SITUATION MANUAL

(SITMAN)

DISASTER BEHAVIORAL HEALTH TRIAGE AND NEEDS ASSESSMENT

BEHAVIORAL HEALTH WORKSHOP/EXERCISE

JULY 14, 2011

OMAHA, NEBRASKA

PREFACE

This workshop on Disaster Behavioral Health Triage and Needs Assessment is sponsored by the University of Nebraska-Lincoln Public Policy Center. This Situation Manual (SitMan) was produced with input, advice, and assistance from the Exercise Design Team (EDT), which followed the guidance set forth in the Federal Emergency Management Agency (FEMA), Homeland Security Exercise and Evaluation Program (HSEEP).

The workshop Situation Manual (SitMan) provides exercise participants with all the necessary tools for their roles in the exercise. This SitMan was developed with the advice and assistance of the members of the EDT. It is tangible evidence of the state of Nebraska's commitment to ensure public safety through collaborative partnerships that will prepare it to respond to any emergency.

The Workshop is an unclassified exercise. The control of information is based more on public sensitivity regarding the nature of the exercise than on the actual exercise content. Some exercise material is intended for the exclusive use of exercise planners, facilitators, and evaluators, but players may view other materials deemed necessary to their performance. The SitMan may be viewed by all exercise participants.

All exercise participants should use appropriate guidelines to ensure the proper control of information within their areas of expertise and to protect this material in accordance with current jurisdictional directives. Public release of exercise materials to third parties is at the discretion of University of Nebraska-Lincoln Public Policy Center and the EDT.

HANDLING INSTRUCTIONS

1. The title of this document is Nebraska Disaster Behavioral Health Situation Manual
2. The information gathered in this SitMan is *For Official Use Only (FOUO)* and should be handled as sensitive information not to be disclosed. This document should be safeguarded, handled, transmitted, and stored in accordance with appropriate security directives. Reproduction of this document, in whole or in part, without prior approval from the University of Nebraska Public Policy Center is prohibited.
3. At a minimum, the attached materials will be disseminated only on a need-to-know basis and when unattended, will be stored in a locked container or area offering sufficient protection against theft, compromise, inadvertent access, and unauthorized disclosure.
4. For more information, please consult the following points of contact (POCs):

Aaron Alward
Exercise Training Officer - NEMA
1300 Military Road
Lincoln, NE 68508
Phone: 402-471-7175 (office)
Email: aaron.alward@nebraska.gov

Denise Bulling, Ph.D
U of NE Public Policy Center
215 Centennial Mall South, Suite 401
Lincoln, NE 68588-0228
Phone: 402-472-5678
Email: dbulling@nebraska.edu

INTRODUCTION

Purpose

This workshop was developed as an exercise in conjunction with the 2011 Nebraska Disaster Behavioral Health Conference. The workshop was designed to provide behavioral health personnel with a review of basic psychological first aid skills then provide a forum to apply them to survivor simulators. This is followed by an exercise to aggregate the information to form a behavioral health needs assessment for the impacted community.

Scope

This workshop will involve members of the Nebraska Behavioral Health Emergency Response Team and representatives from Regional Behavioral Health Authorities including their disaster coordinators, local behavioral health and related partners. Participants will review psychological first aid principles, apply them and aggregate their observations.

Target Capabilities

The National Planning Scenarios and the establishment of the National Preparedness Priorities have steered the focus of homeland security toward a capabilities-based planning approach. Capabilities-based planning focuses on planning under uncertainty, since the next danger or disaster can never be forecast with complete accuracy. Therefore, capabilities-based planning takes an all-hazards approach to planning and preparation which builds capabilities that can be applied to a wide variety of incidents. States and Urban Areas use capabilities-based planning to identify a baseline assessment of their homeland security efforts by comparing their current capabilities against the Target Capabilities List (TCL) and the critical tasks of the Universal Task List (UTL). This approach identifies gaps in current capabilities and focuses efforts on identifying and developing priority capabilities and tasks for the jurisdiction. These priority capabilities are articulated in the jurisdiction's homeland security strategy and Multi-Year Training and Exercise Plan.

The capability of "Medical Surge" has been selected by the exercise design team. This capability provides the foundation for development of the exercise objectives and scenario, as the purpose of this exercise is to measure and validate performance of these capabilities and their associated critical tasks.

