2017
Nebraska Behavioral Health
All-Hazards Disaster Response
& Recovery Plan

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

DIVISION OF BEHAVIORAL HEALTH

PREPARED BY

UNIVERSITY OF
Nebraska
PUBLIC POLICY CENTER

NEBRASKA

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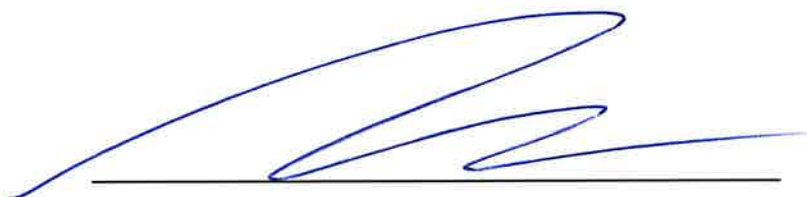
DEPT. OF HEALTH AND HUMAN SERVICES

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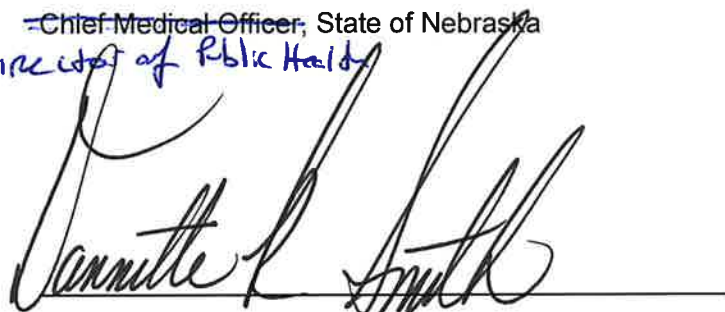
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Director of Public Health

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CEO, NE Department of Health & Human Services   Date

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Director, NE DHHS Division of Behavioral Health   Date

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I. Executive Summary

The Nebraska Behavioral Health All-Hazards Disaster Response and Recovery Plan is a guide for personnel responsible for state behavioral health disaster coordination. The plan narrative includes:

- General assumptions upon which the plan is built
- Concept of operations in a disaster
- Information pertinent to the identification and deployment of trained disaster behavioral health personnel

The appendices contain:

- Information that may assist in the coordination and organization of a disaster behavioral health response
- Relevant statutory information
- General disaster mental health and substance abuse information
- Guidelines for preparation of Federal Crisis Counseling Program grants
- Forms to help document response activities

Nebraska depends on volunteers to carry out behavioral health interventions related to disaster response and recovery. Behavioral health preparedness activities are directed by the Nebraska Department of Health and Human Services, Division of Behavioral Health and carried out by the six Behavioral Health Authorities located across the state.

Disaster behavioral health response activities fall under public health incident command structures locally and at the state level. Local disaster behavioral health resources in Nebraska include locally trained and managed volunteers; mental health functions for the American Red Cross and other Voluntary Organizations Active in Disaster; and local Medical Reserve Corps.

State resources may be requested if an event exceeds the capabilities of a local area. These resources include the State Critical Incident Stress Management Team (CISM), State Behavioral Health Emergency Response Team, State Risk Communication Cadre, and consultation services from subject matter experts.

Coordination with other response entities is an important part of Nebraska's plan to deliver disaster behavioral health interventions. Partners in planning, response and recovery include spiritual care providers, emergency management, public health and healthcare, and first responders.

Deployment of disaster behavioral health resources begins with a request from emergency management. Local and state behavioral health teams are organized using incident command concepts and supervised in the field by qualified personnel familiar with disaster behavioral health service delivery and the local area.

II. Purpose of this Plan

The purpose of this plan is to provide a framework for organizing the Nebraska behavioral health response to disasters. Behavioral health in Nebraska includes mental health, substance abuse, and addictive behaviors.[1] Behavioral Health disaster response addresses psychological, emotional, behavioral and social issues which may arise from a disaster event. Disaster behavioral health services can help mitigate the severity of adverse psychological effects of the disaster and help restore social and psychological functioning for individuals, families, and communities.

This plan is meant to be a dynamic document that can be modified to incorporate changing technologies and emerging best practices in behavioral health. The plan provides guidelines for use by the Nebraska Department of Health and Human Services, Division of Behavioral Health in its role as state coordinator of behavioral health care related to disaster. It also serves as a template for local behavioral health disaster planning.

III. Assumptions & Situation

Guiding Principles

These guiding principles provide the basis for organizing the behavioral health response to disaster in Nebraska.

1. **All-hazards disaster response is a local responsibility first.**

   The first response to a disaster always occurs locally. The capacity to respond to the psychological effects of disaster must also be organized and implemented at the local level first. Local planners understand the cultural, social, and psychological needs of people in their area. The Nebraska Plan builds on the strengths of our communities.

2. **Disaster behavioral health is usually (but not always) part of a larger, multi-layer, multi-disciplinary disaster response.**

   Disaster behavioral health responders typically work in concert with health care providers, public health, emergency management, first responders, and members of Nebraska Voluntary Organizations Active in Disasters (NEVOAD).

3. **The public behavioral health disaster response in Nebraska is organized and coordinated via the six Regional Behavioral Health Authorities in Nebraska.**

   The State recognizes that local behavioral health disaster resources are limited and may be overwhelmed if the effects of the disaster are severe or widespread. Regional coordination of human resources facilitates mutual aid and pooling of resources, and provides a single point of contact if additional resources are needed.

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[1] Nebraska Behavioral Health Services Act, Neb. Rev. Stat. §§ 71-801 to 71-830

4. **State level involvement in the behavioral health response to disaster builds upon the structure and organization of the local and regional response.**

   Human resources mobilized by the State will support and build upon the structured response identified by the local and regional entities responding first to the disaster. The State will augment, not replace, community structures already in place to deliver disaster behavioral health services.

5. **Nebraska Voluntary Organizations Active in Disasters[2] (NEVOAD) members are valuable partners in meeting the psychological, social, and spiritual needs of people in disaster.**

6. **Natural support systems during response to a disaster may include disaster spiritual care.** Spiritual care contributes to promotion of resilience before and after a disaster.

7. **Disaster behavioral health interventions may be systemic[3] and long-term, with the early goal of stabilizing the psychosocial reactions of survivors, and the later goal of restoring or rebuilding the social fabric of a community.**

8. **The tendency of people to seek assistance from natural support systems creates a need for Disaster Behavioral Health Professionals to serve as a resource in a consultative role for natural support systems.**

   Service provision for disaster behavioral health includes working with families and institutions (e.g., churches, schools, neighborhood groups). The consultative role includes being available for questions and acting to equip individuals and groups with the information and tools they need to provide psychological first aid to the people who turn to them for assistance.

9. **Individual disaster behavioral health services must be appropriately delivered, and adjusted to be gender and culturally sensitive, linguistically and developmentally appropriate, and suitable for the type, scope, and phase of the disaster.**

10. **Interventions during disaster response and recovery should be based on accepted professional standards and practices, to the extent possible** Interventions directed at treatment of trauma or disaster-related problems should be evidence-informed[4] when possible.

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[2] Nebraska VOAD is an umbrella organization of existing voluntary agencies. Each member organization maintains its own identity and independence, yet works closely with other agencies to improve service and eliminate unnecessary duplication of efforts in times of disaster.

[3] Systemic interventions are used with communities, families, & institutions. An example of a systemic intervention is a mental health clinician who equips teachers to screen children in their classrooms for disaster stress while the teacher provides education about coping with the disaster stress. More children are touched by this systemic intervention than could be reached by placing an individual clinician in a school to personally screen all children.

[4] There is a growing body of evidence about clinical practices that seem to alleviate disaster-related problems. It is important for disaster clinicians to remain up to date on the latest research related to their practice.

Relevant Geography

Nebraska is 76,872 square miles, averaging 23.8 persons[5] per square mile. The majority of people in Nebraska live in the eastern third of the state or along the central corridor (Interstate 80/Platte River). The 2016 population estimate for Nebraska is 1,907,116 persons. Nebraska has a large agricultural sector with 45,200,000 acres of farmland with a variety of crops, and livestock.[6]

Relevant Demography

General Demographic Considerations

- Rural residents live in areas with few or no behavioral health professionals
- 11.1% of Nebraskan's speak a language other than English at home with Spanish as the predominant language other than English
- There are four federally recognized tribes headquartered in Nebraska each of which have claims to sovereignty and a government-to-government relationship with the State and Federal governments.
(Omaha Tribe; Ponca Tribe; Santee Sioux Nation; Winnebago Tribe)

Populations with Unique/Functional Needs

- Children under age 18 account for 24.8% of Nebraskans
- Adults age 65 or older make up 14.7% of the population
- 12.6% of Nebraskans have incomes below the poverty level
  - 7.3% of Nebraskans under age 65 have a disability[7] (e.g., developmental, physical, psychiatric disabilities)
- People with a history of substance abuse
  - Substance use may increase after a disaster for those with pre-existing substance use/abuse issues.[8]
  - Depending on the disaster, access to treatment may be hindered, particularly for those in opioid treatment programs. (People from across the state are served by Nebraska's Opioid Treatment Programs (OTP) that are primarily located in the eastern third of the state.)
- Approximately 75% of adults in Nebraska identify as Christian, 5% as other

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[5] Source U.S. Census Bureau: State and County QuickFacts. Last Revised: July 1, 2016

[6] USDA, National Agricultural Statistics Service. Data as of March 8, 2017

[7] U. S. Census Bureau, 2015 American Community Survey.

[8] North, C. (2004, July). *Data-based foundations for disaster mental health intervention and policy.* Presented at the Second Annual Nebraska Disaster Behavioral Health Conference, Omaha, NE.

faiths and 20% as unaffiliated[9]

- New Nebraskans, often refugees, may have come from areas of the world where they experienced disaster, war, or famine

- Other populations that may have unique needs include people who are homeless, in institutions, long-term care facilities, college dorms, and other multi-person dwellings

Probable Disaster Situations in Nebraska

The Nebraska Emergency Management Agency identified Flooding, Tornados and Wildfires as the top three hazards in the state. Other potential hazards include:

Natural Hazards

- **Weather related disaster** such as drought, ice, wind, or snow storms

- **Earthquake risk** is difficult to estimate in Nebraska. The New Madrid fault runs through part of Nebraska. More than 50 earthquakes, almost all less than Richter 4.0, have occurred in Nebraska since 1867. Some of the earthquakes were between Richter 4.0 and 6.0, a magnitude large enough to overturn unstable objects and break dishes and windows.[10]

Technological Hazards

- **Biological or Chemical** disaster risk for Nebraska is largely unknown, though the agricultural nature of the State creates unique vulnerabilities in this area. Risks to crops, food production, or the animal industry through intentional or unintentional contamination or disease could result in a number of economic and psychological consequences. Risk of chemical disaster is highest for chemicals such as anhydrous ammonia and other agricultural chemicals

- **Nuclear disaster** risk is related to the transportation and storage of nuclear waste, and the presence of one nuclear power plant in Nebraska (Cooper in Brownville)

- **Transportation system accidents** (railroad, busing, trucking, air travel)

Security Hazards

- This includes terrorist events or disasters linked to illegal activity resulting in community trauma or disruption. The psychological consequences related to these events tend to be more pronounced than for disasters stemming from natural or technological hazards

Public Health Threats

- Disease events such as flu, Ebola or similar highly contagious disease are possible in Nebraska. Population based behavioral health consequences vary depending on level of exposure and degree of impact for the disease.

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[9] http://pewforum.org/religious-landscape-study/state/nebraska

[10] USGS Earthquake Hazards Program. Retrieved March 15, 2017, from: https://earthquake.usgs.gov/earthquakes/byregion/nebraska.php

IV. Concept of Operations

Local Response Structures

Local Emergency Management structures are organized by county in Nebraska. Under state law, all local jurisdictions are responsible for initial response to a disaster.[11] Each county has a Local Emergency Operations Plan (LEOP). The local plan may contain information about how that county intends to meet the psychological and social needs of people in that area after a disaster.

Local Public Health Departments are located across the state. Some are organized by county and others by multi-county districts. Public health departments are responsible for coordinating with the behavioral health disaster response in their local area.

Local behavioral health structures are organized under Regional Behavioral Health Authorities. These multi-county Regions serve as the conduit for public behavioral health funding and as the coordinating body for public behavioral health services. The Division of Behavioral Health within the Nebraska Department of Health and Human Services is responsible for ensuring there is statewide access to behavioral health services through these regional structures.[12] Nebraska administrative code currently states that the Regional Governing Board must have the capacity to respond to the psychosocial needs of disaster victims within the Region's assigned geographic area.[13] The Regional Behavioral Health Authorities coordinate with local Public Health Departments to mobilize and oversee the behavioral health disaster response.

> The challenge associated with coordinating service provision among local structures is that the geographic areas used to organize them are all different. Public Health districts, CISM troop areas, Regional Behavioral Health Authorities, and Local Emergency Management coverage areas differ.

Coordination of the Behavioral Health Disaster Response

The Local Emergency Operations Plan (LEOP), the Local Public Health Emergency Response Plan, and the Regional Behavioral Health Disaster Response and Recovery Plan should designate someone from the area as a disaster behavioral health coordinator. Local providers or agencies are in the best position to understand what may work best with the human resources available. However, emergencies can occur that require more assistance from behavioral health disaster resources than are available in the local area. For this reason, the Behavioral Health Regions serve as the primary local link to regional resources.

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[11]   Nebraska Emergency Management Act, §§ 81-829.46 to 81-829.50

[12] The Nebraska Behavioral Health Services Act, passed by the Nebraska Unicameral July 1, 2004, designates the geographic coverage of each Region and creates a Division of Behavioral Health within the Department of Health and Human Services, §§ 71-805 to 71-807

[13] Nebraska Administrative Code Title 204 Chapter 3-008

Regional Behavioral Health Authorities designate a person(s) to serve as Regional Disaster Behavioral Health Coordinators. The Regional Administrator will ensure the name(s) and contact information for the disaster coordinator(s) for the Region is communicated to the Division of Behavioral Health, Disaster Behavioral Health Coordinator annually on July 1 and will provide up to date information if anything changes (e.g., names, phone numbers, emails) over the course of the year. These coordinators serve as a link between emergency management, public health, and other agencies and organizations within local communities, and the State Division of Behavioral Health. The State will look to the Regions to provide local behavioral health information needed to prepare a FEMA Crisis Counseling Program or other similar grant application if a disaster occurs that makes the area eligible to receive it.[14]

State level coordination of resources during a disaster **occurs only when local and regional resources are inadequate or overwhelmed or when the Governor's Authorized Representative (GAR) activates a state disaster behavioral health team for a specific mission.**

The Division of Behavioral Health is responsible for maintaining capacity and readiness on the state level to assist communities in meeting their behavioral health needs following a disaster. The Director of the Division of Behavioral Health will designate staff, volunteers, or personnel from other State entities with requisite experience and knowledge to serve as State Disaster Behavioral Health Coordinators. These coordinators serve as liaisons from the State Division of Behavioral Health to Regional Behavioral Health Authorities, to other Nebraska State agencies, and to other states with disaster behavioral health needs. Links to the Nebraska Emergency Management Agency (NEMA) are particularly important, as NEMA is a link to all other emergency management activities in the state. The Nebraska Behavioral Health All-Hazards Disaster Response and Recovery Plan serves as the disaster operational plan for NE DHHS Division of Behavioral Health.

SUMMARY

- Local Plans recognize human resources available in the area to meet psychological and social needs of community members following disaster

- Regional Behavioral Health Authorities designate Regional Disaster Behavioral Health Coordinators

- The Nebraska Department of Health and Human Services, Division of Behavioral Health designates State Disaster Behavioral Health Coordinators

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[14] FEMA Crisis Counseling Grant Application information is available in the Appendix.

Coordination with Other Disaster Response Functions/Agencies

The Nebraska Emergency Management Agency (NEMA) maintains the State Emergency Operations Plan (SEOP). The SEOP places DHHS in charge of organizing and activating the behavioral health disaster response for the state, excluding the normal deployment of NEVOAD agencies. The Nebraska Department of Health and Human Services **ESF #8 Coordinator** is assigned to the NEMA Emergency Operations Center (EOC) and serves as the DHHS link with state disaster response activities. **The link with NEMA is important because it ties in the state behavioral health response with Nebraska Voluntary Organizations Active in Disasters (NEVOAD) and government response structures.**

The Division of Behavioral Health makes one of the State Disaster Behavioral Health Coordinators   available to participate in regular **DHHS disaster activities** to ensure readiness and coordination with other DHHS functions.

Local emergency management and **local public health departments coordinate with Regional Behavioral Health Authorities** to identify local behavioral health providers and response agencies, and to identify someone who can serve as the primary local behavioral health disaster response contact.

Summary

- State coordination occurs formally through the Nebraska ESF #8 Coordinator
- The state behavioral health response ties in with VOAD through the ESF #8 Coordinator
- Local coordination facilitated through Regional Behavioral Health Authorities

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Overview of Actions Before, During, & After a Disaster

Before a Disaster Occurs - Preparedness

Every disaster is different, but there are common things that can be done to prepare and be ready to respond when an event occurs.

Local Activities

- Review Local Emergency Operations Plans to ensure existing plans address behavioral health needs of people affected by a disaster.
- Participate in joint exercises to test emergency plans. Encourage inclusion of behavioral health responders as exercise support and participants.

- Familiarize behavioral health providers and volunteers with the Incident Command System,[15] an approach that details a strategy to define how behavioral health, public health, emergency management, hospitals, and other responders prepare, coordinate, and respond to an event.
- Identify faith based leaders who are trained in Disaster Spiritual Care.
- Record key response contacts for behavioral health.

Regional Activities

- Foster relationships among Emergency Management, Public Health Departments, and those responsible for responding to behavioral health disaster needs in each county included in the Behavioral Health Region.
- Develop and maintain Regional Behavioral Health Authority disaster response and recovery plans.
- Identify Regional Behavioral Health Authority personnel who may serve as Regional Disaster Behavioral Health Coordinators.[16]
- Forward contact information for Regional Authority Disaster Behavioral Health Coordinators to local Emergency Managers, the local Public Health Department(s), and the State Division of Behavioral Health.
- Make psychological first aid training available to all involved in disaster response, specifically targeting community responder volunteers who may augment the behavioral health response to disaster.
- Maintain, by the Regional Authority or in coordination with a partner agency (such as Medical Reserve Corps or Public Health), a list of local volunteer behavioral health responders.
- Manage forms and materials that may be needed as part of a disaster behavioral health response.
- Work with mental health, substance abuse and opioid treatment programs to ensure plans are in place for continuity of service in the event of a disruption.

State Activities

- The DHHS Division of Behavioral Health identifies State Disaster Behavioral Health Coordinators. [17,18]
- The Division of Behavioral Health creates, fosters, and/or makes available information about training opportunities related to the psychological and social aspects of disaster response and recovery.
- The Division of Behavioral Health, together with Public Information Officers for

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[15] See Appendix for information on the Incident Command System.

[16] A key contact may be identified by the Region to do preparedness activities. It is recommended that at least 5 people be identified to serve in this role should disaster occur to insure that the role is covered.

[17] Neb. Rev. Stat. 71-806 "The division shall act as the chief behavioral health authority for the State of Nebraska"

[18] Similar to the recommendation for Regions, the State should identify a key contact(s) to carry out preparedness activities. It is recommended that at least 3-5 people be identified and familiarized with the role of the State Disaster Behavioral Health Coordinator to insure the role is covered in the event of a disaster.

the State of Nebraska, identifies a pool of licensed/certified behavioral health professionals with expertise in risk communication to serve as consultants for risk communication efforts.

- The Division of Behavioral Health maintains a list of pre-identified and trained Nebraska Behavioral Health Emergency Response Team (BHERT) members to provide needs assessment, consultation, service provision and training as required.

- State Disaster Behavioral Health Coordinators, BHERT members, and Risk Communication Consultants convene regularly to:

  ◦ Review the Nebraska Behavioral Health All-Hazards Disaster Response and Recovery Plan

  ◦ Participate in State-level disaster exercises and/or training

  ◦ Make key contacts with State-level response agents

  ◦ Review the application process for the FEMA Crisis Counseling Grant Program or similar Disaster Recovery Grants.

  ◦ Review current contact information and activation mechanisms for the Nebraska ESAR-VHP and MRC Program, American Red Cross, Nebraska Critical Incident Stress Management (CISM) teams, and NEVOAD members that provide statewide disaster assistance related to meeting the psychological and or social needs of those touched by disaster

  ◦ Maintain key contacts with Regional Disaster Behavioral Health Coordinators

After a Disaster Occurs - Response

No flowchart or list of duties can accurately depict the exact sequence of events for every disaster response, however there are predictable formal lines of authority that must be observed when requesting or deploying disaster response structures. Figure 1 depicts there formal lines. Response agencies and personnel should use the Incident Command System (ICS) structure.

The numbered items below serve as a general guide for Nebraska's behavioral health disaster response.

1. The appendices contain guidelines and checklists to serve as tools for Regional and State Disaster Behavioral Health Coordinators responding to a disaster.

2. Local emergency management (often through public health) must activate the behavioral health response. Regions are encouraged to contact public health and emergency management to discuss the role of a behavioral health response in the current event.

3. Regions should encourage local emergency management to engage them early in the response to conduct an initial assessment of the behavioral health needs of individuals and the community affected by the disaster.

4. Regional Behavioral Health Authorities oversee the behavioral health response in their areas, sometimes jointly with other agencies, and should be involved in behavioral health deployment and coordination decisions.
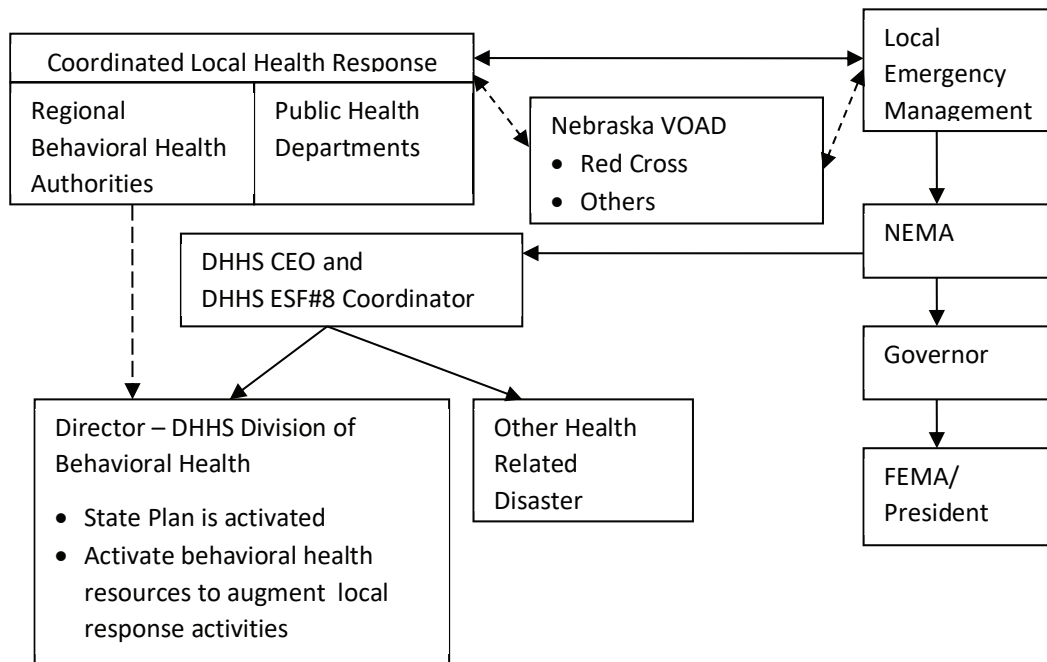
Figure 1. Overview of response coordination among agencies.

