Nebraska Behavioral Health All-Hazards Disaster Response & Recovery Plan

Five-year Update
2022-2026

NEBRASKA

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DEPT. OF HEALTH AND HUMAN SERVICES

DIVISION OF BEHAVIORAL HEALTH

PREPARED BY

University of Nebraska
PUBLIC POLICY CENTER

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Plan Adopted: _____

Date

_____ _____

Chief Medical Officer, State of Nebraska Date

_____ _____

CEO, NE Department of Health & Human Services Date

_____ _____

Director, NE DHHS Division of Behavioral Health Date

Record of Changes

Change Number	Date of Change	Date Entered	Change Approved By: (Signature)

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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 based
- 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 (BHERT), 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 as state coordinator of behavioral health care related to disasters. 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 member organizations 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.

[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. **During a disaster, people often rely on natural support systems that may include family members, neighbors, friends, and existing community supports such as faith communities.**

7. **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.

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

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.**

11. **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, and 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 76,824 square miles, averaging 23.8 persons 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 2021 population estimate for Nebraska is 1,963,692 persons.[5] Nebraska has a large agricultural sector with 44,800,000 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.
- 11.8% 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 has 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[7]

- Children under age 18 account for 24.6% of Nebraskans.
- Adults age 65 or older make up 16.2% of the population.
- 9.2% of Nebraskans have incomes below the poverty level.
- 7.7% of Nebraskans under age 65 have a disability[8] (e.g., developmental, physical, psychiatric disabilities).
- People with a history of substance misuse.
    - Substance use may increase after a disaster for those with pre-existing substance use/abuse issues.[9]
    - 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 faiths and 20% as unaffiliated.[10]
- New Nebraskans, often refugees, may have come from areas of the world where they experienced disaster, war, or famine.

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[5] U.S. Census Bureau: State and County QuickFacts. Last Revised: July 1, 2021

[6] USDA, National Agricultural Statistics Service. Data as of June 2, 2022

[7] U.S. Census Bureau: State and County QuickFacts. Last Revised: July 1, 2021

[8] U. S. Census Bureau: State and County QuickFacts. Last Revised: July 1, 2021

[9] 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.

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

- 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 has 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 snowstorms.
- **Earthquake risk** is difficult to estimate in Nebraska. The Humboldt 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.[11]

Public Health Threats

- Pandemics and other disease events (such as COVID-19, influenza, Ebola or similar highly contagious diseases) are possible in Nebraska. Population-based behavioral health consequences vary depending on the level of exposure and degree of impact for the disease.

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. Threats 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. The risk of a 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** or disruptions may occur anywhere in the state (railroad, busing, trucking, air travel).

Human-Caused Hazards

- Human-caused incidents may include terrorist events or disasters linked to illegal activity (such as a shooting, armed assault, biological or chemical attack, cyber-attack against data or infrastructure) 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.

[11] USGS Earthquake Hazards Program. Retrieved March 15, 2017, from: https://www.usgs.gov/programs/earthquake-hazards/science/information-region-nebraska

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.[12] 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. Some emergency management agencies serve multiple counties.

Local public health departments are located across the state. Some are organized by county and others by multi-county districts. Public health departments coordinate with the behavioral health regions 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.[13] 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.[14] 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. Regional Behavioral Health Authorities, public health districts, 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 well-positioned 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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[12] Nebraska Emergency Management Act, §§ 81-829.46 to 81-829.50

[13] 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

[14] 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.[15]

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, other Nebraska State agencies, and 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 NE DHHS Division of Behavioral Health disaster operational plan.

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

[15] FEMA Crisis Counseling Grant Application information is available through the SAMHSA Disaster Technical Assistance Center (DTAC).

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 aligns 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-related planning and response** 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

Overview of Actions Before, During, and 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.[16] This approach details a strategy to define how behavioral health, public health, emergency management, hospitals, and other responders prepare, coordinate, and respond to an event.

- Record key response contacts for behavioral health and partners.

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.[17]
- Forward contact information for Regional 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, explicitly targeting behavioral health community responder volunteers who may augment the behavioral health response to disaster.
- Maintain a list of local volunteer behavioral health responders. Depending on local plans, this may be maintained by the Regional Behavioral Health Authority or by a partner agency (such as Medical Reserve Corps or public health).
- 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. [18,19]
- The Division of Behavioral Health creates, fosters, and/or makes available information about training opportunities related to disaster response and recovery's psychological and social aspects.
- State Public Information Officers and the Division of Behavioral Health identify

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

[17] 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.

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

[19] 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.

a pool of licensed 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 state affiliated Behavioral Health Emergency Response Team (BHERT) members to provide or augment local capacity for conducting disaster behavioral health related needs assessment, consultation, service provision, and training.

State Disaster Behavioral Health Coordinators 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 member organizations that provide statewide disaster assistance related to meeting the psychological, spiritual, and or social needs of those impacted 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.