Exercise Objectives

Exercise design objectives are focused on improving understanding of a response concept, identifying opportunities or problems, and/or achieving a change in attitude. The exercise will focus on the following overarching design objectives selected by the exercise design team:

Objective 1: Assess short-term behavioral health needs related to disaster impact
Objective 2: Carry out behavioral health field work
Objective 3: Prioritize behavioral health triage & community needs

Participants

- *Players* respond to the situation presented based on expert knowledge of response procedures, current plans and procedures, and insights derived from training.
    - Local behavioral health personnel
    - State behavioral health personnel
- *Facilitators* provide situation updates and moderate discussions. They also provide additional information or resolve questions as required. Planning committee members may also assist with facilitation as subject matter experts (SMEs) during the workshop.
- *Evaluators* provided feedback to the EDT about the role plays and needs assessment recommendations.

Exercise Structure

This will be a multimedia, facilitated workshop. Players will participate in the following three distinct modules:

- Module 1: Workshop Presentation
- Module 2: Practice (Role Plays)
- Module 3: Needs Assessment

Exercise Guidelines

- This is an open, low-stress, no-fault environment. Varying viewpoints, even disagreements, are expected.
- Respond based on your knowledge of psychological first aid and insights derived from training.
- Decisions are not precedent setting and may not reflect your organization's final position on a given issue. This is an opportunity to discuss and present multiple options and possible solutions.
- Issue identification is not as valuable as suggestions and recommended actions that could improve response and preparedness efforts. Problem-solving efforts should be the focus.

Assumptions and Artificialities

In any exercise a number of assumptions and artificialities may be necessary to complete play in the time allotted. During this exercise, the following apply:

- The scenario is plausible, and events occur as they are presented.
- There is no "hidden agenda", nor any trick questions.
- All players receive information at the same time.

Nebraska State & Regional Disaster Behavioral Health Emergency Response Teams Workshop

July 14, 2011
Robert H. Snarr, MPA, LPC, NCC

Acknowledgements

- FEMA Crisis Counseling Program
- SAMHSA /NCTSN / NCPTSD Psychological First Aid and Skills for Psychological Recovery
- Utah Disaster Psychological First Aid
- Nebraska Disaster Psychological First Aid
- Denise Bulling, LPC, PhD – SAMHSA DTAC National Cadre of Consultants
- Office of the Assistant Secretary for Preparedness and Response (ASPR)

DISASTER TRIAGE & INTERVENTIONS

Roles of the Disaster Emergency Response Teams
Survivor Reactions
Interventions (PFA)
Survivor Triage

Disaster

- NATURAL (tornado, flood, earthquake)
- HUMAN-CAUSED (explosion, hazardous materials spill, transportation accident, war)
  - Technology Failure
  - Mass Shooting
  - Terrorism

Natural vs. Human Disasters

Natural	Human Caused
Earthquakes, fires, floods, tornadoes	Airplane crashes, chemical leaks, mass violence, terrorism
No one to blame	People, governments, or businesses to blame
Beyond human control	Seen as preventable and a betrayal by fellow humans
Advance warning is possible	Usually no advanced warning
Post-disaster stress is high and felt mainly by survivors	Stress is often higher & more people not directly affected

FEMA Core Content ISP Training

Disaster impact

- Every disaster is different
- Disasters affect individuals & the community
- Response strategy depends on disaster characteristics
- A disaster causes disruptions and changes.

FEMA CCP Training Program

Role of the Emergency Response Teams

- Provide information, support & referrals for people impacted by a disaster, terrorist event or large scale emergency during response and recovery
- Main Role to assist people to:
  - Understand their situation and reactions.
  - Identify, label, and express emotions.
  - Help accept the disaster and losses.
  - Manage stress & make decisions
  - Develop coping strategies.
  - Promote individual and community resilience & community resources.
  - Recover pre-disaster level of functioning.

FEMA CCP Training Program

Range of Disaster Crisis Counseling Services

- Individual disaster crisis counseling
- Brief educational &supportive contact
- Group disaster crisis counseling
- Public education
- Needs assessment, referral & linkage
- Supporting the community and networking
- Development and distribution of educational materials
- Media messaging and risk communications.

FEMA CCP Core Content Training

Five Core Elements of Psychological First Aid

Promote:

- **A sense of safety**
- **Calm**
- **Sense of self and collective efficacy**
- **Connectedness**
- **Hope**

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

- Intervention of choice for immediate mass trauma intervention – Psychological First Aid

