Department of Health and Human Services Disaster Behavioral Health Concept of Operations

Updated November 2016

References

- National Response Framework (NRF)
- National Incident Management System (NIMS)
- National Health Security Strategy (NHSS)
- National Disaster Recovery Framework (NDRF)
- HHS Emergency Management Group Concept of Operations Emergency Operations Plan (Draft)
- Field Operations Guide (FOG), 9/2011
- Incident Response Coordination Team (IRCT) Standard Operating Procedure

Record of Changes

HHS Disaster Behavioral Health Concept of Operations, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response

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This document will be reviewed and revised as needed to ensure that current planning reflects lessons learned from recent response and recovery experiences, current best practice, and pertinent scientific evidence.

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Introduction

Concept of Operations

This Concept of Operations plan (CONOPS) describes the conceptual framework and coordination for U.S. Department of Health and Human Services (HHS) federal-level behavioral health preparedness, response, and recovery for disasters and public health emergencies. The plan describes how HHS prepares for the behavioral health effects of a public health and medical emergency or disaster and transitions from normal day-to-day operations to coordinated department-wide response and recovery activities.

The CONOPS is consistent with the National Preparedness Goal (NPG), the National Response Framework (NRF), and the National Disaster Recovery Framework (NDRF). It supports the goals and objectives of the National Health Security Strategy (NHSS). The document explains how the Assistant Secretary for Preparedness and Response (ASPR) coordinates HHS-wide response and recovery activities through the ASPR Incident Management structure—the Emergency Management Group (EMG)—on behalf of the Secretary in concert with the specific authorities and responsibilities of HHS Operating Divisions (OPDIVs) and HHS Staff Divisions (STAFFDIVs). The document intentionally differs from traditional CONOPS format and includes conceptual language to frame disaster behavioral health in addition to discussion of federal disaster behavioral health operational response and recovery. A main aim of this CONOPS is to improve coordination of federal preparedness, response, and recovery efforts concerning behavioral health in a manner consistent with—and supportive of—state, local, territorial, and tribal (SLTT[1]) efforts.

Disaster Behavioral Health

Emergency Support Function (ESF) #8 – Public Health and Medical Services provides the mechanism for coordinated Federal assistance to supplement State, tribal, and local resources in response to a public health and medical disaster, potential or actual incidents requiring a coordinated Federal response, and/or during a developing potential health and medical emergency. Public Health and Medical Services include responding to medical needs associated with mental health, behavioral health, and substance

[1] Throughout this document, "SLTT" refers to states, localities, territories, and federally-recognized tribes.

abuse considerations of individuals affected by the incident including survivors, family members, first responders and others.

Disaster behavioral health[2] is an integral part of the overall public health and medical preparedness, response, and recovery system. It includes the interconnected psychological, emotional, cognitive, developmental, and social influences on behavior, mental health, and substance abuse, and the effect of these influences on preparedness, response, and recovery from disasters or traumatic events. Behavioral factors directly and indirectly influence individual and community risks, health, resilience, and the success of emergency response and recovery strategies and public health measures.

This CONOPS adopts a broad view of disaster behavioral health encompassing interventions to address the behavioral health and stress-related needs of disaster survivors and responders; the behavioral implications of risk communication and messaging; surveillance, triage, and assessment; behavioral health promotion; social connectedness; research; and the needs of people with pre- existing behavioral health conditions and the systems that serve them.

During and after an emergency event, it is common for affected people—including response workers—to experience distress and anxiety about safety, health, and recovery, as well as grief and loss. Many people are to some degree personally prepared for an emergency. They have access to pre-existing support systems that contribute to their own and their community's resilience. The majority of people who experience a disaster are likely to psychologically recover without formal behavioral health intervention. However, these protective factors vary, as do the nature of the event and the level of exposure experienced by individuals, families, and communities. As a result of this, some people may experience more severe behavioral health reactions that hinder their recovery. In a smaller subset of people, psychological conditions or substance use/abuse may develop or worsen if not addressed. Therefore, disaster behavioral health aims to provide a continuum of services and activities—including communication, education, basic support, as well as access to clinical behavioral health services when needed—in order to mitigate the progression of adverse reactions into more serious physical and behavioral health conditions.

[2] For more detailed information on behavioral health and at-risk individuals please refer to the materials in Appendix D, Web Resources

Disaster behavioral health actions during the ***preparedness phase*** primarily focus on planning, training, and exercising public health capabilities that mitigate the behavioral health impacts of disaster. Plans that strengthen pre-existing systems, build on the daily delivery of health and behavioral health care, and address reimbursement requirements are essential to effective disaster response. Disaster behavioral health actions during the ***response period*** often focus on supportive, strengths-based interventions such as psychological first aid, crisis counseling, risk communication, and response worker support. These interventions may be provided by behavioral health professionals, but are often also provided by paraprofessionals, other health workers, volunteers, and laypeople who have received training in basic disaster behavioral health support. Behavioral health concerns often emerge or evolve in the longer-term ***recovery period***, including the potential that additional individuals may develop reactions that require behavioral health care and treatment.

Some individuals or populations may be at higher risk for more severe reactions. Children, in particular, can be vulnerable to the behavioral health impact of public health emergencies and disasters as they may lack the experience, skills, and resources to independently meet their own behavioral health needs. Caregivers and educators affected by the disaster also must deal with the stressors on their own behavioral health which can impact the behavioral health of the children under their care. People with pre-existing behavioral health conditions or past traumatic exposure may be at greater risk for exacerbation of symptoms or relapse. Individuals with severe pre-existing behavioral health conditions who rely on the behavioral health care infrastructure to aid their well- being and independence may be greatly affected by damage to that infrastructure. Also of concern is the safety and well-being of at-risk individuals with access and functional needs. For planning purposes, access and functional needs can be categorized according to five domains: Communication, Maintaining health/medical, Independence, Support/Supervision, and Transportation (known by the acronym C-MIST). Examples of individuals or populations at risk include children, senior citizens, pregnant women, people with disabilities, the economically disadvantaged, racial and ethnic minorities, people with pre-existing behavioral health conditions, or people with limited English proficiency.

Trauma, violence, and witnessing violence can also be determinants of behavioral health problems, and groups such as children, senior citizens, pregnant women, and people with disabilities can be at higher risk for these concerns. If these issues are not appropriately addressed by trauma informed behavioral health care they may accumulate and compound resulting in further deterioration of behavioral health following a disaster.

Behavioral health is also concerned with influences on decision making in an affected population. Disaster behavioral health practitioners and approaches can inform risk communication and public health messaging to address anxiety, encourage people to follow public health measures, and prevent misinformation from gaining credibility. Before, during, and after a public health emergency or disaster,

behavioral health promotion activities can enhance individual and community resilience. Population surveillance systems, as well as individual and community assessment strategies, can provide valuable information concerning risks and protective factors affecting recovery. Engaged research can identify longer-term trends to guide future preparedness efforts. Efforts to bolster personal and family psychological resilience and social connectedness aim to mitigate adverse reactions and improve recovery trajectories at both the individual and community levels.

Purpose of the CONOPS

The CONOPS provides a conceptual framework for federal-level coordination of disaster behavioral health activities; informs behavioral health preparedness, response, and recovery efforts; and synchronizes with the overall Incident Management (IM) structure and expertise during response and recovery operations. Although this CONOPS focuses on federal-level operations, it is important to note that the vast majority of disaster behavioral health assets—and preparedness, response, and recovery activities— operate at SLTT levels. Significant support comes from an intricately woven system of voluntary organizations, government, academia, and behavioral health care and professional organizations. The role of federal disaster behavioral health activities is to collaborate with these entities to promote preparedness that is integrated into larger public health and medical response and recovery efforts, to assess mental health and substance abuse needs, to augment local response personnel based on SLTT-defined behavioral health needs, and to partner in longer-term recovery to promote individual and community resilience.

Through the ASPR, the Office of Emergency Management (OEM) is responsible for administering emergency management program functions, including behavioral health. Within OEM, the Emergency Management Group is the incident management structure that coordinates federal human/social services and public health and medical resources during the response and recovery phases of disasters, emergency incidents, or special and tactical events, and in support of Continuity of Operations (COOP). Working in collaboration with the EMG, the Office of Policy and Planning, Division for At-Risk Individuals, Behavioral Health and Community Resilience (ABC) provides subject matter expertise, coordination and consultation support to ensure that behavioral health needs are identified and addressed within the public health and medical response efforts. The Disaster Behavioral Health CONOPS outlines how this collaboration utilizes the strength of the structure to achieve success in both response and recovery.

The Disaster Behavioral Health CONOPS is intended to support, and not replace or supersede, existing agency authorities or national disaster frameworks. It is understood that many HHS OPDIVs, STAFFDIVs, and interagency partners have their own responsibilities and carry out behavioral health activities based on their own authorities. HHS uses this CONOPS to coordinate federal behavioral health response and recovery activity whenever the Secretary determines that there is a need for a coordinated department-

wide response or recovery (whether managed through the NRF, NDRF, or other authorities). ***Key federal disaster behavioral health actions are listed in Table 1. An in depth discussion of actions is found in the Preparedness, Response, and Recovery sections of this CONOPS.***

Authorities

Activities performed under this CONOPS will be carried out in accordance with applicable laws, regulations, and Departmental policies. The primary statutory authority for the Disaster Behavioral Health CONOPS is the Public Health Service (PHS) Act, though other laws may provide authority as well.

Key Federal Disaster Behavioral Health Actions: Preparedness (Table 1)

Preparedness Action	Leads
☐ Convene ***Disaster Behavioral Health Preparedness Forum*** to facilitate interagency collaboration and planning	ASPR-ABC
☐ Participate in the development and review of national disaster policies, plans, funding opportunity announcements, and grant guidance to ensure behavioral health integration	ASPR-ABC
☐ Participate in the development ***of national disaster and emergency plans and exercises*** to ensure behavioral health is appropriately included	ASPR/Federal Agencies
☐ Engage in ***behavioral health promotion*** to enhance day-to-day mental and behavioral functioning and promote resilience following emergencies or disasters	SAMHSA
☐ Develop and disseminate ***behavioral health educational, messaging, and guidance materials***	SAMHSA/ASPR /ACF/ACC
☐ Engage in ***Scientific Preparedness*** activities to coordinate and catalyze the research agenda for disaster behavioral health issues	ASPR/NIH/CDC /CMS

Key Federal Disaster Behavioral Health Actions: Response (Table 2)

Response Action	Leads
☐ Upon imminent threat or occurrence of major disaster or public health emergency, the ***health and medical services function*** of the National Response Framework and the National Disaster Medical System activate	ASPR-EMG
☐ HHS's ***Incident Response Coordination Team***, which includes a behavioral health liaison officer, stands up to coordinate and support the response	ASPR-EMG
☐ ***HHS agencies and response partners activate***; depending on the activation level, agency liaison officers may report to the Secretary Operations Center	ASPR/Federal Agencies
☐ ***SAMHSA contacts behavioral health agencies***, state disaster behavioral health coordinators, and behavioral health grantees in the impacted region to offer technical assistance and support	SAMHSA
☐ ***SAMHSA engages their disaster-related programs*** to provide support, such as Crisis Counseling Program, Disaster Technical Assistance Center, and Disaster Distress Helpline	SAMHSA
☐ ***Federal Disaster Behavioral Health Group***, comprised of federal agencies with behavioral health expertise, convenes and establishes communication and information gathering channels; a summary of FDBHG calls is provided to OEM and to other partners via email and posting on the SOC portal	ASPR-ABC

Response Action	Leads
☐ If indicated, ***behavioral health mission assignments*** are developed and deployed to provide federal behavioral health responders to the disaster impacted region	ASPR-EMG
☐ ***Behavioral health force protection*** is carried out to safeguard deployed HHS responders	IRCT / BH LNO
☐ ***Behavioral health educational and messaging materials*** specific to the needs of the event are disseminated through multiple mechanisms	ASPR/SAMHSA
☐ ***Surveillance/assessment*** mechanisms are queried to gather behavioral health data to inform response and recovery	SAMHSA / CDC

Key Federal Disaster Behavioral Health Actions: Recovery (Table 3)

Recovery Action	Leads
☐ When National Disaster Recovery Framework activation is imminent, ***Health & Social Services Recovery Support Function Primary & Supporting agencies are activated***	ASPR
☐ The ***Federal Disaster Behavioral Health Group transitions to recovery*** and continues to meet in support of health and social services recovery efforts, if indicated, as a Behavioral Health Recovery Task Force	ASPR-ABC
☐ ***Agencies maintain bi-directional communication through relevant agency programs*** and grant programs to assess and address recovery needs and gaps and share information	ASPR/Federal Agencies
☐ ***Agencies identify behavioral health informational*** resources related to disaster recovery/resilience and mobilize access to this information through information channels	ASPR/Federal Agencies
☐ Agencies plan for and implement the ***transition from recovery operations to steady-state activity*** within their agency's programs	ASPR/Federal Agencies

Assumptions and Priorities

The following assumptions and priorities apply to the behavioral health response to disasters and public health emergencies:

1. Behavioral health is an integral part of the public health and medical emergency management system, and should be fully integrated into preparedness, response, and recovery activities.

2. Disaster behavioral health includes mental health, stress, and substance abuse considerations for survivors and responders, and persons with pre-existing serious behavioral health conditions. It also addresses the behavioral health care infrastructure, individual and community resilience, and risk communication and messaging.