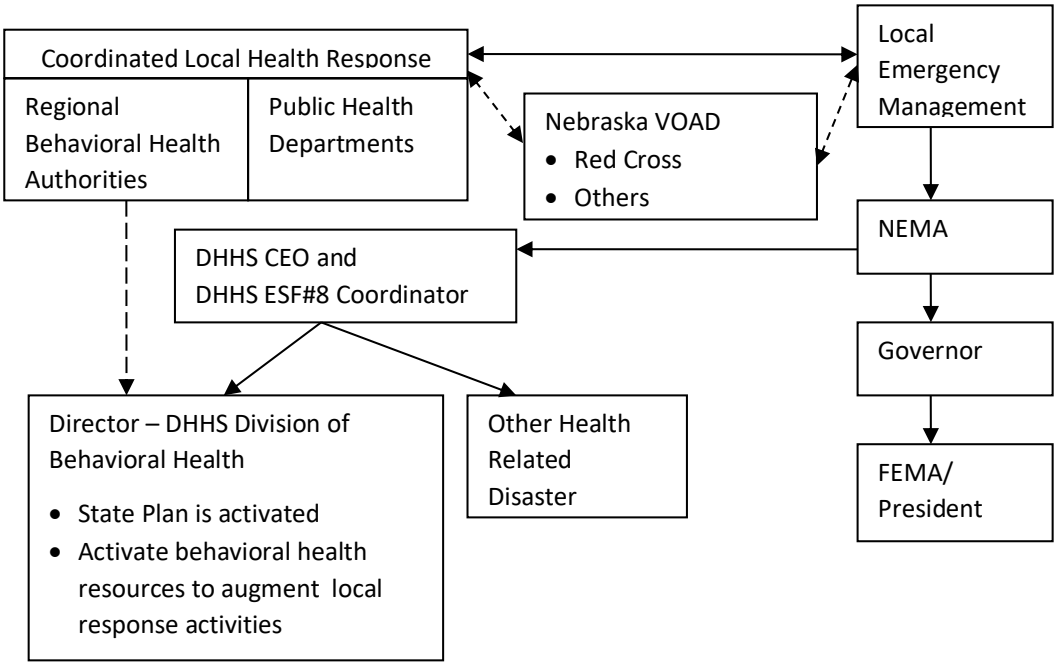


Figure 1. Overview of response coordination among agencies.

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 and individuals, volunteers and 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 or have virtual access 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*)
- Areas conducive to community education and outreach (community centers, shopping malls, schools, religious centers, business associations)
- Organizations who request behavioral health response services (businesses, schools, 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, regular 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
- 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 depend 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 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.[20]
2. The Division of Behavioral Health monitors the 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 assembling the FEMA CCP application with the assistance of the Regional Behavioral Health Authority(s) accountable for serving the affected locations. The initial application is submitted by the Nebraska Emergency Management Agency.
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 administering a FEMA CCP.

[20] 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.

7. Administrative review of a completed response should include the following:

- 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 what were 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 to maintain 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.[21] 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 for establishing 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.[22]

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.[23]

[21] Nebraska Emergency Management Act § 81-829.60

[22] NAC Title 206 Chapter 4

[23] 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 ongoing professional counseling or psychotherapy, but to provide education, prevention and crisis intervention.[24] 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 aid and assistance in a disaster or emergency.[25] This assistance 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 Nebraska.[26]

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.[27] 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.[28] 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 their supervisor. This leave is not to exceed fifteen working days in each calendar year. This leave includes "all administrative, professional, academic, and other personnel of the University of Nebraska, the state colleges, and the State Department of Education."[29] This statute 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, their guardian or conservator, a personal representative if deceased, or the clergy who received the

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

[25] Nebraska Emergency Management Act § 81-829.48

[26] Nebraska Emergency Management Act § 81-829.56

[27] Nebraska Emergency Management Act § 81-829.41

[28] Nebraska Emergency Management Act § 81-829.52

[29] Nebraska Law § 81-1391

communication may claim privilege and refuse to disclose or allow another to disclose this confidential communication.[30]

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."[31] 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 (i.e., 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 essential for behavioral health response volunteers to tell people they speak with that they are part of the behavioral health response. Informed consent gives individuals a chance to decline the interaction if desired.

[30] Nebraska Revised Statutes § 27-506

[31] 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 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 should have a working understanding of NIMS and ICS.

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 primary incident command functions**:

1. Command and Command Staff
   - Safety
   - Information
   - 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 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 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.
- Monitor stress levels of individuals staffing 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 for the behavioral health response.
- Gather information from Operations and field staff related to behavioral health.
- Advise Planning Section staff of any significant changes in incident status related to the behavioral health impact of events.

Operations

Operations 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 managing all incident-related behavioral health 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 are sufficient to support the proposed operations.
- Determine the general organizational structure of the behavioral health 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 & 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 rewrite process every five 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 as needed.