Photograph: Adi Weda/EPA www.guardian.co.uk

Disaster Crisis Counseling and Traditional Treatment

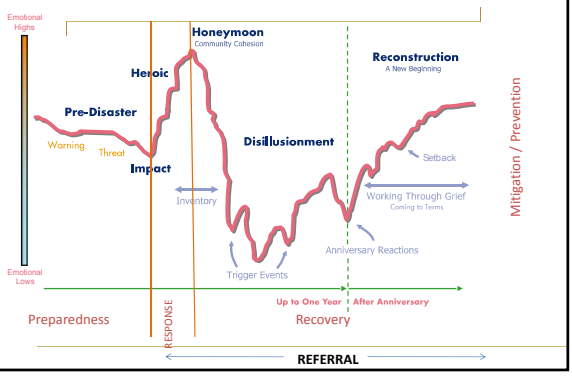
Traditional Treatment	Disaster Crisis Counseling
• Office Based	• Home and Community based
• Diagnoses and treats mental illness	• Assesses strengths and coping skills
• Focuses on personality and functioning	• Provides support on disaster-related issues
•Examines content	• Accepts content at face value
•Explores past experiences and influence on current problems	•Validates common reactions and experiences
• Psycho-therapeutic focus	• Psycho-educational focus
• Keeps records, charts and case files	•Does not collect identifying information

Taken from the FEMA CCP Core Content Training Package

Guiding Principles – Disaster Crisis Counseling

- No one who experiences a disaster is untouched by it
- Most people pull together and function during and after a disaster, but their effectiveness is diminished
- Disaster stress and grief reactions are "common (normal) responses to an abnormal situation"
- Disaster mental health assistance is often more PRACTICAL than psychological in nature (offering a phone, distributing coffee, listening, encouraging, reassuring, comforting)

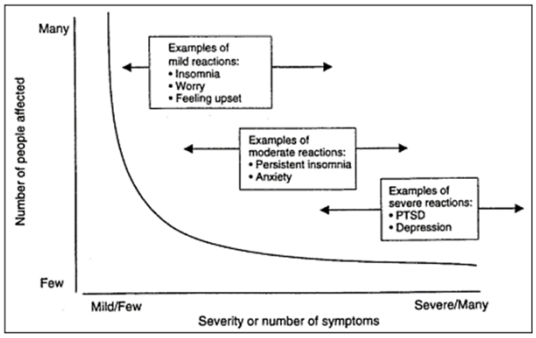
Phases of Disaster



Individual Reactions

- The severity of reactions is affected by the type of, level of exposure to, and casualties associated with the disaster.
- Pre-existing trauma may increase the risk of severe reactions.
- Disaster Crisis Counselors identify and refer for treatment anyone experiencing severe reactions.
- Pre-existing levels of support will affect the severity of reactions.

Common Reactions to Disaster



Common Reactions after a Disaster - Behavioral

- Either isolating or cannot be alone
- Pacing
- Fidgeting
- Fighting/arguing
- Fatigue that does not improve with sleep
- Reckless or risk-taking behaviors (particularly with adolescents)
- Work or school problems

Common Reactions after a Disaster - Emotional

- Shock and disbelief
- Fear
- Helpless/Hopeless
- Anxiety
- Loss of trust and safety
- Feeling detached from others
- Irritable/Moody
- Anger
- Guilt
- Restless
- Sadness
- Numbness

National Center for PTSD, 2007

Common Reactions after a Disaster - Physical

- Change in appetite
- Change in sleeping
- Easily startled
- Being on red alert all the time
- Headaches
- Stomachaches
- Sweating
- Chills
- Tension
- Bodily aches or pains
- Edginess
- Change in sex drive
- Rapid heart beat

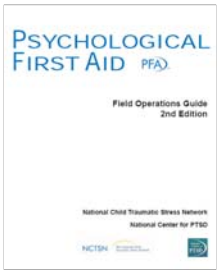
National Center for PTSD, 2007

Common Reactions after a Disaster - Thoughts

- Flashbacks
- Reminded of past experiences of loss/trauma
- Nightmares
- Difficulty concentrating
- Forgetfulness
- Suspicion or blaming
- Difficulty making decisions
- Belief that life will never get better
- Confusion

National Center for PTSD, 2007

PSYCHOLOGICAL FIRST AID (PFA)



Psychological First Aid (PFA)

- An evidence-informed approach to assist individuals in the immediate aftermath of disaster or terrorism
- Used to reduce the initial distress & foster short and long term functioning and coping

Skills used in PFA are….