5. Regional Behavioral Health Authorities work with local resources to track the scope of the response from its onset including:

    ◦ The number and type of behavioral health resources deployed (Organizations & Individuals; Volunteers & Paid Responders)

    ◦ The number and type of individual contacts made by behavioral health responders

    ◦ Costs incurred as a result of the deployment

6. Regional Disaster Behavioral Health Coordinators, in consultation with local resources, notify local emergency management and local public health departments if the disaster type, size, or scope overwhelms the ability of local and Regional Authority resources to adequately respond to the psychological and social needs of those affected by the disaster. (Regional Disaster Coordinators should also notify the Division of Behavioral Health of this decision so locating additional resources can begin. The Division of Behavioral health will receive the official request for additional resources through the Emergency Management system.)

7. Local Emergency Management notifies the Nebraska Emergency Management Agency that area resources in disaster behavioral health are overwhelmed and that additional assistance from the State is required.

8. The Nebraska Emergency Management Agency follows the protocol laid out in the State Emergency Operations Plan (SEOP) and notifies the CEO of the Department of Health and Human Services that State involvement is needed to

support the behavioral health response in the affected area.

9. The Department of Health and Human Services CEO designates the Division of Behavioral Health to assign the State Disaster Behavioral Health Coordinator(s) to work with Regional Disaster Coordinators, the American Red Cross, other active VOAD agencies, and the Nebraska CISM team to identify and deploy appropriate resources to the affected area.

10. Once the disaster progresses through the response phase toward recovery, the Division of Behavioral Health works with the Regional Behavioral Health Authorities to identify recovery needs related to behavioral health in the affected area.

Likely Sites of Intervention

There are a variety of sites where behavioral health disaster responders may be needed. Behavioral health is often not needed at the site of the incident. Although it is a common reaction to want to rush to these sites, the assistance that behavioral health responders provide will most likely be needed at other sites where people gather.

Local and Regional Behavioral Health Authority Disaster Coordinators must be prepared to ensure behavioral health disaster response workers are deployed to the following sites as needed, in coordination with other organizations with behavioral health responders (e.g., American Red Cross) and spiritual care providers:

- Sites where survivors and families of victims gather

  - Shelters, meal sites, disaster application centers, Red Cross service centers, hospitals, schools, police stations, survivors' homes, morgues, farms or ranches, police barriers/perimeters, etc.

- Mass care sites

- Mass clinics for immunizations and/or prophylactic medications

- Sites where first responders and other response workers gather (*coordinate this work with the Nebraska CISM Program*)

- Sites conducive to community education and outreach (Community centers, shopping malls, schools, religious centers, business associations)

- Organizations who request behavioral health response services (Businesses, affected neighborhoods, farms or ranches)

> Behavioral health disaster related concerns include the needs of people already served by the behavioral health system. A plan for continuity of services is primarily the responsibility of the service provider or facility. In some situations, however, disaster service provision may need to be augmented with disaster behavioral health services. Service providers should recognize when their clients are affected by a disaster and request additional resources when needed from the Regional Behavioral Health Authority covering their area.

State Behavioral Health Coordinators should be prepared to identify state behavioral health resources or work with Regions to identify behavioral health personnel to:

- Provide appropriate support to State-sponsored hotlines (i.e., support to staff, training, crafting risk messages)
- Respond to behavioral health needs related to disaster involving State-operated facilities in affected areas
- Work with Regional Behavioral Health Authorities
- Augment Regional Behavioral Health Authority resources when needed
- Respond to missions issued by the Nebraska Emergency Management Agency

After a Disaster Occurs – Recovery

Recovery is a process that occurs over time for individuals and communities. Psychological and social needs in recovery are dependent upon a number of factors, including the pre-existing state of individuals and communities, the nature, scope, and severity of the disaster, and the type of assistance that is made available through formal response mechanisms. Generally, recovery is a local responsibility but there may be opportunities for assistance from State and Federal resources to meet this responsibility.

1. First Responders and other emergency service personnel may be aided through pastoral care and the Nebraska CISM program.[19]
2. The Division of Behavioral Health monitors activities and needs of affected areas so it is in a position to advocate for resources and funding if they become available.
3. Declarations of disaster by the Governor may increase the likelihood of resources becoming available to the affected area to aid in recovery.
4. Declarations of disaster by the President may create opportunities for reimbursement for response activities and the opportunity to apply for the FEMA Crisis Counseling Program (CCP). DHHS Division of Behavioral Health is responsible for deciding whether to apply for a FEMA CCP, and will assemble the application with the assistance of the Regional Behavioral Health Authority responsible for serving the affected locations. (Detailed information about applying for FEMA CCP is available in the Appendix).
5. Long-term recovery may also involve formation of groups to address unmet needs in a community resulting from the disaster which could involve behavioral health.
6. Regional Behavioral Health Authority Disaster Coordinators are responsible for reporting recovery needs and progress to the State Division of Behavioral Health through the State Disaster Behavioral Health Coordinator even if they are not involved in administering a FEMA CCP.
7. Administrative review of a completed response should include the following:

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[19] Per NAC Title 176 Chapter 1, and the Nebraska Critical Incident Stress Management Act §§ 71-7102 and 71-7113, emergency service personnel includes: law enforcement personnel, firefighters, emergency medical services personnel, dispatchers, rescue personnel, hospital personnel, corrections personnel, and emergency management personnel.

- Conduct a review of activities
    - Which parts of the plan worked and didn't work?
    - What lessons were learned from the experience?
    - What could be done differently or better next time?
- Assign a representative to draft an after-action review document
    - What actions were taken during the incident and the results of these efforts?
    - What resource needs were identified as a result of the incident?
    - What will be done to improve the response in the future?
    - What was learned about responding to such an incident?
- Identify gaps and propose remedies for the local or statewide public behavioral health response – revise procedures and plans accordingly

V. Legal Authorities

Division of Behavioral Health, Nebraska Department of Health and Human Services

The Nebraska State Emergency Operations Plan (SEOP) assigns the Nebraska Department of Health and Human Services with maintaining plans and procedures to respond to the psychosocial needs of disaster victims within the state, and for interstate aid (SEOP ESF-6, 8, and 11).

All state agencies and political subdivisions of the state are required to cooperate and extend their services and facilities for the purposes of disaster response upon request.[20] The Division of Behavioral Health is responsible for cooperating with other state agencies to identify behavioral health personnel who can be shared or activated to respond to state disaster behavioral health needs, and to establish contacts/protocol for activating such a response.

Regional Behavioral Health Authority

The state's six Regional Behavioral Health Authorities are required to have a written plan to respond to psychosocial needs of disaster survivors in their coverage area.[21]

Health Care Facilities and Services Licensure

Facility licensure requirements address disaster preparedness in terms of meeting physical needs and continuation of services. This also applies to certification of aging services and mental health programs.[22]

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[20] Nebraska Emergency Management Act § 81-829.60

[21] NAC Title 206 Chapter 4

[22] NAC Title 15 NAC 1; and Title 205 Chapter 5

Nebraska Critical Incident Stress Management Program

The Nebraska Critical Incident Stress Management (CISM) Program is authorized by statute to provide system support services when requested by emergency responders, law enforcement, dispatchers, correctional staff, hospital, and emergency management personnel throughout Nebraska. The CISM Program provides services to public safety personnel to help prevent and to ameliorate stress-related symptoms. It is not the function of the Program to replace on-going professional counseling or psychotherapy, but to provide education, prevention and crisis intervention.[23] CISM is the only statutorily funded program in Nebraska for responding to psychosocial needs in a disaster.

Mobilization of Responders

Locally, the emergency management director or coordinator is responsible for developing mutual aid arrangements for reciprocal aid and assistance in the event of a disaster or emergency.[24] This includes developing mutual aid arrangements with agencies and organizations in other states. Additionally, licensure or certification in another state will be recognized as evidence of qualification for utilizing the licensed skills for disaster response in the State of Nebraska.[25]

Under the Nebraska Emergency Management Act, a roster of persons with training and skills for disaster response can be established as an emergency response team.[26] Only the people who appear on such a roster will be considered members of a disaster response team and therefore covered by the emergency management act.[27] A general roster of individuals who can potentially volunteer is not the same as the team roster submitted to emergency management. The team roster only includes people deployed for that disaster for a specific mission.

Any state employee who is a certified disaster service volunteer of the American Red Cross may be granted leave for disaster response with the authorization of his or her supervisor. This leave is not to exceed fifteen working days in each calendar year. This specifically includes "all administrative, professional, academic, and other personnel of the University of Nebraska, the state colleges, and the State Department of Education."[28] This potentially creates an avenue for employees to respond to disaster situations within organized response structures and obtain valuable experience and training.

Communications with Clergy

Communication with clergy is confidential if made privately and not intended for further disclosure except to other persons present in furtherance of the purpose of the communication. The person who communicated with clergy, his/her guardian or conservator, a personal representative if deceased, or the clergyman to whom the

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[23] Nebraska Critical Incident Stress Management Act §§ 71-7101 to 71-7113; see also NAC Title 176 Chapter 1

[24] Nebraska Emergency Management Act § 81-829.48

[25] Nebraska Emergency Management Act § 81-829.56

[26] Nebraska Emergency Management Act § 81-829.41

[27] Nebraska Emergency Management Act § 81-829.52

[28] Nebraska Law § 81-1391

communication was made may claim privilege and refuse to disclose or prevent another from disclosing this confidential communication.[29]

Governor's Emergency Authority

In the event of a disaster declaration by the Governor, the Governor may "suspend the provisions of any regulatory statute prescribing the procedures for conduct of state business or the orders, rules, or regulations of any state agency if strict compliance with the provisions of any statute, order, rule, or regulation would in any way prevent, hinder, or delay necessary action in coping with the disaster, emergency, or civil defense emergency."[30] In order for this to be possible, requests for such an action by the Governor would have to be channeled through the Nebraska Emergency Management Agency, which is responsible for carrying out the provisions of the Emergency Management Act.

Liability Issues

The Nebraska All-Hazards Disaster Behavioral Health Plan is not a substitute for legal advice regarding liability. Efforts have been made to construct a system of deployment that maximizes protection from liability for volunteers. **There is no liability protection for volunteers who engage in illegal or unethical behavior while responding.** Volunteers are least liable when they:

1. Are part of a formal response activated by emergency management;
2. Operate within the scope of their licensure or responsibility area;
3. Are adequately trained and supervised when in the field.

The Appendix contains summaries of relevant regulations and statutes that may be of interest to the behavioral health disaster volunteer. Liability exposure is also related to supervision and use of best practices (refer to Section XII of this plan, particularly the parts on Supervision of Responders, and Best or Promising Practices).

Licensure is neither necessary nor sufficient to enable a person to be a disaster behavioral health responder. Specialized training in provision of psychological first aid can equip a person (who may be behavioral health professionals, alcohol and drug addiction specialists, faith leaders, health professionals, educators, other human service professionals, and trained community responders such as CISM peers or other community members) to function in the role of a disaster behavioral health responder.

Informed consent is a phrase that implies that a person knowingly gives consent to participate in an interaction with a behavioral health professional. Although psychological first aid is not treatment and informed consent is not required, it is important for behavioral health response volunteers to tell people they speak with that they are part of the behavioral health response. This gives individuals a chance to decline the interaction if desired.

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[29] Nebraska Revised Statutes § 27-506

[30] Nebraska Emergency Management Act § 81-829.40

VI. Behavioral Health and NIMS

The National Incident Management System (NIMS) provides a consistent approach for government and private sector groups to work together to prevent, prepare for, respond to and recover from incidents regardless of the size or cause of the disaster. A best practice within NIMS is the Incident Command System (ICS). ICS is a way to organize and manage on-site response operations. Each entity involved in response should know, understand and be able to function within the structure of the Incident Command System. The framework of NIMS and ICS helps response operations scale up or down for an incident using a system to organize and manage the response that everyone is familiar with. Practically speaking, this means that every disaster behavioral health responder must have a working understanding of NIMS and ICS.[31]

In Nebraska, Disaster Behavioral Health is integrated within a larger Incident Command Structure on the site of a response operation. Typically, disaster behavioral health falls within the Operations Section of ICS. Behavioral health can also serve within the other ICS functions and may be expected to organize teams that address each of the five major incident command functions:

1. Command and Command Staff
   a. Safety
   b. Information
   c. Liaison
2. Operations
3. Planning
4. Logistics
5. Finance

Command and Command Staff

Public Information

A behavioral health representative will often work with the designated Public Information Officer (PIO) to provide behavioral health messages and assist in monitoring hotline trends. This may involve being located at a Joint Information Center (JIC) to address the emotional and behavioral aspects of messages being developed and communicated. Behavioral Health within the public information function will:

- Assess the need for, and help to craft, special messages containing behavioral health content (i.e., coping with the stress of emergency evacuation, etc.).

- Coordinate information releases with information staff from other agencies and jurisdictions.

- Provide requested information about behavioral health issues related to the incident.

- If a hotline is set up, provide education to hotline personnel and assist in

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[31] Draft U.S. Department of Health and Human Services. All-Hazards Disaster Mental Health and Substance Abuse Preparedness Toolkit. Pre-publication version - Rockville, MD: Center for Mental Health Services,Substance Abuse and Mental Health Services Administration, 2009.

monitoring hotline trends related to behavioral health.

- Provide copies of all news releases, bulletins, and summaries pertaining to behavioral health to the PIO.

Liaison with Incident Command

Liaison functions are often accomplished through establishment of an Emergency Operations Center (EOC). If a behavioral health liaison is requested at the EOC, the behavioral health liaison will:

- Monitor EOC information to help structure the behavioral health response.
- Monitor the current behavioral health response and available resources to report back to the EOC.

Safety

Although this function is directly under the incident commander, it is also an inherent part of behavioral health operations. To assist with the safety function, behavioral health will:

- Identify psychological hazards associated with the incident
- Assess whether a location is safe for deploying behavioral health responders.
- Identify potential unsafe acts or practices in disaster behavioral health service delivery
- Identify corrective actions and ensure implementation
- Develop a plan for responder stress management (set up shifts if needed; enforce breaks/mealtimes/sleep times; provide education on worker stress and self-care)
- Coordinate post-deployment individual and/or group support or processing sessions
- Develop an exit plan for workers leaving operations (e.g., re-entry to normal life, recognition of response efforts)

Planning

One of the main tasks of the Planning Section is to create an Incident Action Plan (IAP). Behavioral health, as part of the Planning function, will:

- Assemble information for a behavioral health needs assessment
  - Determine current resource availability, situation status, and behavioral health objectives and strategy
- Activate additional personnel to assist with planning, if necessary
- Maintain a resource tracking system
- Gather information from operations and field staff
- Advise Planning Section staff of any significant changes in incident status related to the behavioral health impact of events

Operations

This is the primary behavioral health function within a response. This function will typically start on the local/Regional level. The Disaster Behavioral Health Coordinator, or designee, is responsible for the direct management of all incident-related operational activities. The person heading up Behavioral Health Operations (often positioned as a Branch Director, Division or Group Supervisor, or Unit Leader) will:

- Direct the behavioral health operations to complete the mission identified in the planning function
- Ensure that logistics support activities are sufficient to support the proposed operations
- Determine general organizational structure of the response
- Coordinate with the Planning function
- Develop a response schedule of activities and tactical assignments
- Review responder activities and modify them based on effectiveness/ needs assessment
- Continually monitor current operations and their effectiveness
- Visit field locations to view activities and assess community needs
- Estimate immediate and long-range resource and logistical requirements
- If community needs are outside the scope of the mission assigned to behavioral health, request a revision of the mission or Incident Action Plan (IAP)
- Supervise and coordinate all behavioral health response activities
- If working in shifts, ensure all shift activities are passed on appropriately to incoming Behavioral Health Operations leaders

Logistics

Behavioral health functions within Logistics overlaps greatly with behavioral health functions in the Planning and Operations Sections. Much of the logistics support for behavioral health will be provided by emergency management, such as:

- Necessary communications equipment for field operations
- Transportation to/from field locations
- Meals or Lodging, if necessary

Within the Logistics function, behavioral health will:

- Receive requests for, and locate, behavioral health resources
- Identify staging areas to assemble behavioral health resources

Finance/Administration

The Finance/Administration function for behavioral health primarily involves tracking and reporting response activities. The person(s) serving in this role typically carry out the following duties:

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

VII. Plan Development and Maintenance

The DHHS Division of Behavioral Health is responsible for ongoing evaluation and updating of the Nebraska Behavioral Health All-Hazards Disaster Response and Recovery Plan. The Plan will go through a formal review and re-write process every four years. Routine corrections and updates of the Plan will be informed by exercises and any disaster events that occur. Notification and contact lists will be updated semi-annually.

Changes to the plan should be communicated to stakeholders and other response agencies. Changes should be thoughtfully considered and made in a manner that maintains or enhances compatibility with other state plans.

VIII. Mass Care (ESF-6)

The Division of Behavioral Health, as part of Nebraska DHHS, coordinates with NEMA, the American Red Cross, and other ESF-6 partners to provide for the immediate and short term behavioral health and spiritual care needs of disaster victims, families of victims and responders. Responsibilities are the same as those described in the Nebraska State Emergency Operations Plan ESF-8, Health and Medical.

IX. Health and Medical (ESF-8)

ESF-8 details the Nebraska DHHS Behavioral Health response and recovery procedures. The responsibilities of the Division of Behavioral Health are to:

- Assist local government and Regional Behavioral Health Authorities in the assessment of behavioral health needs
- Identify emerging behavioral health needs of the affected area

- Determine the extent of the local or regional behavioral health response that has been or is currently active
- Procure and coordinate resources that may be required to meet the behavioral health needs of the affected area
- Coordinate with behavioral health disaster resources at the local and regional levels
- Coordinate services with other responding agencies to provide behavioral health services to emergency responders
- Coordinate with the State Joint Information Center to provide behavioral health information to those affected
- Monitor and coordinate the deployment of behavioral health resources
- Complete and submit the FEMA Crisis Counseling Program grant.

X. Agriculture (ESF-11)

Under ESF-11, the Nebraska DHHS Division of Behavioral Health is responsible for providing mental health support to survivors, emergency responders, those that suffer significant property loss and the public in general to prevent or minimize stress, grief, and depression that can occur following natural or manmade disasters. Procedures are the same as under ESF-8, with the added requirement of coordinating with the Nebraska Department of Agriculture.

XI. Resource Management

Disaster Behavioral Health Resources in Nebraska

There are a number of organizations and programs whose role in disaster response includes addressing behavioral health needs. In addition to the organizations listed below which focus on disaster response, behavioral health disaster response and recovery will require working in concert with multiple groups, such as local community social services and behavioral health providers, to serve the behavioral health needs of a community affected by a disaster.

Formal State Resources

- **Nebraska Behavioral Health Emergency Response Team (BHERT):** The BHERT is a mechanism for organizing and deploying state disaster behavioral health resources. The primary value of the team to local areas is rapid deployment of behavioral health personnel experienced in disaster-related community needs assessment, coordination of resources, and training. NBHERT is also a resource for state-run facilities and emergency response operations, and it is expected that NBHERT will be available as a resource of the Governor in the event behavioral health expertise is requested by another state.

- **Nebraska Risk Communication Cadre:** This pool of behavioral health and public information professionals with competency[32] in risk communication, risk assessment, and public information includes behavioral health professionals, subject matter experts, and State Public Information Officials (PIOs). These professionals may serve as a consultant[33] to local areas or joint information centers. The group meets regularly to craft messages with behavioral health content for use in all phases of disaster.

- **Nebraska CISM Program:** This is a statewide program authorized under Nebraska Statute.[34] Critical Incident Stress Management (CISM) Teams are organized by State Patrol Troop area. The system uses volunteer mental health professionals and peers trained to support the psychological health and functioning of first responders and other emergency personnel: Law Enforcement, Firefighters, Emergency Medical Services, Corrections, Hospital personnel, Emergency Management Personnel, and Dispatchers. The teams are coordinated by the Nebraska Department of Health and Human Services, Division of Public Health, Emergency Medical Services Program.

- **ESAR-VHP (Emergency System for Advance Registration of Volunteer Health Professionals):** The Nebraska Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program is an electronic database of healthcare workers (including behavioral health) willing to volunteer to work during disasters or large scale emergencies. It is more commonly known as the Nebraska Medical and Health Volunteer Registry. The on-line registration system includes verifiable, up-to-date information regarding the potential volunteer's identity, license, professional credentials and privileges in hospitals or other medical facilities. The State of Nebraska owns, maintains, monitors and secures the database. The U.S. Department of Health and Human Services requires all States to develop a system for the advance registration of health professionals with the ultimate goal of linking States to create a national database of potential health care volunteers.

- **Public Behavioral Health System:** The publicly funded mental health and substance abuse services in Nebraska are organized by defined geographic service regions. Each Region has an identified network of service providers who receive public funds to provide mental health, substance abuse, and addiction services in the area.

Other Resources

- **Medical Reserve Corps (MRCs):** The Nebraska Medical Reserve Corps is a community-based program focused on improving the health, safety and resiliency of local communities. MRC units organize volunteer health and medical professionals (including behavioral health) and other support personnel who volunteer to promote healthy living throughout the year and to prepare

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[32] See the Appendix for qualities and competencies required of persons in the Risk Consultant role.

[33] The role of consultant is to offer professional advice within the scope of licensure and competence of the practitioner.

[34] Nebraska Critical Incident Stress Management Act §§ 71-7101 to 71-7113

for and respond to emergencies. MRC units in the State of Nebraska are geographically based to serve multi-county areas. MRC's have minimum training requirements to ensure volunteers are prepared to respond in emergency situations. They may be a source of behavioral health response volunteers, when additional volunteers are needed.

- **American Red Cross:** Red Cross disaster mental health services are readily available in the most populous areas of the state and somewhat available in other parts of Nebraska. The State of Nebraska currently has a policy that allows state employees two weeks of paid time to respond to disaster in Nebraska as part of the Red Cross response.[35] The Red Cross uses only licensed mental health professionals to provide mental health services for survivors of a disaster and for Red Cross workers.[36] The Red Cross also provides formal Disaster Spiritual Care (DSC) training for volunteers. Faith leaders are often part of the behavioral health response, but they formally occupy the role of providing spiritual care when operating within Red Cross structures.

- **NEVOAD:** Nebraska Voluntary Organizations Active in Disaster are involved in a variety of disaster response activities in the state.

- **Employee Assistance Programs (EAPs)**

- **Faith leaders / Disaster Spiritual Care Volunteers:** Nebraska recognizes that faith leaders and disaster spiritual care volunteers have a special role in disaster response. They are uniquely positioned to provide spiritual care for many individuals in an affected population.

- **Community volunteers**

- **School crisis teams**

- **Private mental health and substance abuse practitioners**

Organization of a Behavioral Health Response to Disaster

Organization of the behavioral health work force for disaster response occurs at the local and regional level. This work force is mostly volunteers, and consists of behavioral health professionals, alcohol and drug addiction specialists, faith leaders, health professionals, educators, other human service professionals, and community responders like CISM peers or community members trained to respond to disaster.[37]

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[35] Nebraska Emergency Management Act § 81-1391

[36] The original Congressional Charter for the American Red Cross was in 1900. A new charter was given in 1905 with several amendments since. For more history of the American Red Cross see http://www.redcross.org/museum/history.html

[37] Community members trained to augment the behavioral health response to disaster could include farmers, ranchers, minority group members, and other natural helpers. Training refers to education and practice of psychological first aid.