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)

As part of Nebraska DHHS, the Division of Behavioral Health coordinates with NEMA, the American Red Cross, and other ESF-6 partners to provide for the immediate and short term behavioral health 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 make behavioral health services available 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 to prevent or minimize stress, grief, and depression that can occur following 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 that 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. BHERT is also a resource for state-run facilities and emergency response operations, and it is expected that BHERT will be available as a resource of the Governor in the event behavioral health expertise is requested by another state.
- **Nebraska CISM Program**: This is a statewide program authorized under Nebraska Statute.[32] Critical Incident Stress Management (CISM) Teams are organized according to State Patrol Troop area. The system uses volunteer mental health professionals and peers trained to support 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

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

Nebraska Medical and Health Volunteer Registry. The online 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 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 for and respond to emergencies. MRC units in the state of Nebraska serve multi-county areas aligned with the state Healthcare Coalitions (HCCs). MRCs have minimum training requirements to ensure volunteers are prepared to respond to emergencies. 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 somewhat available in Nebraska. The State of Nebraska currently has a policy that allows state employees two weeks of paid time to respond to disasters in Nebraska as part of the Red Cross response.[33] The Red Cross uses only licensed mental health professionals to provide mental health services for survivors of a disaster and for Red Cross workers.[34] The Red Cross also provides formal Disaster Spiritual Care (DSC) training for volunteers. Faith practices formally occupy the role of providing spiritual care when operating within Red Cross structures.
- **NEVOAD:** Nebraska Voluntary Organizations Active in Disaster is involved in various 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 individuals in an affected population.
- **Community volunteers**

[33] Nebraska Emergency Management Act § 81-1391

[34] 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

- **School crisis / psychological first aid teams**
- **Private mental health and substance abuse practitioners**

Organization of a Behavioral Health Response to Disaster

Organization of the behavioral health workforce 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 such as CISM peers or community members trained to respond to disaster.[35]

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.[36] 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 workforce 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 charged with maintaining a listing or database of pre-identified disaster behavioral health responders that can potentially respond to a local, regional, or statewide disaster.[37]

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.

[35] 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.

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

[37] 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.

Credentialing

Licensed/certified behavioral health professionals must always bring their professional license(s) 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 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.

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

Supervision of Responders During Disaster Response

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 subordinates and communicate with and manage all resources under their supervision. In ICS, the span of control of any supervisor should range from three to seven 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, radio, or virtual format 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 are deployed in teams—never solo.
    - Take time to know the strengths and limitations of the responders assigned to you for supervision.
    - If possible, consider pairing community responders with licensed behavioral health, active CISM peer, or ARC Disaster Mental Health responder—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 before 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. In the interim, community responders assuming a lead role in behavioral health responses 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 about 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 Substance Abuse and Mental Health Services Administration (SAMHSA) maintains an inventory of disaster behavioral health interventions through the Disaster Technical Assistance Center that is regularly updated.

Substance Use/Abuse and Disaster

In general, disasters do not appear to trigger new substance use/abuse cases in survivors and first responder populations. However, it can endanger recovery for individuals with pre-existing substance use/abuse issues.[38]

Nebraska's Opioid Treatment Programs (OTP) are subject to federal regulations that make them unique.[39] Regions with these programs in their areas should communicate with them in advance to ensure viable continuity of operations plans are in place to

[38] See the FEMA Crisis Counseling Program Core Content Training Curriculum.

[39] Federal Regulation 42 CFR Part 8

provide backup 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 additional task requirements or unique 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 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.[40]

Presidential Declaration of Disaster

If a presidential disaster declaration includes Individual Assistance, a Federal Emergency Management Agency (FEMA) Crisis Counseling Assistance and Training Program (CCP) grant must be applied for within 14 days of the declaration.[41] 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 nine months of services.

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 ESF-8 Coordinator to establish behavioral health objectives for behavioral health personnel.
- Work with the Public Information Officer (PIO) to activate a behavioral health 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. Nebraska has several hotlines available for crisis counseling response and referral, including the Rural Response Hotline, Nebraska Family Helpline, and 988.

[40] Nebraska Emergency Management Act § 81-1391

[41] 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 federally recognized Indian Tribe may apply for a crisis counseling grant.

- 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 state response teams have access to qualified behavioral health services 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.

State Operated Facility is Involved in the Disaster

Nebraska Department of Health and Human Services oversees numerous facilities, including Veterans' Homes, psychiatric regional centers, youth rehabilitation and treatment centers, and a 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.
- When possible, involve local and regional resources in the behavioral health response to a disaster that involves a state-operated facility.
- 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 behavioral health needs of survivors of the incident and families of survivors and victims.[42, 43]
- 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 behavioral health 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 may require continuous staffing by behavioral health professionals.

Public Health Emergency

- Public health is the lead agency for declared public health emergencies. The behavioral health response should coordinate closely with public health agencies.
- Safety of behavioral health responders must be taken into account for all public health emergencies. This may include issuing personal protection equipment, virtual delivery of services, or other appropriate safety precautions. Behavioral health response activities may need to be altered depending on directed health measures in place.

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

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

[43] 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.

determine need for local or on site consultation between members of the Livestock Emergency Disease Response System (LEDRS) group and behavioral health.