3. Disaster behavioral health is part of a layered, multidisciplinary ensemble of preparedness, response, and recovery activities. Community partners—such as private for-profit and non-profit entities; public health and emergency management personnel; national, SLTT and community behavioral health providers; media; and non-governmental organizations, including Voluntary Organizations Active in Disaster (VOADs) and child caregivers/educators—play an important positive role in resilience and should be actively engaged in preparedness, response, and recovery.

4. Disaster survivors and responders directly impacted by the incident are at greater risk for developing behavioral health sequelae from the disaster. Active identification of this group, outreach, and delivery of appropriate support and treatment (if indicated) may mitigate the development of serious behavioral health conditions.

5. Disaster behavioral health activities, as an integral part of overall force health protection, include provision of psychological and stress protection and substance abuse prevention strategies and services to responders.

6. Behavioral health interventions during disaster response and recovery should consider the culture of the community, should be based on accepted standards, be founded on empirical knowledge, should target specific groups at higher risk, and be delivered by trained volunteers, paraprofessionals, and professionals.

7. Individuals with pre-existing behavioral health issues will be among survivors receiving medical services.

8. Some individuals or populations may be at higher risk for more severe behavioral health reactions; for example, individuals with pre-existing behavioral health conditions or past

traumatic exposure and at-risk individuals with access or functional needs. Children, in particular, can be vulnerable as they may lack the experience, skills, and resources to independently meet their own behavioral health needs and their reactivity to stress reactions or behavioral health conditions of their caregivers. This vulnerability requires special planning considerations for parents in addition to the caregivers, educators, and professionals working with these children and youth.

9. Primary care providers, emergency responders, early care and school age providers and educators and others delivering behavioral health support in the affected community may benefit from training, technical assistance, support, and referral points for disaster behavioral health services.

10. In certain incidents, such as biologic, radiological/nuclear, chemical events or terrorist incidents, emergency departments and health care facilities may experience an influx of patients with psychologically-based complaints or unexplained physical symptoms, as well as more severe behavioral health symptomology than is experienced in natural disasters, requiring targeted preparedness and response activities.

11. In addition to disaster-related behavioral health services and grant programs, federal steady-state programs addressing behavioral health needs are leveraged—when appropriate and allowable within legal authorities—to provide access to services, bi-directional communication with response and recovery coordinators, and education.

12. Risk communication, messages, information, and educational materials that specifically address behavioral health issues that may arise following a disaster are essential components of the overall public health messaging strategy. Such behavioral health issues include anxiety, stress, fear, grief, increased risk of substance use/abuse, the particular needs of at-risk individuals such as children, reactions due to separation from pets. Messages should be made available in accessible, alternative, culturally-informed, and age-appropriate formats.

13. Strong coordination is needed between behavioral health and human services stakeholders and providers as issues and needs in these sectors can be closely associated.

14. As many behavioral health issues arise long after the response period has ended, recovery planning and activities must address current and anticipated behavioral health consequences.

15. HHS relies on SLTT infrastructure, equipment, and supplies to provide supplemental or augmented care to affected populations.

Roles and Responsibilities

HHS provides disaster behavioral health preparedness, response, and recovery support to SLTT and local communities through a variety of mechanisms, including emergency and disaster systems (such as NRF and NDRF sponsored efforts) as well as through the activities of OPDIVs and STAFFDIVs as part of their normal operations.

HHS may support affected jurisdictions in preparedness, response, and recovery for a variety of hazards, medical emergencies, and events with implications for public health. These include:

- Natural and man-made disasters;
- Public health and medical emergencies;
- Terrorist threats or incidents involving chemical, biological, nuclear/radiological, or large explosive devices;
- Mass violence events;
- Infectious disease outbreaks and pandemics;
- National Security Special Events (e.g., G20 Summits, Presidential Inaugurations, major sporting events, National Party Conventions); and
- Any other circumstance that creates an actual or potential public health or medical emergency where federal assistance may be necessary.

Federal behavioral health support typically includes the provision of technical assistance, educational resources, grant assistance, actions to support federal responder workforce protection and resilience, and participation in response and recovery planning and coordination efforts at the SLTT and national levels. Higher severity disasters or public health emergencies may include deployment of trained behavioral health responders, Federal Emergency Management Agency (FEMA) Crisis Counseling Training and Assistance Program (CCP) technical assistance, assessment and health surveillance, behavioral health messaging, and coordination of special appropriation funding. All preparedness, response, and recovery efforts are predicated on appropriate authorization and resources.

General Roles and Responsibilities in Preparedness

Disaster behavioral health must be integrated into plans and preparedness activities to promote effective response and recovery, build resilience, and mitigate future adverse reactions. Many HHS

agencies and partners conduct steady-state programs and activities that strengthen preparedness, build resilience, and address the psychological and behavioral implications of trauma and disaster.

The Federal Disaster Behavioral Health Preparedness Forum is an interagency group convened by ASPR through the Disaster Behavioral Health CONOPS to address issues of concern regarding federal disaster behavioral health preparedness and the psychological implications of resilience.

General Roles and Responsibilities in Response

The NRF is a guide to how the nation conducts all-hazards response. Emergency Support Function (ESF) Annexes of the NRF classify federal resources and capabilities into the functional areas that are most frequently needed in a national response. ESF #8 covers Public Health and Medical Services, including the behavioral health needs of incident survivors and response workers. The federal ESF #8 response is led by the HHS Secretary, with activities carried out by relevant HHS components and pre- identified ESF #8 support agencies under the principal coordination of the ASPR.

This coordinated response most frequently occurs in concert with a Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act). When an incident overwhelms SLTT resources or is expected to do so, the governor of an affected state may request federal assistance. Following a presidential emergency or major disaster declaration, the Stafford Act authorizes the federal government to provide certain financial and other disaster assistance depending on the declaration type to SLTT, businesses, and individuals. Outside the Stafford Act, HHS may exercise its own authorities and resources to provide certain assistance to states and other entities, including leveraging of steady-state federally-supported programs and assets.

General Roles and Responsibilities in Recovery

Disaster recovery is guided by the NDRF. The NDRF defines how federal agencies will effectively organize and operate to utilize existing resources to promote effective recovery and support to SLTT and other jurisdictions affected by a disaster. HHS is the coordinating agency for the Health and Social Services (H&SS) Recovery Support Function (RSF). The overarching recovery capability as described in the National Preparedness Goal for health and social services is the ability to restore and improve health and social services systems to promote the resilience, health (including behavioral health), independence, and well-being of the whole community. Health and social services recovery is particularly attentive to the health, behavioral health, and wellness needs of response and recovery workers, children, seniors, people living with disabilities, people with functional needs, people from diverse cultural origins, people with limited English proficiency, and underserved populations. The H&SS RSF National Coordinator and ASPR Office of Emergency Management (OEM) Division of Recovery

coordinate the H&SS RSF on behalf of the Secretary with activities carried out by relevant HHS components, pre-identified NDRF H&SS RSF primary agencies, and supporting organizations.

SLTT and Non-governmental Disaster Behavioral Health Systems and Assets

While this CONOPS details federal activities, SLTT efforts serve to address behavioral health needs before, during, and after public health emergencies and disasters. State, territorial and local awardees receive annual funding from the ASPR Hospital Preparedness Program and the Centers for Disease Control and Prevention (CDC) Public Health Emergency Preparedness Program to build and strengthen public health and healthcare capabilities, which include behavioral health, for their jurisdictions. SLTT and locally-managed behavioral health assets typically consist of a coalition of response groups with varying structures and capacities, including community-based volunteer groups (e.g. Medical Reserve Corps [MRC] units, non-governmental organizations [NGOs], volunteer organizations active in disaster [VOADs], and behavioral health professional associations). A number of states have also developed behavioral health responder capacity within their health or behavioral health departments and within their communities. These assets may be deployed prior to award of any federal grants or activation of federal response assets. States that belong to the Emergency Management Assistance Compact (EMAC) may use this mechanism to request state-to-state behavioral health support.

Many states have Disaster Behavioral Health Plans that detail how services will be provided and coordinated with ESF #6 (Mass Care, Emergency Assistance, Housing, and Human Services), ESF #8, and with SLTT emergency plans. The majority of states manage disaster behavioral health services through a State Disaster Behavioral Health Coordinator. In some states, these responsibilities may be shared by a Disaster Mental Health Coordinator and a Disaster Substance Abuse Coordinator. Typically, Coordinators work closely with state emergency management agencies and public health departments to ensure that identified behavioral health needs are seamlessly incorporated into an overall health emergency response. In tribal communities, tribally managed clinics and centers and Indian Health Service (IHS) provide behavioral health services and substance abuse assistance. IHS or tribal behavioral health leadership is often a point of contact for disaster behavioral health issues.

NGOs and VOADs play a vital role in providing behavioral health and human services following emergency events. For example, the American Red Cross (Red Cross) is an ESF #8 partner with significant disaster behavioral health capacity, including headquarters staff and trained disaster mental health responders across the country in the volunteer management system (a continuously updated roster of national volunteers). Red Cross has well-defined procedures to provide disaster behavioral health support, identify behavioral health needs through triage and assessment, promote resilience and coping, and target interventions—including crisis interventions, secondary assessments, referrals, and psycho-education. This system relies on a general corps of volunteers trained in Red Cross Psychological

First Aid and on mental health professionals trained in disaster behavioral health. Red Cross, through its local chapters, also offers basic psychological first aid and resilience training for the public. Unmet needs committees or recovery planning groups that include behavioral health stakeholders, state public health entities, human service agencies, and VOADs often form following the immediate disaster response to ensure that behavioral health needs are met during recovery.

National associations and professional guilds are also significant partners in disaster behavioral health preparedness, response, and recovery. These groups include organizations such as the National Association of State Mental Health Program Directors, the National Association of State Alcohol/Drug Abuse Directors, the American Psychological Association, the American Psychiatric Association, the National Association of Social Workers, the Multi-State Disaster Behavioral Health Consortium, and many others. These entities may provide disaster behavioral health training to their members. During disaster response and recovery, they may work with their primary federal partners (such as the Substance Abuse and Mental Health Services Administration [SAMHSA]) to act as conduits for situational awareness and information exchange. Some of these entities have developed disaster behavioral health response capabilities. Academia also can be a valuable partner, providing specialized expertise and identifying scientific research that can inform planning, response, and recovery actions.

Other Federal Departments

In the course of a disaster or emergency response, HHS may interact with other federal departments that are ESF #8 response partners. The Department of Defense (DoD), Department of Veterans Affairs (VA), Department of Housing and Urban Development (HUD), and Department of Homeland Security (DHS) are key inter-agency federal partners in disaster behavioral health preparedness, response, and recovery. Roles and engagement do vary by phase of disaster. In preparedness activities, the VA National Center for Post-Traumatic Stress Disorder, the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, and programs such as Comprehensive Soldier Fitness provide research and education to help prevent or treat behavioral health problems among military members, veterans, and their families. Primary care providers, other medical professionals, and first responders often have additional training in behavioral health techniques through programs such as RESPECT-Mil and Psychological First Aid. Although these professionals primarily serve military beneficiaries, they often assist their entire communities in an emergency.

DoD and VA together operate hundreds of medical treatment facilities that can take on additional responsibilities during the response phase. They operate public health teams that can identify public health needs, including behavioral health issues, and assist with response. DoD transportation resources such as Army medevac helicopters and Air Force aircraft, as well as DHS Coast Guard helicopters, are available to move people out of danger zones, as was done in the responses to Hurricanes Katrina,

Gustav, and Ike. Finally, the armed forces can provide logistics and security to assist survivors of disasters and facilitate their recovery.

In addition, HUD plays an important role in supporting disaster housing and serves as the Housing RSF coordinating agency under the NDRF. Through this, HUD addresses pre- and post-disaster housing issues and coordinates and facilitates the delivery of federal resources and activities to assist local and SLTT governments in the rehabilitation and reconstruction of destroyed and damaged housing, whenever feasible, and in the development of other new accessible, permanent housing options.

During the transition to recovery, the VA, DoD, HUD, and DHS continue to play important roles in rebuilding communities struck by disasters, thus reducing incident related stressors that can impact survivors' behavioral health.

Coordination with Human Services

The ESF #8 behavioral health response and the transition from response to recovery require close coordination with certain aspects of the ESF #6 (Mass Care, Emergency Assistance, Housing, and Human Services) response. Activities in the areas of Human Services and of Mass Care and Housing require particular attention.

Human services programs mitigate psychosocial risks and stresses—such as unemployment, loss of housing, and disintegration of neighborhoods and communities—that can lead to behavioral health illness and injury. They also work to maintain services to address the functional needs of at-risk individuals in order to promote independent living.

The Administration for Children and Families (ACF) leads the HHS ESF #6 Human Services response and administers the Disaster Case Management (DCM) program for FEMA. ACF's Office of Human Services Emergency Preparedness and Response (ACF-OHSEPR) partners with ASPR's Division for At-Risk Individuals, Behavioral Health, and Community Resilience (ABC) and ASPR's OEM to coordinate human services preparedness, response, and recovery activities across HHS. ACF and ASPR also work closely with FEMA's Office of Disability Integration & Coordination to forward their mission of "integrating and coordinating emergency preparedness, response and recovery for children and adults with disabilities and others with access and functional needs before, during and after a disaster."