Regional Behavioral Health Authorities

Regional Behavioral Health Authorities represent multi-county geographic areas with an existing organizational structure for public behavioral health resources. The Regions also have responsibility related to organization and coordination of emergency behavioral health services in the State.[38] Regions may choose to extend their emergency capacity by taking on some or all of the responsibilities for coordinating capacity development for the disaster behavioral health work force or may choose to relinquish this responsibility by designating a consenting community partner for this work. The Regional Behavioral Health Program Administrator will include information about how their Region intends to coordinate capacity development in the Region's Behavioral Health All Hazards Disaster Response and Recovery Plan and provide the plan to the Division of Behavioral Health.

The Regions may provide leadership or designate a consenting community partner as the area leader as Nebraska moves toward the development of a listing or database of pre-identified disaster behavioral health responders that can potentially respond to a local, regional, or statewide disaster.[39]

Pre-identification is important for several reasons:

- It provides a more accurate picture of Nebraska's behavioral health disaster response capabilities
- It facilitates quick and strategic deployment of human resources
- Pre-identifying can assist in getting appropriate help to affected areas that may be restricted.

For those who are pre-identified, information is readily available to confirm their identity and their qualifications so that an access ID can be issued to them quickly. Not being listed in the database does not prevent a qualified disaster behavioral health responder from assisting with the response, but it does take longer to verify their qualifications.

Credentialing

Licensed/certified behavioral health professionals must always bring their professional license with them when they respond to a disaster.

Regional Behavioral Health Authorities and local emergency management agencies are urged to pre-identify volunteer community responders when possible. The Regions and local emergency management should

> Those who respond with the American Red Cross (ARC) or a Nebraska CISM team are already credentialed through their respective programs, and their ARC and/or CISM ID's will be accepted as credentials for participating in a Regional, or state behavioral health disaster response.

coordinate any pre-credentialing and issue ID's suitable for local response needs to those who participate in trainings and are listed in the Regional responder databases.

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[38] Nebraska Administrative Code Title 204 Chapter 3-008

[39] Credentialing disaster mental health volunteers includes verification of current licensure, adequate training, and any screening required by local areas or law enforcement to gain access to restricted sites.

<u>Supervision of Responders During Disaster Response</u>

Nebraska recognizes that the initial phases of disaster response are intense and often chaotic, requiring supervisors to be skilled and experienced in disaster behavioral health work. For this reason, supervision of field work should fall to licensed mental health professionals, preferably with disaster response training and experience.

1. Adequate clinical supervision of behavioral health disaster responders protects both service recipients and responders.

2. Licensed mental health professionals with experience in assuming clinical supervision roles should use the following guidelines to provide "adequate supervision" to behavioral health disaster responders:

   - Supervisors must be able to adequately oversee and control their subordinates, as well as communicate with and manage all resources under their supervision. In ICS, the span of control of any individual should range from 3 to 7 subordinates or teams. The type of incident, safety factors, and distances between personnel and resources all influence span-of-control considerations

   - Be accessible to responders in the field – this includes availability by phone or radio for immediate consultation, and availability on site for intervention or referral

   - Insist that behavioral health responders receive orientation prior to service and opportunities for defusing/debriefing following service

   - Insist that behavioral health responders be deployed in teams – never solo

   - Take time to know the strengths and limitations of the responders assigned to you for supervision

   - Consider pairing community responders with licensed behavioral health, credentialed clergy, active CISM peer, or ARC Disaster Mental Health responder if possible – use a "buddy system"

   - Insist that behavioral health responders identify themselves to survivors and those they are serving to allow the potential recipient of service to decline if desired

       ◦ Licensed behavioral health responders should identify themselves according to their licensed profession

       ◦ Community responders should identify themselves as "psychological support" volunteers

   - Insist that behavioral health responders who are licensed mental health professionals conform to provision of informed consent when engaging in formal interventions such as debriefing – reviewing the potential risks and benefits prior to beginning the intervention

- Work with administrative personnel to create reasonable working hours and conditions for those you supervise

3. Region Behavioral Health Authorities without immediate access to licensed mental health professionals experienced in disaster response should request the addition of such a responder as soon as possible, from local network providers, other Regional Authorities, or the Division of Behavioral Health. Community responders assuming a lead role in behavioral health responses in the interim should be cognizant of the guidelines listed above when actively deploying or supervising behavioral health responders immediately following a disaster.

4. The behavioral health response is part of an overall coordinated health response. Clinical supervisors should keep administrative personnel apprised of activities in the field through incident command structures. The clinical supervisors may also be in the field and can forward information to administrators about conditions, responses, and concerns that may contribute to the coordination of an overall response that more effectively meets the needs of those affected.

Best or Promising Practices

Mental Health and Disaster

Information on best or promising practices is emerging from ongoing research. The following recommendations are based on what is currently known.

- Any psychological defusings/debriefings requested or undertaken under the State Behavioral Health All-Hazards Disaster Response and Recovery Plan will be voluntary on the part of participants

  - The Nebraska Critical Incident Stress Management (CISM) Program has its own guidelines and operating procedures to serve the mental health needs of first responders, and will follow those guidelines

- The number of responders activated should be enough to have a **consistent** presence at sites of intervention

  - Behavioral health responders should spend adequate time at a site to ensure behavioral health needs are met

Substance Use/Abuse and Disaster

Current research indicates that although alcohol and other substance use increases after a disaster, it increases only for those who had pre-existing substance use/abuse issues.[40] In general, disasters do not appear to trigger new cases of substance use/abuse in survivors and first responder populations.

Nebraska's Opioid Treatment Programs (OTP) are subject to federal regulations that

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[40] North, C. (2004, July). Data-based foundations for disaster mental health intervention and policy. Presented at the Second Annual Nebraska Disaster Behavioral Health Conference, Omaha, NE.

make them unique.[41] Regions with these Programs in their areas should communicate with them in advance to ensure viable continuity of operations plans are in place that ensure back up service for current clientele. A large scale disaster may also increase the role of these Programs by creating potential new consumers who may require rapid identification and enrollment. Inclusion of Opioid Treatment Programs in disaster planning at the Regional level is encouraged.

XII. Special Situations / Response Plans

The following special situations have either additional task requirements, or special organizational details to be considered when deploying disaster behavioral health resources. The State Disaster Behavioral Health Coordinator is responsible for coordinating these details.

State Declaration of Disaster

Work closely with the Nebraska Emergency Management Agency (NEMA) to determine if State resources are available to fund deployment of personnel. A State declared disaster may also place some state employees in a position to respond either as part of the disaster behavioral health response (if qualified) or as part of an American Red Cross response.[42]

Presidential Declaration of Disaster

If a presidential disaster declaration makes individuals eligible for assistance, a Federal Emergency Management Agency (FEMA) Crisis Counseling Training and Assistance Program (CCP) grant must be applied for within 14 days of the declaration.[43] The Immediate Services Program (ISP) Application covers the first 60 days of services. A Regular Services Program (RSP) Application is due within 60 days of the presidential declaration, and provides funds for an additional 9 months of services. See the Appendix for further information.

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[41] Federal Regulation 42 CFR Part 8

[42] Nebraska Emergency Management Act § 81-1391

[43] Section 416 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 1974, authorizes FEMA to fund mental health assistance and training activities in areas which have been presidentially declared a disaster. Only a State or a Federally-recognized Indian Tribe may apply for a crisis counseling grant.

Activation of State Emergency Operations Center (EOC)

If the State Emergency Operations Center (EOC) is activated, the State Disaster Behavioral Health Coordinator takes the following actions:

- Work with ESF8 Coordinator to establish Behavioral Health objectives for Behavioral Health personnel.

- Work with the Public Information Officer (PIO) to activate a Risk Communication Consultant if needed and release messages with behavioral health content.

- Work with Regional Behavioral Health Authorities to identify behavioral health personnel to consult in any call centers that are activated by the State. The Nebraska Rural Response Hotline has historically served as the hotline for crisis counseling response and referral.[44]

- Communicate regularly with local and/or Regional behavioral health contacts at the disaster site to obtain status reports and provide updates on state activities related to disaster response.

- Ensure that State response teams have access to qualified behavioral health service during and following their assignments.

- State Disaster Behavioral Health Coordinators or staff from the Division of Behavioral Health may be asked to travel to the disaster site to assist local and Regional resources in assessing behavioral health needs or coordinating the behavioral health response. This may be done as part of the staff person's regular job, or as a volunteer activated by the Nebraska Emergency Management Agency.

- A daily log of activities should be kept by Coordinators and passed from shift to shift.

Requesting Assistance from Other States

If the type, scope, or scale of a disaster is such that behavioral health resources from other states are needed, the Interstate Emergency Management Assistance Compact (EMAC) may be activated. To request behavioral health resources from other states, the State Disaster Behavioral Health Coordinator sends a request to the ESF #8 Coordinator. The ESF #8 Coordinator then contacts the incident commander, who will follow the standard operating procedures for requesting assistance from other states.

Large Scale Behavioral Health Emergencies

Typically, the behavioral health response is part of a larger response in which emergency management, public health, or the Department of Agriculture is the lead agency. However, there are some situations, declared by the Governor, in which the Regional Behavioral Health Authority or the Nebraska DHHS Division of Behavioral Health will be designated the lead agency. This may be particularly true in the recovery period after events that involve multiple casualties but little to no property damage. The Region or Division will take a more active role in decision-making in these situations. Many other response activities and responsibilities will not change.

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[44] See the Appendix for Memorandum of Understanding with the Rural Response Hotline.

State Operated Facility is Involved in the Disaster

Nebraska Department of Health and Human Services oversees numerous facilities, including four Veterans' Homes, three psychiatric regional centers, two youth rehabilitation and treatment centers, and one habilitation campus for developmental disabilities.

- Refer to the disaster plan of the facility for operational details.

- Work with the facility management to determine if additional resources are needed by customers, staff, and their families to meet the behavioral health needs that result from the disaster.

- Involve local and Regional resources in a behavioral health response to a disaster that involves a state operated facility when possible.

- Contact other state operated facilities to determine if qualified personnel are available to serve as part of the behavioral health response to the affected facility.

Air Transportation Incidents

- According to Federal law and their agreement with the National Transportation and Safety Board (NTSB), the American Red Cross is responsible for responding to all of the behavioral health needs of survivors of the incident, and families of survivors and victims.[45, 46]

- The Regional Behavioral Health Authority responsible for the geographic area in which the air transportation incident occurred should be ready to assist with any requests from the Red Cross or the NTSB.

- The Regional Behavioral Health Authority is responsible for serving the behavioral health needs of the community in which the incident occurred.

Terrorism/Bioterrorism

- Incidents of terrorism, particularly biological or chemical terrorism, create fear. The role of behavioral health becomes acutely important in these instances. The State Disaster Coordinator will advocate for inclusion of a risk communication consultant in planning and discussions with public health, the public information officer, government officials, and law enforcement. The level of security will be higher than for a natural disaster as a criminal investigation is potentially part of the incident response.

- Instances of quarantine or recommendations to shelter in place should trigger the opening of a hotline that will require continuous staffing by behavioral health professionals.

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[45] Aviation Disaster Family Assistance Act of 1996, Public Law 104-264, Title VII

[46] Statement of Understanding between American Red Cross and National Transportation Safety Board , September 28, 1998, as cited in: National Transportation Safety Board (2000). Federal Family Assistance Plan for Aviation Disaster.

Agricultural Terrorism / Disease Outbreak

- Agricultural terrorism or disease outbreak that results in depopulation of animals or quarantine of farms/ranches should trigger strategic deployment of professionals familiar with rural issues and community responders able to relate to rural populations. Work with the Regional Disaster Behavioral Health Coordinators to insure that these responders in the field communicate their observations and activities to the State Behavioral Health Disaster Coordinator.

- Communicate with the State Veterinarian within the Department of Agriculture to determine need for local or on site consultation between members of the Livestock Emergency Disease Response System (LEDRS) group and behavioral health.

Research Requests

- The Division of Behavioral Health will work with the University of Nebraska to designate an appropriate department of the University to coordinate behavioral health research following a disaster, as recommended by the American Psychological Association (APA).[47] All research following a disaster must be approved through the process designated by the University. Information on which department to contact and the process to follow when submitting a research request is contained in the Appendix.

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[47] American Psychological Association (July 1997). Final Report: Task Force on the Mental Health Response to the Oklahoma City Bombing. Washington, D.C.: Author.

Appendix A-1:
Nebraska Behavioral Health Regions
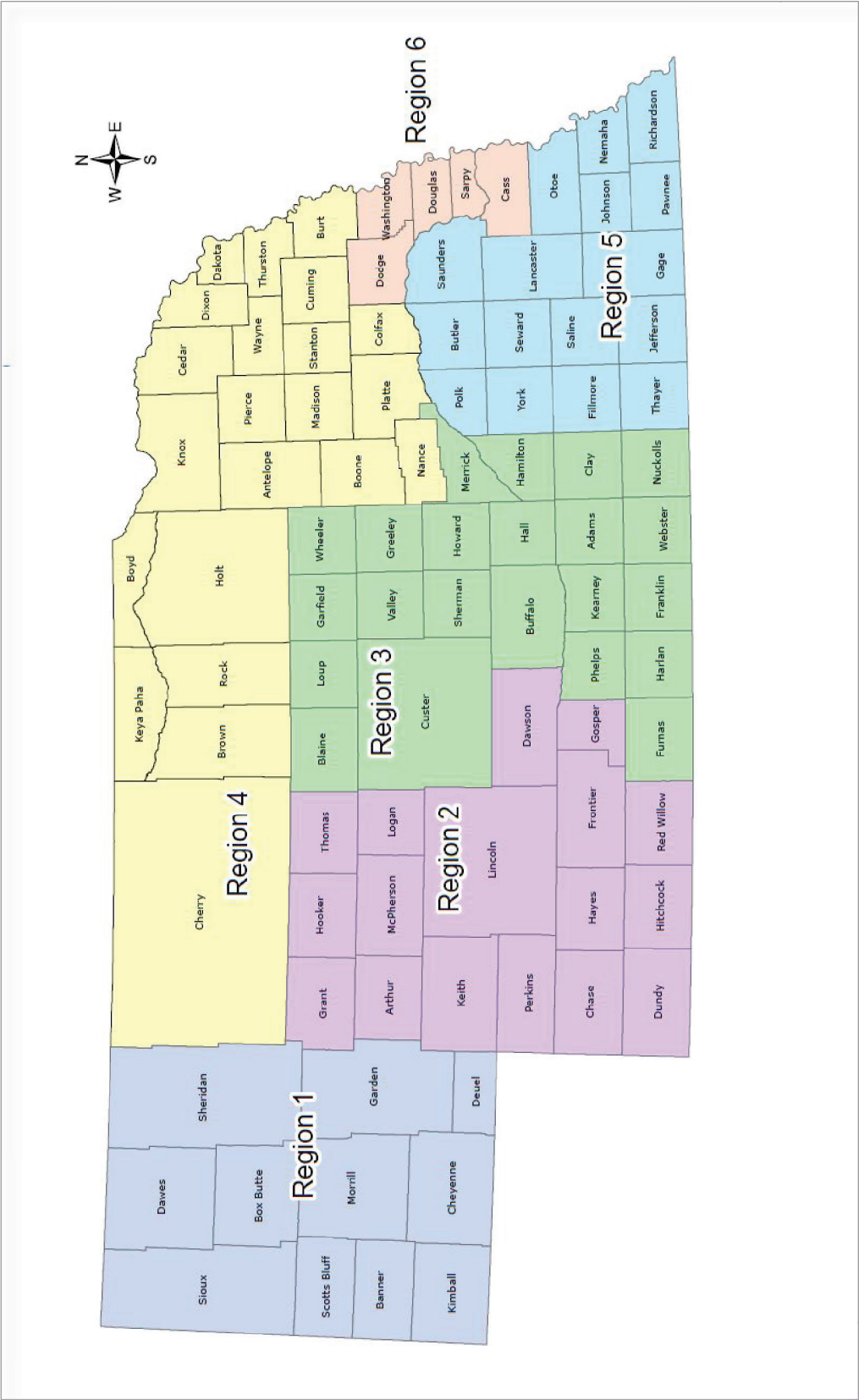
Appendix A-1 (Cont.):
Nebraska Behavioral Health Regions

Region 1 Behavioral Health Authority

18 West 16th Street

Scottsbluff, NE 69361

Phone: (308) 635-3173

FAX: (308) 632-2326

region1bhs.net

Region 2 Human Services

110 North Bailey Street

P.O. Box 1208

North Platte, NE 69103

Phone: (308) 534-0440

FAX: (308) 534-6961

www.r2hs.com

Region 3 Behavioral Health Services

4009 6th Avenue, Suite 65

P.O. Box 2555

Kearney, NE 68848

Phone: (308) 237-5113

FAX: (308) 236-7669

www.Region3.net

Region 4 Behavioral Health System

206 Monroe Avenue

Norfolk, NE 68701

Phone: (402) 370-3100 x 120

FAX: (402) 370-3125

www.region4bhs.org

Region 5 Systems

1645 "N" Street

Lincoln, NE 68508

Non-Emergency Phone: (402) 441-4343

Disaster Line: (402) 434-9888

(*For Public Health, Emergency Management & State Behavioral Health Coordinators*)

FAX: (402) 441-4335

www.region5systems.net

Region 6 Behavioral Healthcare

4715 South 132nd Street

Omaha, NE 68137

Phone: (402) 444-6573

FAX: (402) 444-7722

www.Regionsix.com

Appendix A-2: American Red Cross Guidelines for Emergency Response Partners

When do I call in American Red Cross Disaster Mental Health Workers?

American Red Cross Quick Response Teams will be asked to determine when to request Disaster Mental Health Workers as part of an initial response team. This document is meant to serve as a general guideline to gauge how urgent your request should be.

ARC Disaster Mental Health (DMH) Workers should always be present when other disaster functions are asked to serve.

One of the primary roles of DMH is to insure that ARC workers in all functions are given psychological support during and after their service. The ARC DMH Workers are all licensed mental health professionals. There are areas of the state that lack these professionals and are more likely to use natural helpers like clergy or school counselors to provide this support until DMH can be activated or brought in to respond. You can facilitate the psychological health of your response team by knowing who to call locally for this support until other DMH Workers can arrive. Developing a relationship in advance with natural helpers who are likely to be called upon for support by others in a disaster will be beneficial to you and your team.

There are situations when your request for DMH will take on more urgency.

These are situations that cause particular hardship for ARCworkers, survivors and those close to the disaster. Generally, the people you are most concerned about psychologically are those who are directly involved in the disaster either as responders, survivors, or on-lookers. Below is a list of disaster characteristics that may cause you to ask for a DMH presence quickly. You can site these characteristics as reasons for your urgent request.

Mass Casualty Situations

You will want to place an urgent request for DMH in disasters with multiple deaths. The visibility of the situation, violence associated with the casualties, and vagueness or uncertainty about the situation all contribute to an increased need for a mental health presence.

- **Visibility**: Mass casualty situations that are highly visible and lead to many people being exposed to a situation are cause for concern. Seeing or being near these situations could be distressing for responders, survivors, and on-lookers.

- **Violence**: No ARC workers should be called into a relief operation until authorities believe it is safe.

  Violence in this context refers to the manner in which the casualties occurred. Violent events that are human made can have more psychological impact than those that are a result of nature.

- **Vagueness**: Uncertainty or vagueness of a mass casualty situation can lead to considerable psychological distress. An example of vagueness could be deaths from a biological or chemical agent causing fear and panic. One of the roles DMH can assume is to help people deal with this vagueness and perhaps lessen fear and panic. It may be helpful to have DMH working with public officials to help keep people calm.

Human Made Disasters

The human made disaster that is due to malevolence is more psychological stressful than one due to human error. For example, a terrorist caused nuclear power plant failure is as damaging as a failure due to human error, but the psychosocial consequences may be even greater for the terrorist caused event. In both cases you should ask for DMH, but special urgency can be attached to your request when malice is suspected.

Large Scale Disaster

Consider requesting DMH sooner when it appears likely that a disaster will overwhelm local resources quickly and require outside responders. It can be very stressful for local responders to take care of others while seeing to their own disaster recovery. Long term psychological recovery issues can be lessened with quick, appropriate intervention.

What the DMH worker will want to know:

The disaster characteristics

- Estimated number of people involved or affected by the disaster (Note any special populations affected – elderly, children, non-English speaking, disabled, etc)
- Which ARC operations/functions will be activated (Shelters, Service Centers, Outreach teams needed for rural areas, mass care operations, etc)
- The natural helpers in the area who can be of assistance

You are on the ground and have the best view of the situation. Trust your instincts. If you believe it is urgent for DMH to be activated but have trouble articulating the reasons why, trust yourself and insist that DMH be part of the initial response.