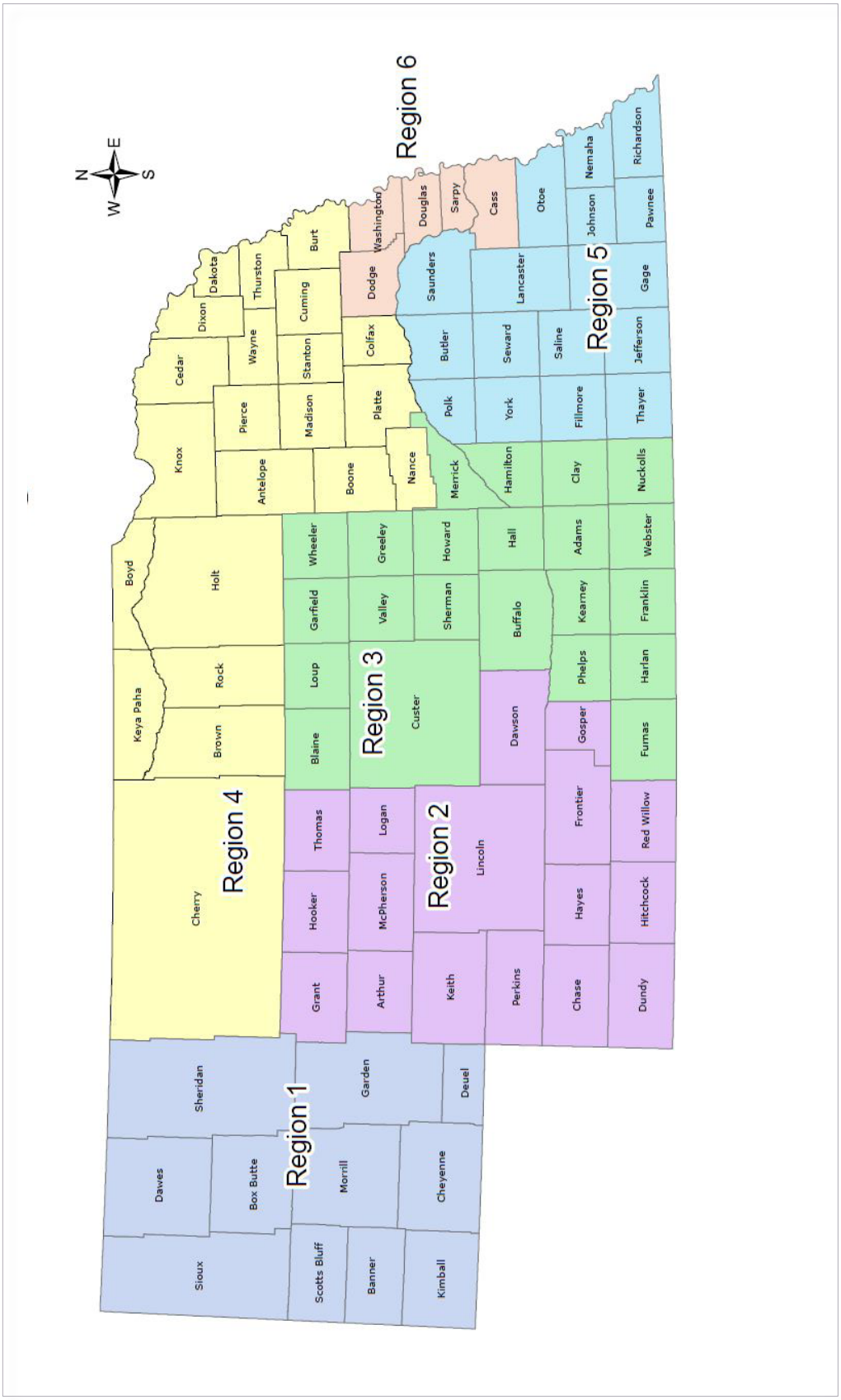
Research Requests

- 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).[44] All research following a disaster must be approved through the process designated by the University.

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

Appendices

Appendix A-1:
Nebraska Behavioral Health Regions



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

Region 1 Behavioral Health Authority
4110 Avenue D
Scottsbluff, NE 69361
Phone: (308) 635-3171
FAX: (308) 635-7026
region1bhs.net

