and potential
- Encourage the use of natural support networks
- Tailor interventions to fit a person’s community
- Be innovative in helping
- Crime victim assistance
- Psycho-education

CMHS and OVC recommend different behavioral health interventions/activities at different stages of a disaster[2]

Immediate Interventions include:

- Rapid assessment and triage
- Psychological first-aid
- Crisis intervention
- Participation in death notifications
- Behavioral health consultations
- Information and referral
- Participation in official informational briefings
- Presence at community meetings
- Community outreach
- Crime victim assistance
- Psycho-education

Long-Term Interventions include:

- Community outreach
- Crime victim assistance
- Psycho-education
- Brief counseling
- Support and therapy groups

[2] U.S. Department of Health and Human Services, (2004). Mental Health Response to Mass Violence and Terrorism: A Training Manual. DHHS Publication No. SMA 3959. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Appendix B-7: Role of Behavioral Health in Mass Fatality Incidents

Behavioral health issues will arise quickly in mass-fatality incidents. Family members of those known to be in the area of a mass fatality incident may gather at the incident scene or other areas to search for loved ones, and to seek information on unaccounted family members. The needs of family members who may have lost loved ones causes increased demand for behavioral health intervention support services[1].

The Center for Mental Health Services and Office for Victims of Crime, U.S. Department of Justice[2] provided guidelines for the role of behavioral health in mass fatality incidents. Behavioral Health provides:

- Behavioral health consultation
- Liaison with key agencies
- Psycho-social education through the media
- Behavioral health services with survivors and families of survivors/victims
- Behavioral health services with responders
- Stress management support to responders

If they are responding **on-scene**, behavioral health responders:

- Direct people to medical care, safety, and shelter
- Protect survivors from additional trauma, media, and onlookers
- Connect survivors to family, information, and comfort

If they are assigned to a ***family/survivor's assistance center*** or shelter, behavioral health responders operate in a support role[3], and use psychological first aid and crisis interventions to:

- Provide comfort, empathy, and a listening ear
- Make sure physical needs, safety, and security are taken care of
- Provide concrete information, when available, about what will happen next
- Link people to their natural support systems (friends, family, clergy)
- Provide education on common reactions
- Assess and reinforce functioning and coping skills
- Help people identify their priority needs and solutions

Behavioral health responders may also assist with death notifications.

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[1] South Carolina Mass Casualty Plan Annex 4: Mass Fatality Management Plan. Retrieved 8/26/2011 from: http://www.scemd.org/plans/ MassCasualtyPlan/15-Annex%204%20-%20Mass%20Fatality%20Management.pdf

[2] U.S. Department of Health and Human Services, (2004). Mental Health Response to Mass Violence and Terrorism: A Training Manual. DHHS Publication No. SMA 3959. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

[3] Gursky, E. A., on behalf of the Joint Task Force Civil Support Mass Fatality Working Group (2007). A Working Group Consensus Statement on Mass-Fatality Planning for Pandemics and Disasters. Journal of Homeland Security online. Retrieved 8/26/2011 from: http://www.homelandsecurity.org/journal/Default.aspx?oid=160&ocat=1&AspxAutoDetectCookieSupport=1