Appendix A-3:
Nebraska Local Health Departments Map

Appendix A-4:
Map of Healthcare Coalitions in Nebraska
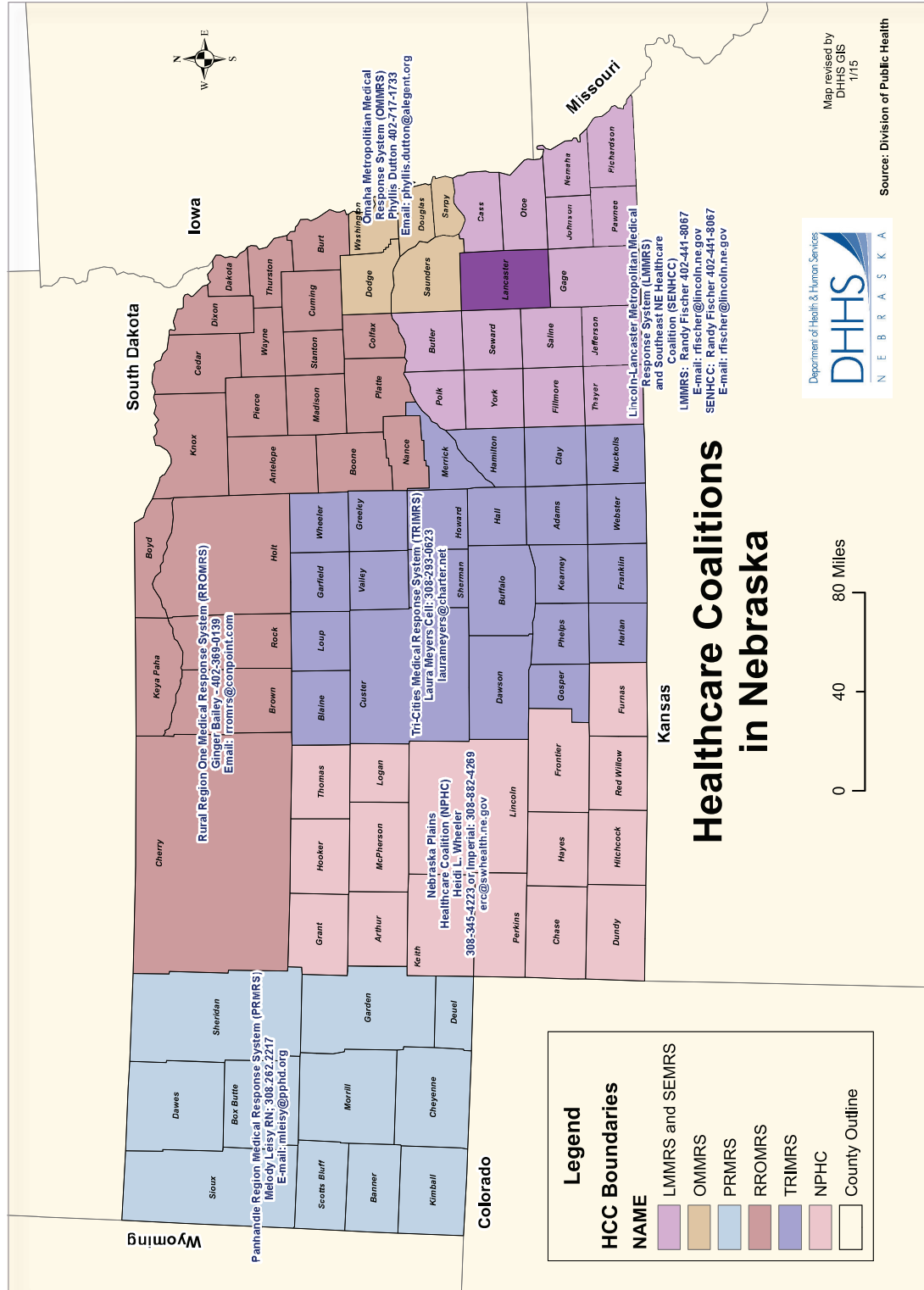
Appendix A-5: Nebraska Medical Reserve Corps Regions

Appendix A-5:
Nebraska Medical Reserve Corps Regions

43
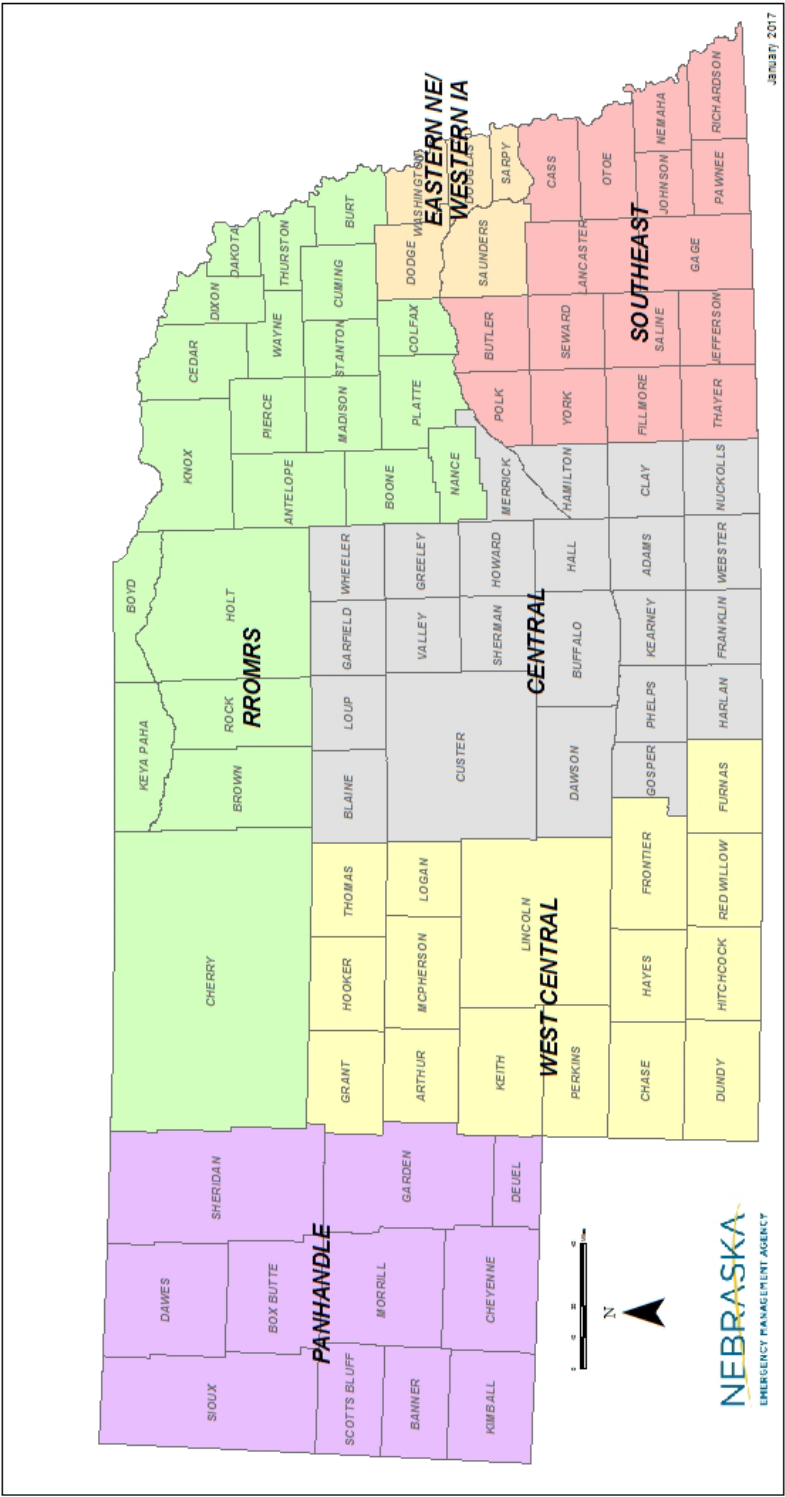
Appendix A-6: Requesting CISM Services

How to Request CISM Services

- Following the incident, the State Patrol Troop in your area is informed of the possible need for a Critical Incident Stress Management session by someone from the responder agency impacted by the event.
  - *CALL 402-479-4921 to request an intervention*
- The troop dispatcher asks for the name of the community involved, nature of the incident, and the name and telephone number of the contact person.
- Information regarding the incident is given to the Clinical Director (or someone he/she designates).
- The Clinical Director calls the site to confirm the need for CISM service.
- If CISM service is needed, a designated CISM contact in the area is notified.
- CISM services are arranged.

Appendix A-7: Memorandum of Understanding
(Template)

Use this template as a basis to formalize a working relationship with any disaster services agency, institution or group and to describe how the two organizations will work together.

BETWEEN

_____

(Your Agency Name)

AND

_____

(Partner Agency)

I. PURPOSE: Describe the reasons for this agreement between the two parties.

Example: The purpose of this Memorandum of Understanding is to define the working relationship between Agency X and Agency Y. This agreement will clarify the collaborative roles and responsibilities of the two agencies with respect to disaster response.

II. AUTHORITY OR LEGAL STATUS: Provide a citation of the legal authority the two agencies are operating under and reference documents as appropriate.

Example: Your agency, (Agency X) is mandated under State Statutes x, w, and z to coordinate all non-aviation disaster services.

III. ROLES AND RESPONSIBILITIES: Describe in detail all the roles and responsibilities that define the working relationship between the two parties. This will include any coordinated training or planning related to disaster preparation as well as the relationship during an event.

IV. GENERAL TERMS AND CONDITIONS: This section contains the aspects of the agreement related to the execution of the agreement between the two parties. This could include:

- Avenues for periodic review
- Process for cancellation of the agreement by either party
- Procedure for Amendments to the agreement (if any)
- Statements related to any liability
- Terms of the agreement

V. SIGNATURES Include signature lines and date for all signatures required by Agency X and Agency Y.

_____   _____

Signature, Agency X   Date

_____   _____

Signature, Agency Y   Date

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.
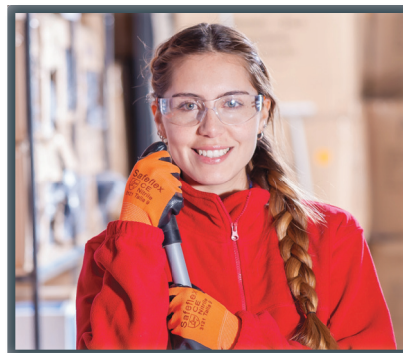
  Without the appropriate Presidential Declaration there will be a need to give providers information and support in their efforts to work within affected communities and areas.
  - Assist local behavioral health providers in identifying additional resources to meet their current clients' needs. Provide 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]			
						Travel for Deployment		
					Personnel	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]

```
                        Incident
                        Commander
                                                    ┐
           Liaison          Safety/Security         Command
           Officer          Officer                 Staff

           Information
           Officer

Logistics      Planning       Finance        Operations
Section        Section        Section        Section

                                             Behavioral
                                             Health
```
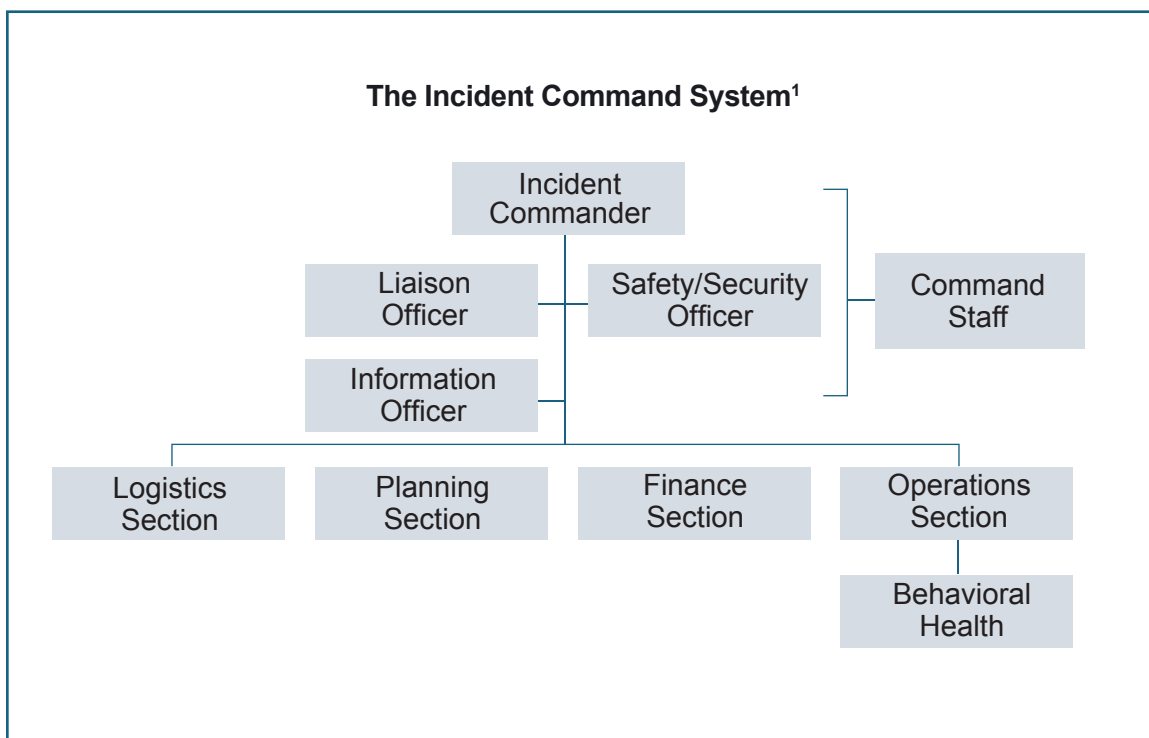
Information Officer

- 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

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[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

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[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

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[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

Appendix C-1: FEMA Crisis Counseling Grant Information

Instructions and application forms for a FEMA Crisis Counseling Grant are available from the CCP toolkit, available at the time of this writing from: https://www.samhsa.gov/dtac/ccp-toolkit

The State is eligible for a FEMA Crisis Counseling Program (CCP) Grant only when a disaster has been federally declared, and only the counties declared eligible for **Individual Assistance** can receive services under the crisis counseling grant. Crisis counseling services in counties not declared eligible for individual assistance will have to depend on resources not funded through the FEMA CCP Grant.

There are two types of grants available:

Immediate Services Program (ISP) – funds services for the first 60 days after the federal disaster declaration is issued. This grant application is due **14 days** after the federal disaster declaration.

Regular Services Program (RSP) – funds services for 9 months beyond the end of the ISP. The application is due **60 days** after the federal disaster declaration.

Tips for the Application

- Start collecting data for the ISP needs assessment as soon as the disaster occurs:
  - Collect **newspaper articles** on the disaster
  - Have local service providers track the **number and hours of counselors deployed**
  - Have counselors begin recording **service data** using the CCP contact sheets[1]
    - During the initial response, before a CCP grant is awarded, counselors need to be deployed through the volunteer processing center so that emergency management can add them to the volunteer hours they track
    - Counselors' time can only be reimbursed if they are deployed in a county covered by their agency (i.e., if they work for Lancaster County, hours worked in Gage county are not reimbursable)
- **Needs Assessment data**[2] required for a FEMA CCP grant is provided by Emergency Management. If there is an **Expedited Disaster Declaration**, all counties declared may not have collected this data before they are included in a disaster declaration. These counties may receive services in this case during the ISP. However, in order for these counties to receive services under an RSP, the Needs Assessment data will need to be collected and reported in the RSP application. If these counties do not provide Needs Assessment data, they cannot receive services under the RSP. It

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[1] Crisis Counseling Program contact sheets are available from the toolkit online.
[2] The Needs Assessment data form is in Appendix C-3.

is important to work with emergency management to collect Needs Assessment data from all counties included in the disaster declaration as eligible for Individual Assistance.

- A generic **Plan of Services** can be developed and written up ahead of time, and copied into the CCP application with modifications to address the specific disaster that has just occurred.

   - The service plan should by designed **assuming the worst will happen** and that the most will occur. Services can be cut back during program implementation based on the actual level of need observed.

Budgeting for the CCP

For official information on allowable costs, see "ISP Supplemental Instructions" available under the "CCP Materials" page on the website listed at the beginning of this document.

Costs that have been funded in other CCP grants include:

- Full-time supervisor

- Administrative support

- Stress moderator outside the management structure to serve the crisis counseling staff
   - Give workers a safe place to talk

- Employee benefits

- Mileage

- Daily conference calls with CCP workers

- Trainings

   - Standard/required FEMA trainings – budget 2 ½ to 3 days each

      - Initial training for workers and for management

         - For new staff

         - For staff staying from ISP, shift from 60 day sprint to longer term project

      - Mid-point (RSP only)

         - Revitalize & re-focus

         - Probably no more canvassing at this point, and more focus on information to communities and community recovery

      - Phase down (RSP only)

         - Help staff transition to mainstream workforce

   - Supplemental trainings

      - Such as 1/2 day in-service trainings

         - Topics such as how to relate to farmers, children, staying safe while providing outreach

- Supplies
  - Cell phones
  - Laptop computers
- Photocopying (All with messages re: signs & symptoms of stress and who to call)
  - Brochures
  - Door hangers
  - Bookmarks for the library
- Media & advertising

Tips for the Response

- Relationships and networking are very important. People will often rely on who they know, rather than a protocol that is in any plan. It is important to establish relationships **based on the plan** before any disaster occurs, so that the appropriate people are called.

- The **Rural Response Hotline** has serves as the hotline number in the case of emergencies and disasters throughout Nebraska. Hotline workers are trained in assessment and referral. Regional Behavioral Health Authorities may also have other already existing hotlines in their area that can be used for disaster hotline purposes.

- Relationships with medical providers and pharmacies are important in helping to deal with peoples' immediate needs **regarding medication and prescriptions that have been lost**.

- FEMA and emergency management will not release information on people who have registered for disaster assistance. Have an alternate plan to get **releases of information** from people, so they can be contacted at a later date regarding services.
  - It is also important to find out **how to contact people who are dislocated** from their homes by the disaster.

Appendix C-2: FEMA Crisis Counseling Application – FAQs[1]

1. **What is the purpose of the application?**

    The application serves complementary purposes for the Federal and State governments. The application fulfills the Federal regulatory requirement to document need, determine services are appropriate, and justify expenditures. The application is a tool to be used by the State to assess the needs of disaster victims and develop a plan of action.

2. **Can the application format be modified?**

    The ISP Standard Application Format has been developed to address key information required under Federal regulations for the Crisis Counseling Assistance and Training Program. The format is provided for technical assistance purposes. Within the application format and instructions, there are notes about potential modifications. For example, charts and tables may be modified to fit specific State proposals. States may add pages within the format. States may also choose to reformat portions of the needs assessment and program planning sections and assign writing tasks to county or community service providers. The current format has been designed to ensure that all necessary information for a successful application can be provided in a simple and flexible format.

3. **What components of the application are required in regulations?**

    The CCP regulations (44 CFR 206.171) establish the following components of the application:

    1. Geographical areas within designated disaster area
    2. Needs assessment
    3. Description of the State and local resources and capabilities, and a justification of why these resources cannot meet the estimated disaster mental health needs
    4. Description of response activities from the date of the disaster incident to the date of the application submission
    5. Plan of services
    6. Budget

Each component is discussed in detail in the supplemental instructions.

4. **When is the application due?**

    The ISP application is due no later than the 14th day following the Presidential Disaster Declaration. Day one is the day after the declaration. Therefore, if the disaster is declared by the President on the 1st of the month, the application must be submitted by close-of-business on the 15th.

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[1] Retrieved 9/30/2004 from: http://www.mentalhealth.samhsa.gov/cmhs/EmergencyServices/grantfaq.asp

5. **May the application be submitted electronically?**

   The original signed copy of the cover sheet and SF-424 must be submitted in hard copy, as well as any attachments only available on hard copy. With the permission of the FEMA Regional Director, an application may be submitted using either the Word or Word Perfect software version.

6. **Can any portions of the application be prepared before a disaster?**

   Yes, State Disaster Mental Health Coordinators are strongly encouraged to become familiar with the ISP Standard Application Format before a disaster strikes. It is possible to develop templates for many portions of the application prior to a disaster.

   - The SF-424 is available electronically and a template may be prepared in advance, including all necessary assurances, so that this form can be processed and signed expeditiously.

   - The signature sheet can be completed, including the name of the State Disaster Mental Health contact person.

   - Part II of the application, entitled "State and Local Resources and Capabilities" may be completed prior to a disaster.

   - States may prepare and customize job descriptions, templates for organizational charts, and descriptions of types of service they will provide as a part of their overall State Disaster Mental Health Plan.

   States are also strongly encouraged to identify and train potential service providers in communities across the State and to develop procedures for contacting and mobilizing services in the immediate aftermath of a disaster. By maintaining contact information, developing activation procedures, maintaining ongoing training, and preparing materials in advance, States and localities can significantly simplify the process of developing an Immediate Services Application.

7. **Will CMHS and FEMA provide consultation on the application process?**

   FEMA is located at a Disaster Field Office within or near the declared area and is available to assist the State. CMHS will either be on-site or available by phone. FEMA and the State Emergency Management Agency can assist with obtaining disaster damage information and provides consultation on the disaster operation, the application processing, and awarding funds. The FEMA Human Services Officer or Crisis Counseling

   Coordinator assigned to the disaster may provide the SMHA with preliminary damage assessment information as well as teleregistration information on the number of persons applying for specialized disaster assistance.

   CMHS provides consultation on developing and implementing services and application development. CMHS realizes that the State Mental Health Authority is not only responding to the ongoing mental health needs of its impacted citizens but also trying to implement, manage and monitor a crisis counseling program.

Therefore, project officers from the ESDRB, CMHS are available to consult with the State in organizing the disaster mental health response. The project officers can be reached at 301/443-4735 (phone) and 301/443-8040 (fax).

8. **May the Governor select an agency or organization other than the State Mental Health Authority to administer the ISP grant?**

If the Governor's Authorized Representative determines during the needs assessment that because of unusual circumstances or serious conditions within the State or local mental health network, the State Mental Health Authority cannot carry out the crisis counseling program, he or she may identify a public or private mental health agency or organization to carry out the program. Several States have elected to have a non-profit organization carry out the program in the past. In each instance, the State was the grantee and subcontracted the grant.

9. **What are some of the most commonly-used acronyms a State Disaster Mental Health Coordinator should be familiar with?**

There are many acronyms and abbreviations in the disaster response field and terminology changes frequently. Therefore, States are encouraged in their applications to minimize the use of acronyms and abbreviations. However, **some of the most commonly-used acronyms that may be considered are the following:**

CCP	Crisis Counseling Assistance and Training Program	**HS**	Human Services
CMHS	Center for Mental Health Services	**HSO**	Human Services Officer
DFO	Disaster Field Office	**IA**	Individual Assistance
DHHS	Department of Health and Human Services	**IFG**	Individual and Family Grant
DLS	Disaster Legal Services	**IRS**	Internal Revenue Service
DRM	Disaster Recovery Manager	**IS**	Immediate Services
DUA	Disaster Unemployment Assistance	**PA**	Public Assistance
ESDRB	Emergency Services and Disaster Relief Branch	**RS**	Regular Services
FCO	Federal Coordinating Officer	**SBA**	Small Business Administration
FEMA	Federal Emergency Management Agency	**SEMA**	State Emergency Management Agency
GAR	Governor's Authorized Representative	**SF**	Standard Form (refers to a Federal form)
HCC	Healthcare Coalition	**SMHA**	State Mental Health Authority
HM	Hazard Mitigation	**USDA**	United States Department of Agriculture

Appendix C-3: FEMA CCP Needs Assessment Table

The instructions and table below can help you organize the needs assessment information required for a FEMA CCP grant application. If emergency management has conducted a preliminary damage assessment (PDA), then much of this information is available from them. Even if a PDA was conducted, they may only have some of this information, and you will have to supplement using 'Other' categories. See below the table for suggestions on 'Other'

A. CMHS Needs Assessment Formula—Estimated Crisis Counseling Needs

Complete a CMHS Needs Assessment Formula Table for each designated area to be covered by the grant. Use the following steps to complete the table:

1. Identify the number of people for each loss category from collected needs assessment information.

2. Identify any disaster- or region-specific "other"[1] loss categories, and establish a traumatic impact risk ratio for any other loss categories. Note that other loss categories are not multiplied by the household size multiplier.

3. Determine the total number of people who would benefit from services for each loss category by multiplying across each row as follows: (Number of People) x (Household Size Multiplier)[2] x (Traumatic Impact Risk Ratio)[3] = (Total Number of People Who Would Benefit from Services).

4. Add all of the results in the column of Total Number of People Who Would Benefit from Services to determine a sum for the number of people who would benefit from crisis counseling services.

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[1] If appropriate, the State may identify other loss category groups related to the disaster. These categories are not multiplied by a House- hold Size Multiplier. The State should also identify a Traumatic Impact Risk Ratio for each additional loss category specified. Add rows as necessary.

[2] Household Size Multiplier means the average number of people per household (ANH). The national average is 2.5, but applicants should consult U.S. Census information for State or county averages.

[3] The Traumatic Impact Risk Ratio assesses the likelihood of individual and community adverse reactions to this disaster. In previous versions of this application, the term "at-risk multiplier" was used.

Loss Category	Number of People		Household Size Multiplier[2] (ANH = 2.5)		Traumatic Impact Risk Ratio[3]		Total Number of People Who Would Benefit from Services
Dead		x	ANH x 4	x	100%	=	
Hospitalized		x	ANH x 1	x	100%	=	
Nonhospitalized Injured		x	ANH x 1	x	50%	=	
Homes Destroyed		x	ANH x 1	x	100%	=	
Homes Major Damage		x	ANH x 1	x	20%	=	
Homes Minor Damage		x	ANH x 1	x	10%	=	
Disaster Unemployed		x	ANH x 1	x	10%	=	
Other 1 (Specify)[1]				x		=	
Other 2 (Specify)[1]				x		=	
					TOTAL:	=	

Items in the following table may be listed under 'Other' in the Needs Assessment Formula if they are relevant to the current disaster.

Needs Assessment Matrix

INDICATORS	INFORMATION SOURCES			
Total number	American Red Cross	Disaster Field Office/ State Emergency Management Agency	Media	Key Informants (list sources)
Displaced				
Unemployed				
# shelters				
# persons sheltered				
Supplemental housing availability % vacancy				
Number of applications for assistance				
Closed businesses				
Closed schools				
Number of impacted students				
% of impact rural				
% of impact urban (and small town)				
Population of declared areas				
Impacted population of declared areas				
Estimated number of people needing disaster MH services				

Appendix D-1: Disaster Behavioral Health Concepts

Definition of Disaster Behavioral Health[1]

Disaster behavioral health is a departure from traditional behavioral health practice in many ways. Disaster behavioral health interventions are designed to address incident-specific stress reactions, rather than ongoing or developmental behavioral health needs. Outreach and crisis counseling activities are the core of disaster behavioral health activities. Behavioral health professionals work hand-in-hand with paraprofessionals, volunteers, community leaders, and survivors of the disaster in ways that may differ from their formal clinical training.