- Consistent with research evidence on risk and resilience following trauma
- Applicable and practical in field settings
- Appropriate for developmental levels across the lifespan
- Culturally informed and delivered in a flexible manner

Psychological First Aid (PFA)

- Relies on field tested, evidence-informed strategies
- Includes basic information gathering techniques to help make rapid assessment of what is needed and what to do
- Emphasizes developmentally and culturally appropriate interventions for all ages and backgrounds
- Includes important elements of risk communication and educational outreach

Core Actions of PFA

- Contact and engagement
- Safety and comfort
- Stabilization (if needed)
- Information gathering: Current needs and concerns
- Practical assistance
- Connection with social supports
- Information on coping
- Linkage with collaborative services

NCPTSD PFA Field Operations Guide, 2nd Edition

Core Actions of PFA

- Contact & Engagement
  - Appropriate to age/culture
  - Ask about immediate needs
- Stabilization
  - Gather information to make a referral to local resources
  - Help survivors understand their reactions
- Safety & Comfort
  - Attend to physical needs
  - Help with death notification / identification
  - Appropriately attend to spiritual or grief concerns
  - Connect survivors with practical resources & other people
  - Reduce fear by providing information about risks

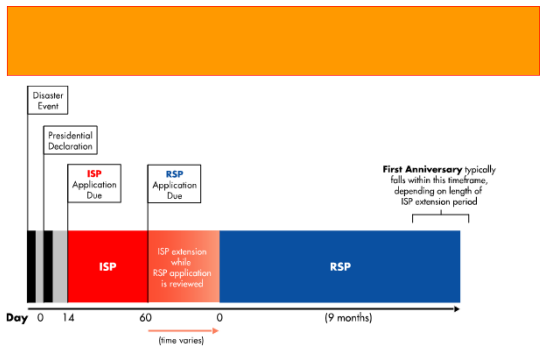
NCPTSD PFA Field Operations Guide, 2nd Edition

Core Actions of PFA

- Information Gathering
  - Survivor Triage (more later)
  - Determine need for immediate referral or additional resources
- Practical Assistance
  - Assist with problem solving
- Connect with Social Supports
  - Foster connections with natural supports (friends, family, community)
  - Assist as appropriate to foster appropriate help seeking and giving behaviors

NCPTSD PFA Field Operations Guide, 2nd Edition

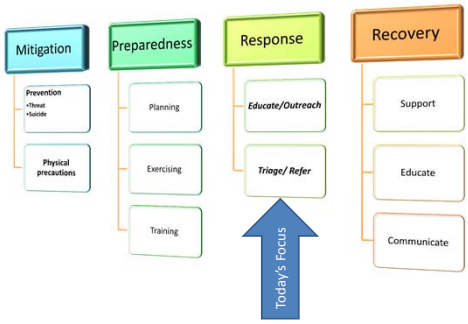
FEMA


Disaster Event
Presidential Declaration
ISP Application Due
RSP Application Due
First Anniversary typically falls within this timeframe, depending on length of ISP extension period
ISP
ISP extension while RSP application is reviewed
RSP
Day 0 14 60 0 (9 months)
(time varies)

Characteristics of a CCP

- Is strengths based.
- Assumes natural resilience and competence.
- Is culturally competent.
- Is diagnosis free.
- Is community based.
- Bolsters community support systems.
- Is outreach oriented.

Phases of Emergency Management Behavioral Health Actions

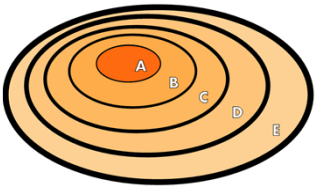


Assumptions

- Insufficient mental health resources are available when they are actually needed
- Even when there are population based risks, individuals are resilient and may not be at as high a risk
- **Triage – sorting and deciding who gets what level of attention <u>now</u>**

(Adapted from a presentation by Merritt Schreiber 2006)

Population Exposure Model



A. Injured survivors, bereaved family members
B. Survivors with high exposure to disaster trauma, or evacuated from disaster zones
C. Bereaved extended family and friends, first responders
D. People who lost homes, jobs, and possessions; people with pre-existing trauma and dysfunction; at-risk groups; other disaster responders
E. Affected people from the larger community

Adapted from DeWolfe, 2002

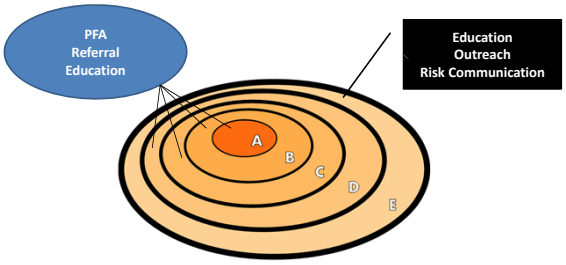
Survivor Triage

- Who gets attention first?
  - Most distressed versus most likely to develop long term disorders?
  - Who is at risk for developing long term disorders?
  - What do we do about it?