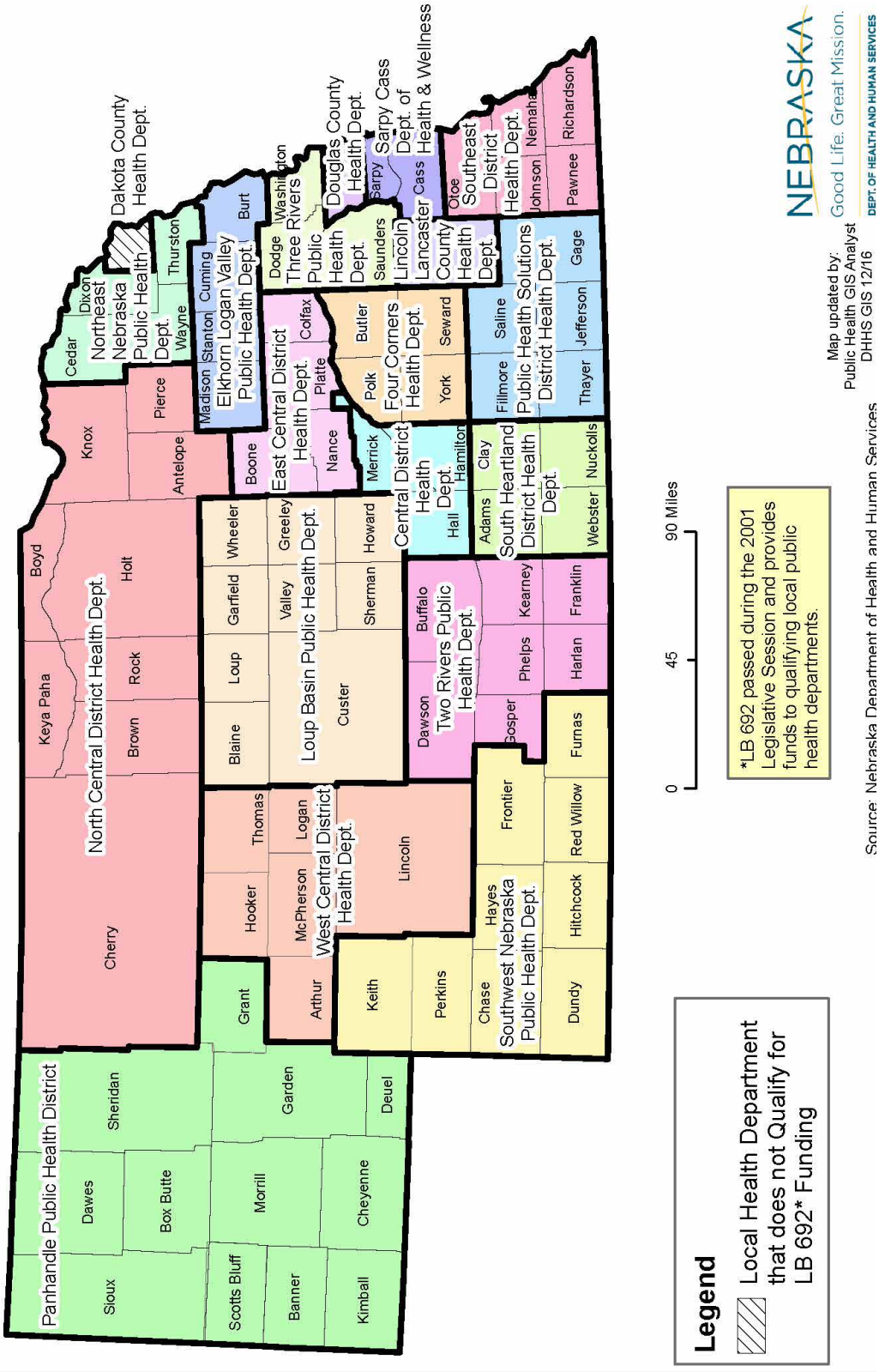
Region 2 Human Services
110 North Bailey Street
P.O. Box 1208
North Platte, NE 69103
Phone: (308) 534-0440
FAX: (308) 534-6961
www.r2hs.com

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

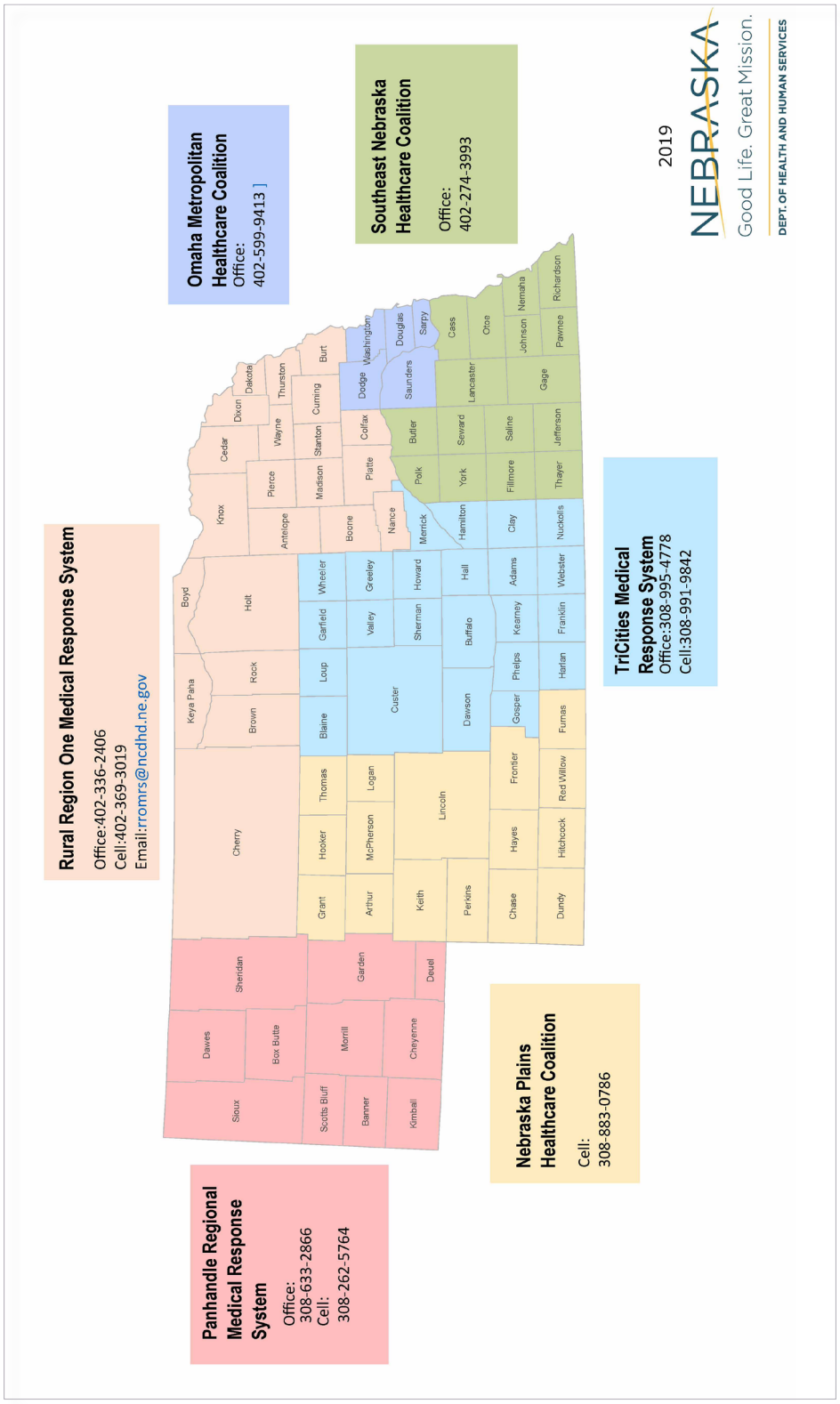
Region 4 Behavioral Health System
206 Monroe Avenue
Norfolk, NE 68701
Phone: (402) 370-3100 x 120
FAX: (402) 370-3125
www.region4bhs.org