Key Concepts of Disaster Behavioral Health[2]

1. No One Who Sees a Disaster Is Untouched By It.

In any given disaster, loss and trauma will directly affect many people. In addition, there are many other individuals who are emotionally impacted simply by being part of the affected community.

A disaster is an awesome event. Simply seeing massive destruction and terrible sights may evoke deep feelings. Often residents of disaster-stricken communities report disturbing feelings of grief, sadness anxiety and anger, even when they themselves are not directly impacted. Such strong reactions confuse them when, after all, they were spared any personal loss.

2. There Are Two Types of Disaster Trauma.

There are two types of disaster trauma that can occur jointly and continuously in most disasters: individual and collective.

Individual trauma is defined as "a blow to the psyche that breaks through one's defenses so suddenly and with such brutal force that one cannot react to it effectively." Individual trauma manifests itself in the stress and grief reactions which individual survivors experience.

Collective trauma is a "blow to the basic tissues of social life that damages the bonds attaching people together and impairs the prevailing sense of community." Collective trauma can sever the social ties of survivors with each other and with the locale.

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[1] Adapted from: Jackson, G. & Cook, C.G. (1999). Disaster Mental Health: Crisis Counseling Programs for the Rural Community. DHHS Publication No. SMA 99-3378, Washington, D.C.: U.S. Government Printing Office.

[2] Adapted from: Myers, D. (1994). Disaster Response and Recovery: A Handbook for Mental Health Professionals. DHHS Publication No. SMA 94-3010, Washington, D.C.: U.S. Government Printing Office.

These may be ties that could provide important psychological support in times of stress. Disaster disrupts nearly all activities of daily living and the connections they entail. People may relocate to temporary housing away from their neighbors and other social supports such as church, clinics, childcare, or recreation programs. Work may be disrupted or lost due to business failure, lack of transportation, loss of tools, or a worker's inability to concentrate due to disaster stress. For children, there may be a loss of friends and school relationships due to relocation. Fatigue and irritability can increase family conflict and undermine family relationships and ties.

3. Most People Pull Together and Function During and After a Disaster, but Their Effectiveness Is Diminished.

There are multitudes of stressors affecting disaster survivors. In the early "heroic" and "honeymoon" phases there is much energy, optimism and altruism. However, there is often a high level of activity with a low level of efficiency. As the implications and meaning of the losses become more real, grief reactions may intensify. As fatigue sets in and frustrations and disillusionment accumulate, more stress symptoms may appear. Diminished cognitive functioning (short-term memory loss, confusion, difficulty setting priorities and making decisions, etc.) may occur because of stress and fatigue. This can impair survivors' ability to make sound decisions and take necessary steps toward recovery and reconstruction.

4. Disaster Stress and Grief Reactions Are Normal Responses to Abnormal Events.

Most disaster survivors are normal persons who function reasonably well under the responsibilities and stresses of everyday life. However, with the added stress of disaster, most individuals usually show some signs of emotional and psychological strain. These reactions are <u>normal</u> reactions to an extraordinary and abnormal situation, and are to

be expected under the circumstances. Survivors, residents of the community, and disaster workers alike may experience them. These responses are usually transitory in nature and very rarely imply a serious mental disturbance or mental illness. Contrary to myth, neither post-traumatic stress disorder nor pathological grief reactions are rampant following a disaster.

The post-traumatic stress process is a dynamic one, in which the survivor attempts to integrate traumatic event into his or her self-structure. The process is natural and adaptive. It should not be labeled pathological (i.e. "a disorder") unless it is prolonged, blocked, exceeds a tolerable quality, or interferes with regular functioning to a significant extent.

Grief reactions are a normal part of the recovery from disaster. Not only may individuals lose loved ones, homes and treasured possessions, but hopes, dreams, and assumptions about life and its meaning may be shattered. The grief response to such losses are common and are not pathological (warranting therapy or counseling), unless the grief is an intensification, a prolongation or an inhibition of normal grief.

Relief from stress, the ability to talk about the experience, and the passage of time usually lead to the reestablishment of equilibrium. Public information about normal reactions, education about ways to handle them and early attention to symptoms that are problematic can speed recovery and prevent long-term problems.

5. Many Emotional Reactions of Disaster Survivors Stem From Problems of Living Caused by the Disaster.

Because disaster disrupts so many aspects of daily life, many problems for disaster survivors are immediate and practical in nature. People may need help locating missing loved ones; finding temporary housing, clothing, and food; obtaining transportation; applying for financial assistance, unemployment insurance, building permits, income tax assistance; getting medical care, replacement of eyeglasses or medications; obtaining help with demolition, digging out and clean-up.

6. Disaster Relief Procedures Have Been Called "The Second Disaster."

The process of obtaining temporary housing, replacing belongings, getting permits to rebuild, applying for government assistance, seeking insurance reimbursement and acquiring help from private or voluntary agencies is often fraught with rules, red tape hassles, delays and disappointment. People often establish ties to bureaucracies to get aid they can get nowhere else. However, the organizational style of the aid-giving bureaucracies is often too impersonal for survivors in the emotion-charged aftermath of the disaster. To complicate the matter, disasters and their special circumstances often foul up the bureaucratic procedures even of organizations established to handle disaster. Families are forced to deal with organizations that seem or are impersonal or inefficient.

7. Most People Do Not See Themselves as Needing Behavioral Health Services Following a Disaster, and Will Not Seek Out Such Services.

Many people equate "mental health services" with being "crazy." To offer behavioral health assistance to a disaster survivor may seem to add insult to injury – "First I have lost everything and now you think I'm mentally unstable." In addition, most disaster survivors are overwhelmed with the time-consuming activities of putting the concrete aspects of their lives back together. Counseling or support groups may seem esoteric in the face of such pragmatic pressures. Very effective behavioral health assistance can be provided while the worker is helping survivors with concrete tasks.

8. Survivors May Reject Disaster Assistance of All Types.

People may be too busy cleaning up and dealing with other concrete demands to seek out services and programs that might help them. Initially, people are relieved to be alive and well. They often underestimate the financial impact and implication of their losses, and overestimate their available financial resources. The bottom-line impact of losses is

often not evident for many months or, occasionally, for years.

The heroism, altruism, and optimism of the early phases of disaster may make it seem that "others are so much worse off than I am." For most people, there is a strong need to feel self-reliant and in control. Some people equate government relief programs with "welfare." For others, especially recent immigrants who have fled their countries of origin because of war or oppression, government is not to be trusted. Pride may be an issue for some people. They may feel ashamed that help is needed, or may not want help from "outsiders." Tact and sensitivity to these issues are important.

9. Disaster Behavioral Health Assistance is Often More "Practical" Than "Psychological" in Nature.

Most disaster survivors are people who are temporarily disrupted by a severe stress, but can function capably under normal circumstances. Much of the behavioral health work at first will be to give concrete types of help. Behavioral health personnel may assist survivors with problem-solving and decision-making. They can help them to identify specific concerns, set priorities, explore alternatives, seek out resources and choose a plan of action. Behavioral health staff must inform themselves about resources available to survivors, including local organizations and agencies in addition to specialized disaster resources. Behavioral health workers may help directly with some problems, such as providing information for filling out forms, helping cleanup, locating health care or child care, and finding transportation. They may also make referrals to specific resources such as assistance with loans, housing, employment, permits.

In less frequent cases, individuals may experience more serious psychological responses such as severe depression, disorientation, immobilization, or an exacerbation of prior mental illness diagnosis. These situations will likely require referral for more intensive psychological counseling. The role of the disaster behavioral health worker is not to provide treatment for severely disturbed individuals directly, but to recognize their needs and help link them with an appropriate treatment resource.

10. Disaster Behavioral Health Services Must Be Uniquely Tailored to the Communities They Serve.

The demographics and characteristics of the communities affected by disaster must be considered when designing a behavioral health program. Urban, suburban and rural areas have different needs, resources, traditions and values about giving and receiving help. It is essential that programs consider the ethnic and cultural groups in the community and provide services that are culturally relevant and in language of the people. Disaster recovery services are best accepted and utilized if they are integrated into existing, trusted community agencies and resources. In addition, programs are most effective if workers are from the community and its various ethnic and cultural groups are integrally involved in service delivery.

11. Behavioral Health Staff Need to Set Aside Traditional Methods, Avoid the Use of "Mental Health" Labels, and Use an Active Outreach Approach to Intervene Successfully In Disaster.

The traditional, office-based approach is of little use in disaster. Very few people will come to an office or approach a desk labeled "mental health." Most often, the aim will be to provide human services for problems that are accompanied by emotional strain. It is essential not to use words that imply emotional problems, such as counseling, therapy, psychiatric, psychological, neurotic, or psychotic.

Behavioral health staff need to use an active outreach approach. They must go out to community sites where survivors are involved in the activities of their daily lives. Such places include impacted neighborhoods, schools, disaster shelters, Disaster Application Centers, meal sites, hospitals, churches, community centers, and the like.

12. Survivors Respond to Active Interest and Concern.

They will usually be eager to talk about what happened to them when approached with warmth and genuine interest. Behavioral health outreach workers should not hold back from talking with survivors out of fear of "intruding" or invading their privacy.

13. Interventions Must be Appropriate to the Phase of the Disaster.

It is important that disaster behavioral health workers recognize the different phases of disaster and the varying psychological and emotional reactions of each phase[3]. For example, it will be counterproductive to probe for feelings when shock and denial are shielding the survivor from intense emotion. Once the individual has mobilized internal and external coping resources, he or she is better able to deal with feelings about the situation. During the "heroic" and "honeymoon" phases, people are seeking and discussing the facts about the disaster, trying to piece the reality together and understand what has happened. They may be more invested in discussing their thoughts than talking about feelings. In the "disillusionment" phase, people will likely be expressing feelings of frustration and anger. It is not usually a good time to ask if they can find something "good" that has happened to them through their experience.

Most people are willing and even eager to talk about their experiences in a disaster. However, it is important to respect the times when an individual may not want to talk about how things are going. Talking with a person in crisis does not mean always talking about the crisis. People usually "titrate their dosage" when dealing with pain and sorrow, and periods of normalcy and respite are also important. Talking about ordinary events and laughing at humorous points is also healing. If in doubt, ask the person whether they are in the mood to talk.

14. Support Systems Are Crucial to Recovery.

The most important support group for individuals is the family. Workers should attempt to keep the family together (in shelters and temporary housing, for example). Family members should be involved as much as possible in each others' recovery.

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[3] See Appendix D-2 for an overview of the phases of a disaster.

Disaster relocation and the intense activity involved in disaster recovery can disrupt people's interactions with their support systems. Encouraging people to make time for family and friends is important. Emphasizing the importance of "rebuilding relationships" in addition to rebuilding structures can be a helpful analogy.

For people with limited support systems, disaster support groups can be very helpful. Support groups help to counter isolation. People who have been through the same kind of situation feel that can truly understand one another. Groups help to counter the myths of uniqueness and pathology. People find reassurance that they are not "weird" in their reactions. The groups not only provide emotional support, but survivors can share concrete information and recovery tips. In addition to the catharsis of sharing experiences, they can identify with others who **are** recovering and feel hope for their own situation. Behavioral health staff may involve themselves in setting up self-help support groups for survivors, or may facilitate support groups.

In addition, behavioral health workers may involve themselves in community organization activities. Community organization brings community members together to deal with concrete issues of concern to them. Such issues may include social policy in disaster reconstruction, or disaster preparedness at the neighborhood level. The process can assist survivors with disaster recovery not only by helping with concrete problems, but by reestablishing feelings of control, competence, self-confidence, and effectiveness. Perhaps most important, it can help to reestablish social bonds and support networks that have been fractured by the disaster.

Appendix D-2: Disaster Typologies

As defined under the **Stafford Act**[1], a major disaster is 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.

Geography of a Disaster

A **Local Disaster** is any event real or perceived that threatens the well-being (life or property) of citizens in one municipality. A local disaster is manageable by local officials without a need for outside resources.

A **Regional Disaste**r is any event real or perceived that threatens the well-being of multiple communities or contiguous geographic areas of Nebraska.

A **State Disaster** is any event, real and/or perceived, which threatens the well-being of citizens in multiple cities, counties, regions and/or overwhelms a local jurisdiction's ability to respond, or affects a State-owned property or interest. In these situations, the Governor is likely to issue a State Disaster Declaration.

A **Federally Declared Disaster** is any event, real and/or perceived, which threatens the well-being of citizens, overwhelms the local and State ability to respond and/or recover, or the event affects federally owned property or interests. If it appears that a disaster is of a magnitude to warrant a Presidential Disaster Declaration, then steps need to be taken to quantify the extent of needed human services to justify a request to receive federal funding for a Crisis Counseling Program (CCP). There are two types of Federally Declared Disasters: a) federally declared disasters eligible for public assistance and b) federally declared disasters eligible for individual assistance.

Types of Hazards[2]

Natural disasters are of many types and have diverse characteristics. Their onset and duration can be rapid or slow, and the intensity of disruptions caused to people, property and human need vary greatly and are, in part, a product of the degree to which people are prepared, as well as the extent and severity of the event.

Natural disasters include many events such as floods, tornados, earthquakes, forest and bush fires. Natural disasters are often familiar to the survivors, and the affected communities may have developed a lot of experience with these particular hazards.

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[1] Public Law 93-288

[2] Adapted from: NSW Health. (2000). Disaster Mental Health Response Handbook. New South Wales: NSW Health.

Usually, these disasters are seen as unavoidable. Although early warning systems are developed to various degrees, the impact can be extremely powerful and may cause substantial destruction, social disruption and many secondary stressors, such as loss of both home and income.[3]

Natural hazards identified as potential risks in Nebraska are (in alphabetical order): Drought, Earthquake, Flood/ Flash Flood, Severe Thunderstorm, Tornado, Wildfire, and Winter Storm.

Technological disasters are due to **human failures or accidents**, and are rarely preceded by warnings. Such incidents may have a sudden onset and produce reactions of shock. While the impact is extremely powerful, the destruction is often concentrated and causes little social disintegration. These disasters may result in a sense of loss of control, for which someone or some agency may be seen as responsible. The feeling that someone is to blame may make it more difficult for survivors to cope with the situation.

Technological hazards identified as potential risks in Nebraska are (in alphabetical order): Dam Failure, HAZMAT-Fixed Facility, HAZMAT-Transportation, Power Failure, Radiological‑Fixed Facility, Radiological‑Transportation, Transportation (Air or Rail Incident), and Urban Fire.

Security-related disasters are caused by **violence, war, and specific acts of human malevolence** (mass shootings, bombings). Chemical, biological and radiological (or nuclear) **terrorism** adds a new dimension to such human-made disasters. The threat may be sudden, focused or unfocused. The intent of such terrorism is, of course, to evoke terror, and the uncertainty and anxiety generated may lead to panic. Physical or physiological responses may be of 'epidemic' proportions, leading to further impact, even in otherwise unaffected populations.[4,5]

Security Hazards (National and State) identified as potential risks in Nebraska are (in alphabetical order): Biological/Chemical Attack, Civil Disorder/ Insurrection, Conventional Attack, Nuclear Attack, Sabotage, and Terrorism.

Many authors have argued that human-caused disasters, both technological and security-related, are phenomenologically and etiologically different from natural disasters. Human-caused disasters seem to be more traumatic to mental health[6]. Their higher **unpredictability**, **uncontrollability** and culpability may partly account for this. Generally, natural and human-caused disasters are differentiated based on distinct

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[3] Weisæth, L. (1995). Preventive psychosocial intervention after disaster. In S. E. Hobfoll & M. W. deVries (Eds.), Extreme stress and communities: Impact and intervention. (pp. 401-419). Dordrecht, The Netherlands: Kluwer Academic/Plenum Publishers.

[4] DiGiovanni, C. J. (1999). Domestic terrorism with chemical or biological agents: Psychiatric aspects. American Journal of Psychiatry, 156(10), 1500-1505.

[5] Holloway, H. C., Norwood, A. E., Fullerton, C. S., Engel, C. C., & Ursano, R. J. (1997). The threat of biological weapons. Prophylaxis and mitigation of psychological and social consequences. JAMA, 6, 425-427.

[6] Weisaeth, L. (1994). Psychological and psychiatric aspects of technological disasters. In R. J. Ursano & B. G. McCaughey (Eds.), Individual and community responses to trauma and disaster: The structure of human chaos. (pp. 72-102). New York: Cambridge University Press.

qualities of the stressor (e.g. its **suddenness** and **severity**), mediating factors such as **sense of control** perceived by the victims, or modifying characteristics such as effect on **social suppor**t. Each of these characteristics may theoretically have a differential effect on psychological outcomes.[7]

Psychological Phases of a Disaster[8]

Pre-Disaster Phase

Disasters vary in the amount of warning communities receive before they occur. For example, earthquakes typically hit with no warning; whereas, hurricanes and floods typically arrive within hours to days of warning. When there is no warning, survivors may feel more vulnerable, unsafe, and fearful of future unpredicted tragedies. The perception that they had no control over protecting themselves or their loved ones can be deeply distressing.

When people do not heed warnings and suffer losses as a result, they may experience guilt and self-blame. While they may have specific plans for how they might protect themselves in the future, they can be left with a sense of guilt or responsibility for what has occurred.

Impact Phase

The impact phase of a disaster can vary from the slow, low-threat buildup associated with some types of floods to the violent, dangerous, and destructive outcomes associated with tornadoes and explosions. The greater the scope, community destruction, and personal losses associated with the disaster, the greater the psychosocial effects.

Depending on the characteristics of the incident, people's reactions range from constricted, stunned, shock-like responses to the less common overt expressions of panic or hysteria. Most typically, people respond initially   with confusion and disbelief, and focus on the survival and physical well-being of themselves and their loved ones. When families are in different geographic locations during the impact of a disaster (e.g., children at school, adults at work), survivors will experience considerable anxiety until they are reunited.

Heroic Phase

In the immediate aftermath of a disaster event, survival, rescuing others, and promoting safety are priorities. Evacuation to shelters, motels, or other homes may be necessary. For some, post-impact disorientation gives way to adrenaline-induced rescue behavior to save lives and protect property. While activity level may be high, actual productivity is often low. The capacity to assess risk may be impaired and injuries can result. Altruism is prominent among both survivors and emergency responders.

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[7] Havenaar, J. M., & van den Brink, W. (1997). Psychological factors affecting health after toxicological disasters. Clinical Psychology Review, 17(4), 359-374.

[8]   U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2000). Training manual for mental health and human services workers in major disasters, second edition. Washington, DC. Retrieved 8/25/2011 from: http://www.samhsa.gov/dtac/CCPtoolkit/Phases_of_disaster.htm

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 posttrauma reactions. When the family unit is not together due to shelter requirements or other factors, an anxious focus on the welfare of those not present may detract from the attention necessary for immediate problem solving.

Honeymoon Phase

During the week to months following a disaster, formal governmental and volunteer assistance may be readily available. Community bonding occurs as a result of sharing the catastrophic experience and the giving and receiving of community support. Survivors may experience a short-lived sense of optimism that the help they will receive will make them whole again. When disaster mental health workers are visible and perceived as helpful during this phase, they are more readily accepted and have a foundation from which to provide assistance in the difficult phases ahead.

Disillusionment Phase

Over time, survivors go through an inventory process during which they begin to recognize the limits of available disaster assistance. They become physically exhausted due to enormous multiple demands, financial pressures, and the stress of relocation or living in a damaged home. The unrealistic optimism initially experienced can give way to discouragement and fatigue. As disaster assistance agencies and volunteer groups begin to pull out, survivors may feel abandoned and resentful. Survivors calculate the gap between the assistance they have received and what they will require to regain their former living conditions and lifestyle. Stressors abound—family discord, financial losses, bureaucratic hassles, time constraints, home reconstruction, relocation, and lack of recreation or leisure time. Health problems and exacerbations of pre-existing conditions emerge due to ongoing, unrelenting stress and fatigue.

The larger community less impacted by the disaster has often returned to business as usual, which typically is discouraging and alienating for survivors. Ill will and resentment may surface in neighborhoods as survivors receive unequal monetary amounts for what they perceive to be equal or similar damage. Divisiveness and hostility among neighbors undermine community cohesion and support.

Reconstruction/Recovery Phase

The reconstruction of physical property and recovery of emotional well-being may continue for years following the disaster. Survivors have realized that they will need to solve the problems of rebuilding their own homes, businesses, and lives largely by themselves and have gradually assumed the responsibility for doing so.

With the construction of new residences, buildings, and roads comes another level of recognition of losses. Survivors are faced with the need to readjust to and integrate new surroundings as they continue to grieve losses. Emotional resources within the family may be exhausted, and social support from friends and family may be worn thin.

When people come to see meaning, personal growth, and opportunity from their disaster experience despite their losses and pain, they are well on the road to recovery. While

disasters may bring profound life-changing losses, they also bring the opportunity to recognize personal strengths and to reexamine life priorities.

Individuals and communities progress through these phases at different rates, depending on the type of disaster and the degree and nature of disaster exposure. This progression may not be linear or sequential, as each person and community brings unique elements to the recovery process. Individual variables, such as psychological resilience, social support, and financial resources, influence a survivor's capacity to move through the phases. While there is always a risk of aligning expectations too rigidly with a developmental sequence, having an appreciation of the unfolding of psychosocial reactions to disaster is valuable.

Phases of Disaster Response for Organizations

Pre-Disaster/Preparation Phase

The primary goal during this phase is to insure that the behavioral health system continuously improves the capacity to competently respond to a disaster. During the pre-disaster phase, training and planning will occur that will increase the capacity of the system to respond to the needs precipitated by a disaster.

Immediate Response Phase

The primary goal during this phase is to ensure that there is an immediate and appropriate behavioral health response to the needs created by a disaster. During this phase crisis counseling services may be provided, often implementing the existing local capacity of the behavioral health system. If it appears that the behavioral health needs precipitated by the disaster require a response greater than the capacity of local resources, additional resources should be sought.

Long-term Response/Recovery Phase

Recovery services continue beyond the first month of the immediate phase of disaster response services, up to several years depending on the nature of the disaster. Local service providers will often be expected to address the needs of disaster survivors during the recovery phase. In the case of a Presidentially Declared Disaster, federal funding may be available for those who are eligible for individual assistance.
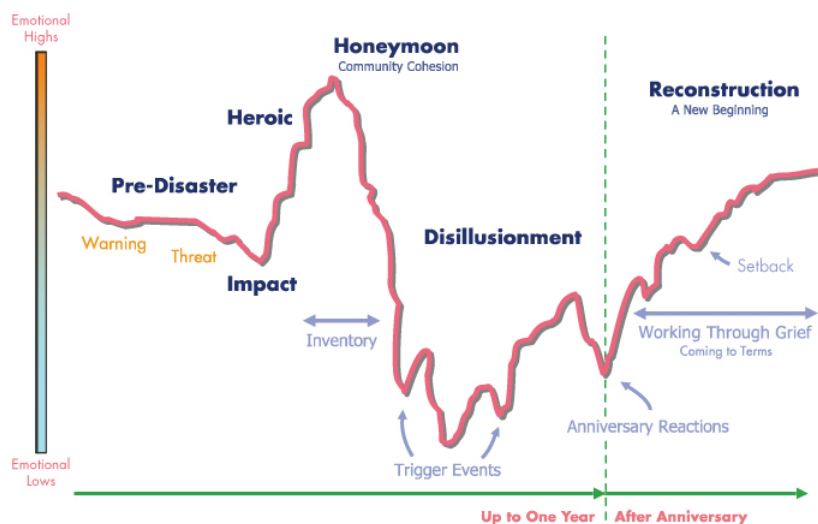
Appendix D-3: Terms and Acronyms

ARC (American Red Cross) - The American Red Cross is a congressionally chartered, humanitarian organization, led by volunteers, that provides relief to victims of disasters and helps people prevent, prepare for, and respond to emergencies

ASD (Acute Stress Disorder) – Acute Stress Disorder, or ASD, is a psychological diagnosis used to explain extreme reactions to stress above what is often expected as a normal response to disaster.