Which Survivors are in the Center Rings of the Population Exposure Model?

	yes	no	unsure
Did you actually have a family member or close friend who was killed, injured or missing?			
Did you fear that a family member of friend who was in or around the site of the event might be killed, injured or missing?			
As a result of your exposure to the event did you feel that you were at risk of being injured or killed?			
Did you witness death or serious injury?			
Were you displaced from your home?			
Have you been the victim of traumatic events in the past?			

Survivor Triage



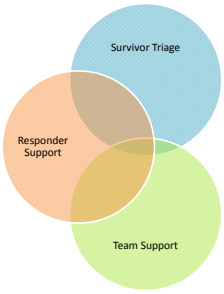
DISASTER BEHAVIORAL HEALTH FIELD TOOLS

Personal Preparedness and Deployment
Nebraska Field Guide
Guidelines: Working with People with Functional Needs
Rapid Disaster Behavioral Health Community Needs Assessment

Personal Preparedness Expectations

- Personal Preparedness
  - How long will you be deployed?
  - What are the conditions?
  - Pack a "go-bag" with electronic and hard copies of needed information
- Deployment Information Sheet
  - What is your role?
    - Field Supervision – Span of Control (1 to 5)
    - Field Work – Embedded in other teams or working in crisis counseling teams

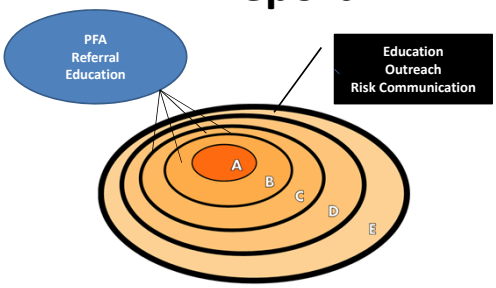
Tools for Disaster Crisis Counseling with Individuals



- Nebraska Field Guide
- Guidelines for Functional Needs

PRACTICE SESSION

Teams Follow up and Report



Teams Follow up and Report

- What phase of the disaster are we in now?
- How would you describe the barriers to providing PFA in the scenarios you experienced?
- What strengths did you observe?
- What factors may impede recovery for the individual and the community?
- What resources (personnel, material, etc) are needed to meet the behavioral health needs you identified?

Robert H. Snarr, MPA, LPC, NCC

Rsnarr@hotmail.com
801-243-6904

MODULE 2: PRACTICE (ROLE PLAYS)

Ash Falls, a city in your region with 15,000 residents is home to a state run office building. It is one of the largest employers in the town. Today at noon there was an explosion in the building that was followed by shots fired by two unidentified shooters. Before the police arrived the shooters killed themselves. At the time of the shooting an elementary school class of 30 was visiting the energy office in the state office building. There was chaos in the entire building during the event. After it was over, at least 35 people were killed with many others injured. Seventeen of the school children were among the fatalities. Everyone in the building was interviewed by police. It is three hours after the event and survivors are gathered in a central location awaiting clearance to reunite with relatives. Behavioral health has been allowed in to assist survivors as they wait. In another area relatives are anxiously waiting to either reunite or find out the fate of their loved ones. Behavioral health has also been deployed to this location. The overall behavioral health mission is to 1) provide psychological first aid and 2) assess the behavioral health needs of survivors and community members to determine if resources in the community are sufficient to deal with current and future behavioral health needs related to the incident.

Instructions to Groups:

- Identify a team leader who will ensure all members of the group have the opportunity to interact with role players. Monitor team members and move them timely from station to station.

- Identify one person to interact with each survivor simulator and one person to assist (scanning the environment, looking at safety elements, providing prompts to the person interacting with the simulator).

- Use skills reviewed in the workshop in your interactions.

MODULE 3: BEHAVIORAL HEALTH NEEDS ASSESSMENT

You had the opportunity to observe and participate in provision of psychological first aid for several individuals impacted by this event. Now your team is charged with bringing together the behavioral health reactions and needs you observed in a report. This helps determine the type and number of behavioral health resources required by the community in this phase and future phases of the disaster. Take time to answer the following questions as a group. Identify one person to serve as the spokesperson for your group during the report period that will follow your deliberation time.

Questions

- What phase of the disaster are we in now?
- How would you describe the barriers to providing PFA in the scenarios you experienced?
- What strengths did you observe?
- What factors may impede recovery for the individual and the community?
- What resources (personnel, material, etc) are needed to meet the behavioral health needs you identified?