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

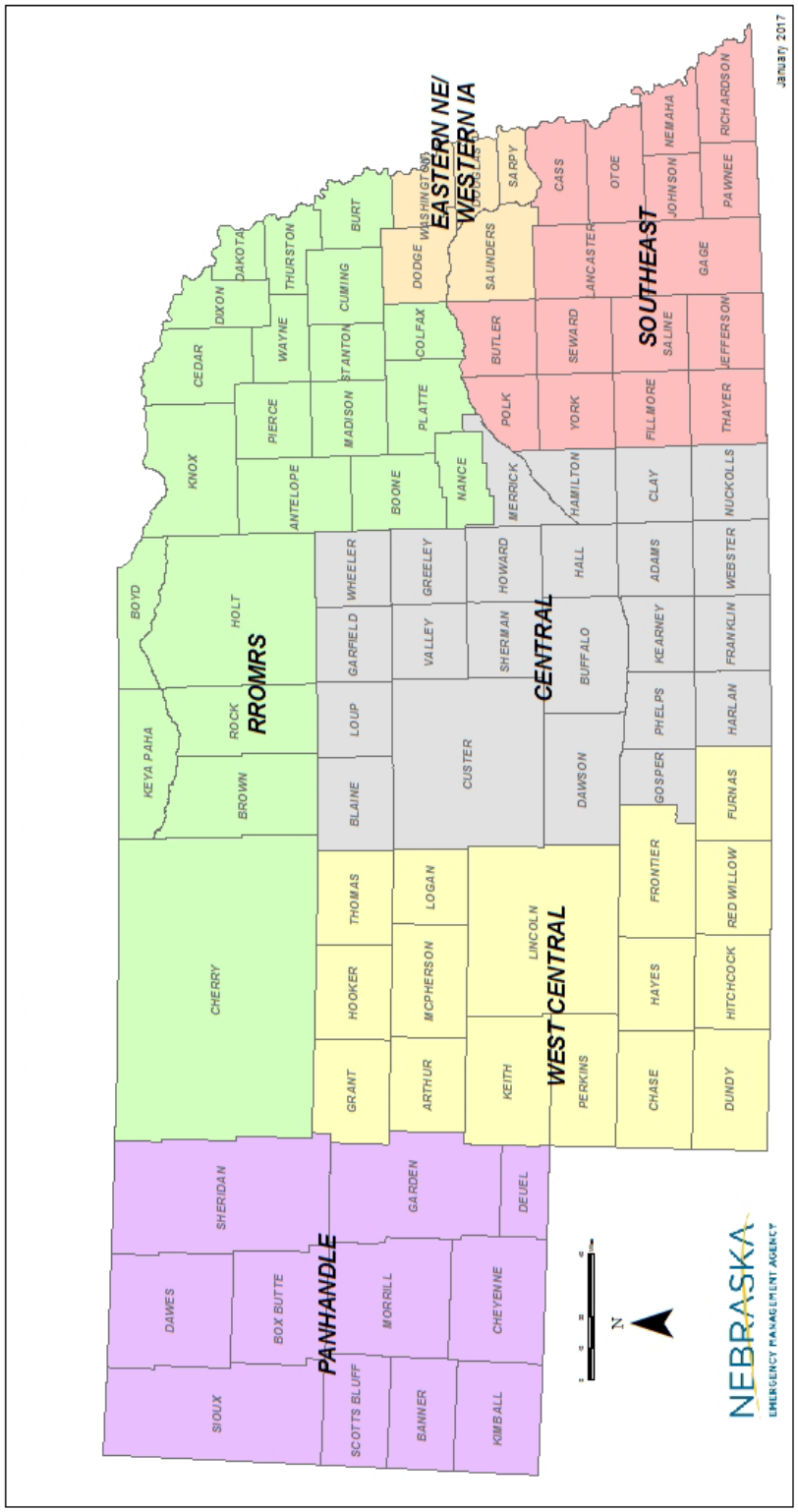
Region 6 Behavioral Healthcare
4715 South 132nd Street
Omaha, NE 68137
Phone: (402) 444-6573
FAX: (402) 444-7722
www.Regionsix.com