BHERT (pronounced 'be-hurt'**; Behavioral Health Emergency Response Team)** – Nebraska state team that can be requested through the State Disaster Behavioral Health Response Coordinator in the Division of Behavioral Health.

CDC (Centers for Disease Control and Prevention)

CERT (pronounced 'sert'; **Community Emergency Response Team)** – The Community Emergency Response Team (CERT) is collection of individuals who are trained in basic disaster response skills, such as fire safety, search and rescue, team organization, and disaster medical operations. CERT members can assist others in their neighborhood or workplace following an event when professional responders are not immediately available to help.

CISD (Critical Incident Stress Debriefing) – CISD is a technique that is specifically designed to assist others in dealing with the physical or psychological symptoms that are generally associated with trauma exposure. Debriefing, ideally conducted near the site of the event, allows those involved with the incident to process the event and reflect on its impact. This is a central component of Critical Incident Stress Management. *See CISM.*

CISM (Critical Incident Stress Management) – CISM is an intervention protocol, consisting of several elements, that was developed specifically for dealing with traumatic events. This protocol is a formal, highly structured process for helping those involved in a traumatic event to share their experiences, vent emotions, learn about stress reactions and symptoms and receive referrals for further help if required.

CMHS (Center for Mental Health Services) – The CMHS is a federal agency contained within the Substance Abuse and Mental Health Services Administration and the U.S. Department of Health and Human Services. This organization is mandated to adopt a leadership role in mental health services delivery and policy development. Further, CMHS has a specific interest in Disaster Mental Health and has created a branch specifically for this focus. CMHS disaster mental health programs are conducted by the Emergency Mental Health and Traumatic Stress Services Branch of the Federal Center for Mental Health Services (CMHS). In partnership with the Federal Emergency Management Agency (FEMA), this Branch of CMHS is responsible for assessing, promoting, and enhancing the resilience of Americans in times of crisis. The Branch disseminates mental health information about disasters and traumatic events in print and on the Internet.

CCP (Crisis Counseling Assistance and Training Program) – The Crisis Counseling Training and Assistance Program is funded by the Federal Emergency Management Agency (FEMA) under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act. The purpose of the CCP is to support short term interventions with individuals and groups experiencing psychological sequelae to large scale disasters. The CCP is implemented as a supplemental assistance program available to the United States and its Territories, by the Federal Emergency Management Agency (FEMA).

CC (Crisis Counseling) – CC refers to the short term intervention that is focused upon assisting disaster survivors in understanding their current situation and reactions, mitigating additional stress, assisting survivors in reviewing their options, promoting the use of or development of coping strategies, providing emotional support, and encouraging linkages with other individuals and agencies who may help survivors recover to their pre-disaster level of functioning

CSAT (Center for Substance Abuse Treatment) – The Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS), was congressionally mandated to expand the availability of effective treatment and recovery services for alcohol and drug problems.

Emergency – As defined by the Stafford Act an "Emergency" means any occasion or instance for which, in the determination of the President, Federal assistance is needed to supplement State and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the United States.

DAC (Disaster Application Center)

DFO (Disaster Field Office) – usually staffed by FEMA

DHHS (Department of Health and Human Services)

DHS (Department of Homeland Security)

DMH (Disaster Mental Health)

DTAC (Disaster Technical Assistance Center)

ECC (Emergency Coordination Center) – This usually refers to the State Department of Health and Human Services Command/Coordinator Center.

EMS (Emergency Medical Services)

ESF (Emergency Support Function)

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

FEMA (Federal Emergency Management Agency) – FEMA is a federal agency affiliated with the Department of Homeland Security (DHS) that reports to the President. FEMA is also the lead federal agency for disaster/emergency management. However, FEMA cannot direct a state or its agencies. *See also NEMA*

Hazard – Any situation with the potential for causing damage to people, property or the environment.

Hazard Mitigation Plan – Hazard mitigation plan means the plan resulting from a systematic evaluation of the nature and extent of vulnerability to the effects of natural hazards present in society and includes the actions needed to minimize future vulnerability to hazards.

HAZMAT (Hazardous Materials) – This refers to substances that are flammable, corrosive, reactive or toxic chemical, infectious biological (etiological) agent, or radioactive material. A hazardous material can be either a material intended for use or a waste intended to be treated or disposed of.

HCC (Healthcare Coalition)

HHS – *See DHHS*

HRSA (pronounced 'her-sa'; **Health Resources and Services Administration)** – a division of HHS

ICC (Incident Command Center)

ICS (Incident Command System) – An all-hazards, functional incident management system that establishes common standards in organization, terminology, and procedures and further provides a means (unified command) for the establishment of a common set of incident objectives and strategies during multi-agency / multi-jurisdiction operations while maintaining individual agency/jurisdiction authority, responsibility, and accountability. The ICS is a component of the National Interagency Incident Management System (NIIMS).

ICU (Information Coordination Unit)

Immediate Response – Actions taken from the time a disaster/emergency strikes or is imminent to the time which Mental Health Response Teams (MHRT's) and other mental health responders begin leaving the scene and the transition to longer-term, follow-up services begin. *Please see MHRT*

ISP (Immediate Services Program) – This is the initial phase of a Crisis Counseling Program which includes screening techniques, as well as outreach services such as public information and community networking.

Immediate Services Application – The immediate Services Application is an application for funding for Immediate Services Crisis Counseling Program; this must be submitted within 14 days of the Presidentially Declared Disaster and is eligible for individual assistance.

JIC (Joint Information Center) JOC (Joint Operations Center)

LEDRS (Livestock Emergency Disease Response System) – Veterinarians trained and deployed by the Nebraska Department of Agriculture to investigate suspected livestock disease.

LEOP (pronounced 'lee-op'; Local Emergency Operations) – Plan within Nebraska, in which each county's emergency management system maintains their own plan using a template distributed by the state; **Please also see SEOP.**

LMMRS (pronounced 'el-mers'; Lincoln Metropolitan Medical Response System) – *See also MMRS, OMMRS Mental Health Needs Assessment* – A mental health needs assessment is an assessment conducted by the state or local mental health agencies to determine the approximate size, cost, and length of the proposed mental health program. The assessment also must identify why supplemental grant assistance will be needed. It is the basis for the Immediate Services Application (due 14 days following the Presidentially Declared Disaster) and therefore must be initiated as soon as possible.

MHRT (Mental Health Response Team) – MHRT's are multi-disciplinary teams of mental health professionals and paraprofessionals who provide necessary interventions in the initial phases of disaster/emergency recovery.

MMRS (Metropolitan Medical Response System) – This system is funded through the U.S. Department of Homeland Security and instituted in metropolitan areas of a certain size, including Omaha and Lincoln. The focus of this system is to focus on preparation and coordination of local law enforcement, fire, HAZMAT, EMS, hospital, public health, and other "first response" personnel plan to more effectively respond in the first 48 hours of a public crisis. *See also LMMRS, OMMRS*

MOA or MOU (Memorandum of Agreement OR Memorandum of Understanding)

NCP (National Oil and Hazardous Substances Pollution Contingency Plan) – The federal government's blueprint for responding to both oil spills and hazardous substance releases. This is the result of our country's efforts to develop a national response capability and promote overall coordination among the hierarchy of responders and contingency plans.

NDMS (National Disaster Medical System) – The National Disaster Medical System (NDMS) is a section within the U.S. Department of Homeland Security, Federal Emergency Management Agency, Response Division, Operations Branch, and has the responsibility for managing and coordinating the Federal medical response to major emergencies and Federally declared disasters including: natural disasters, technological disasters, major transportation accidents, and acts of terrorism including weapons of mass destruction events. Working in partnership with the Departments of Health and Human Services (HHS), Defense (DoD), and Veterans Affairs (VA), the NDMS Section serves as the lead Federal agency for medical response.

NDMSOSC (National Disaster Medical System Operations Support Center)

NEMA (pronounced 'nee-ma'; **Nebraska Emergency Management System)** – *See also FEMA*

NICC (National Interagency Coordination Center)

Non-PDD (Non-Presidentially Declared Disasters) – A Non-PDD is a disaster or emergency of any magnitude, which does not receive a proclamation of Presidentially Declared Disaster.

NPSC (National Processing Service Center)

NVOAD – *See VOAD*

ODP (Office of Domestic Preparedness)

OMMRS (pronounced 'oh-mers'; **Omaha Metropolitan Medical Response System)** – *See also MMRS, LMMRS*

POA (Point of Arrival) – The designated location (typically an airport) within or near the disaster-affected area where newly arriving staff, equipment, and supplies are initially directed. Upon arrival, personnel and other resources are dispatched to either the DFO, a mobilization center, a staging area, or directly to a disaster site.

POD (Point of Departure) – The designated location (typically an airport) outside the disaster-affected area from which response personnel and resources will deploy to the disaster area.

PDA (Preliminary Damage Assessment)

PDD (Presidentially Declared Disaster) – A PDD is any natural catastrophe (including any hurricane, tornado, storm, flood, high water, wind driven water, tidal wave, tsunami, volcanic eruption, landslide, mudslide, snowstorm, or drought) or, regardless of cause, any fire, flood, or explosion, which in the determination of the President, causes damage of sufficient severity and magnitude to warrant major disaster assistance under the Federal Disaster Relief Act. The PDD grant is intended to supplement the efforts and available resources of states, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering.

PIO (Public Information Officer)

Presidentially Declared Emergency – A Presidentially Declared Emergency is any occasion or instance for which, in the determination of the President, federal assistance is needed to supplement state and local efforts and capabilities to save lives and to lessen or avert the threat of a catastrophe in any part of the United States.

PTSD (Post-Traumatic Stress Disorder) – Posttraumatic Stress Disorder, or PTSD, is a psychological disorder that can occur following the experience or witnessing of life-threatening events such as military combat, natural disasters, terrorist incidents, serious accidents, or violent personal assaults like rape. People who suffer from PTSD often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged, and these symptoms can be severe enough and last long enough to significantly impair the person's daily life.

RSP (Regular Services Program) – A Regular Services Program is a continuing portion of a Crisis Counseling Program designed to provide crisis counseling, community outreach, and consultation and education services to people affected by the disaster for the purpose of relieving continued emotional problems caused by the disaster. Funding is available for a period of 9 months beyond the 60 days of an Immediate Service Program for purposes of providing disaster crisis counseling services.

Robert T. Stafford Disaster Relief and Emergency Assistance Act – Public Law 93-288, as amended (P.L. 100-707); an act intended to provide an orderly and continuing means of assistance by the federal government to state and local government in carrying out their responsibilities to alleviate the suffering and damage which results from disaster/emergencies.

SAMHSA (pronounced 'sam-sa'; **Substance Abuse and Mental Health Services Administration)** – an independent agency of the U.S. Department of Health and Human Services (HHS) that was created to focus attention, programs, and funding on improving the lives of people with or at risk for mental and substance abuse disorders. *See also CMHS and CSAT*.

SEOP (pronounced 'see-op'; **State Emergency Operations Plan)** – *See also LEOP*

SITREP (Situation Report)

Stafford Act - **See Robert T. Stafford Disaster Relief and Emergency Assistance Act**

Terrorism – As defined by the FBI, terrorism is the unlawful use of force against persons or property to intimidate or coerce a government, the civilian population, or any segment thereof, in the furtherance of political or social objectives." This definition includes three elements: terrorist activities are illegal and involve the use of force, the actions are intended to intimidate or coerce, and the actions are committed in support of political or social objectives.

VAL – Department of Homeland Security Voluntary Agency Liaison

VOAD (pronounced 'voh-ad'; **Voluntary Organizations Active in Disasters)** or **NVOAD (National Voluntary Organizations Active in Disasters)** – This is a nation-wide coalition that is compromised of individual member organizations that typically specialize in an aspect of disaster response. Different organizations often have different specialty areas, so that by working in concert, they are able to provide a range of services with little duplication.

WMD (Weapons of Mass Destruction)

Appendix D-4: Websites

Government Agencies

Administration on Aging: Disaster Assistance Resources

http://www.aoa.gov/AoARoot/Preparedness/index.aspx

Links to web-based resources for older persons, their families and caregivers

Assistant Secretary for Preparedness and Response (ASPR)

http://www.phe.gov/about/aspr/Pages/default.aspx

The Office of the Assistant Secretary for Preparedness and Response (formerly the Office of Public Health Emergency Preparedness) was created under the Pandemic and All Hazards Preparedness Act in the wake of Katrina to lead the nation in preventing, preparing for, and responding to the adverse health effects of public health emergencies and disasters Public Health Emergencies – preparedness information
http://www.phe.gov/preparedness/pages/default.aspx

Centers for Disease Control – Emergency Preparedness and Response

www.bt.cdc.gov

The Center for Disease Control is a governmental organization that is charged with the task of protecting the health of the populace. This includes: agents of bioterrorism, chemical agents, radiation emergencies, mass trauma, natural disasters, outbreaks of disease (i.e. SARS, Influenza, etc.)

Disaster Technical Assistance Center (DTAC)

http://www.mentalhealth.samhsa.gov/dtac/default.asp

Established by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Disaster Technical Assistance Center (DTAC) helps SAMHSA ensure that our Nation is prepared and able to respond rapidly when events increase the need for trauma-related mental health and substance abuse services.

Federal Emergency Management Agency (FEMA)

http://www.fema.gov/

An agency in Homeland Security, whose mission is to reduce loss of life and property and protect our nation's critical infrastructure from all types of hazards through a comprehensive, risk-based, emergency management program of mitigation, preparedness, response and recovery.

Guide to Citizen Preparedness

http://www.citizencorps.gov

Citizen Corps, a component of USA Freedom Corps, was created to help coordinate volunteer activities. It provides opportunities for people to participate in a range of measures to make their families, their homes, and their communities safer from the threats of crime, terrorism, and disasters of all kinds.

National Institute of Mental Health - Information About Coping with Traumatic Events

http://www.nimh.nih.gov/health/topics/coping-with-traumatic-events/index.shtml

The National Institute of Mental Health conducts research not only on a wide range of mental health disorders, but also on the reactions that occur in a time of crisis or terror.

Nebraska Health and Human Services System

http://www.hhs.state.ne.us

The Nebraska Health and Human Services System is a governmental agency that seeks to help people live better lives through effective service provision. This agency consists of the: Department of Services (including mental and behavioral health and public health services), Department of regulation and licensure, and Department of Finance and Support.

U.S. Census Bureau

http://www.census.gov/

This is a link to the United States Census Bureau that provides a wealth of information regarding people (i.e. income, housing, population estimates), Businesses (i.e. economic census, government, etc.), Geography (Maps, etc.) and Current Events (i.e. recent news releases, etc). This site is often extremely valuable when writing grants and proposals.

U.S. National Library of Medicine

http://www.nlm.nih.gov/medlineplus/disasters.html

This MEDLINE Plus site provides links to information on dealing with emergencies and disasters.

U.S. Food and Drug Administration

http://www.fda.gov/oca/sthealth.htm

This site lists contact information for each State Health Agency and links to their web sites.

General Information About Psychological Responses to Emergencies

American Psychological Association

http://www.apa.org/helpcenter/disaster/index.aspx

Information on managing distress, recovery, and the role of psychologists in disaster recovery.

American Red Cross http://www.redcross.org/

Dart Center for Journalism & Trauma http://dartcenter.org/

Gateway to Post Traumatic Stress Disorder Information

http://www.ptsdinfo.org/

This link service is a public Service of the Dart Foundation. It is a gateway to four nonprofit sites that offer PTSD information and resources.

International Society of Traumatic Stress Studies

http://www.istss.org/

The International Society for Traumatic Stress Studies provides a forum for the sharing of research, clinical strategies, public policy concerns, and theoretical formulations on trauma.

National Center for Post-Traumatic Stress Disorder

http://www.ptsd.va.gov/

The National Center for Post-Traumatic Stress Disorder is involved in multidisciplinary activities in research, education, and training related to PTSD.

National Mental Health Association

http://www.nmha.org/reassurance/anniversary/index.cfm

The National Mental Health Association has prepared several fact sheets for adults, seniors, children, individuals with mental illness, employers, and physicians on coping with war-related stress and terrorism. Many are also available in Spanish.

National Rural Behavioral Health Center

http://nrbhc.phhp.ufl.edu/disaster/

This is the National Rural Behavioral Health Center rural disaster & trauma page.

National Voluntary Organizations Active In Disaster

http://www.nvoad.org/

NVOAD coordinates planning efforts by many voluntary organizations responding to disaster. Member organizations provide more effective and less duplication in service by getting together before disasters strike.

Nebraska Disaster Behavioral Health

http://www.disastermh.nebraska.edu/

This link provides information on disaster behavioral health activities in Nebraska.

New South Wales Disaster Mental Health

http://www.churchdisasterhelp.org/files/manuals/Disaster Mental Health Response Handbook.pdf

This is a link to the New South Wales Disaster mental health handbook for professionals.

ReliefWeb http://www.reliefweb.int/w/rwb.nsf

ReliefWeb is an electronic clearinghouse for those needing timely information on humanitarian emergencies and natural disasters – designed specifically to help the humanitarian community improve its response to emergencies.

Sweeney Alliance http://www.sweeneyalliance.org/

The Sweeney Alliance is a nationally recognized non-profit organization that provides help to families and professionals coping with grief and stress.

Resources for Faith Communities

American Academy of Experts in Traumatic Stress

www.aaets.org/arts/art82.htm

Discusses roles of funeral, memorials, and spiritual fellowship for communities affected by disaster as well as the effectiveness of pastoral counseling.

National Council of Churches USA

www.ncccusa.org/nmu/mce/childrenterrorism.html

Sponsored by the National Council of Churches, this site provides a short list of tips for talking to children about terrorism and also lists religious and secular resources for work with children.

Resources for Families and Educators

After the Disaster: A Children's Mental Health Checklist

http://www.fema.gov/kids/tch_mntl.htm

A checklist to assess a child's mental health status, following a disaster or traumatic experience.

Center for Disease Control - National Advisory Committee on Children and Terrorism (NACCT)

http://www.bt.cdc.gov/children/

The National Advisory Committee on Children and Terrorism (NACCT) provides recomm-endations for the preparedness of the health care system to respond to bioterrorism as it relates to children.

Helping Children After A Disaster

http://www.aacap.org/publications/factsfam/disaster.htm

Strategies for parents who are comforting children after a disaster. It explains that children must be allowed to talk about the frightening parts of the disaster and their experience must not be minimized.

Substance Abuse and Mental Health Services Administration

http://store.samhsa.gov/product/Psychosocial-Issues-for-Children-and-Adolescents-in-Disasters/ADM86-1070R

Psychosocial Issues for Children and Adolescents in Disasters

http://store.samhsa.gov/shin/content/SMA11-DISASTER/SMA11-DISASTER-09.pdf

Tips for Talking to Children and Youth After Traumatic Events: A Guide for Parents and Educators

National Child Traumatic Stress Network

http://www.nctsnet.org/

The mission of the National Child Traumatic Stress Network (NCTSN) is to raise the standard of care and improve access to services for traumatized children, their families, and communities throughout the United States.

http://nctsnet.org/resources/audiences/school-personnel

This is a brief overview of child trauma and additional websites provided by the National Center for Child Traumatic Stress about trauma risk, normal reactions, best practices and other resources.

Cultural Competence and Populations of Special Concern

Federal Emergency Management Agency – Spanish Version

http://www.fema.gov/spanish/ Agencia Federal para el manajo de emergencias.

National Organization on Disability

http://nod.org/disability_resources/emergency_preparedness_for_persons_with_disabilities/

This page links to a list of information and resources to help individuals with disabilities and their families plan for emergencies or disasters.

Substance Abuse and Mental Health Services Administration (SAMSHA)

http://store.samhsa.gov/product/Developing-Cultural-Competence-in-Disaster-Mental-Health-Programs/SMA03-_3828

Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations was developed to assist States and communities in planning, designing, and implementing culturally competent disaster mental health services for survivors of natural and human-caused disasters.

Appendix E-1: State Disaster Behavioral Health Coordinator

Nebraska maintains a pool of qualified employees ready to assume the role of Nebraska State Disaster Behavioral Health Coordinator. It is recommended that at least 5 people be identified and familiarized with the role of the State Disaster Behavioral Health Coordinator to ensure the role is covered in the event of a disaster. The role will be assumed on a day-to-day basis by a person designated by the Behavioral Health Division Administrator.

Qualifications

- Considerable knowledge of the State Behavioral Health delivery system
- Knowledge of Disaster Behavioral Health concepts and applications
  - Experience in behavioral health disaster response preferred, but not required

Roles/Responsibilities

- Serve as state behavioral health liaison to Regional disaster behavioral health contacts, state emergency service/disaster agents, state bioterrorism efforts, and federal disaster agency staff
- Represent the agency in the State Emergency Coordination Center if needed
- Coordinate the administrative tasks listed in Appendix B on behalf of the Nebraska Division of Behavioral Health

Appendix E-2: Regional Disaster Behavioral Health Coordinator

Each Regional Behavioral Health Authority in Nebraska will identify locally appropriate strategies to maintain a pool of qualified personnel ready to assume the role of Disaster Behavioral Health Coordinator for its coverage area. It is recommended that at least 5 people be identified to serve in this role should disaster occur to insure that the role is covered. The role will be assumed on a day-to-day basis by a person designated by each Regional Program Administrator.

Qualifications

- Knowledge of Disaster Behavioral Health concepts and applications
    - Experience in behavioral health disaster response preferred
- Considerable knowledge of local behavioral health resources
- Considerable knowledge of the State Behavioral Health delivery system

Roles/Responsibilities

- Serve as regional behavioral health liaison to local behavioral health contacts, county emergency service/ disaster agents, local public health departments, and the State Disaster Behavioral Health Coordinator
- Represent the Regional Behavioral Health Authority with area Emergency Management
- Coordinate administrative tasks listed in Appendix B for their coverage area

Appendix E-3: Risk Consultants

A statewide pool of behavioral health professionals with competency in risk/threat assessment and risk communication will be identified jointly by the Division of Behavioral Health, Nebraska State Patrol, and Nebraska Health and Human Service System Public Information Officers. These professionals will assume the role of consultant[1] to Nebraska officials when needed.

Two specialties have been identified that potentially involve the need for pre-identified, competent consultation:

1. The first is for potential psychological consultation with law enforcement, public officials, or public information officers as threats or risks are identified. Consultation involves assessing and making recommendations about managing the threats and their psychological implications.

    ### Qualifications for threat/risk assessment consultants

    - Experience in threat/risk assessment and management
    - Current Nebraska licensure as a psychologist, psychiatrist, mental health practitioner
    - Experience working with law enforcement

    ### Roles/Responsibilities

    The person(s) in this role may be asked to consult in the following areas:

    - Assist emergency planners and responding agencies in assessing and responding to threats

2. The second is for expertise in the area of communicating risk and using content and context to communicate effective, consistent messages that encourage compliance and calm.