Appendices

1. Workshop Agenda
2. Guidelines for working with people with functional needs
3. Rapid behavioral health community needs assessment
4. Workshop evaluation form

Nebraska State & Regional
Disaster Behavioral Health Emergency Response Team
Workshop
July 14, 2011

Embassy Suites Omaha Downtown
555 South 10th Street

This workshop will prepare crisis counselors to:

- Assess short-term behavioral health needs related to disaster impact
- Carry out behavioral health field work
- Prioritize behavioral health triage & community needs

Time	Topic
12:30-1:00	Registration
1:00-1:15	Introduction & Welcome Remarks - Jim Harvey & Denise J. Bulling
1:15-2:15	Disaster Behavioral Health Interventions- Robert H. Snarr
2:15-2:30	**Break**
2:30-3:30	Disaster Behavioral Health Practice Sessions - Robert H. Snarr
3:30-4:45	Teams Convene and Report out - Robert H. Snarr
4:45-5:00	Wrap up & Closing Remarks - Jim Harvey & Denise J. Bulling

Presenters:

Jim Harvey, LCSW, Nebraska Department of Health and Human Services, Division of Behavioral Health

Denise J. Bulling , Ph.D., LIPC, University of Nebraska Public Policy Center,

Robert H. Snarr, MPA, LPC, NCC, Disaster Behavioral Health, National Consultant

Guidelines for Working with People with Functional Needs

Compiled by
Robin Zagurski, LCSW
Department of Psychiatry – University of Nebraska Medical Center

Basic psychological first aid

- Make a statement of **empathy** within the *first 30 seconds*. For example:
  - "I know this is difficult for you"
  - "Looks like you're having a tough time"
- **Introduce** yourself
  If you have a title within an organization, people will expect you to be competent until you prove otherwise
- Be **respectful** from the start
  - Use "please" and "thank you", "sir" or "ma'am"
  - Address people by Mr., Mrs., or Ms. and their last name
  - Use last names until given permission to use first names
- People do best when they can take some sort of **action** themselves
  - People in crisis want to be participants, not spectators
  - Give the person some task to accomplish
  - Allow people to make their own decisions, even if they ask your opinion
    - Remember that a decision that would work well for you, may not work for someone else

People who are hard of hearing or deaf

- Not all people who are hard of hearing or deaf use sign language
  - They may use spoken language, visual communication or sign language
- Get the person's attention by tapping their shoulder or waving your hand
- Speak clearly at a normal rate of speed and volume
- Make sure your mouth is clearly visible
  - Only 30-35% of language is visible by lip-reading, yelling distorts the face, making lip-reading more difficult
- Use gestures if at all possible, make sure your non-verbal communication matches the message you are sending
- Offer pen and paper. Write notes to make sure the communication is clear
- If you will be the with the person for a length of time (i.e., in a shelter or family assistance center), ask if the person would like a qualified sign language interpreter

People who are deaf-blind

- Mark an "X" on the person's back or shoulder (universal communication) to indicate there is an emergency and that he/she should trust you and follow you

- Use printing on the person's palm (capitol block letters), making sure your finger remains in constant contact with the hand until you complete the letter
- Provide assistance when moving in an unfamiliar location

People who are blind

- Blind and visually impaired persons have widely varying levels of independence skills. Some will need no more help than a sighted person, while some with less skills will need more help
- A minority of the blind use guide dogs and many do use white canes
- Do identify yourself verbally
- Do ask if they need help
- Do explain what you are doing
- Ask if they have any questions

People with service animals

- Only touch the service animal if the owner gives permission

Seniors

- Make sure they bring any assistive devices, such as walkers, canes, hearing aides (and batteries) and eyeglasses
- If the person has a vision loss, offer your arm for them to hold as you guide them to safety
- If possible, assist the person in gathering all medications, inhalers and nebulizers before evacuating. Remember that some medications, such as insulin, may be kept in the refrigerator
- Ask how to reach family/friends before evacuating, as the person may have family phone numbers programmed onto speed dial on a phone and may not remember phone numbers once outside the home

People with mobility impairments

Always ask the person how you can help before attempting any assistance. Every person and every disability is unique – even though it may be important to evacuate the location, respect the person's independence as much as extent possible. Don't make assumptions about the person's abilities.

- Ask if they have limitations or problems that may affect their safety.
- Some people may need assistance getting out of bed or out of a chair, but CAN then proceed without assistance.
- Here are some other questions you may find helpful:
  "Are you able to stand or walk without the help of a mobility device like a cane, walker or a wheelchair?"
  "You might have to [stand] [walk] for quite awhile on your own. Will this be ok? Please be sure and tell someone if you think you need assistance."
  "Do you have full use of your arms?"

Wheelchair Users

- If the conversation will take more than a few minutes, sit down to speak at eye level.
- Ask before you assume you need to help, or what that help should be.