Appendix A-2:
Nebraska Local Health Departments Map
Panhandle Public Health District
Sioux
Dawes
Box Butte
Sheridan
Scotts Bluff
Morrill
Garden
Banner
Cheyenne
Deuel
Kimball
North Central District Health Dept.
Cherry
Keya Paha
Boyd
Brown
Rock
Holt
Knox
Antelope
Pierce
Cedar
Dixon
Northeast Nebraska Public Health Dept.
Dakota County Health Dept.
Thurston
Wayne
Madison
Stanton
Cuming
Elkhorn Logan Valley Public Health Dept.
Burt
Boone
East Central District Health Dept.
Colfax
Platte
Nance
Merrick
Dodge
Washington
Three Rivers Public Health Dept.
Douglas County Health Dept.
Sarpy
Saunders
Lincoln
Lancaster
Cass
Sarpy Cass Dept. of Health & Wellness
Polk
Butler
Four Corners Health Dept.
York
Seward
Central District Health Dept.
Hall
Hamilton
Otoe
Southeast District Health Dept.
Johnson
Nemaha
Richardson
Pawnee
Fillmore
Saline
Adams
Clay
South Heartland District Health Dept.
Public Health Solutions District Health Dept.
Thayer
Jefferson
Gage
Webster
Nuckolls
Wheeler
Greeley
Garfield
Valley
Loup
Blaine
Loup Basin Public Health Dept.
Custer
Howard
Sherman
Buffalo
Dawson
Two Rivers Public Health Dept.
Kearney
Phelps
Franklin
Harlan
Furnas
Red Willow
Hitchcock
Dundy
Chase
Hayes
Frontier
Gosper
Southwest Nebraska Public Health Dept.
West Central District Health Dept.
Thomas
Logan
Hooker
McPherson
Arthur
Grant
Keith
Perkins
Lincoln
0
45
90 Miles
Legend
Local Health Department that does not Qualify for LB 692* Funding
*LB 692 passed during the 2001 Legislative Session and provides funds to qualifying local public health departments.
Source: Nebraska Department of Health and Human Services
Map updated by:
Public Health GIS Analyst
DHHS GIS 12/16
NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Appendix A-3:
Map of Healthcare Coalitions in Nebraska



Appendix A-4:
Nebraska Medical Reserve Corps Regions



Appendix A-5: Requesting Critical Incident Stress Management (CISM) Services

How to Request CISM Services

How to Request an Intervention

1. Following the incident, contact the State Patrol Troop requesting the need for a Critical Incident Stress Management session. Call 402-479-4921.
2. NSP dispatcher finds out the name of the community involved, nature of the incident, and the name and telephone number of the contact person.
3. Information regarding the incident is distributed to designated team members who do the call-outs.
4. The designated team member will call the point of contact to confirm the need for a CISM intervention and request further information, (i.e., date, time, location, and number of participants).
5. The designated team member will determine what type of intervention is needed (e.g., one-on-one, defusing, debriefing, community management briefing, rest information transition services (RITS), or public education).
6. A CISM session is conducted at the designated location and time.

Appendix A-6: 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.
  - **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.
    - **American Red Cross (ARC) and Critical Incident Stress Management (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. 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 including any available damage assessment information from Emergency Management.
    - Note any high-risk groups or vulnerable 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: https://www.samhsa.gov/dtac/ccp-toolkit
    - 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 cleanup 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-5 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 hotline sites.
  - The State Coordinator should consider activating and publicizing an existing 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 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 Department of Health and Human Services **within 14 days of a Presidential Declaration of Disaster eligible for individual assistance**.
        - Arrange access to specialized resources.
- Build on local response capabilities, requests, and organization.
    - Access closest and most appropriate resources.
    - 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.** 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/field-manual-mental-health-and-human-service-workers-major-disasters/adm90-0537

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 Disaster Behavioral Health 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 Behavioral Health Emergency Response Team (BHERT)
  - ☐ No
- Is the **State** Department of Health and Human Services (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.** *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 burnout 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
- ☐ **Contact the State Disaster BH Coordinator to relay information about conditions and needs**
- ☐ **Consider the need for Rural Response Hotline involvement**
  - ☐ Link with Critical Incident Stress Management (CISM) to relay possible support needs of emergency workers