ACF assists with strategic leveraging of federal human services programs, including program flexibilities and waivers, establishes human services liaisons to state, regional, and national emergency operations centers, and advises on the needs of children and at-risk individuals. ACF's Administration on Children, Youth, and Families also addresses the needs of victims of domestic violence and their children through

emergency sheltering, statewide services coordination, tribal services, and administering the National Domestic Violence Hotline.

Effective HHS regional coordination in disaster human services builds on the preparedness work of ACF and HHS Administration for Community Living (ACL) Program and Regional Offices and ASPR Regional Emergency Coordinators (RECs) working with SLTTs and grantees. In response to emergency events impacting a region, HHS regional partners (including the ACF and ACL Regional Administrators, ACF Regional Emergency Managers, and ASPR RECs) coordinate information and activity to ensure unity of effort and to leverage the strengths of different HHS components in providing a disaster human service response.

Other HHS divisions provide human services-related support, though not necessarily as part of ESF#6 response activities. The Administration on Aging (AoA) within ACL works with ACF and ASPR-ABC to address the needs of seniors and persons with disabilities. The Centers for Disease Control and Prevention (CDC) advises on human services aspects of communication, surveillance, field investigation, clinical guidance and other issues.

Crisis Counseling Assistance and Training Program (CCP)

The CCP is authorized under the Robert T. Stafford Disaster Relief and Emergency Assistance Act and requires a presidential declaration of disaster for individual assistance. The CCP is intended for short-term behavioral health support when disaster response needs are beyond SLTT capacity. CCP is funded by FEMA and administered through an interagency federal partnership between FEMA and SAMHSA. The CCP consists of two grant programs, the Immediate Services Program (ISP), which is 60 days in duration, and the Regular Services Program (RSP), which is 9 months in duration. SLTTs are eligible to apply for CCP grants with services typically provided to the affected areas by behavioral health organizations through contracts with a state's department of mental health. CCPs use a combination of mental health professionals and paraprofessionals, who are trained and supervised to deliver an array of crisis counseling services, including individual and group crisis counseling; basic supportive or educational contact; public education; community networking and support; assessment, referral, and resource linkage; and development and distribution of educational materials and media or public service announcements. CCPs are culturally competent, understanding, respectful, and sensitive to the cultural makeup of communities served. CCP staff is usually indigenous to the affected communities and are sometimes survivors themselves.

Mass Care and Housing

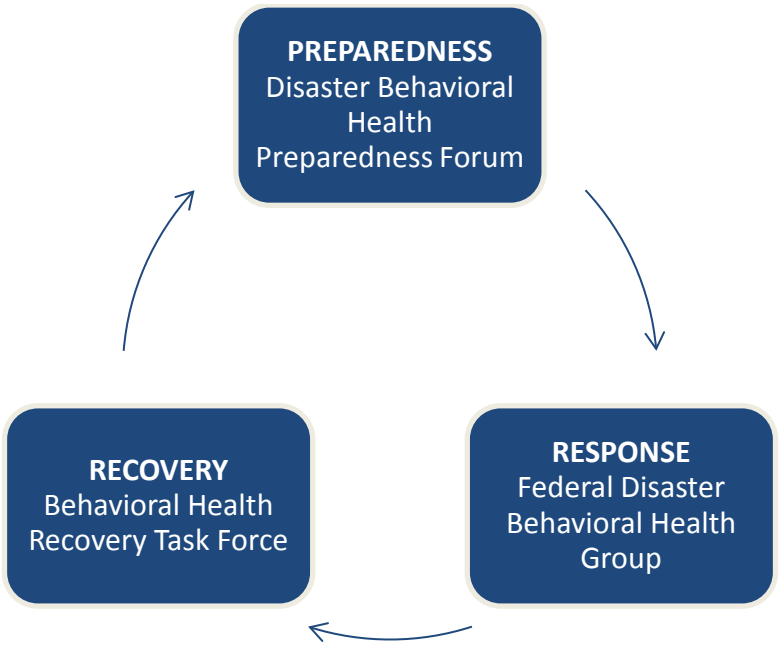
HHS works with federal partners (such as FEMA and HUD) and NGOs (such as Red Cross) to promote the inclusion of behavioral health support in shelters and disaster housing. Within HHS, ASPR-ABC, ACF, ACL,

and the Office on Disability (OD) provide subject matter expertise and technical assistance to meet the needs of children and at-risk individuals in mass care and congregate shelters. Through the mission assignment process, HHS behavioral health responders can provide psychological first aid and referral services to shelter residents or those in temporary, transitional housing, as assigned. Several OPDIVs and STAFFDIVs participate in the National Disaster Housing Task Force, which may be called upon to provide guidance on disaster housing following a major event.

Preparedness

Three groups with a focus on behavioral health issues convene during preparedness, response, and recovery. National **preparedness** is informed by the Disaster Behavioral Health Preparedness Forum. Public health and medical **response** activities are supported by the Federal Disaster Behavioral Health Group. Health and social services **recovery** needs are addressed via the Behavioral Health Recovery Task Force.

HHS DBH CONOPS Groups by Phase of Disaster (Figure 1)



Disaster Behavioral Health Preparedness

Evidence informed disaster behavioral health strategies and actions promote community resilience and are an essential part of public health and medical emergency response and recovery. Disaster behavioral health must be integrated into plans and preparedness activities in order to promote effective and comprehensive response, recovery, and national health security.

Planning

PREPAREDNESS FORUMS: ASPR-ABC convenes Disaster Behavioral Health Preparedness Forums. The format of these forums is flexible to meet current preparedness needs for behavioral health as identified through stakeholder engagement and after-action activity, and may include in-person

meetings, teleconferences, or web-based venues. Meetings of the Forums are typically convened semi-annually. Federal agency participation includes—but is not limited to—HHS agencies that address behavioral health, human services, emergency management, or related issues including ASPR, SAMHSA, CDC, ACF, ACL, and HHS's Center for Faith-based and Neighborhood Partnerships (CNFBP) and Health Resources and Services Administration (HRSA). Participation from both headquarters and regional office staff is encouraged.

Through the Forum, key federal partners with equities in disaster behavioral health preparedness and the psychological and behavioral aspects of community resilience:

- Share information and best practices;
- Leverage opportunities for coordinated efforts, joint projects, and presentations at national and regional conferences;
- Incorporate lessons learned into preparedness plans;
- Gather external stakeholder input; and
- Promote shared objectives.

REGIONAL PREPAREDNESS: Regional Emergency Coordinators (RECs) are the regional representatives of the Assistant Secretary for Preparedness and Response. The primary mission of the RECs is to assist partners to prepare for, and respond to, public health and medical emergencies, including behavioral health needs. The RECs are senior members of the Federal emergency operations community and have diverse professional educational backgrounds and expert health systems knowledge and experience. The RECs work to establish engaged partnerships with State, county, and local governments, tribal nations, international counterparts, as well as the private sector. The national response is more effective when all levels of government work together well before an incident to develop effective plans and achieve a heightened state of preparedness.

DISASTER BEHAVIORAL HEALTH CAPACITY ASSESSMENT: ASPR RECs may conduct behavioral health capacity assessments using the HHS Disaster Behavioral Health Capacity Assessment Tool, available at http://www.phe.gov/preparedness/planning/abc/documents/dbh-capacity-tool.pdf. To accomplish this, ASPR RECs collaborate with ASPR National Hospital Preparedness Program Field Project Officers, CDC Public Health Emergency Preparedness project officers, SAMHSA Regional Administrators, and/or DHS-FEMA partners to determine and implement appropriate methodologies to support an assessment to establish capacity, address gaps, and promote resilient systems. ASPR-ABC and SAMHSA are available

to provide technical assistance for this process, and SAMHSA Regional Administrators are available for liaison activities involved in the assessment development.

GeoHEALTH: GeoHEALTH is a tool that can be populated with information about the behavioral health infrastructure in each state, territory, or tribal area, such as availability of SLTT, community, and private providers of mental health and substance abuse services as well as pertinent federal grantees. The HHS Emergency Management Group (EMG) compiles and analyzes behavioral health GeoHealth data to inform response and recovery efforts, target resources, and address gaps.

PLANNING: HHS OPDIVs and STAFFDIVs with disaster behavioral health expertise (such as ACF, ASPR, CDC, and SAMHSA) participate in preparedness activities such as liaising with the ASPR OEM Plans group to ensure that behavioral health planning is incorporated into all hazards plans and all appropriate event specific annexes. During active disaster response, these entities may be called upon to contribute to the development of an ESF #8 Incident Coordination Plan (ICP).

AFTER-ACTION MEETINGS, DRILLS, AND EXERCISES: OPDIVs and STAFFDIVs that are engaged in response and recovery also work with the ASPR OEM Training, Exercise, and Lessons Learned (TELL) Branch through participation in exercises, after-action meetings, and lessons-learned sessions.

RESILIENCE: Agencies participating in the Preparedness Forums foster the principles of individual and community psychological resilience, the importance of social connectedness, and the value of behavioral health promotion in preparedness plans and approaches. These agencies also are typically invited to participate in the resilience-related meetings convened by ASPR, such as the National Community Health Resilience Coalition.

Technical Assistance and Information Dissemination

HHS ASPR Technical Resources, Assistance Center, and Information Exchange (TRACIE): was created to meet the information and technical assistance needs of regional ASPR staff, healthcare coalitions, healthcare entities, healthcare providers, emergency managers, public health practitioners, and others working in disaster medicine, healthcare system preparedness, and public health emergency preparedness. TRACIE offers a self-service collection of disaster medical, healthcare, and public health preparedness materials; provides access to Technical Assistance Specialists for one-on-one support; and allows open discussion through a user-restricted, peer-to-peer discussion board.

SAMHSA REGIONAL ADMINISTRATORS: SAMHSA Regional Administrators are regional resources for planning, preparedness and response, with the ability to work directly with federal, state and local planning, preparedness, and response assets in their region.

COOPERATIVE AGREEMENTS/GRANTS: ASPR and CDC educate SLTT stakeholders and grantees participating in ASPR's Hospital Preparedness Program and CDC's Public Health Emergency Preparedness program on the importance of including behavioral health as part of public health and healthcare capabilities for disaster preparedness and response.

MULTI-STATE DISASTER BEHAVIORAL HEALTH CONSORTIUM: ASPR-ABC and SAMHSA communicate with the Multi-State Disaster Behavioral Health Consortium to exchange information, resources, and promising practices.

DISSEMINATION OF INFORMATION:

- A number of agencies—including ASPR-ABC, CDC, VA, ACF, and SAMHSA, create tip sheets, educational resources, and factsheets and disseminate them to ESF #8, ASPR OEM's Division of Recovery, and SLTT partners.
- The SAMHSA Disaster Kit contains SAMHSA disaster behavioral health publications for professionals, and the general public. Materials may be used to support immediate disaster behavioral health response efforts (See Appendix D).
- The SAMHSA Disaster Behavioral Health Information Series (DBHIS) contains themed resource collections and toolkits pertinent to the disaster behavioral health field (See Appendix D).

BEHAVIORAL HEALTH PROGRAMS:

- SAMHSA's Disaster Technical Assistance Center (DTAC) provides resources that help SLTT entities deliver an effective mental health and substance abuse response to disasters.
- SAMHSA's National Child Traumatic Stress Network is dedicated to improving access to care, treatment, and services for children and adolescents exposed to traumatic events.
- ACF's Administration on Children, Youth, and Families' National Domestic Violence Hotline provides support, information, referrals, safety planning, and crisis intervention in 170 languages to domestic violence victims.
- SAMHSA's National Center for Trauma Informed Care is dedicated to building awareness of trauma-informed care and promoting the implementation of trauma-informed practices in programs and services.

SCIENTIFIC PREPAREDNESS AND RESEARCH: ASPR facilitates dialog with research agencies across government and academia to promote proactive planning for research and evaluation for a range of disaster related health concerns, including behavioral health. The National Institutes of Health (NIH) and

the National Library of Medicine (NLM) conduct research and literature reviews to determine best practices and evidence-informed approaches to disaster behavioral health and resilience. This includes collecting and disseminating information on disasters and behavioral health from National Institute of Mental Health (NIMH), SAMHSA and other agencies via MedlinePlus, PubMed, and the Disaster Information Management Research Center. Awareness of the most up to date findings of the scientific community supports HHS training, guidance, and educational and policy documents.

Training

REGIONAL STAFF TRAINING: ASPR-ABC provides guidance and training as needed and/or as requested on disaster behavioral health preparedness, response, and recovery; at-risk individuals; behavioral health force protection; and community resilience.

PSYCHOLOGICAL FIRST AID: All ASPR-OEM-National Disaster Medical System (NDMS) responders are directed to take an online introductory course on psychological first aid. The online course is also available to any ASPR employee who wishes to take it. ASPR-OEM-NDMS members with behavioral health or related roles are encouraged to take more in-depth psychological first aid training to meet the emotional and medical needs of survivors and responders. Additional psychological first aid training for leaders is available through the ASPR and National Association of City and County Health Officers (NAACHO) developed Building Workforce Resilience through the Practice of Psychological First Aid – A Course for Supervisors and Leaders online course.

CDC TRAINING: CDC offers training in terrorism preparedness and emergency response, including content specific to psychological implications, to CDC employees and contractors and provides training materials to assist local and regional practice partners.

MRC TRAINING: The Division of the Civilian Volunteer Medical Reserve Corps (DCVMRC) provides access to educational opportunities to MRC units and volunteers through MRC-TRAIN to ensure that behavioral health and at-risk individual needs are integrated into their preparedness, response, and recovery activities. In many localities, MRC units are incorporating psychological first aid training in their curricula.

CRISIS COUNSELING TRAINING: SAMHSA provides training in crisis counseling for SLTT personnel.

Office of the Assistant Secretary for Health (OASH)-Office of the Surgeon General (OSG)-DIVISION OF COMMISSIONED CORPS PERSONNEL AND READINESS (DCCPR): Under the operational management of the Readiness and Deployment Operations Group (RedDOG), DCCPR provides its Mental Health Teams with annual training in four areas of competency: disaster behavioral health triage, assessment, analysis, and implementation of sustainable interventions supporting continuity and recovery.

Related Preparedness Considerations

Behavioral Health Promotion

Beyond traditional disaster preparedness activities, approaches that promote good behavioral health as part of overall health and that prevent mental illness and substance abuse can be applied to build individual and community resilience. This can potentially ameliorate adverse behavioral health reactions following an emergency event. Behavioral health promotion and mental illness and substance abuse prevention methods empower individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors and lifestyles. In the context of disaster and public health emergency preparedness, behavioral health promotion and illness prevention include a continuum of approaches to educate the public, disaster survivors, and at-risk individuals, as well as medical and behavioral health professionals and early and school age children's caregivers/educators. Such education is accomplished by developing and delivering training and messaging through live, online, and social media, and through printed materials; by mobilizing and analyzing research; by conducting surveillance of behavioral health concerns; and by pre-developing customizable templates for educational materials. Disseminating information through multiple media, in many languages, and in formats that are age-appropriate and user-friendly, are essential considerations when developing response and recovery plans and coordinating services for at-risk individuals.

Community Resilience

Community resilience is a prevalent theme in the policy and practice that guide national disaster and public health and medical emergency preparedness, response, and recovery. Community resilience may be defined as the sustained ability of communities to withstand and recover—in both the short and long terms—from adversity (NHSS, 2009). Promoting community resilience is a multi-sector endeavor that addresses a wide range of variables that can potentially impact resilience such as infrastructure, connectedness, health, organizational, psychological, and economic (I-C-HOPE) considerations. This effort requires the engagement of diverse partners with direct ties and established trust among the individuals who live in their communities and who are able to mobilize their networks to build community resilience.

Community resilience in the context of national health security is an intersection of preparedness/emergency management, traditional public health, and community development. Preventive care, health promotion, and community capacity building are important in fostering health resilience. Different sectors working in disaster and emergency preparedness, response, and recovery have unique capabilities and have something to offer, and something to receive from, the health sector in a whole community approach to resilience. In particular, behavioral health and psychological resilience science and approaches, the value of behavioral health promotion, and the importance of

social connectedness must be included in disaster behavioral health preparedness efforts and should also inform the larger community resilience discussion to forward integrated whole community planning.

Climate Change Adaptation

As noted in the U.S. Global Change Research Program's Climate and Health Assessment (2016), "The effects of global climate change on mental health and well-being are integral parts of the overall climate-related human health impacts. Mental health consequences of climate change range from minimal stress and distress symptoms to clinical disorders, such as anxiety, depression, post-traumatic stress, and suicidal thoughts. Other consequences include effects on the everyday life, perceptions, and experiences of individuals and communities attempting to understand and respond appropriately to climate change and its implications." Climate change may pose risks for increased natural disasters, extreme weather events, and other climate-related stressors and public health impacts. Careful longer-term planning and preparedness must take into account increased these risks. This includes planning for robust capabilities for behavioral health educational materials and support to meet the challenges of increased severe weather disasters. The potential for re-traumatization in communities affected by recurrent weather-related emergency events is also a planning consideration.

Response

Overview of Response Coordination

General Structure

On behalf of the Secretary of HHS, the ASPR directs and coordinates all federal public health and medical assistance—including behavioral health assistance— pursuant to the NRF. The ASPR also acts as the senior-level HHS liaison to DHS and other federal departments and agencies. Within ASPR, OEM is responsible for ensuring preparedness to respond to and recover from public health and medical threats and emergencies. OEM is also responsible for ensuring that ASPR has the systems, logistical support, and procedures necessary to coordinate the Department's operational response to acts of terrorism and other public health and medical threats and emergencies.

ASPR-OEM maintains a standing headquarters element that includes the HHS Emergency Management Group (EMG) within the Secretary's Operations Center (SOC). The EMG and the SOC routinely function in an awareness and monitoring posture during steady-state times. ASPR- OEM also maintains regional offices led by a Regional Administrator and staffed by Regional Emergency Coordinators (RECs). Both the headquarters and regional staff maintain situational awareness and share information on incidents of potential interest. The RA and RECs from the affected region form the core leadership for field response operations. Upon learning of an incident, RECs will investigate or "size-up" the incident, and initiate contact with colleagues in the affected state and other federal regional offices. If there are no immediate concerns from the state, the REC will communicate the information to the SOC and continue to monitor the situation. The REC's will adopt a "lean forward" posture, review response plans associated with the incident type, and anticipate likely response requirements, should the situation change.

A senior REC in the impacted region is designated by the OEM Director as the Federal Health Coordinating Official (FHCO) responsible for leading the federal response. The FHCO is supported by the EMG and assisted in the area of operations by the Incident Response Coordination Team (IRCT). The IRCT is often situated in the region near the event theatre of operations.

On activation to a response level, the EMG transforms to an established Incident Command System (ICS) and coordinates ESF #8 resources, including coordination with HHS's federal partners, to meet requests for assistance.

Emergency Management Group (EMG)

The EMG is the HHS element responsible for coordination and communications of national or international-level intra and inter-agency public health, medical, and social services response and recovery activities. The EMG is modular, flexible and scalable based on the situation and mission requirements. The EMG loosely follows an incident command system (ICS) structure and the National Incident Management System (NIMS) with General and Command Staff components.

The EMG has the following critical functions:

- Support the needs of deployed public health, medical, or human services response and recovery resources;
- Provide real-time department-level situational awareness, analysis, and monitoring of the public health, medical, and human services environment; and
- Conduct national-level public health, medical and social services inter and intra agency communications and coordination.

Behavioral Health Roles in the EMG

The EMG Behavioral Health Liaison Officer (BH LNO) serves in the Command Staff of the Emergency Management Group (EMG). This role serves as the single point of contact for federal-level behavioral health response and recovery coordination. The EMG Behavioral Health Liaison Officer is responsible for several important functions within the EMG. These include, but are not limited to: provide strategic, department-level guidance by assisting with the development of federal level behavioral health response and recovery priorities and objectives; ensure seamless communication and coordination of Federal Disaster Behavioral Health Group/Behavioral Health Recovery Task Force activities and the EMG; participate in EMG conference calls and meetings; and facilitate the coordination of behavioral health related requests for assistance, information, and resources.

The Incident Response Coordination Team (IRCT)

The IRCT is scalable, has a built-in command structure, and provides support and direction for all ESF #8 response assets in the field. When deployed, under the guidance of the FHCO, the IRCT directs and coordinates activities of all deployed HHS personnel, and assists SLTT and other federal and government agencies, as applicable. Critical to an effective field response is a regional plan developed in collaboration with key public and private sector stakeholders well before an incident. The plan should detail how to perform field assessments. When deployed, the IRCT supports the field assessment for the specific incident for which it is deployed. The IRCT has flexible staffing and may deploy with subject matter experts from HHS and the region. It may include public health, emergency medical,

environmental health, veterinary, behavioral, and mortuary service representatives as well as operations, logistics, and communications team members. Because it is normally regionally based, assessment team members are familiar with local threats, resources, plans, health and behavioral health care delivery systems, key contacts, and geography.

Behavioral Health Roles on the IRCT

The IRCT structure includes a behavioral health function that coordinates behavioral health response activities and facilitates behavioral health force protection. The behavioral health functions are assigned to the Behavioral Health Liaison Officer (BH LNO) who acts as the single point of contact for the IRCT for assisting and cooperating with federal agency representatives on matters related to behavioral health, serves as liaison with SLTT behavioral health officials regarding response operations issues, and monitors behavioral health force protection being provided to deployed teams. If necessary, based on the magnitude of the disaster or emergency, a Behavioral Health Safety Officer will be included on the IRCT and assigned to the behavioral health force protection function. For more information on the IRCT, see the OEM IRCT CONOPS.

The nature of behavioral health activities and defining the scope of care for response operations is determined by the FHCO, IRCT Commander, and National Disaster Medical System (NDMS) Chief Medical Officer (CMO). The behavioral health scope of care is based on assessment of needs with SLTT officials, and in consultation with the SAMHSA Regional Administrator, EMG, IRCT Chief Medical Officer, and ASPR-ABC, as needed. It is expected that disasters or emergencies that include deployment of response assets will require Behavioral Health LNO and Behavioral Health Safety Officer functions on the IRCT due to the inherent behavioral health impacts associated with traumatic events.

Disaster Behavioral Health Response Activities

Disaster behavioral health response efforts primarily address the needs of three population groups: 1) survivors affected by the emergency that require support; 2) incident responders/workers; and 3) existing recipients of services or providers of the behavioral health care infrastructure.

Because behavioral health needs evolve in variable ways after public health emergencies and disasters, and because behavioral health response capabilities are spread across many federal, SLTT, voluntary, non-profit, and grant-based organizations, behavioral health generally does not follow as clear a timeline as other emergency public health and medical response activities. Indeed SLTT, voluntary, and NGO entities are often the first to begin to assess behavioral health needs and initiate a response with existing assets immediately following an emergency event. These actions often occur prior to the deployment of federal behavioral health assets, such as the Division of Commissioned Corps Personnel and Readiness (DCCPR) Mental Health Teams (MHTs). Nevertheless, key activities can be placed into a

general sequence of events, with many of these actions taking place concurrently. For a disaster with a warning period (such as a hurricane), many activities may be completed earlier in the sequence, or even before the disaster's onset. Table 2 outlines the typical disaster behavioral health response sequence of events.

Table 2: Federal Disaster Behavioral Health Response: ESF#8 Response General Sequence of Events

Action/Capability	<24 Hours	<72 Hours	Days-Weeks	Lead Agency
SLTT, voluntary, and NGO entities assess health and medical needs and initiate response	YES	YES	n/a	SLTT
ESF #8 and NDMS activate; OEM deploys IRCT, with assignment of the Behavioral Health LNO to support coordination and force health protection functions. Behavioral Health Safety Officer assigned by the EMG Incident Manager, when appropriate.	YES	n/a	n/a	HHS-ASPR
EMG Command Staff positions added as needed (depending on the EMG activation level).	YES	n/a	n/a	ASPR-EMG
ASPR coordinates with regional partners, including Regional OpDivs, MRC Regional Coordinators and state ESAR-VHP Coordinators to assess BH needs	n/a	YES	YES	ASPR-IRCT supported by BH LNO
Federal Disaster Behavioral Health Group (FDBHG) convenes, establishes communication and information gathering channels; a summary of FDBHG calls is provided to OEM and to other partners via email and posting on the SOC portal	n/a	YES	YES	ASPR-ABC
Human Services needs assessment and reporting for ESF #8 and ESF#6 situation reports begin; information is shared with FDBHG due to linkages between behavioral health and human services issues.	n/a	YES	YES	ACF
Federal Mental Health Teams deployed if indicated and missions defined	n/a	YES	YES	RedDOG, NDMS-CMO
Behavioral health force protection is provided to HHS responders	n/a	YES	YES	ASPR-OEM & IRCT
GeoHEALTH analysis of needs, gaps	n/a	YES	YES	ASPR-OEM-Fusion
Distribution of behavioral health information and resource coordination	n/a	YES	YES	ASPR-ABC, PIO/CDC/SAMHSA
SAMHSA initiates programs and activities, including CCP and Disaster Distress Helpline	n/a	YES	YES	SAMHSA

Action/Capability	<24 Hours	<72 Hours	Days-Weeks	Lead Agency
CMS works with SLTTs to maximize flexibility in Medicaid/Medicare payment and coverage in the disaster or emergency affected region.	n/a	YES	YES	CMS
HRSA identifies the health centers, service delivery sites and types of behavioral health providers (including NHSC clinicians) that offer behavioral health services in the disaster or emergency affected region.	n/a	YES	YES	HRSA
Surveillance conducted to gather behavioral health information; information provided to OEM-Fusion	n/a	YES	YES	CDC/SAMHSA/ASPR-OEM-Fusion
NIH and ASPR mobilize research findings and subject matter expertise	n/a	YES	YES	NIH/ASPR
Analysis of behavioral health contact and Electronic Medical Record data	n/a	YES	YES	IRCT/NDMS

Federal Activation

HHS/ESF #8 ACTIVATES: The Secretary activates a department-wide response based on FEMA activation of the NRF ESF #8 or determination that a significant incident or public health emergency requires a department-wide response. ASPR-OEM designates an FHCO to lead the response in affected region, and deploys an IRCT to support and direct deployed resources. EMG Command Staff, including HHS OPDIVS/STAFFDIVS and ESF #8 partners, are activated through the SOC for response activities. H&SS RSF maintains situational awareness to inform potential NDRF RSF activation.

SUPPORTING AGENCIES ACTIVATE: The CDC Emergency Operations Center (EOC) Mental/Behavioral Health Functional Desk, ACF Emergency Operations and SOC Liaison, ASPR-ABC Operations Lead, American Red Cross Mental Health, and SAMHSA Emergency Coordination functions activate in response mode and coordinate any immediate outreach to SLTT partners to address urgent needs. Once the IRCT is operational, ESF #8 communications and reporting mechanisms are used to ensure that agency outreach is coordinated with the IRCT.

Coordination, Assessment, and Analysis

FEDERAL DISASTER BEHAVIORAL HEALTH GROUP (FDBHG): ASPR-ABC convenes the FDBHG, which includes participants indicated by the needs of the disaster such as SAMHSA; ACF; ARC; ASPR RECs, Recovery, Communications, and Ops; CDC; Federal Occupational Health (FOH) Employee Assistance Program (EAP); ACL; HRSA; OASH; NIH; and the IRCT Behavioral Health LNO/Behavioral Health Safety

Officer. The FDBHG is responsive to the disaster- or emergency-related behavioral health needs and provides behavioral health information analysis and coordination to the FHCO, IRCT Commander, and EMG in support of federal public health and medical response operations; it does not replace or supersede OPDIV and STAFFDIV authorities, responsibilities, or reporting. The FDBHG:

- Implements a coordinated outreach approach so that outreach to state and local behavioral health stakeholders is targeted, appropriate, and non-duplicative. Outreach to the affected region will be in concert with the FHCO;
- Establishes bi-directional communication through relevant agency programs and grants to identify needs, share governmental information, gather essential elements of information, and develop a common operating picture regarding behavioral health (Appendix F summarizes the Essential Elements of Information);
- Analyzes information to identify capabilities, gaps, and response recommendations;
- Identifies informational and psycho-educational resources related to the disaster event and mobilizes access to this information through public information systems; and
- Generates information and conducts analysis to inform transition to recovery, long-term recovery, and after-action/lessons-learned activities.

FEDERAL PUBLIC HEALTH AND MEDICAL RESPONSE REPORTING: A variety of sources, including response team personnel, contribute behavioral health information and encounter data to situation reports submitted by the IRCT. ASPR-ABC also summarizes pertinent information from the FDBHG for the SOC and ASPR leadership and to inform the Incident Action Plan (IAP) and HHS policy coordination meetings. A written summary of all FDBHG calls are provided to OEM and to other partners via email and posting on the SOC portal.

MRC COORDINATION: The Medical Reserve Corps (MRC) Program, within the OEM Partner and Readiness and Emergency Programs (PREP) Division assists federal public health and medical response partners regarding situational awareness of MRC activities and coordination with MRC member units. The MRC Program works with the coordinator of the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) to provide liaison to ESF #8 partners on civilian deployment.

MISSION ASSIGNMENTS: ASPR-EMG, along with RedDOG, creates rosters of responders eligible for mission assignments that HHS receives from FEMA in accordance with the Stafford Act. ASPR executes mission assignments and deploys behavioral health assets based on SLTT requests and needs. ASPR-ABC assists by analyzing and vetting complex behavioral health mission assignments to ensure that appropriate behavioral health skillsets are represented.

Response Assets, Resources, Technical Assistance, and Information Dissemination

HUMAN SERVICES: ACF contacts program grantees and regional coordinators in affected areas to determine the impact of the disaster on human services provision and related behavioral health needs. ACF can make use of flexibilities and waivers in its routine grantee programs to provide services as necessary.

BEHAVIORAL HEALTH LNO: Upon deployment of NDMS or DCCPR teams, the HHS-EMG assigns a Behavioral Health LNO to support the IRCT to help coordinate federal response operations assets with local and voluntary assets, identify needs, report on behavioral health activities, monitor federal behavioral health force protection efforts, and facilitate the transition to recovery operations. ASPR-ABC serves as a reach-back resource on disaster behavioral health for the NDMS CMO, the IRCT, the Behavioral Health LNO, and for leadership in the field.

RedDOG MENTAL HEALTH TEAMS: RedDOG provides operation management of US Public Health Service (PHS) Mental Health Teams capable of responding to the many immediate and midterm behavioral health issues or needs arising from large scale emergencies and disasters. USPHS officers are capable of deploying directly to assist SLTT and multilateral resources in responding to a range of disaster and emergency responses. As Tier 2 teams, the Mental Health Teams can deploy within 36 hours of activation and are scalable to provide only those resources needed.

INFORMATION PROMULGATION: ASPR-ABC works with SAMHSA, CDC, the ASPR Public Information Officer, and pertinent stakeholders to coordinate dissemination of relevant behavioral health information and psycho-educational resources. Information on behavioral health, coping, resilience, and resources available via HHS are disseminated through multiple mechanisms including social media (e.g., Twitter and Facebook) accounts.

SAMHSA Behavioral Health Programs/Activities:

- SAMHSA contacts grantees and response partners to determine impact and coordinates with the State Disaster Behavioral Health Coordinator and stakeholders (e.g.: Departments of Mental Health/Behavioral Health, Substance Abuse/Addiction Services) in the affected region to assess need and offer technical assistance and resources. Examples of relevant projects and grants include the National Child Traumatic Stress Network, Suicide Prevention, block grants, tribal programs, and mental health and substance abuse prevention and treatment programs.
- SAMHSA provides technical assistance on CCP (a Stafford Act program) and the SAMHSA Emergency Response Grant (SERG) program to SLTT entities. CCP assists individuals and communities in recovering from the challenging effects of disasters through the provision of

community-based outreach and psychoeducational services. Services are typically provided by behavioral health organizations through contracts with a state's department of mental health.

- SAMHSA disseminates resource materials via the SAMHSA website, Information Clearance Center, and DTAC.
- SAMHSA Regional Administrators are able to work directly with federal, state and local response and recovery assets as regional SAMHSA leadership, as well as provide liaison between incident command(s) and national SAMHSA programs.
- The SAMHSA Disaster Distress Helpline connects those experiencing emotional distress related to a disaster with crisis center counselors who can provide support and referrals to local resources by calling SAMHSA's 24/7 Disaster Distress Helpline at 1-800-985-5990 or texting TalkWithUs to 66746.
- SAMHSA GO2AID—The Field Resources for Aiding Disaster Survivors App allows responders to access critical, disaster-related behavioral health resources from their phone.
- SAMHSA helps VOADs and professional guilds that provide behavioral health services, such as the American Psychological Association, the National Association of Social Workers and the American Counseling Association, to coordinate their activities with federal and SLTT efforts.

MEDICAID/MEDICARE: CMS works with states to maximize flexibility in Medicaid/Medicare payment and coverage in the disaster or emergency affected region.

HRSA: HRSA identifies the health centers, service delivery sites and types of behavioral health providers (including National Health Service Corps clinicians) that offer behavioral health services in the disaster or emergency affected region.

SURVEILLANCE: Agencies query existing surveillance systems for information about behavioral health and resilience. CDC and SAMHSA, if indicated, tailor existing surveillance systems, such as the Behavioral Risk Factor Surveillance System, to ascertain disaster-related behavioral health trends.

RESEARCH FINDINGS AND SUBJECT MATTER EXPERT (SME) INPUT: NIH and its National Library of Medicine (NLM) identify pertinent research findings and scientific evidence relevant to behavioral health and resilience concerns of the disaster event in order to inform policy and response decisions. NIH, ASPR-ABC, and ASPR's National Biodefense Science Board (ASPR-NBSB) obtain input from additional behavioral health and resilience SMEs when indicated.

RESEARCH OPPORTUNITIES: NIH examines the response environment for opportunities to promote research on behavioral health through existing programs, through specialized funding announcements, or the NIH unsolicited parent grant announcement.

Responder Behavioral Health

- The HHS EMG and ASPR IRCT integrate behavioral health force protection assets and materials into federally deployed teams, with coordination by the Behavioral Health LNO.
- During response events that carry a high risk of secondary trauma, a Behavioral Health Safety Officer may be assigned to the IRCT, in addition to the Behavioral Health LNO, to coordinate on site force health protection to deployed HHS personnel.
- In catastrophic, complex, or large scale events, behavioral health providers and materials are integrated into the NDMS Mobilization Processing Center (MPC) to provide information, pre- and post-deployment briefings, and informal one-on-one supportive interventions to HHS responders (see OEM MPC CONOPS for more detail).
- After deployment the NDMS CMO, ASPR-ABC, and RedDOG—informed by input from the field leaders of the response— will determine whether additional efforts to ensure responder resilience are warranted. These efforts could include follow up emails, telephone calls or material distribution.

RedDOG MENTAL HEALTH TEAMS (MHTs): RedDOG PHS MHTs may be deployed to provide force health protection services, stress mitigation/management, counseling services for responding agencies' personnel and their family members, crisis intervention including psychological first aid and triage for disaster survivors and incident responders/workers, and public behavioral health agency/community assistance.

CDC RESPONDER RESILIENCY: Through its Responder Resiliency Program, CDC provides trained team members to monitor and support the well-being and resilience of CDC emergency response personnel and enhance their awareness of psychosocial conditions in the populations they serve.

CDC RESPONDER HEALTH MONITORING: CDC's National Institute for Occupational Safety and Health (NIOSH) offers guidance for emergency responder health monitoring and provides communication products and technical consultation to employers and worker organizations following requests submitted either through routine channels or through the CDC Emergency Operations Center Worker Safety and Health Function Desk.

FOH EAP SERVICES: FOH EAP Emergency Response Teams report to impacted agencies requesting services and can provide post-deployment education, support, and referrals to responders. Information on how to access the EAP is provided to responders during the mission and after their return home.

Considerations for Mass Violence Events

After acts of mass violence or acts of terrorism, a Stafford Act may not be enacted. The structure for command and control and the way services and resources are coordinated and accessed may be different then after natural disasters. Different partners are often engaged in providing behavioral health support and services to the impacted community. These additional partners may include the Department of Justice (DOJ) Federal Bureau of Investigation (FBI) Office for Victim Assistance (OVA) and the DOH Office for Victims of Crime (OVC). The Department of Education may be involved if an educational setting has been impacted by the incident and the learning environment disrupted. If an incident is determined to be criminal in nature, DOJ-FBI usually serves as the lead for the incident response.

Shortly after a mass violence event or act of terrorism, ASPR-ABC convenes a coordinating call with the above partners and others depending on the nature of the incident. Participants may include ASPR Regional Emergency Coordinators, SAMHSA headquarters personnel and Regional Administrators, and the American Red Cross. Other HHS OPDIVs and STAFFDIVs may also be included along with relevant national partners and local representation. The purpose of the coordinating call is to:

- Facilitate communication across agencies and programs at the federal level who are involved with providing behavioral health support, services, technical assistance or funding so that there is a coordinated and common understanding of behavioral health needs and support being provided and to be able to share that information with leadership.
- Engage national, regional, and local partners to help address needs or gaps that federal assets can assist with or facilitate resolution. Needs or gaps often include specific subject matter expertise, policy guidance, communication to leadership to release or activate certain programs or waivers, or the need for technical assistance and contacts at other agencies.
- Ensure for rapid dissemination of resources and information.

Transportation, Railway, and Aviation Disasters

The National Transportation Safety Board (NTSB) will determine if a rail or aviation accident fits the requirements of either the Aviation or Rail Act. The aviation legislation applies to any domestic or foreign commercial aviation accidents occurring within the United States, its territories, possessions,

and territorial seas and resulting in a major loss of life. The rail legislation only applies within the United States. Major loss of life is the key determination for activation of either legislation, is defined by the NTSB for each incident, and can be dependent on community characteristics and resources.

Once the legislation is activated, the Federal Response Plan to Aviation Disasters or the Rail Response Plan will be followed. The plan identifies organizational leads and clearly defines roles, responsibilities, and expectations for all involved. NTSB has overall leadership and responsibility for implementation of the plan and the response. In either plan, the American Red Cross is congressionally mandated, through NTSB coordination, to provide crisis counseling and short term disaster mental health services for family members, friends, and survivors. Through their local chapters across the country, the American Red Cross partners with professional mental health providers who have received disaster response training. Use of this service is voluntary and is offered throughout the United States to family members, friends, and survivors of transportation accidents investigated by the NTSB. The plan has six Victim Support Tasks (VSTs) similar to the ESFs in the Federal Response Framework. The VST leads are responsible for fulfilling their assigned tasks within their agency or organizational mission and parameters, however, by agreeing to serve as a VST lead each agency/organization agrees to work together under the leadership of the NTSB resulting in a coordinated and cohesive response.

Considerations for Catastrophic Disaster

Catastrophic disasters impose extensive and urgent behavioral health needs that may significantly exceed the response capabilities of SLTTs, voluntary organizations, partners, and federal assets. Examples of catastrophic scenarios are devastating, widespread natural disasters affecting multiple SLTTs, large public health emergencies or epidemics, or disasters with very high loss of life and traumatic exposure. Catastrophic disasters necessitate actions above and beyond those listed in this CONOPS to ensure that disaster survivors and responders receive the critical behavioral health services they need. Catastrophic events likely entail extensive, acute needs in the population and the potential for damage to the behavioral health infrastructure that would normally provide treatment. Behavioral health force protection for deployed responders will also be a concern. As described earlier, NDMS may opt to stand up a Mobilization Processing Center to provide additional support to HHS responders. The specific risks, needs, and behavioral health response actions will be dictated by the characteristics of the catastrophic disaster. Depending on legal authorities, presidential or legislative actions, and/or supplemental funding support, a number of response resources may be available.

1. **Additional Partners:**

By reaching out and facilitating coordination, ASPR, SLTTs, and other organizations may expand their respective responses by maximizing potential surge resources for behavioral health, such as:

- HHS behavioral health professionals beyond those normally engaged in response activities;
- VA and DoD;
- State volunteer behavioral health responders from the MRC and the ESAR-VHP network outside the affected area;
- National VOADs and community and faith-based organizations with behavioral health capabilities from outside the affected area;
- Behavioral health and health professional associations such as the American Psychological Association, the National Association of Social Workers, the American Psychiatric Association, the National Association of State Alcohol and Drug Abuse Directors, the National Association of State Mental Health Program Directors, the American Academy of Pediatrics, the American Medical Association, etc.;
- State-to-state behavioral health resources available through the Emergency Management Assistance Compact (EMAC);
- Behavioral health professionals tracked through ESAR-VHP systems; and
- Behavioral health professionals from other countries and international organizations made available through established international agreements or structures.

2. **Deployment of Tools and Resources:** HHS can potentially draw on a number of mechanisms and assets to expand the disaster behavioral health response effort:

    - Facilitating the provision of just-in-time disaster behavioral health training (such as psychological first aid) for additional federally-sponsored volunteers or other responders who may be put on rosters and deployed;
    - Assisting SLTTs with access to critical psychiatric or substance abuse treatment medications;
    - Using science-based tools to prioritize use of scarce clinical resources; and
    - Offering evidence-based and culturally informed interventions at the population and community level to reduce morbidity or severity of psychological illness and injury in situations that hamper or prevent provision of behavioral health treatment to significant numbers of individuals.

3. **Waivers and Supplemental Funding:** The federal role in disaster response may be broadened through utilization of statutory authorities or new authorities enacted by Congress:

    - Exercise of allowable federal program and grant flexibility or waivers to broaden provision of behavioral health services; and
    - Securing supplemental appropriations from Congress to fund critical disaster behavioral health services and determining delivery mechanisms for funding (such as the SERG program, which may also be used without Stafford Act declaration).

Recovery

Overview of Health and Social Services Recovery

HHS is the Coordinating Agency for the NDRF Health and Social Services (H&SS) Recovery Support Function (RSF) 4 and the Department has designated a National H&SS RSF Coordinator within ASPR. The Recovery Federal Interagency Operational Plan (FIOP) establishes coordination mechanisms for Federal H&SS RSF operations in support of locally-led recovery efforts.

Mental health reactions and substance abuse conditions often emerge or intensify during recovery, impeding individual and community resilience. Behavioral health is a critical part of a multi-sector recovery approach that engages the whole community to foster partnerships among government and local institutions, the private for-profit and non-profit sectors, and voluntary, community, cultural, and faith-based groups.

Recovery coordination for behavioral health may include:

- Assessment of disaster-related structural, functional , and operational impacts to behavioral health facilities and programs;
- Provision of technical assistance in leveraging existing resources to meet community needs that have surfaced during the response phase, such as increasing surge capacity of existing behavioral health service systems;
- Engagement with behavioral health partners to assess needs, provide technical assistance, and identify best practices (including those for prevention) and connect practitioners with resources;
- Engagement with stakeholders to develop strategies, including population-based strategies, to address ongoing behavioral health assessment, surveillance and long-term treatment needs; and
- Development and dissemination of consistent messaging and guidance concerning stress management and mitigation strategies.

Recovery Integration

ASPR OEM's Division of Recovery staff members are engaged throughout preparedness, response, and recovery phases and participate in the Disaster Behavioral Health Preparedness Forum and the FDBHG to ensure that recovery issues are anticipated and addressed in all phases of disaster.

FDBHG DURING RESPONSE—RECOVERY INVOLVEMENT: During response, ASPR-ABC ensures that FDBHG meetings include behavioral health issues that can be expected to evolve or arise during recovery. ASPR Division of Recovery is invited to participate in FDBHG meetings.

FDBHG— RESPONSE TO RECOVERY TRANSITION: The final meeting(s) of the FDBHG during the response phase typically focus on recovery, and involve additional recovery stakeholders, as needed such as public health and medical response.

Behavioral Health Recovery Task Force: When NDRF activation is imminent, the H&SS RSF National Coordinator convenes the H&SS RSF Primary Agencies and Supporting Organizations to support the overall health (including behavioral health) and social services activities. The H&SS RSF can include content area working groups, such as the BH Recovery Task Force.

- If indicated by the needs of the disaster/emergency, the H&SS RSF National Coordinator, in consultation with ABC and the H&SS Field Coordinator, establishes a working group to address behavioral health needs and provide reach-back subject matter expertise to the H&SS Field Coordinator. The Recovery BH Task Force, when activated to support recovery, serves this function.

- Pertinent members of the FDBHG typically continue to participate in the BH Recovery Task Force if convened during the recovery phase. Additional task force members from HHS agencies and H&SS Primary and Supporting Organizations— both from headquarters and the impacted region—are added, as necessary, to meet the needs of the disaster or emergency.

- The H&SS RSF Field Coordinator identifies behavioral health issues in need of Recovery BH Task Force support and convenes meetings and calls with reach-back support and facilitation assistance from ASPR ABC. The BH Recovery Task Force in support of health and social services recovery may:

    - Provide behavioral health information analysis and coordination in support of H&SS RSF operations. The BH Recovery Task Force does not replace or supersede OPDIV and STAFFDIV authorities, responsibilities, or H&SS RSF reporting;

    - Support bi-directional communication through relevant agency programs and grants to identify needs, share governmental information, gather pertinent information, and develop a common operating picture that are needed to guide behavioral health recovery activities.

    - Analyze information to identify capabilities and gaps, and make recommendations to inform recovery actions for behavioral health;

- Identify informational and psycho-educational resources related to the disaster event and mobilize access to this information through public information systems; and
- Generate information to inform longer-term behavioral health issues that may arise later in recovery.

- Pertinent information from the BH Recovery Task Force is summarized for H&SS situation reports and for ASPR leadership.
- The BH Recovery Task Force may be called upon to provide technical assistance, support, and analysis regarding disaster behavioral health recovery issues throughout the H&SS RSF recovery activation period. The BH Recovery Task Force stands down when the H&SS RSF stands down, if it has not been adjourned prior to this.

Responsibilities of HHS Agencies Supporting Recovery for Behavioral Health

HHS agencies with behavioral health responsibilities:

- Maintain bi-directional communication through relevant agency programs and grants to assess and address locally-driven recovery needs and gaps and share governmental information;
- Support work groups established by the HSS RSF Field Coordinator and the impacted SLTT to address local disaster behavioral health recovery needs;
- Provide information to the H&SS RSF Field Coordinator to inform recovery assessments and to guide H&SS RSF activities (including requests for support based on the H&SS Field Coordinator's Mission Scoping Assessment Report and/or recovery mission assignments);
- Identify informational and psychoeducational resources related to disaster recovery and resilience and mobilize access to this information through recovery information channels; and
- Plan for and implement the transition from recovery operations to steady-state activity within their agency's programs.

Additional Resources, Technical Assistance, and Information Dissemination

GeoHEALTH IN RECOVERY: The OEM Division of Fusion compiles and analyzes relevant GeoHEALTH data to inform recovery efforts and track reconstituted infrastructure.

SUPPORT FOR H&SS RSF COORDINATORS: ASPR-ABC provides subject matter expertise and reach- back support to H&SS RSF National and Field Coordinators.

BEHAVIORAL HEALTH PROGRAMS/ACTIVITIES: SAMHSA:

- Partners with SLTT entities to examine behavioral health recovery needs and recommend ways to transition federal response supports into existing structures (e.g., CCP or SERG and/or VOAD or community behavioral health efforts);
- Offers technical assistance and resources from existing SAMHSA-sponsored programs and grantees such as the Disaster Technical Assistance Center, National Child Traumatic Stress Network, Suicide Prevention, block grants, tribal community programs, and mental health and substance abuse prevention and treatment programs;
- Works in partnership with SLTT CCP grantees to continue to carry out crisis counseling services to promote individual and community resilience and recovery; compiles and analyzes data from CCP to inform the behavioral health recovery; and
- SAMHSA Regional Administrators are able to work directly with federal, state and local response assets as regional SAMHSA leadership, as well as provide liaison between incident command(s), H&SS RSF Field Coordinators, and national SAMHSA programs.

HUMAN SERVICES: ACF provides recovery-related technical assistance for ACF programs.

MEDICARE/MEDICAID: CMS works with SLTTs to maximize flexibility in Medicaid/Medicare payment and coverage in the disaster or emergency affected region.

HRSA: Identifies health centers, service delivery sites and types of behavioral health providers (including NHSC clinicians) that offer behavioral health services in the disaster or emergency affected region.

SURVEILLANCE: Agencies query existing surveillance systems for information to track trends in behavioral health recovery in the affected region. CDC, if indicated, tailors existing surveillance systems to continue to ascertain disaster-related behavioral health trends.

RESEARCH OPPORTUNITIES: NIH, placing the care and safety of disaster survivors above all else and remaining sensitive to the complexities associated with disaster research, examines the recovery environment for opportunities to promote research on behavioral health through existing programs, through specialized funding announcements, or through the NIH unsolicited parent grant announcement.

RESEARCH AND SME INPUT: NIH and its NLM provide literature reviews and gather pertinent research on recovery and resilience issues, as indicated. ASPR-ABC obtains input from additional behavioral health, recovery, and resilience subject matter experts when indicated.

FOH EAP SUPPORT: The FOH EAP and Work/Life program offer information and transition services for qualified individual federal employees, their families, and supervisors after an event. Assistance might include provision of psychological support sessions, information about what to expect in the aftermath of an event, including expectations about work performance, and coaching on specific issues.

Transition from H&SS RSF Activation to Steady-State

PHASE-DOWN AND TRANSITION TO STEADY-STATE: Transition from NDRF H&SS RSF coordinated recovery activity to steady-state federal, SLTT, and community resources are a key planning consideration throughout the H&SS RSF operational period. The NDRF and the Recovery FIOP provide guidance for assessing the progress of this transition. Prior to the transition, phase- down planning is conducted. For behavioral health this involves:

- Ensuring the disaster-impacted community is aware of any changes in behavioral health service provision and engaged in the transition to steady-state activity, working through the H&SS RSF Field Coordinator and regional agency personnel; and
- Documenting and applying behavioral health lessons learned through engaging in after-action review activity and revising related recovery documents, including documenting the new promising practices, approaches, knowledge, and resources concerning behavioral health developed though the recovery process that can assist communities to recover and become more resilient.

Appendices

The Appendices include:

- Appendix A: Disaster Behavioral Health Operational Checklist
- Appendix B: IRCT Behavioral Health LNO Job Aid;
- Appendix C: IRCT Behavioral Health Safety Officer Job Aid
- Appendix D: Web Resources
- Appendix E: List of Acronyms
- Appendix F: Essential Elements of Information

Appendix A: Disaster Behavioral Health Operational Checklist

DISASTER BEHAVIORAL HEALTH OPERATIONAL CHECKLIST

TASK: INITIAL ASSESSMENT	RESPONSIBLE
☐ **ASPR's RECs in the affected region engage with SLTT officials** to provide technical assistance, assess situation, and identify gaps. RECs contact/consult with HHS RD, RHA, SAMHSA RA, and ASPR-ABC as necessary.	ASPR-RECs, EMG
☐ **RECs notify ASPR leadership and EMG to apprise them of situation, request for federal assistance (if any), and recommended course of action,** including Mission Assignment, if Stafford Act declaration is anticipated.	ASPR-RECs, EMG
☐ **Request for DHHS Support is received and approved by EMG**	ASPR-EMG
☐ **Review Mission Assignment (MA) for behavioral health needs, approved activities, and appropriate scope of care.**	ASPR-EMG, RECs, ABC
☐ **ASPR-ABC notifies ASPR-RECs and ASPR-EMG of intent to convene Federal Disaster Behavioral Health Group to promote a common operating picture for disaster behavioral health.** ASPR-RECs provide input on behavioral health needs/issues based on the Disaster Behavioral Health Capacity Assessment for states in their region.	ASPR-ABC
☐ **Convene Federal Disaster Behavioral Health Group** to ensure situational awareness of needs/issues related to federal assistance requests, identify existing resources, and provide reach-back support for the Behavioral Health LNO and other deployed HHS field assets	ASPR-ABC
☐ **Contact stakeholders in the Region** to provide supporting information regarding disaster behavioral health issues/needs related to the request and connect RECs to behavioral health federal partners or stakeholders if needed.	ASPR-RECs/ ABC, SAMHSA

TASK: INITIAL ACTION	RESPONSIBLE
☐ **A response is authorized** based on FEMA activation of the NRF ESF #8 or determination that a significant incident or public health emergency exists. EMG Incident Manager/OEM Director or designee designates FHCO to lead response in affected region, and deploys IRCT to support and direct deployed resources. HHS OPDIVS/STAFFDIVS and ESF #8 partners are activated through SOC for response activities.	ASPR-EMG
☐ **A Behavioral Health Liaison Officer (LNO) is assigned** to act as single point of contact for assisting and cooperating with agency representatives, serve as liaison with federal and SLTT behavioral health officials regarding response operations, and coordinate behavioral health force protection.	ASPR-EMG

TASK: INITIAL ACTION	RESPONSIBLE
☐ **Behavioral health activities and scope of care are defined** based on needs assessment by the IRCT CO, the FHCO, and the NDMS CMO, and in consultation with the EMG, SAMHSA, IRCT Chief Medical Officer, Behavioral Health LNO, ABC, and federal and SLTT officials, as needed.	IRCT
☐ **A Behavioral Health Safety Officer (SFO) is assigned**, if additional support is needed, to monitor and facilitate behavioral health force protection for the IRCT and deployed resources	ASPR-EMG
☐ **Determine BH assets to include those embedded in NDMS Teams and PHS MHT assets and make contac**t. Determine a coordination plan for daily deployment.	IRCT BH-LNO
☐ **Establish a daily protocol for communication with the IRCT Commander to include morning and afternoon briefings or meetings as needed and data collection procedures.**	IRCT BH LNO
☐ **Identify responder behavioral health force protection personnel and assets.** Determine whether a Deployment/Re-entry center will be established for this response. Ensure that deployed teams have behavioral health staff assigned.	IRCT BH-LNO
☐ **Identify responder behavioral health force protection resource materials.** May include print and Web-based materials addressing how to anticipate and address behavioral health reactions and how to access additional support if needed. Ensure mechanism to deliver/transmit resources to deployed team members.	ASPR-ABC / SAMHSA
☐ **Establish communication with SAMHSA RA and with the State Disaster Behavioral Health Coordinator.** Determine activities and BH resources available.	IRCT BH LNO
☐ **Identify Interagency partners (other Federal agencies, State, Local, Tribal), HHS OPDIV/ STAFFDIV (SAMHSA, etc.) and any NGOs (Red Cross, etc.), in coordination with the EMG Incident Manager, FHCO and IRCT Commander,** who will participate in the execution of the mission.	ASPR-EMG
☐ **Convene and participate in Federal Disaster Behavioral Health Group (FDBHG).**	ASPR-ABC / FDBHG Members
☐ **Identify, in consultation with NDMS CMO and ASPR-ABC, behavioral health materials and resources for disaster survivors for use in the field.** Ensure mechanism to deliver/transmit resources to deployed team members.	IRCT BH LNO
☐ **Develop common operating picture, communications flow, and plan to collect behavioral health Essential Elements of Information (EEIs).**	IRCT BH LNO

TASK: DEMOBILIZATION/TRANSITION TO RECOVERY	RESPONSIBLE
☐ **Focus IRCT and MH responder on Transition to Recovery Issues.** As the transition to recovery nears, ensure that plans are in place to transition care and services to local assets.	IRCT BH LNO
☐ **Identify behavioral health gaps/risks for the demobilization/transition plan.** Base identification of gaps/risks on coordination with staff on the ground, input from the RECs and LNO, feedback from other federal, state, local, tribal or NGO agencies, EEI data, conceals or email traffic, assessment of OPDIV / STAFFDIV personnel or Senior Leaders.	IRCT BH LNO
☐ **Identify responder behavioral health force protection needs regarding demobilization.** Provide information and print and or Web-based resources to demobilizing responders to anticipate and address behavioral health reactions that might arise following the end of the mission, including how to access additional support if needed. Identify a process for assessment/check-in/follow-up with responders, if indicated.	IRCT BH LNO
☐ **Collect behavioral health After-Action Report/Lessons Learned items**. Collect behavioral health lessons learned from FDBHG members and ASPR OEM's Division of Recovery to transmit to TELL and FDBHG members and stakeholders, as appropriate.	ASPR-ABC

Appendix B: IRCT Behavioral Health LNO Job Aid

Overview

Based on the needs of the disaster or emergency response, the Incident Response Coordination Team (IRCT) Behavioral Health Liaison Officer (BH LNO) role may be assigned to an IRCT member with other functions or be assigned an IRCT member as their sole role. The BH-LNO reports to the IRCT Commander or to another IRCT member as assigned. The nature of behavioral health activities and defining the scope of care during response is determined by the IRCT Commander, the Federal Health Officer identified for the region, and the NDMS Chief Medical Officer (CMO), in consultation with the Emergency Management Group (EMG), SAMHSA, the IRCT CMO, and ASPR's Division for At-Risk Individuals, Behavioral Health, and Community Resilience (ABC).

Behavioral health, in a public health and medical response and recovery context, is concerned with:

- the stress, trauma, mental health, and substance abuse issues of disaster survivors and responders with a particular focus on mitigation of adverse behavioral health impacts;
- the behavioral health service system and the people that use these services; and
- Positively influencing human behavior through effective public health messaging.

Duties

Coordination Activities

1. Act as single point of contact in the field/impacted region for assisting, cooperating with, and providing linkages to federal agency representatives regarding disaster behavioral health.
    a. Serve as a subject matter expert for IRCT and NDMS CMO on behavioral health needs of survivors and responders, local and state capabilities, services being provided, gaps and shortfalls, and determination of appropriate strategies and tactics to address needs.
    b. Maintain contact with ASPR-ABC and the Federal Disaster Behavioral Health Group (FDBHG) through email and conference calls to ensure information flow between the field and HQ and to promote seamless access of federal technical assistance and resources.
    c. Participate on ESF #8, ESF #6, FDBHG, and Recovery calls.
2. Develop the initial response operations plan and act as the single point of contact for members of NDMS and PHS Response Teams.

3. Serve as liaison for the IRCT with State, Tribal, Territorial, and local behavioral health officials.

    a. Establish and maintain communication with relevant partners, such as the State Disaster Behavioral Health Coordinator and/or the SAMHSA Regional Administrator.

    b. Participate in, and inform IRCT activities to ensure behavioral health considerations and current behavioral health activities are understood.

Response Activities

1. Coordinate orientation and pre- and post-deployment briefings for behavioral health response team members.

2. Ensure monitoring and facilitation of behavioral health force protection among IRCT and field personnel.

3. Educate IRCT personnel and response teams about the role of disaster behavioral health, the use of psychological first aid, and the importance of responder physical and psychological self-care.

4. Work with the IRCT Commander, Chief Medical Officer, and Safety Officer to promote work practices conducive to optimal physical and psychological health (e.g., regular breaks, time for sleep and/or exercise, contact with supports at home, etc.).

5. Communicate with embedded team-based behavioral health personnel and monitor overall behavioral health force protection of deployed teams.

    a. Establish and maintain regular communication with imbedded BH personnel on NDMS and DCCPR teams.

    b. Obtain and provide behavioral health related resources and information as requested.

    c. Report on force health protection activities and risk issues to be mitigated to the IRCT Commander.

Assessment, Information and Reporting Activities

1. Conduct an initial community needs assessment to determine local behavioral health needs.

2. Gather information to inform the common operating picture as this pertains to the behavioral health needs of survivors, responders, behavioral health service recipients, and the behavioral healthcare infrastructure.

a. Track activity, encounters and services provided by behavioral health response teams for inclusion in daily reports.

b. Create daily SitReps/SPOT reports summarizing daily activities (see attached examples).

c. Develop regular reports or information to provide to State and local stakeholders and the Secretary's Operation Center (SOC).

d. Inform reporting to ESF 8/SOC with information related to behavioral health needs and actions.

e. Utilize FDBHG partners as reach back resources and as sources to both obtain and disseminate behavioral health information and materials.

Reference: HHS Disaster Behavioral Health Concept of Operations

http://www.phe.gov/abc

Appendix C: IRCT Behavioral Health Safety Officer Job Aid

Overview

The Emergency Management Group (EMG) Command Staff or Incident Response Coordination Team (IRCT) may assign a Behavioral Health (BH) Safety Officer, when the behavioral health force protection needs surpass that which can be managed solely by the Behavioral Health Liaison (BH LNO). The BH Safety Officer may be deployed to the Secretary's Operation Center (SOC) to act as a liaison between the field and headquarters, or to the field as part of the IRCT to monitor and facilitate behavioral health force protection for the IRCT and deployed resources. The BH Safety Officer reports to the FHCO or IRCT Commander.

Behavioral health, in a public health and medical response and recovery context, is concerned with:

- The stress, trauma, mental health, and substance abuse issues of disaster survivors and responders with a particular focus on mitigation of adverse behavioral health impacts;
- The behavioral health service system and the people that use these services; and
- Positively influencing human behavior through effective public health messaging.

Duties

Response Activities

1. Ensure monitoring and facilitation of behavioral health force protection among IRCT and field personnel.
2. Educate IRCT personnel about the role of disaster behavioral health, the use of psychological first aid, and the importance of responder physical and psychological self-care.
3. Work with the FHCO, IRCT Commander, Chief Medical Officer, and Safety Officer to promote work practices conducive to optimal physical and psychological health (e.g. regular breaks, time for sleep and/or exercise, contact with supports at home, etc.).
4. Facilitate seamless communication between ASPR-EMG, ASPR-ABC and the BH LNO.
5. Communicate with embedded team-based behavioral health personnel and monitor overall behavioral health force protection of deployed teams.
    a. Establish and maintain regular communication with imbedded BH personnel on NDMS and PHS Response teams.

b. Obtain and provide behavioral health related resources and information as requested.

c. Report on force health protection activities and risk issues to be mitigated to the FHCO and IRCT Commander.

Information and Reporting Activities

1. Contribute information to inform the common operating picture as this pertains to the behavioral health needs of responders and the behavioral healthcare infrastructure.

    a. Ensure that force behavioral health encounters and activities are captured to inform daily reports.

    b. Contribute to daily SitReps/SPOT reports summarizing daily activities.

    c. Utilize Federal Disaster Behavioral Health Group partners as reach back resources and as sources to both obtain and disseminate behavioral health information and materials.

Reference: HHS Disaster Behavioral Health Concept of Operations

http://www.phe.gov/abc

Appendix D: Resources

Web Sites

- HHS Assistant Secretary for Preparedness and Response (ASPR)

  http://www.phe.gov

- ASPR Division for At-Risk Individuals, Behavioral Health, and Community Resilience (ASPR-ABC)

  http://www.phe.gov/abc

- Centers for Disease Control and Prevention (CDC) Emergency Preparedness and Response Page

  http://emergency.cdc.gov/

- National Library of Medicine

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

- Coping With Disasters

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

- Post-Traumatic Stress Disorder (PTSD)

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

- Disaster Information Management Research Center (DIMRC)

  http://disasterinfo.nlm.nih.gov/

- Substance Abuse and Mental Health Services Administration (SAMHSA) Coping with Traumatic Events Page

  http://www.samhsa.gov/trauma/index.aspx

- SAMHSA Disaster Technical Assistance Center (DTAC)

  http://www.samhsa.gov/dtac/

- SAMHSA National Child Traumatic Stress Network (NCTSN)

  http://www.nctsnet.org/

- SAMHSA After the Crisis Initiative: Healing from Trauma after Disaster Resource Page

  http://gainscenter.samhsa.gov/atc/text/papers/trauma_paper.htm

Information and Factsheets

- ACF Disaster Case Management Program (DCMP)

  The Disaster Case Management Program augments state and local capacity to provide disaster case management services in the event of a major disaster declaration which includes Individual Assistance. This web site explores the options states may exercise in implementing the Disaster Case Management Program http://www.acf.hhs.gov/programs/ohsepr/disaster-case-management.

- At-Risk Individuals (ASPR-ABC)

  At-risk individuals have needs in one or more of the following functional areas: communication, medical care, maintaining independence, supervision, and transportation. This fact sheet defines "at-risk individuals" and their needs before, during and after an emergency.

  http://www.phe.gov/Preparedness/planning/abc/Documents/at-risk-individuals.pdf

- Disaster Behavioral Health (ASPR-ABC)

  This fact sheet highlights behavioral health concerns affecting survivors/responders and the need for disaster behavioral health capabilities.
  http://www.phe.gov/Preparedness/planning/abc/Documents/disaster-behvioral-health.pdf

- Disaster Behavioral Health Capacity Assessment (ASPR-ABC)

  This tool serves as a template for a behavioral health organizational assessment that organizations may opt to use or adjust to identify disaster behavioral health capacity and gaps. The tool was developed during a September 2009 meeting convened by ASPR where representatives from each state in Region I (New England) met with federal representatives to discuss current disaster behavioral health capacity in that region.
  http://www.phe.gov/Preparedness/planning/abc/Documents/DisasterBHCapacityTool.pdf

- Domestic Violence and Disasters Specialized Resource Collection

This collection of fact sheets and resources highlights the disproportionate vulnerability of women and children to domestic and sexual violence in disaster and emergency situations, and organizes information to help increase the safety and well-being of those at higher risk for violence (or re- traumatization) during and after a major disaster or crisis. This special collection was developed by the National Resource Center on Domestic Violence in consultation with the National Sexual Violence Resource Center, the Alabama Coalition Against Domestic Violence, the Florida Coalition Against Domestic Violence, and the Family Violence Prevention and Services Program Office of the Department of Health and Human Services.
http://www.vawnet.org/special-collections/DisasterPrep.php

- Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) ESAR-VHP is a national network of state-based systems, which verifies the identity and credentials of health professionals. This fact sheet explains and addresses the need for an ESAR-VHP program and defines the mission of the program.
  http://www.phe.gov/esarvhp/pages/about.aspx

- Family Violence Prevention and Services Act (FVPSA)
  FVPSA provides the primary federal funding stream dedicated to the support of emergency shelter and related assistance for victims of domestic violence and their dependents. FVPSA is located in the Family and Youth Services Bureau (FYSB), a division of the Administration on Children, Youth and Families in the Administration for Children and Families. Through the FVPSA Program (FVPSP), FYSB administers FVPSA formula grants to States, Territories and Tribes, State domestic violence coalitions, and national and special-issue resource centers.
  http://www.acf.hhs.gov/programs/fysb/programs/family-violence-prevention-services

- Federal Occupational Health (FOH) Employee Assistance Program

  The FOH Emergency Preparedness and Response Services fact sheet describes employee services and highlight some of the comprehensive emergency response services available to employees and their families. http://www.foh.dhhs.gov/library/factsheets/emergfactsheet.pdf

- Force Readiness and Deployment

  This fact sheet describes resources and assistance the U.S. Public Health Service Access Team provides to local health authorities in response to public health emergencies and urgent health needs arising from major disasters or other events.
  http://ccrf.hhs.gov/ccrf/FactSheets/SAT_Fact_Sheet_FINAL.pdf

- Medical Reserve Corps (OASH-OSG-DCVMRC)

This fact sheet defines the role of the OASH-OSG-DCVMRC, its volunteers, and how it can benefit local communities.
http://www.medicalreservecorps.gov/File/MediaKit/MediaKit_FactSheet_English_2007.pdf

- National Domestic Violence Hotline
  The National Domestic Violence Hotline is a 24-hour, confidential, toll-free hotline. Hotline staff immediately connects the caller to a service provider in his or her area. Highly trained advocates provide support, information, referrals, safety planning, and crisis intervention in 170 languages to hundreds of thousands of domestic violence victims. 800-799-SAFE (7233)
  http://www.thehotline.org/

- Pet Owners: Planning for the safe evacuation and/or care of the animals that are an important part of many individual's and families' lives enhances overall well-being in the event of a disaster. These fact sheets provide pet owners with information on planning for pet disaster needs, preparing to shelter a pet, and recommendations for during and after a disaster.

  - Arc Pets and Disaster Safety Checklist
    http://www.redcross.org/images/MEDIA_CustomProductCatalog/m3640126_PetSafety.pdf

  - DHS-FEMA Information for Pet Owners
    http://www.ready.gov/caring-animals

- SAMHSA Crisis Counseling Assistance and Training Program (CCP)
  CCP assist individuals and communities in recovering from the effects of natural and human-caused disasters through the provision of community-based outreach and psychoeducational services. This fact sheet provides a brief overview of the CCP program, key principles of the program, and a link to the CCP application toolkit. http://www.samhsa.gov/dtac/proguide.asp

- SAMHSA Disaster Behavioral Health Information Series (DBHIS)
  DBHIS is a collection of resources on numerous subjects, including Children and Youth, Deployed Military Personnel and Their Families, Languages other than English, Older Adults, Persons with Functional and Access Needs, Rural Populations, Tribal Organizations, and many more.
  http://www.samhsa.gov/dtac/resources.asp#dbhis

- SAMHSA Disaster Response Template Toolkit
  This Disaster Response Template Toolkit features public education materials that disaster behavioral health response programs can use to create resources for reaching people affected by a disaster. The Template Toolkit includes print, website, audio, video, and multimedia

materials that disaster behavioral health response programs can use to provide outreach, psycho-education, and recovery news for disaster survivors. Many of the links contain sample materials and online tools that have been used in previous disaster situations across the country. The templates can also be adapted for future use as desired. http://www.samhsa.gov/dtac/dbhis/dbhis_templates_intro.asp

- The SAMHSA Disaster Kit
  The SAMHSA Disaster Kit arms disaster recovery workers with a toolkit on mental health awareness. The Kit includes materials for responding effectively to the general public during and after a disaster and in dealing with workplace stress. It also includes materials for the general public. http://store.samhsa.gov/product/SMA11-DISASTER or http://www.samhsa.gov/Disaster/

- SAMHSA DTAC Webinars
  SAMHSA DTAC webinars and podcasts present information on disaster behavioral health topics, including an introduction to the field of disaster behavioral health, promising practices in disaster behavioral health planning, and cultural awareness. Developed to build disaster behavioral health awareness for individuals in all levels of disaster behavioral health, first responders, survivors, and students. http://www.samhsa.gov/dtac/webinars/webinars.asp

Appendix E: List of Acronyms

ACRONYM	DEFINITION
ACF	Administration for Children and Families
ACF-OHSEPR	ACD Office of Human Services Emergency Preparedness and Response
ACL	Administration for Community Living
AHRQ	Agency for Healthcare Research and Quality
AoA	Administration on Aging
APHT	Applied Public Health Team
ASA	Assistant Secretary for Administration
ASFR	Assistant Secretary for Financial Resources
ASL	Assistant Secretary for Legislation
ASPA	Assistant Secretary for Public Affairs
ASPE	Assistant Secretary for Planning and Evaluation
ASPR	Assistant Secretary for Preparedness and Response
ASPR-ABC	ASPR Division for At-Risk Individuals, Behavioral Health, and Community Resilience
ASPR-NBSB	ASPR National Biodefense Science Board
ASPR-OEM-REC	ASPR Regional Emergency Coordinator
ATSDR	Agency for Toxic Substances and Disease Registry
CCP	Crisis Counseling Assistance and Training Program
CDC	Centers for Disease Control and Prevention
CMO	Chief Medical Officer
CFBNP	Center for Faith-Based and Neighborhood Partnerships

ACRONYM	DEFINITION
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
DAB	Departmental Appeals Board
DBHIS	Disaster Behavioral Health Information Series
DCCPR	OASH-OSG-Division of Commissioned Corps Personnel and Readiness (Formerly the Office of Force Readiness and Deployment)
DCVMRC	Division of the Civilian Volunteers Medical Reserve Corps
DCM	Disaster Case Management
DHS	Department of Homeland Security
DMAT	Disaster Medical Assistance Team
DMORT	Disaster Mortuary Operational Response Team
DoD	Department of Defense
DSWG	Disaster Surveillance Work Group
DTAC	Disaster Technical Assistance Center
EAP	Employee Assistance Program
EEI	Essential Elements of Information
EMAC	Emergency Management Assistance Compact
EMG	Emergency Management Group
EOC	Emergency Operations Center
EPCO	Emergency Preparedness and Continuity of Operations
ESAR-VHP	Emergency System for Advance Registration of Volunteer Health Professionals
ESF	Emergency Support Function

ACRONYM	DEFINITION
FACT	Family Assistance Center Team
FDA	Food and Drug Administration
FDBHG	Federal Disaster Behavioral Health Group
FEMA	Federal Emergency Management Agency
FHCO	Federal Health Coordinating Official
FOG	Field Operations Guide
FOH	Federal Occupational Health
HHS	Department of Health and Human Services
HRSA	Health Resource and Services Administration
HSPD	Homeland Security Presidential Directive
H&SS RSF	Health and Social Services Recovery Support Function
IAP	Incident Action Plan
ICP	Incident Coordination Plan
ICS	Incident Command System
IGA	Office for Intergovernmental Affairs
IHS	Indian Health Service
IMSuRT	International Medical Surgical Response Team
IRCT	Incident Response Coordination Team
ISP	Immediate Services Program
LNO	Liaison Officer
MHT	Mental Health Team
NCPTSD	National Center for Post-Traumatic Stress Disorder
NDRF	National Disaster Recovery Framework

ACRONYM	DEFINITION
NERCS	National Emergency Responder Credentialing System
NGB	National Guard Bureau
NGO	Non-Governmental Organization
NHPP	National Hospital Preparedness Program
NHSC	National Health Service Corps
NHSS	National Health Security Strategy
NIMH	National Institute of Mental Health
NIMS	National Incident Management System
NIOSH	National Institute for Occupational Safety and Health
NLM	National Library of Medicine
NRF	National Response Framework
NMRT	National Medical Response Team
NVRT	National Veterinary Response Team
OASH	Office of the Assistant Secretary for Health
OCCIO	Office of Consumer Information and Insurance Oversight
OCD	Office for Civil Rights
OD	Office on Disability
OEM	Office of Emergency Management
OGC	Office of the General Counsel
OGHA	Office of Global Health Affairs
OHR	Office of Health Reform
OIG	Office of the Inspector General
OMHA	Office of Medicare Hearings and Appeals

ACRONYM	DEFINITION
OPDIV	Operating Division
OPP	Office of Policy and Planning
OSG	Office of the Surgeon General
OSSI	Office of Security and Strategic Information
PAHPA	Pandemic and All Hazards Preparedness Act
PERRC	Preparedness and Emergency Response Research Center
PFA	Psychological First Aid
PHEP	Public Health Emergency Preparedness
PHS	Public Health Service
RDF	Rapid Deployment Force
RedDOG	Readiness and Deployment Operations Group
RSP	Regular Services Program
SAMHSA	Substance Abuse and Mental Health Services Administration
SAMHSA RA	SAMHSA Regional Administrator
SERG	SAMHSA Emergency Response Grant
SME	Subject Matter Expert
SOC	Secretary's Operations Center
STAFFDIV	Staff Division
SLTT	State, Local, Territorial, and Tribal
USDA	U.S. Department of Agriculture
USPHS	U.S. Public Health Service
VA	Department of Veterans Affairs
VOAD	Voluntary Organizations Active in Disaster

Appendix F: Essential Elements of Information

1. **EVENT: What is the nature and scope of the event?**
    - How many people are affected and how (e.g. fatalities, injuries, etc.)? Data Source: ASPR-REC, ASPR, CDC
    - What members of at-risk or special populations have been affected and how many? Data Source: ASPR-REC, ASPR-ABC, CDC, DCCPR
    - What are the potential short-term psychological consequences? Data Source: ASPR-ABC, CDC, DCCPR, SAMHSA, ASPR-REC
    - What are the potential mid and long term consequences? Data Source: ASPR-ABC, CDC, DCCPR, SAMHSA, ASPR-REC
2. **EVENT: Has the event triggered emergency declarations and if so what kind?**
    - What types of federal assistance have been made available (e.g., DHS-FEMA Individual Assistance)? Data Source: ASPR, SAMHSA
3. **BEHAVIORAL HEALTH INFRASTRUCTURE: What is the status of behavioral health critical infrastructure in the affected area(s)?**
    - Is evacuation of inpatient facilities required and will federal assistance be needed? Data Source: ASPR-REC, DCCPR, SAMHSA
    - What is the status of behavioral health outpatient providers in the affected area (including mental health, substance abuse, opioid replacement treatment, etc.?) Data Source: ASPR-REC, DCCPR, SAMHSA
    - Are psychiatric beds available or being used for non-psychiatric patients? Data Source: ASPR-REC, DCCPR
4. **DISASTER BEHAVIORAL HEALTH SERVICES: What disaster behavioral health services are being provided?**
    - What SLTT, VOAD, or local entity is coordinating disaster behavioral health services? Data Source: ASPR-REC, ASPR-ABC, SAMHSA, CDC, DCCPR

- How are services being provided and are there any gaps? Data Source: ASPR-REC, ASPR-ABC, SAMHSA, CDC, DCCPR

5. **BEHAVIORAL HEALTH CARE: What is the SLTT or local steady state capacity for behavioral health care?**

    - What long term capacity exists for providing care in the behavioral health care system?

    Data Source: ASPR-REC, ASPR-ABC, SAMHSA, DCCPR

6. **BEHAVIORAL HEALTH CARE: What assistance have state officials requested from HHS agencies and partners relevant to behavioral health?**

    - What agency or partner is providing assistance or preparing to provide assistance (e.g., DCCPR, ASPR-OEM-NDMS, CDC, and SAMHSA)? Data Source: ASPR-REC, ASPR-ABC, ASPR- OEM-NDMS, CDC, SAMHSA

    - What is the status of HHS Programs (SAMHSA, ACF, CDC, IHS, etc.) in the affected area? Data Source: ASPR-REC, ASPR, CDC, IHS, DCCPR, SAMHSA

    - What is the nature of assistance being provided? Data Source: ASPR-REC, DCCPR, SAMHSA, ASPR, CDC

    - What capabilities by specialty are required from HHS? Data Source: ASPR-REC, DCCPR, ASPR

7. **BEHAVIORAL HEALTH CARE: What is the need for behavioral health support to any Federal Medical Missions?** Data Source: ASPR-REC, ASPR-ABC, ASPR-OEM-NDMS, DCCPR

8. **BEHAVIORAL HEALTH CARE: What behavioral health assets can HHS OPDIVS and ESF #8 partners roster and deploy?** Data Source: ASPR-REC, OASH-OSG-DCVMRC, ASPR-OEM-NDMS, FOH, DCCPR

9. **BEHAVIORAL HEALTH CARE: What behavioral health care response assets have deployed, including assessment teams or subject matter experts to the IRCT, etc.?**

    - What HHS behavioral health assets have been deployed and what is their mission? Data Source: ASPR-REC, ASPR-OEM-NDMS-CMO, FOH, DCCPR, ASPR-ABC

- What other federal behavioral health assets are providing assistance and what is the nature of the assistance? Data Source: ASPR-REC, ASPR-OEM-NDMS- CMO, ASPR-ABC, DCCPR

10. **RESPONDERS: What procedures are in place to monitor the behavioral health and well-being of workers; perform field investigations and studies to address worker health and safety issues; and provide technical assistance and consultation on worker health and safety measures and precautions?** Data Source: CDC, DCCPR, ASPR, ASPR-REC

11. **SURVEILLANCE: What social indicators can be tracked to assess community distress and/or resilience (e.g., domestic violence shelter populations, school absences, child abuse reports)?** Data Source: ASPE, CDC, SAMHSA, ASPR-REC

12. **RECOVERY: What is the plan for transitioning behavioral health care back to the state and local communities, affected workplaces, and/or coordinated disaster recovery efforts?** Data Source: ASPR-OEM-NDMS, ASPR-Recovery, FOH, SAMHSA, ASPR-REC