Children

- Children may need you to repeat directions, or answers to their questions, several times
- Validate the child's thoughts and feelings
- Reassure, but only promise what you can actually do (say "I'm here to help you", not "everything is going to be alright")
- Use digital or Polaroid photos to document children separated from parents
- Index the photos and provide a system for presenting select photos to parents (i.e., similar age/gender/ethnicity)
- Provide a site where arriving parents can review photos with privacy

People with mental illness

- If at all possible, arrange for the person to call their regular service provider or caseworker to provide for continuity of care
- Ask them to bring their medications with them if at all possible

People who are agitated

- Remember to start with a statement of empathy
- Try to find a point of agreement
- Act calm, even if you're not (keep your voice calm, maintain soft eye contact)
- Approach from the side when possible
- Speak in a calm, neutral tone of voice
- Intervene only during the lulls if the person is talking or shouting
- Maintain an L-shaped stance
- If threatened, get out and get help

References:

Cahill, A., et. al.. (2006). Tips for Emergency Responders. Center for Development and Disability. Albuquerque, New Mexico.

Reynolds, B. (2002). Crisis and Emergency Risk Communication. Centers for Disease Control and Prevention.

Zagurski, R., Bulling, D., Chang, R. (2004). Nebraska Psychological First Aid Curriculum. Lincoln, NE: University of Nebraska Public Policy Center.

Rapid Disaster Behavioral Health Community Needs Assessment

The data indicated below are needed for an effective assessment. This table is to be used by the team leader to maintain an overall picture of which information was obtained by team members. Numbers/ estimates and other similar information must be described and reported with great caution to avoid over interpretations and misunderstandings.

Affected Population

Statistics are not always available during a crisis. Therefore data collected on these aspects can be simple estimates that should later be confirmed through official sources.

Est. Number of people affected *by the event* in the following categories:		Information from:
_	Dead	
_	Hospitalized	
_	Non-hospitalized injured	
_	Missing persons	
_	Displaced persons	
_	Unemployed (due to event)	

Information for the above table may be available from Emergency Management.

Est. Number of people *in the affected population* in the following categories:			Information from:
_	Widowed persons (due to event)		
	Orphans (due to event)		
_	Children/Youth		
	Elderly		
_	Single mothers		
_	People with serious mental illness		
_	People with substance abuse/dependency problems		
_	Methadone clients		
_	Developmentally disabled		
_	Physically disabled		
_	Homeless (pre-event estimate)		
_	Immigrants (note refugee status if known)		
_	Members of the military with war experience		
_	Farm/Ranch families		
_	Emergency responders deployed (est. number of individuals)		
_	_	Emergency Management	
_	_	Fire	
_	_	EMS	
_	_	Law Enforcement	
_	_	Military	
_	_	Utility workers	
_	_	Health workers	
_	_	Mental Health workers	

Rapid Disaster Behavioral Health Community Needs Assessment

-		Other (Please specify)	

Please note which departments/towns responded:

Information for the above table may be available from Emergency Management.

How many persons are in each exposure group?		
Number of persons:		Information from:
	Injured survivors & bereaved immediate family members	
	Non-injured survivors with high exposure; and first responders	
	Bereaved extended family, friends, coworkers	
	People in community with pre-existing trauma; and other responders (Red Cross; dispatchers; clergy; media)	
	Affected community at large (population estimate)	

Critical Infrastructure

Number of:		Information from:
	Homes destroyed	
	Homes with major damage	
	Homes with minor damage	
	Schools damaged	

Information for the above table may be available from Emergency Management.

Which occupations did most people depend on before the disaster?		Information from:
	Agriculture	
	Fisheries / Forestry	
	Manufacturing / Industry	
	Trade / Commerce	
	Transportation / Services	

Which occupations were most affected by the disaster?		Information from:
	Agriculture	
	Fisheries / Forestry	
	Manufacturing / Industry	
	Trade / Commerce	
	Transportation / Services	

Rapid Disaster Behavioral Health Community Needs Assessment

Number & type of animals **killed**		Information from:
	Cattle	
	Swine	
	Poultry	
	Other farm/ranch animal (specify)	
	Pets	

Information for the above table may be available from Emergency Management or the Dept. of Agriculture.

How were animals killed?		Information from:
	By disaster	
	By authorities	
	Other (specify)	

Information for the above table may be available from Emergency Management or the Dept. of Agriculture.

Number & type of animals **missing**		Information from:
	Cattle	
	Swine	
	Poultry	
	Other farm/ranch animal (specify)	
	Pets	

Information for the above table may be available from Emergency Management or the Dept. of Agriculture.