Remember...
Disaster Behavioral Health Responders do not have to be the first on the 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
- ☐ Ethnic/cultural populations
- ☐ Immigrants including refugees, asylees
- ☐ Homeless

- ☐ Visually impaired, blind
- ☐ Deaf/hard of hearing
- ☐ Religious communities
- ☐ Frail/elderly
- ☐ Physically disabled
- ☐ Severe mental illness
- ☐ People in correctional institutions
- ☐ People with high trauma exposure
- ☐ Women/girls in the area
- ☐ Rural vs urban
- ☐ Other? List and estimate number

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

Public Health Emergencies

Directed Health Measures

- ☐ Consult with public health about the impact on the area's population
- ☐ Identify safe outreach methods

Quarantine

- ☐ Activate hotlines
- ☐ Consider phone or virtual 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 Tracking Form

(Use to fill out current state or Federal Expense Reimbursement Form – Request Form from State Disaster Behavioral Health Coordinator)

AGENCY: _____

Date Submitted: _____

Contact Person (Name & Phone Number): _____

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

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

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

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

Appendix B-4: Daily Unit Activity Log Form

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-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."

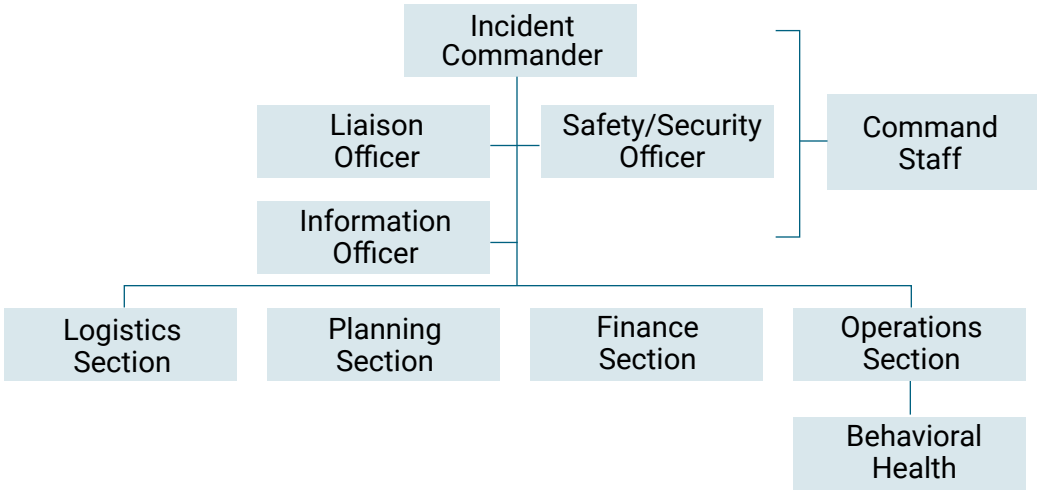
Management by objectives:

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.

The Incident Command System[1]



[1] Adapted from: Northwest Oklahoma Amateur Radio Emergency Services (n.d.). The Incident Command System. Retrieved April 13, 2022 from http://www.qsl.net/nwokares/ICS_1.htm

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

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

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: 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)

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[1] South Carolina Mass Casualty Plan Annex 4: Mass Fatality Management Plan. Retrieved 4/13/2022 from: https://www.scemd.org/em-professionals/plans/sc-mass-casualty-plan

[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

- 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.

Appendix C-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 C-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 C-3: 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, and quickly identify 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 C-4: 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 M.A. 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.

[1] Available at: https://dhhs.ne.gov/licensure/pages/mental-health-and-social-work-practice.aspx

Appendix C-5: 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 post-disaster intervention such as psychological first aid. These individuals may include:

- Community volunteers
- Disaster responders
- Faith Leaders
- Medical professionals, including primary care practitioners, pediatricians, and family practice doctors
- Behavioral health community responders
- 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.

[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 2.Introduction to Disaster Mental Health (ARC) -Scope of practice possible in disaster AND/OR 2. Psychological First Aid Training (Nebraska model) -Disaster behavioral health response skill development	Same training as for Emergency Phase Some kind of optional training would be nice	Advanced Disaster Behavioral Health training through ARC Supervision experience in their field Some disaster experience Some degree of maturity	
Physician Extenders (APRN, PA)				
Psychiatrists (including Residents)				CBT for Post-Disaster Distress
Certified Psychiatric RN				
Licensed Psychologists				
Licensed Mental Health Professionals (Counselors, Social Workers)				
Certified Mental Health-Related Professionals (School Psychologists and Counselors)				
Provisionally licensed psychologists (includes psychology graduate students)			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 C-6: 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.

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

Appendix D-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: https://dhhs.ne.gov/pages/dhhs-regulations.aspx

Regional Governing Boards

Unlike the requirements for services and facilities (see below), the Regional Governing Boards must 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.

[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]

Nebraska Mental Health Commitment Act

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 : https://dhhs.ne.gov/Pages/Mental-Health-Commitment.aspx

[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.

[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 the 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.

[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 D-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 emergencies. 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 acts 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 explicitly 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 providing 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 D-3: Nebraska “Good Samaritan Law”

25-21,186 (1961)

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 D-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.

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

Notes

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