    ### Qualifications for risk communication consultants

    - Considerable knowledge of risk communication principles
    - Current Nebraska licensure as a psychologist, psychiatrist, mental health practitioner
    - Experience functioning in a consultative role with government

    ### Roles/Responsibilities

    - Review and comment on prepared messages with mental health content
    - Consult at the request of the PIO on message development or delivery before, during, or following a disaster
    - Provide consultation to public officials as requested

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[1] The role of consultant is to offer professional advice within the scope of licensure and competence of the practitioner. This is not an official paid position and will generally be occupied by volunteers or state employees.

- Work closely with the State Disaster Behavioral Health Coordinator and NE HHS Public Information Officer to monitor information from behavioral health responders in the field, with a goal of quickly identifying trends and concerns that can be brought to the attention of Public Information Officers

Risk Consultants are pre-identified to serve alongside the State Disaster Behavioral Health Coordinator and augment that function as required. The placement of the Risk Consultant with the State Disaster Behavioral Health Coordinator will facilitate initial communication with the NE HHSS Public Information Officer.

Appendix E-4: Behavioral Health Emergency Response Team (BHERT)

A pool of state-employed behavioral health professionals is identified to serve on a Nebraska Behavioral Health Emergency Response Team, when activated.

The purpose of the Nebraska Behavioral Health Emergency Response Team (BHERT) is to support local behavioral health disaster response capabilities when needed by:

- Conducting community psycho-social impact/needs assessments,
- Providing support for state operations affected by disaster (such as Regional Centers or Correctional facilities)
- Other duties as assigned by the Nebraska Emergency Management Agency (NEMA).

Qualifications

Basic physical requirements ensure that all team members are able to navigate disaster sites, rapidly gather and communicate information as part of a community needs assessment, and contend with hardship conditions that often accompany deployment in response to a disaster. Members should be able to walk unaided, lift 30 pounds, see and hear within a normal range (vision/hearing correction to normal range is acceptable), and have no medical restrictions on everyday activities. Applicants must also be at least 21 years old, willing to travel across the state, possess a valid Nebraska Drivers' License. Background checks may be required.

To serve as a clinical content expert during a response, a team member must have experience in the provision of disaster behavioral health services. They must also possess full Nebraska licensure (not provisional) in their clinical specialty.

Roles/Responsibilities

Team Leader

Team leaders are active BHERT members identified as team leader for each deployment according to the qualifications and experience needed to complete the mission as assigned. Responsibilities include:

- Maintain responsibility for all team activity and assignments during deployment
- Communicate with the NDHHS State Disaster Behavioral Health Coordinator during deployment
- Assist NDHHS State Disaster Coordinator with team member selection & notification
- Communicate and coordinate with local behavioral health response representatives
- Serve as the primary incident command contact for BHERT during deployment
- Transition responsibilities to local officials as soon as possible
- Maintain documentation for team deployment

Team Member

Team members are identified and screened prior to being eligible for deployment. Deployed team members represent clinical and administrative specialty areas required to meet mission objectives. Responsibilities include:

- Carry out duties related to specialty area as assigned by team leader during deployment

- Document deployment activities

- Coordinate deployment activities with local behavioral health response representatives

- Participate in readiness activities including training, exercises and team meetings

- Participate in post-deployment activities including operational debriefings and after-action reporting

- Attend demobilization services for team members returning from deployment as requested by the NDHHS State Behavioral Health All-Hazards Disaster Coordinator or his/her designee

- Serve as a team leader if requested

There are several different roles assigned by the team leader that will be filled by **BHERT team members**, depending on the requirements of the specific incident:

1. *Behavioral Health Risk Communication Specialist*

   Description

   Behavioral health and public information professionals with competency in risk communication.

   Qualifications

   - Considerable knowledge of risk communication principles

   - Experience functioning in a consultative role

   - Excellent oral and written communication skills

   - Extensive knowledge and experience creating disaster messages

   Primary Roles/Responsibilities

   - Prepare, review and comment on prepared messages with mental health content

   - Consult at the request of public information officers, public officials, or hotline coordinators on message development or delivery before, during, or following a disaster

   - Provide consultation to public officials as requested

   - Work closely with the rest of the NBHERT team to monitor information from behavioral health responders in the field, with a goal of quickly identifying

trends and concerns that can be brought to the attention of public information officers

- Provide consultation to officials responsible for state-run hotlines related to disaster

2. *Disaster Behavioral Health Trainer*

Description

This is a person who can either present or prepare local resources to present educational material related to disaster behavioral health. Typically educational content will be for hotline workers, behavioral health responders or affected community members.

Qualifications

- In-depth knowledge of disaster behavioral health concepts
- Ability to train diverse audiences in psychosocial aspects of disasters/ emergencies
- Excellent oral and written communication skills
- Competency in content of training areas

Primary Roles/Responsibilities

- Provide just-in-time training to disaster behavioral health responders
- Provide disaster behavioral health training for hotline workers
- Prepare local personnel to present relevant training
- Facilitate educational community forums related to stress management, coping or disaster reactions

3. *Administrative Specialist*

Description

The administrative specialist may perform a variety of administrative functions. Team members in this function may be called upon to consult regarding management issues in behavioral health organizations, create or acquire documents, to assist with set up of operations, or track deployment of disaster behavioral health response activities.

Qualifications

- Knowledge of Nebraska behavioral health infrastructure
- Knowledge and expertise related to administrative processes required to coordinate disaster behavioral health response.
- Demonstrated knowledge of administrative processes related to Nebraska behavioral health systems or facilities licensed or operated by the state of Nebraska

- Excellent oral and written communication skills

- Knowledge and expertise in administrative forms and procedures

- Knowledge of federal emergency management agency crisis counseling program requirements

- Detail-oriented

Primary Roles/Responsibilities

- Work closely with other NBHERT members to track activities, compile information and transmit information to state disaster coordinators

- Work closely with managers of behavioral health agencies to assess organizational needs related to the disaster

4. Clinical Expert

Description

Clinical experts consult regarding specific services needed by special populations. They may also assist with the design of services or programs for specific populations.

Clinical experts may represent one or more of the following specialty areas:

- Substance Abuse
- Critical Incident Stress Management

- Spiritual Care
- Mental Health

Specialty areas may include sub-specialty populations such as children, elderly, racial/ethnic groups, developmentally disabled, methadone consumers, etc.

Qualifications

- Current license/certification (not provisional), as recorded by the Nebraska Department of Health and Human Services

- Knowledge of Nebraska behavioral health infrastructure

- General knowledge of disaster behavioral health structures in Nebraska

- Experience and knowledge of clinical interventions and strategies required as part of a disaster behavioral health response

- Excellent oral and written communication skills

Primary Roles/Responsibilities

- Provide clinical consultation as needed after a disaster

Appendix E-5: Key Characteristics/Abilities of Response Personnel

Disaster behavioral health work is not a vocation suited to all people. To complicate matters, individuals who have qualities that make them thrive as responders immediately after a disaster may not possess qualities and skills required when providing services during the long term recovery stage. Often, once the community begins the long process of recovery, response personnel need different qualities and skills than were needed during the immediate response.

Overall, the key personal characteristics and abilities of those who are particularly suited for disaster work are:[1]

• Mature	• Sociable
• Flexible	• Knowledgeable about how systems work
• Calm	• Tolerates ambiguity well
• Empathetic	• Genuine
• Good listener	• Shows positive regard for others

The recruitment and selection of professional and paraprofessional disaster response personnel should also take into account the demographics of the disaster-stricken location (including ethnicity and language), and the phase of the disaster. Note that workers selected for disaster response and recovery work should not be so severely impacted by the disaster that their responsibilities at home or their emotional reactions will interfere with participation as responders in the program, or vice versa.

Immediate Response Phase[2]

In the immediate response phase of disaster, an "**action orientation**" is important. Workers who do well with crisis intervention do well in this phase. Personnel who have worked in emergency services in a local mental health center or a hospital emergency room are frequently well-suited to this phase of disaster work.

There are going to be some people who cannot tolerate and do not function when exposed to the sights and sounds of physical trauma. These staff members should obviously not be asked to provide mental health services at the scene of injuries or in first aid stations, emergency rooms, or morgues. This does not mean they cannot participate in disaster response, as there are many other roles that these individual may fill.

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[1] Adapted from: 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 Practices. NIH Publication No. 02-5138, Washington, D.C.: U.S. Government Printing Office.

[2] Adapted from: Myers, D. (1994). Disaster response and recovery: A handbook for mental Health Professionals. Rockville, Maryland: Center for Mental Health Services.

Long-term Response Phase

Long-term behavioral health disaster programs, covering the period from about one month to one year post- disaster, are different in nature and pace from the immediate response. During this phase, immediate services are beginning to shut down and locating disaster survivors becomes more difficult and thus mental health workers need to be adept and creative with outreach in the community.

Additional qualities required by staff during this phase include:

- Patience
- Perseverance
- Tolerance for slow, non-immediate results of one's work

Appendix E-6: Scope of Licensure for Nebraska Behavioral Health Professionals

Refer to Nebraska licensing laws[1] for complete information about the scope of licensure for behavioral health professionals. Registered Nurses and Advance Practice Registered Nurses may specialize in psychiatry and may also serve in the role of behavioral health professional. This licensure discussion does not address these medical professionals. The following is a very brief differentiation of the licensed behavioral health professionals in Nebraska.

Psychiatrists – Medical Doctors, M.D. or O.D.; Can prescribe medication, diagnose and treat major mental illnesses, and supervise other behavioral health professionals

Psychologists – Ph.D. or Psy.D.; Can diagnose and treat major mental illnesses, and supervise other behavioral health professionals

Licensed Independent Mental Health Practitioners (LIMHP) and Licensed Mental Health Practitioners (LMHP) –This category covers Masters and Doctorate level clinicians with at least 3000 hours of experience after receiving the MA or Ph.D Degree.

LIMHPs can assess and treat all major and minor mental illnesses unsupervised. LMHPs can assess and treat mental illnesses that are not considered major mental disorders unsupervised, but supervision by a Psychologist or Psychiatrist is needed if they engage in treatment activities with someone who has behaviors associated with a major mental disorder.

Three certifications are available to those in this licensure category:

- CMSW – Certified Master Social Worker
- CPC – Certified Professional Counselor
- CMFT – Certified Marriage and Family Therapist

Provisionally Licensed Mental Health Practitioners (PLMHP) – Masters level clinician in the process of accumulating post-Masters experience hours; Clinical supervision by a LMHP, Psychologist or Psychiatrist is required.

Licensed Alcohol and Drug Addiction Counselors (LADAC) – Specialized training in addiction is required; level of formal education varies.

There are also recognized behavioral health professionals with specializations who are not "licensed" by the Nebraska Department of Health and Human Services. These professionals may serve special populations:

Certified Social Workers – C.S.W.; Bachelor's level social workers

School Psychologists & School Counselors – May have a certification, but often are not licensed; Specialize in children's issues; Minimum of Masters Degree required.

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[1] Available at: http://dhhs.ne.gov/Pages/reg_t172.aspx

Appendix E-7: Disaster Behavioral Health Professionals (Licensed/Certified)

The role of individual behavioral health professionals in disaster response will conform to the scope of practice for their licensed profession.[1]

Qualifications

- Current license/certification, as recorded by the Nebraska Department of Health and Human Services, Office of Regulation and Licensure
- Basic training in behavioral health disaster response is required for pre-registration. Currently recognized formal training programs are:
  - American Red Cross – Disaster Mental Health
  - Critical Incident Stress Management (CISM) response training
  - Nebraska Psychological First Aid training
- Advanced training in behavioral health disaster response is encouraged

Responsibilities

- Provide basic support and comfort to the population affected by the event
- Provide specialized care consistent with professional licensure/certification
- Supervision of other behavioral health responders (i.e., those with provisional licenses, students training in behavioral health professions, CISM peers, and community responders/natural helpers)

During the recovery phase of disaster response, treatment of severe mental disorders such as Post-Traumatic Stress Disorder, depression, anxiety, and other emotional disorders should be undertaken by professional mental health practitioners who have the appropriate training and skills to treat the disorder.

A more detailed listing of the clinical roles of licensed/certified behavioral health professionals is presented in the charts on the next two pages, which were excerpted from a public domain manual published by the National Center for Post-Traumatic Stress Disorder, and modified to fit conditions in Nebraska.[2]

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[1] See Appendix E-5 for information about scope of licensure.

[2] Charts adapted from: Young, B.H., Ford, J.D., Ruzek, J.I., Friedman, M.J., & Gusman, F.D. (2000). Disaster Mental Health Services: A Guidebook for Clinicians and Administrators. Menlo Park, CA: National Center for Post-Traumatic Stress Disorder, Department of Veterans Affairs. Available via website: http://www.ncptsd.org/publications/disaster/index.html

Emergency Phase: Clinical Roles

	SURVIVORS	RESPONDERS/HELPERS	COMMUNITY	ORGANIZATIONS
Types of Disaster	Protect	Triage/Assess	Information Dissemination	Consultation
Mental Health Services	Direct	Consult		Needs Assessment
	Connect	Defusing/Debriefing		Service development
	Triage	Crisis intervention		Support Employee Assistance Programs (EAPs)
	Acute Care	Referral when appropriate		

Early Post-Impact Phase: Clinical Roles

	SURVIVORS	RESPONDERS/HELPERS	COMMUNITY	ORGANIZATIONS
Types of Disaster	Outreach Services			
Mental Health Services	Assessment	Assessment	Psychoeducational articles, interviews, reports, brochures about stress reactions & stress management	Phone & on-site consultation to management
	Referral when appropriate	Consult		Ad hoc counseling program design & implementation
	Psychoeducational presentations	Referral when appropriate		Support Employee Assistance Programs (EAPs)
	Initial defusings/ debriefings	Initial defusings/debriefings		
	Follow-up defusings/ debriefings	Follow-up defusings/ debriefings		
	Assistance with death notification			
	Activities in large group settings & vigils			
SITES OF INTERVENTIONS	Shelters, meal sites, disaster application centers, Red Cross service centers, hospitals, schools, police stations, survivors' homes, morgues, etc. (wherever survivors are)	Work Sites; Rest Sites; Home office	Newspapers, radio, TV, Internet, community centers, shopping malls, schools, religious centers, business associations	Work sites; Corporate offices

Recovery Phase: Clinical Roles

Types of Disaster	SURVIVORS	RESPONDERS/HELPERS	COMMUNITY	ORGANIZATIONS
Mental Health Services	<u>Outreach Services</u>			
	PTSD Assessment	Assessment as appropriate	Psychoeducational articles, interviews, reports, brochures about stress reactions & stress management	Phone & on-site consultation
	Referral as appropriate	Referral as appropriate		Needs Assessment surveys
	Psychoeducational presentations	Consultation	Group educational presentations	Educational presentations
	Defusings/debriefings	Follow-up defusings/debriefings	Needs Assessment surveys	Consultations and trainings with Employee Assistance Programs (EAPs)
	Memorial & commemoration support	Commemoration planning	Commemoration planning	
	<u>Clinical services</u> Crisis intervention			
	Consultation with schools; school programs			
	PTSD & psychosocial assessment and treatment			
	Individual, couples, family & group counseling			

Appendix E-8: Disaster Behavioral Health Community Responders/Natural Helpers[1]

Behavioral Health Community Responders may augment the behavioral health response to disaster. Many of these responders already occupy natural helping roles within a community. They may be educators, human service professionals, or community volunteers. Many will self-identify as wanting to be ready to respond or help if a disaster occurs. It is important to note that even with the appropriate training, not everyone is suited for disaster response work. Training in psychological first aid can be a first step toward building readiness.

Pre-credentialing these volunteers includes a requirement that they complete a course in psychological first aid with the recommendation that it be augmented by the American Red Cross course "Disaster Mental Health Overview."

Key Characteristics

The key personal characteristics and abilities of those who are particularly suited for disaster work are noted here:

- Mature
- Sociable
- Calm
- Good listener
- Flexible

- Tolerates ambiguity well
- Empathetic
- Genuine
- Knowledgeable about how systems work
- Shows positive regard for others

Roles/Responsibilities

- Serve as an empathetic listener
- Provide education and outreach to community members about normal reactions to disaster
- Refer individuals to a professional for assessment if needed

Community Responders will not be trained or expected to perform any tasks in disaster response which are best reserved for behavioral health professionals. Initial training should include psychological first aid principles, an overview of disaster behavioral health, and when to refer to a professional.

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[1] Adapted from: 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 Practices. NIH Publication No. 02-5138, Washington, D.C.: U.S. Government Printing Office.

Appendix E-8: Disaster Behavioral Health Community Responders/Natural Helpers (Cont.)

The following tasks are inappropriate for Community Behavioral Health Disaster Responders to perform:

- Functioning without supervision by a licensed professional
- Agreeing to or establishing long-term care or case management (implicit or explicit)
- Clinical assessment
- Evaluating, diagnosing, or using diagnostic terms (i.e., "you have…")
- Giving advice about what to do
- Making any final decisions regarding behavioral health disaster services and/or referrals
- Minimizing reported symptoms
- Prescribing or dispensing drugs/medication
- Sharing certain types of information, i.e., fatalities
- Therapy/acting as a therapist
  - Emotional delving
  - Engaging in reprocessing of trauma
  - Debriefing

Appendix E-9: Training Chart[1]

Different forms of early intervention require different sets of skills, training, and background knowledge. Behavioral health practitioners are key professionals in this respect. In addition, many early intervention and follow-up activities may be delivered to trauma survivors by individuals who are specifically pre-trained in early intervention. These individuals may include:

- Community volunteers
- Disaster responders
- Faith Leaders
- Medical professionals, including primary care practitioners, pediatricians, and family practice doctors
- Paraprofessionals
- School personnel
- Students in training to be professional behavioral health practitioners

It is recommended that interested individuals who are not licensed behavioral health practitioners complete the Nebraska course in Psychological First Aid. Individuals who complete this training and any other required screening may be listed in a database of potential responders maintained by Regional Behavioral Health Authorities.

Advanced behavioral health disaster response training is recommended for licensed/certified behavioral health professionals participating in the disaster response. Currently accepted advanced training is CBT for Post- Disaster Distress, and advanced disaster mental health trainings offered by the American Red Cross.

The chart on the next two pages outlines recommended training for disaster response personnel. This chart is consistent with recommendations from the National Center for Post-Traumatic Stress Disorder. Many sections of the chart have been left blank, either because there is currently no consensus on best practices and training in these areas, and/or no formal training is currently available.

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[1] Young, B.H., Ford, J.D., Ruzek, J.I., Friedman, M.J., & Gusman, F.D. (2000). Disaster Mental Health Services: A Guidebook for Clinicians and Administrators. Menlo Park, CA: National Center for Post-Traumatic Stress Disorder, Department of Veterans Affairs. Available via website: http://www.ncptsd.org/publications/disaster/index.html

Recommended Training/Experience of Disaster Behavioral Health Responders by Disaster Phase

	Emergency Phase	Early Post-Impact Phase	To Supervise	Restorative/ Recovery Phase
Professional Behavioral Health Practitioners				
Primary Care Physicians, Family Practitioners	1. General Introduction to Disaster (ARC) -Phases of disaster -Introduction to incident command structure & terminology			
Physician Extenders (APRN, PA)		Same training as for Emergency Phase	Advanced Disaster Behavioral Health training through ARC	
Psychiatrists (including Residents)		Some kind of optional training would be nice	Supervision experience in their field	CBT for Post-Disaster Distress
Certified Psychiatric RN	2. Introduction to Disaster Mental Health (ARC)		Some disaster experience	
Licensed Psychologists	-Scope of practice possible in disaster		Some degree of maturity	
Licensed Mental Health Professionals (Counselors, Social Workers)	AND/OR			
Certified Mental Health-Related Professionals (School Psychologists and Counselors)	2. Psychological First Aid Training (Nebraska model)			
Provisionally licensed psychologists (includes psychology graduate students)	-Disaster behavioral health response skill development		Possibly faculty will supervise students	
Provisionally licensed Mental Health Professionals (includes students in training)				

	Emergency Phase	Early Post-Impact Phase	To Supervise	Restorative/ Recovery Phase
Faith leaders				
Certified Pastoral Counselors			Same as for Professional Behavioral Health Practitioners	
Faith leaders				
Community Responders/Natural Helpers				
Certified Alcohol & Drug Abuse Counselor (CADAC)	1. General Introduction to Disaster (ARC) -Phases of disaster -Introduction to incident command structure & terminology 2. Psychological First Aid Training (Nebraska model) -Disaster behavioral health response skill development		Community responders are not recommended for supervisory roles in the behavioral health response to disaster	
Provisional CADAC				
Non-licensed behavioral health professionals (faculty, management)				
Indigenous workers/ Behavioral Health Outreach Workers				
Members of other volunteer responder organizations				

CISM Peers are not included in this table – They may be busy with primary first response activities, or engaged in delivery of CISM services. They are already trained under the CISM program.

Appendix E-10: Guidelines for Responders Working through Interpreters[1]

These suggestions can help facilitate interaction, help the person feel more comfortable, and make the interpreter's job somewhat easier.

1. Allow extra time because everything has to be said at least twice.

2. Use trained bilingual/bicultural interpreters whenever possible.

3. Never use children as interpreters. Most persons will not discuss problems of a personal nature in front of their children, interpreting serious problems may traumatize children, and in many cultures using the child to interpret will upset the family's social order.

4. Face the person directly and speak directly to him or her.

5. Watch the person (not the interpreter) during interpretation.

6. Speak slowly and clearly. Don't raise your voice or shout.

7. Sentence by sentence interpretation works best.

8. Remember that the time needed for the interpreter to interpret may be much longer than it took you to say something in English.

9. Allow the interpreter to ask open-ended questions if needed to clarify what the person says.

10. Use simple language and straightforward sentences. Avoid metaphors, slang / jargon.

11. Observe and evaluate what is going on before interrupting the interpreter, i.e., if the interpreter is taking too long to interpret a simple sentence or if the interpreter — outside his role — is having a conversation with the person, or there are no words in the target language to express what the provider said.

12. Explain all medical terms in simple language, especially if the person/interpreter is not knowledgeable about western medicine.

13. Always allow time for persons to ask questions and seek clarifications.

14. Question the interpreter if he or she seems to answer for the person.

15. Learn some basic words and phrases in the person's language.

16. Always ask the person to repeat instructions to you to be certain they have been properly interpreted and understood.

17. Remember that some persons who require an interpreter may actually understand English quite well. Any comments you make to other providers or to the interpreter may be understood by the person.

18. Document in the progress notes the name of the interpreter who interpreted for the person.

19. Before meeting with the person, the provider should give the interpreter a brief summary about the person, and set the goals and procedures for these sessions.

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[1] Center for Multicultural and Multilingual Mental Health Services.

Appendix F-1: Overview of Nebraska Rules and Regulations

For the full text of all Nebraska rules and regulations that apply to the Health and Human Services System, see:
http://dhhs.ne.gov/publichealth/Pages/LeadRules.aspx

Regional Governing Boards

Unlike the requirements for services and facilities (see below), the Regional Governing Boards are required to have a written plan to respond to psychosocial needs of disaster victims in their coverage area.[1] Up to this point, this requirement has been unfunded and un-enforced.

Nebraska Critical Incident Stress Management Program

The Nebraska Critical Incident Stress Management Program (CISM) is established by statute to serve the psychosocial needs of first responder groups.[2] CISM is the only statutorily created program in Nebraska for responding to psychosocial needs of those involved in a disaster. This program serves the psychosocial needs of responder groups, and the spouse/significant/other/adult relative living in the same household (*not disaster survivors*). Responder groups served are: Law enforcement, firefighters, EMS, dispatchers, hospital personnel, corrections personnel, local or state emergency management and responders deployed through emergency management.

Nebraska Emergency Management Act

Governor's Declaration of Disaster

The Nebraska Emergency Management Agency is responsible for carrying out the provisions of the Emergency

Management Act. All state agencies and political subdivisions of the state are required to cooperate and extend their services and facilities for the purposes of disaster response upon request.[3]

In the event of a disaster declaration by the Governor, the Governor may "suspend the provisions of any regulatory statute prescribing the procedures for conduct of state business or the orders, rules, or regulations of any state agency if strict compliance with the provisions of any statute, order, rule, or regulation would in any way prevent, hinder, or delay necessary action in coping with the disaster, emergency, or civil defense emergency."[4] Requests for such an action by the Governor must be sent through the Nebraska Emergency Management Agency.

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[1] NAC Title 204 Chapter 3

[2] Nebraska Critical Incident Stress Management Act §§ 71-7101 to 71-7113; *see also* NAC Title 176 Chapter 1

[3] Nebraska Emergency Management Act § 81-829.60

[4] Nebraska Emergency Management Act § 81-829.40

Responders/Volunteer

Emergency Response Team

Under the Nebraska Emergency Management Act, a roster of persons with training and skills for disaster response will be established.[5] Only the people who appear on such a roster will be considered members of a disaster response team.[6] This makes it essential to establish a roster of persons across the state who can and will respond to psychosocial needs of disaster survivors and communities. It may be necessary for behavioral health disaster responders to join with an already existing and recognized disaster response team, or to establish their own teams specializing in behavioral health.

Release of State Employees for Red Cross Service

Any state employee who is a certified disaster service volunteer of the American Red Cross may be granted leave for disaster response with the authorization of his or her supervisor. This leave is not to exceed fifteen working days in each calendar year. This specifically includes "all administrative, professional, academic, and other personnel of the University of Nebraska, the state colleges, and the State Department of Education."[7] This potentially creates an avenue for employees to respond to disaster situations within organized response structures and obtain valuable experience and training.

From Other States – Licensure/Certification

Local emergency management directors or coordinators are responsible for developing mutual aid arrangements for reciprocal aid and assistance in the event of a disaster or emergency.[8] Subject to the approval of the Governor, this includes developing mutual aid arrangements with agencies and organizations in other states. Licensure or certification in another state will be recognized as evidence of qualification for utilizing the licensed skills for disaster response in the state of Nebraska.[9]

<u>Nebraska Mental Health Commitment Act</u>

A law enforcement officer who has probable cause to believe that a person is mentally ill and dangerous, and likely to harm his/herself or others before mental health board proceedings under the Nebraska Mental Health Commitment Act may be initiated to obtain custody of the person, may take such person into emergency protective custody, cause him or her to be taken into emergency protective custody, or continue his or her custody if he or she is already in custody. Such person shall be admitted to the nearest appropriate and available medical facility, and shall not be placed in a jail.[10] More information about Nebraska's Commitment Act is available at :
http://dhhs.ne.gov/behavioral_health/Pages/beh_commit_commit.aspx

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[5] Nebraska Emergency Management Act § 81-829.41

[6] Nebraska Emergency Management Act § 81-829.52

[7] Nebraska Law § 81-1391

[8] Nebraska Emergency Management Act § 81-829.48

[9] Nebraska Emergency Management Act § 81-829.56

[10] Nebraska Law § 71-919

Privacy and Security Rules (HIPAA and FERPA)

Health Insurance Portability and Accountability Act (HIPAA)

The HIPAA Privacy Rule requires covered entities to protect individuals' health records and other identifiable health information. The Secretary of HHS (Federal) can waive provisions of the Rule under the Project Bioshield Act of 2004(PL 108-276) and section 1135(b)(7) of the Social Security Act. Regardless of the activation of a waiver, HIPAA permits disclosers for treatment purposes and for some disclosures to disaster relief organizations. For example, covered entities can share patient information with the Red Cross so it can notify family members of the patients location (45 CFR 164.510(b)(4)).

The Privacy Rule permits use and disclosure of protected health information, without an individual's authorization or permission, for national priority purposes[11], including:

- *Law Enforcement Purposes.* Covered entities may disclose protected health information to law enforcement officials for law enforcement purposes under the following *six* circumstances:

    - As required by law (including court orders, court-ordered warrants, subpoenas) and administrative requests

    - To identify or locate a suspect, fugitive, material witness, or missing person

    - In response to a law enforcement official's request for information about a victim or suspected victim of a crime

    - To alert law enforcement of a person's death, if the covered entity suspects that criminal activity caused the death

    - When a covered entity believes that protected health information is evidence of a crime that occurred on its premises

    - By a covered health care provider in a medical emergency not occurring on its premises, when necessary to inform law enforcement about the commission and nature of a crime, the location of the crime or crime victims, and the perpetrator of the crime.

- *Serious Threat to Health or Safety.* Covered entities may disclose protected health information that they believe is necessary to prevent or lessen a serious and imminent threat to a person or the public

    - Disclosure must be made to someone they believe can prevent or lessen the threat (including the target of the threat)

    - May also disclose to law enforcement if the information is needed to identify or apprehend an escapee or violent criminal

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[11] See 45 C.F.R. § 164.512

Family Educational Rights and Privacy Act (FERPA)

The Family Educational Rights and Privacy Act (FERPA)[12] is a Federal law that protects the privacy of student education records.

- Applies to all schools that receive funds under an applicable program of the U.S. Department of Education
- Schools must have written permission from the parent or eligible student in order to release any information from a student's education record
- EXCEPT, schools may disclose records, without consent, to certain parties under specific conditions, including the following:
  - To comply with a judicial order or lawfully issued subpoena
  - Appropriate officials in cases of health and safety emergencies
  - State and local authorities, within a juvenile justice system, pursuant to specific State law

Health Care Facilities and Services Licensure/Accreditation

Facility licensure requirements[13] general address disaster preparedness in terms of meeting physical needs and continuation of services, but do not address psychological consequences of disaster.

This also applies to certification of aging services and mental health programs.[14]

NAC Title 175 requires facilities address disaster preparedness in terms of meeting physical needs of clients and continuation of services.[15]

- Facilities must have a plan for addressing emergency care and treatment of clients, including approved interventions to be used in a client emergency.
  - This may apply to health and medical emergencies, as well as violence toward other clients and staff.
- Staff must be trained in emergency procedures during their initial orientation after hire.

Council on Accreditation (COA) (accreditation for child & family services, and behavioral health services)

- Requires organizations to develop an emergency response plan
  - Plan must address a variety of situations including hostage situations, bomb threats, and unlawful intrusion
  - Must also include continuity of operations in the plan

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[12] U.S.C. § 1232g; 34 CFR Part 99

[13] NAC Title 175 Health Care Facilities and Services Licensure

[14] NAC Title 15 NAC 1; and Title 205 Chapter 5

[15] NAC Title 175 Health Care Facilities and Services Licensure

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

Emergency management standards for hospitals, critical access hospitals, and long term care organizations were implemented in 2008. Specifically, the previous single standard was broadened into eight new standards that became effective January 1, 2008.

- The new standards emphasize an all-hazards approach
    - Supports preparedness to address a range of emergencies, including addressing patient and staff safety and security.

Commission on Accreditation of Healthcare Facilities (CARF)

Requires facilities to meet a variety of quality standards, including standards for minimizing organizational risk

- Risk management plan
    - Guidance on what to consider including in a risk management plan, includes emergency response, facility evacuation, and violence situations
    - Facilities develop a plan appropriate for their unique structure, programs/ services provided, and populations served
- Insurance to protect against loss from actualized threats

Appendix F-2: Liability Issues for Volunteer Disaster Behavioral Health Workers

A reoccurring theme that arises in discussion about mental health professionals volunteering in disaster or emergency situations is the topic of professional liability. The practice of mental health in disaster situations is relatively new and not yet accompanied by widely endorsed, evidence based standards of care. This has led many to ask questions about professional liability in relation to the delivery of professional services in the field as part of disaster response.

Nebraska is fortunate to have statutes in place that protect volunteers in certain emergency situations. The Nebraska Emergency Management Act, The Good Samaritan Act, and the Federal Volunteer Protection Act limit liability for the volunteer, though gaps exist that still leave the mental health volunteer vulnerable in certain circumstances. At the most simplistic level it can be said that a mental health disaster volunteer in Nebraska can feel relatively protected if they operate under the auspices of an organization such as the Red Cross or if they are part of an organized response that is activated by an emergency management agency. Liability is murkier and appears to be considerably higher when the volunteer is acting alone.

The following summary addresses some of the highlights of the statutes currently in place to protect Nebraska volunteers. It also points out a few of the questions that arise when specifically applying them to the mental health volunteer.

Note: *This is not legal advice, but is intended only to point out some of the issues to be considered in the provision of disaster mental health services by volunteers*.

II. The Nebraska Emergency Management Act (NEMA): 81-829.36-829.75

A. *Who is an emergency management worker?* Under NEMA, the definition of an "[e]mergency management worker includes any full-time or part-time paid, **volunteer,** or auxiliary employee of this state or other states, territories, or possessions of the federal government or any neighboring country or of any political subdivision thereof, of the District of Columbia, or of any agency or organizations performing emergency management services at any place in this state **subject to the order or control of or pursuant to a request of the state government or any political subdivision thereof** and also **includes instructors and students** in emergency management educational programs **approved** by the Nebraska Emergency Management Agency or otherwise under the provisions of the Emergency Management Act." 81-829.39 (5).

B. *What is considered "emergency management"?* Under NEMA, the definition of "[e]mergency management means the preparation for and the carrying out

of all emergency functions, other than functions for which military forces are primarily responsible, to mitigate, prevent, minimize, respond to, and recover from injury and damage resulting from disasters, emergencies, or civil defense emergencies" 81-829.39 (4).

C. *What is considered an "emergency"?* Under NEMA, an emergency is "any event or the imminent threat thereof causing serious damage, injury, or loss of life or property resulting from any natural or manmade cause which, **in the determination of the Governor or the principal executive officer of a local government**, requires immediate action to accomplish the purposes of the Emergency Management Act and to effectively respond to the event or threat of the event." 81-829.39 (3). "A state of emergency proclamation **shall be issued** by the Governor if he or she finds that a disaster, emergency, or civil defense emergency has occurred or that the occurrence or threat thereof is imminent." 81-829.40 (3).

D. *Are emergency management workers liable?* Under NEMA, "[a]ll functions provided for in the Emergency Management Act and all other activities relating to emergency management are hereby declared to be **governmental functions**. The United States, the state, any political subdivision thereof, any other agencies of the United States, the state, or a political subdivision thereof, and, **except in cases of willful misconduct, gross negligence, or bad faith**, any emergency management worker **complying with or reasonably attempting to comply** with the provisions of the act, any emergency management act of Congress, or any order, rule, or regulation promulgated pursuant to the act or any emergency management act of Congress or acting pursuant to any ordinance relating to black-out or other precautionary measures enacted by any political subdivision of the state **shall not be liable for the death or injury to persons or for damage to property as a result of such activity**." 81-829.55 (1).

E. *What license requirements are there?* Under NEMA, "[a]ny requirement for a license to practice any professional, mechanical, or other skill **shall not apply** to any authorized emergency management worker who in the course of performing duties as such practices such professional, mechanical, or other skill during a civil defense emergency or declared state of emergency." 81-829.55 (2).

II. Emergency care at scene of emergency ("Good Samaritan Act"): 25-21,186.

A. *The law:* "No person who **renders emergency care** at the scene of an accident or other emergency **gratuitously**, shall be held liable for any civil damages as a result of any act or omission by such person in rendering the emergency care or as a result of any act or failure to act to provide or arrange for medical treatment or care for the injured person."

III. Volunteer Protection Act of 1997: 42 USC 14501-14505.

A. *Why did Congress pass this law?* "The purpose of this Act is to promote the interests of social service program beneficiaries and taxpayers and to sustain the availability of programs, nonprofit organizations, and governmental entities

that depend on volunteer contributions by reforming the laws to provide certain protections from liability abuses related to volunteers serving nonprofit organizations and governmental entities." 42 USC 14501 (b).

B. *Who is liable?* "**[N]o volunteer of a nonprofit organization or governmental entity shall be liable** for harm caused by an act or omission of the volunteer on behalf of the organization or entity if—(1) the volunteer was acting **within the scope** of the volunteer's responsibilities in the nonprofit organization or governmental entity at the time of the act or omission; (2) if appropriate or required, the volunteer was properly licensed, certified, or authorized by the appropriate authorities for the activities or practice in the State in which the harm occurred, where the activities were or practice was undertaken within the scope of the volunteer's responsibilities in the nonprofit organization or governmental entity; (3) the harm was **not caused by willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious, flagrant indifference** to the rights or safety of the individual harmed by the volunteer; and (4) the harm was **not caused** by the volunteer operating a motor vehicle, vessel, aircraft, or other vehicle for which the State requires the operator or the owner of the vehicle, craft, or vessel to -- (A) possess an operator's license; or (B) maintain insurance." 42 USC 14503 (a).

C. *Can the nonprofit organization or governmental entity be liable?* "Nothing in this section shall be construed to affect the liability of any nonprofit organization or governmental entity with respect to harm caused to any person." 42 USC 14503 (c).

D. *When would the volunteer be liable?* The volunteer may be liable for "harm **caused by willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious, flagrant indifference** to the rights or safety of the individual harmed by the volunteer" 42 USC 14503 (a). "The limitations on the liability of a volunteer under this Act shall not apply to any misconduct that—(A) constitutes a crime of violence . . . or act of international terrorism . . . for which the defendant has been convicted in any court; (B) constitutes a hate crime . . . ; (C) involves a sexual offense, as defined by applicable State law, for which the defendant has been convicted in any court; (D) involve misconduct for which the defendant has been found to have violated a Federal or State civil rights law; or (E) where the defendant was under the influence . . . of intoxicating alcohol or any drug at the time of the misconduct." 42 USC 14503 (f).

Source: Laws 1961, c. 110, § 1, p. 349; Laws 1971, LB 458, § 1, R.S.1943, (1979), § 25-1152.

Appendix F-3: Nebraska "Good Samaritan Law"

25-21,186

Emergency care at scene of emergency; persons relieved of civil liability, when:

No person who renders emergency care at the scene of an accident or other emergency gratuitously, shall be held liable for any civil damages as a result of any act or omission by such person in rendering the emergency care or as a result of any act or failure to act to provide or arrange for medical treatment or care for the injured person.

Source: Laws 1961, c. 110, § 1, p. 349; Laws 1971, LB 458, § 1, R.S.1943, (1979), § 25-1152.

Appendix F-4: State Employee American Red Cross Leave

81-1391

Certified disaster service volunteer of American Red Cross; leave authorized.

Any state employee who is a certified disaster service volunteer of the American Red Cross may, with the authorization of his or her supervisor, be granted a leave not to exceed fifteen working days in each year to participate in specialized disaster relief services in Nebraska for the American Red Cross, upon the request of the American Red Cross, without loss of pay, vacation time, sick leave, or earned overtime accumulation.

For purposes of this section, state employee means any employee of the state or of any state agency, specifically including all administrative, professional, academic, and other personnel of the University of Nebraska, the state colleges, and the State Department of Education, but excluding any employee or officer of the state whose salary is set by the Constitution of Nebraska or by statute. An employee of any local government or entity, including any entity created pursuant to the Interlocal Cooperation Act or the Joint Public Agency Act, shall not be considered a state employee for purposes of this section.

Laws 1993, LB 697, § 7; Laws 1997, LB 314, § 23; Laws 1999, LB 87, § 97. Effective date August 28, 1999.

Appendix F-5: Nebraska Critical Incident Stress Management Statute

71-7101 Act, how cited.

Sections 71-7101 to 71-7113 shall be known and may be cited as the Critical Incident Stress Management Act.

Source: Laws 1991, LB 703, § 1; Laws 1993, LB 536, § 107; Laws 1997, LB 184, § 1.

71-7102 Terms, defined.

For purposes of the Critical Incident Stress Management Act:

1) Committee means the Interagency Management Committee;

2) Council means the Critical Incident Stress Management Council;

3) Critical incident means a traumatic or crisis situation;

4) Critical incident stress means a strong emotional, cognitive, or physical reaction which has the potential to interfere with normal functioning, including physical and emotional illness, loss of interest in the job, personality changes, marital discord, and loss of ability to function;

5) Emergency service agency means any law enforcement agency, fire department, emergency medical service, dispatcher, rescue service, hospital as defined in section 71-419, or other entity which provides emergency response services;

6) Emergency service personnel includes law enforcement personnel, firefighters, emergency medical services personnel, and hospital personnel; and

7) Program means the Critical Incident Stress Management Program.

Source: Laws 1991, LB 703, § 2; Laws 1997, LB 138, § 53; Laws 1997, LB 184, § 2; Laws 2000, LB 819, § 142.

71-7103 Legislative findings.

The Legislature finds that emergency service personnel are potentially placed in a high-risk situation every time they are called upon to respond to an emergency since the extent of the emergency cannot be anticipated and the eventual outcome cannot be predicted. Since the services of emergency service personnel affect the public health, safety, and welfare, the Legislature declares that a critical incident stress management program designed to reduce critical incident stress experienced by such personnel would be in the public interest and would assist such personnel with the demands which occur in their work.

Source: Laws 1991, LB 703, § 3; Laws 1997, LB 184, § 3.

71-7104 Critical Incident Stress Management Program; created; duties.

There is hereby created the Critical Incident Stress Management Program. The focus of the program shall be to minimize the harmful effects of critical incident stress for emergency service personnel, with a high priority on confidentiality and respect for the individuals involved. **The program shall:**

1) Provide a stress management session to emergency service personnel who appropriately request such assistance in an effort to address critical incident stress;

2) Assist in providing the emotional and educational support necessary to ensure optimal functioning of emergency service personnel;

3) Conduct preincident educational programs to acquaint emergency service personnel with stress management techniques;

4) Promote interagency cooperation; and

5) Provide an organized statewide response to the emotional needs of emergency service personnel impacted by critical incidents.

Source: Laws 1991, LB 703, § 4; Laws 1997, LB 184, § 4.

71-7105 Critical Incident Stress Management Council; created; members; duties.

There is hereby created the Critical Incident Stress Management Council. The council shall be composed of the Director of Regulation and Licensure, the Director of Health and Human Services, the State Fire Marshal, the Superintendent of Law Enforcement and Public Safety, and the Adjutant General as director of the Nebraska Emergency Management Agency. The council shall specify the organizational and operational goals for the program and shall provide overall policy direction for the program.

Source: Laws 1991, LB 703, § 5; Laws 1996, LB 1044, § 773; Laws 1997, LB 184, § 5.

71-7106 Interagency Management Committee; created; members; duties.

There is hereby created the Interagency Management Committee. Each member of the council shall designate a representative of his or her agency to be a member of the committee. The committee shall be responsible for:

1) Planning and budget development;

2) Program development and evaluation;

3) Coordination of program activities and emergency response;

4) Providing a mechanism for quality assurance which may include certification of critical incident stress management team members;

5) Identifying critical incident stress management regions;

6) Developing regulations and standards;

7) Arranging for and supporting training of critical incident stress management teams; and

8) Providing backup to regional critical incident stress management teams.

   Source: Laws 1991, LB 703, § 6; Laws 1997, LB 184, § 6.

71-7107 Department of Health and Human Services Regulation and Licensure; duties.

The Department of Health and Human Services Regulation and Licensure shall be the lead agency for the program. The department shall:

1) Provide office support to program activities;

2) Provide necessary equipment for the program and participants;

3) Provide staff support to the council;

4) Adopt and promulgate rules and regulations to implement the program;

5) Recruit hospital personnel and emergency medical workers to be trained as critical incident stress management peers;

6) Participate in the training and continuing education of such peers and mental health professionals; and

7) Appoint a director for the program who shall be an employee of the department and shall be the chairperson of the committee.

   Source: Laws 1991, LB 703, § 7; Laws 1996, LB 1044, § 774; Laws 1997, LB 184, § 7.

71-7108 Department of Health and Human Services; Nebraska State Patrol; State Fire Marshal; Nebraska Emergency Management Agency; duties.

1) The Department of Health and Human Services shall participate in the council and committee, recruit mental health workers for each critical incident stress management region, and participate in the training and continuing education activities of critical incident stress management peers and mental health professionals.

2) The Nebraska State Patrol shall participate in the council and committee, receive all initial requests for stress management sessions, coordinate transportation requirements for critical incident stress management team members, recruit members of the law enforcement profession in each region to be trained as critical incident stress management peers, participate in the training and continuing education activities of critical incident stress management peers and mental health professionals, and appoint a member of the patrol to each regional management committee.

3) The State Fire Marshal shall participate in the council and committee, cooperate in providing transportation for critical incident stress management teams, recruit firefighters to be trained as critical incident stress management peers in each critical incident stress management region, participate in the training and continuing education activities of critical incident stress management peers and mental health professionals, and appoint an individual who is employed by the State Fire Marshal to be on each regional management committee.

4) The Nebraska Emergency Management Agency shall participate in the council and committee, promote stress management planning as part of emergency management preparedness, promote pre-incident education programs to acquaint emergency service personnel with stress management techniques, and participate in the training and continuing education activities of critical incident stress management peers and mental health professionals.

Source: Laws 1991, LB 703, § 8; Laws 1996, LB 1044, § 775; Laws 1997, LB 184, § 8.

71-7109 Statewide clinical director; appointment; duties.

The council shall appoint a statewide clinical director. The statewide clinical director shall be a member of the committee and, working with the committee, shall supervise and evaluate the professional and peer support team members, including the regional clinical directors. The statewide clinical director may conduct critical incident stress management training and continuing education activities.

Source: Laws 1991, LB 703, § 9; Laws 1997, LB 184, § 9.

71-7110 Critical incident stress management region; regional management committee; membership; regional clinical director; duties.

Each critical incident stress management region shall have a regional management committee composed of representatives of the Department of Health and Human Services Regulation and Licensure, the State Fire Marshal, and the Nebraska State Patrol and a regional clinical director. The regional clinical director shall have a graduate degree in a mental health discipline. The regional management committee shall be responsible for the implementation and coordination of the program in the region according to the specifications developed by the council and Interagency Management Committee.

The regional management committee shall develop critical incident stress management teams to facilitate the stress management process.

Source: Laws 1991, LB 703, § 10; Laws 1996, LB 1044, § 776; Laws 1997, LB 184, § 10.

71-7111 Statewide critical incident stress management team; members; immunity.

No individual who provides gratuitous assistance to emergency service personnel as a member of the statewide critical incident stress management team in accordance with the Critical Incident Stress Management Act and the rules and regulations shall be held liable for any civil damages as a result of any act of commission or omission arising out of and in the course of rendering such assistance in good faith or any act or failure to act to provide or arrange for mental health treatment or care for emergency service personnel.

Source: Laws 1991, LB 703, § 11; Laws 1997, LB 184, § 11.

71-7112 Confidentiality of information.

Any information acquired during a stress management session shall be confidential and shall not be disclosed except to the extent necessary to provide assistance pursuant to the stress management session. Information otherwise available from the original source shall not be immune from discovery or use in any civil or criminal action merely because the information was presented during a stress management session if the testimony sought is otherwise permissible and discoverable.

Source: Laws 1993, LB 536, § 108; Laws 1997, LB 184, § 12.

71-7113 State correctional employees; services provided.

All services available and provided to emergency service personnel under the Critical Incident Stress Management Act shall also be available and provided to state correctional employees for incidents which occur in the course of their duties or at their worksite.

Source: Laws 1997, LB 184, § 13.

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