What critical community infrastructures have been most affected by the disaster? Please describe how.	
	Economic
	Agricultural
	Health
	Education
	Administration
	Communication
	Transportation
	Socio-cultural

Rapid Disaster Behavioral Health Community Needs Assessment

Other than the disaster itself, what other factors have worsened the impact of the disaster? Please describe how.	
	Physical structures (housing, businesses, etc.)
	Government leadership and programs
	Economic health of community (livelihood, savings, unemployment)
	Knowledge of danger, warnings
	Natural disaster vs. accident vs. intentional act
	Other (Specify)

Current Situation

Is the emergency/disaster site a crime scene?	
	Yes
	No
	Unknown

Adequacy of sanitation at general disaster site:	
	Site is clean/sanitation good
	Site is not clean/ sanitation is an issue (Please describe):

_____ Number of shelters (ARC/FEMA/other)

Location of Shelter	Shelter sponsor (e.g., ARC)	Est. # people in shelter

Information for the above table may be available from Emergency Management.

Rapid Disaster Behavioral Health Community Needs Assessment

_____ Number of assistance centers (ARC/FEMA/other)

Location of center	Center sponsor (e.g., ARC)	Est. # people served

Information for the above table may be available from Emergency Management.

_____ Number of feeding stations (ARC/Salvation Army/other)

Location of station	Station sponsor (e.g., ARC)	Est. # people served

Information for the above table may be available from Emergency Management.

Is a mobile morgue operating?
___ Yes ___ No

Current Resources

What are the existing psychological support structures (example: family, church, Community)?

Local behavioral health professionals still active in the community	Number (estimated)	Names / Agencies
Psychiatrists/APRNs/PAs		
Psychologists/LIMHPs/LMHPs		
SA Professionals		
Other		

What mental health training activities are available? By whom?

Which relief agencies are on site with mental health workers (e.g., American Red Cross)?

Rapid Disaster Behavioral Health Community Needs Assessment

Conclusions and Recommendations for behavioral health response

Recommendations for immediate care	
	Of the most vulnerable (who are they; what do they need; who should provide it)
	Of the most serious mental health problems of the overall population
	Of the substance abuse population (e.g. detoxification; methadone)
	Of institutional populations (Corrections; Jails; Long-term care facilities)
	For immediate capacity building (type & location of BH needed)

CISM services needed by emergency workers	
	Information about accessing CISM in the future
	Unobtrusive CISM presence in respite center, gathering places, or on site (e.g., hospitals or event site)
	Defusing (CISM at site for immediate use or CISM on standby?)
	Individual or group stress management sessions (CISM at site for immediate use or CISM on standby?)
	CISM should follow-up with command staff for future needs

What is being done to ensure people's participation in the recovery process?

What else needs to be done to strengthen people's participation in the recovery process?

Describe major obstacles – constraints, risks, assets for implementation (i.e., spontaneous volunteers; barriers to resource integration; barriers to social/cultural traditions or rituals):

Types of workers and anticipated length of deployment needed to meet immediate needs:

Nebraska State and Regional
Disaster Behavioral Health Emergency Response Team Workshop

July 14, 2011
Embassy Suites Hotel - Downtown
Omaha, NE

PARTICIPANT SATISFACTION EVALUATION

INSTRUCTOR

Robert H. Snarr	**Low/Poor**	**Fair**	**Adequate**	**Very Good**	**High/Excellent**
1. Organization of material	1	2	3	4	5
2. Attitude toward subject	1	2	3	4	5
3. Knowledge of subject	1	2	3	4	5
4. Speaking ability	1	2	3	4	5
5. Use of audio-visual aids	1	2	3	4	5
6. Effectiveness of presentation	1	2	3	4	5
7. Overall rating of instructor	1	2	3	4	5

Comments:

LEARNING OBJECTIVES

	Low/Poor	**Fair**	**Adequate**	**Very Good**	**High/Excellent**
1. Assess short-term behavioral health needs related to disaster impact	1	2	3	4	5
2. Carry out disaster behavioral health field work	1	2	3	4	5
3. Prioritize behavioral health triage & community needs	1	2	3	4	5

Comments:

WORKSHOP AND FACILITIES

	Low/Poor	**Fair**	**Adequate**	**Very Good**	**High/Excellent**
1. Relevance of material to your work	1	2	3	4	5
2. Organization of material	1	2	3	4	5
3. Completeness of coverage	1	2	3	4	5
4. Usefulness of handouts	1	2	3	4	5
5. How well did this workshop meet the stated objectives	1	2	3	4	5
6. Meeting room	1	2	3	4	5
7. Quality of audio-visuals	1	2	3	4	5
8. Acoustics	1	2	3	4	5
9. Overall workshop rating	1	2	3	4	5

Comments: