Mental Health All-Hazards Disaster Planning Guidance

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
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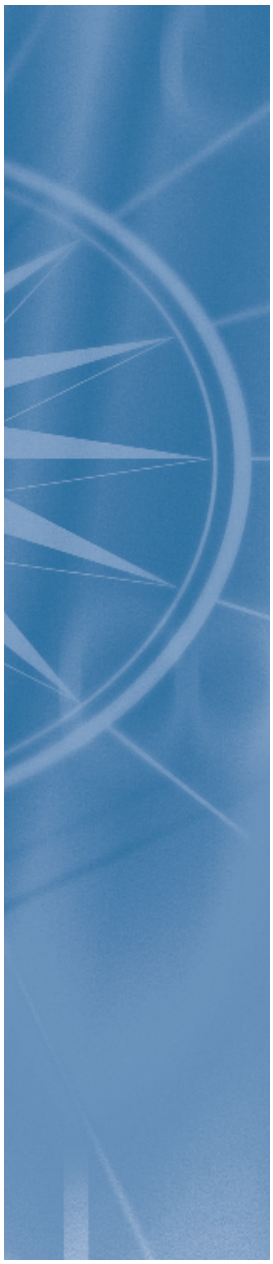

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2003

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FOREWORD

Prior to the publication of the Federal Emergency Management Agency's *Guide for All-Hazard Emergency Operations Planning* (FEMA, 1996), State and local emergency management leaders did not have sufficient, nationally accepted guidance to help them respond to natural and man-made disasters. FEMA's publication, also known as *State and Local Guide (SLG) 101*, provided a geographically diverse group of planners and decision makers with a comprehensive "toolbox" of best practices, suggested collaborations, ideas, and advice on how to adequately prepare for worst-case scenarios of all kinds.

While the SLG serves as an effective resource for emergency management leaders, it does not focus on guidance for State mental health leadership. This document, the *Mental Health All-Hazards Disaster Planning Guidance*, is intended to serve as a companion piece to the SLG by providing direction and support tailored specifically for State and local mental health leaders as they create and/or revise all-hazards response plans. In particular, the document provides counsel to States on considerations for the planning process, and for actual plan content.

The tragic loss of life that occurred on September 11, 2001 was one outcome of the day's horrendous events. While most Americans were resilient in the face of this tragedy, some experienced depression, grief, and Post-Traumatic Stress Disorder. Thus, the events of that day were both a challenge and a call to action for all those responsible for the organization and provision of mental health services. The feelings of loss of our security and well-being—arguably the most crucial abstract ingredients for leading a happy, healthy life—dramatically affected the citizens of this country. Looking to the future, we believe this document can be used to lessen the blow—especially the behavioral health consequences delivered by subsequent disasters.

The *Mental Health All-Hazards Disaster Planning Guidance* was created through collaboration between Substance Abuse and Mental Health Services Administration and the National Association of State Mental Health Program Directors. It uses a concise, yet comprehensive format to offer policy makers practical, experience-driven advice on a complex and important topic. We invite State and local planners to use this document to help alleviate the pain and suffering that all too often accompanies large-scale tragedies of every type.

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Introduction

Nearly three decades ago, the Robert T. Stafford Disaster Relief and Emergency Assistance Act was enacted by Congress to help State and local governments prepare for disasters. Since its enactment, which also established the Crisis Counseling program (CCP), States have been required to have a plan to focus on the mental health aspects of disasters. Unfortunately, this portion of the legislation has not achieved the type of in-depth, comprehensive, and integrated planning hoped for—and, that in the current environment has become essential.

In some cases, insufficient planning at the State level has delayed Federal funding to meet the mental health needs of disaster victims and survivors. In other cases, the planning requirement has been technically met with only skeletal planning documents. The need to enhance State mental health disaster plans has become apparent to all involved as disaster and emergency planning has evolved through the years. The increased focus on mental health, as exemplified by the President's New Freedom Commission on Mental Health, and the increasing complexity of both the traditional and potential roles played by State Mental Health Agencies (SMHAs) and the disaster situations they face has made this clear.

Better planning can help make available appropriate interventions to those in need, and help promote resiliency and recovery. It also provides an opportunity for a more efficient mental health response. It is possible, with sound, integrated planning, to fill the new, complex roles of identifying disease outbreaks, integrating health and mental health response, and conducting epidemiological surveillance—all of which are necessary in the new age of bioterrorism threats.

To that end, the Center for Mental Health Services (CMHS), within the Substance Abuse and Mental Health Services Administration (SAMHSA), collaborated with the National Association for State Mental Health Program Directors (NASMHPD) to assess the status of disaster mental health plans in the country, and provide guidance to States regarding important components in the planning process as well as potential content and organization of viable plans.

This document is the result of that process. Along with the comprehensive matrix for planners found in Appendix A, this document is intended to help guide State and local mental health agencies create or revise plans for response to human or natural disasters and emergencies. It is a companion document to the *Guide for All-Hazard Emergency Operations Planning*, which was published by the Federal Emergency Management Agency (FEMA) in 1996. While this *Mental Health All-Hazards Disaster Planning Guidance* is full of helpful information and applicable resources for State and local mental health entities, it is strictly a guide and does not establish any requirements.

The document draws heavily on a number of sources, including:

- Content review of State disaster mental health plans;
- In-depth, structured interviews of individuals with long and diverse histories in disaster mental health as well as in State and/or Federal emergency management;
- The results of a focus group that included representatives from the SMHAs, Federal disaster health and mental health leaders, and key health and mental health organizations (a list of participants can be found in Appendix B);
- Guidance to SEMAs by FEMA; and
- The experience of many contributors with relevant knowledge and background.

The guidance is based upon the "all-hazards" model of emergency preparedness. This model has been promoted by FEMA and is used, nearly universally, by SEMAs as they formulate and implement State plans. In addition to being based on a sound planning model for disasters, this document can help improve integration of the SMHA's roles and activities into the overall State emergency management and operations.

In recent years, FEMA has placed growing emphasis on moving States toward an all-hazards model of disaster preparedness. Historically, States often had separate plans for different types of events. As mentioned earlier, the primary document used to guide this planning has been the *Guide for All-Hazards Emergency Operations Planning* (FEMA, 1996).

The goals of a comprehensive all-hazards plan, as described in that guide, are to—

- Serve as the basis for effective response to any hazard that threatens a jurisdiction;
- Facilitate the integration of mitigation into response and recovery activities; and
- Facilitate coordination with the federal government during catastrophic disaster situations.

The FEMA guide describes a comprehensive all-hazards plan as one that:

- Assigns responsibility to carry out actions in emergencies that exceed existing capacity;
- Sets forth lines of authority and organizational relationships;
- Describes how people and property will be protected in emergencies;
- Identifies personnel, equipment, facilities, supplies, and other resources available; and
- Identifies steps to address mitigation.

PART ONE

The State of the States

States and Territories were asked for their existing plans to assess both the status of disaster mental health response planning and the best reference point for this publication. Thirty-one plans were submitted and analyzed, using a matrix similar to the one found in Appendix A of this document. Although it employed an admittedly high standard, the matrix provided a way to look at specific areas in the plans in which key content was included or missing. In general, the status of the disaster mental health plans submitted was both variable and incomplete.

Virtually all of the reviewed plans lacked key elements that a comprehensive and viable all-hazards plan should contain, and format and content varied among States. However, several plans had elements that were especially well done, and a few plans, while not in the all-hazards format, were comprehensive and creative.

It became clear in the development of this document that resources—both human and financial—are key elements to successful planning and implementation. Few States, however, have even a single person whose full-time responsibility is disaster and emergency mental health. Most States rely on leadership from a single person who devotes 5 percent to 50 percent of his or her time to this type of activity.

While funding for disaster mental health planning often is limited and must compete with other SMHA priorities, it was dramatic to see what could be accomplished in States with full-time staff and even small amounts of funding. The Massachusetts plan, for example, demonstrates what can be accomplished with an infusion of a relatively small amount of funding (provided by SAMHSA following the terrorist attacks of September 11, 2001). Another example of this is Texas, which has been able to

accomplish a great deal by having full-time staff jointly funded by SEMA and SMHA.

Most States indicated they are in the process of plan revision. This interest in plan revision is primarily a result of a broad, renewed interest in disaster preparedness—sparked by the events of September 11, 2001—and the recognition that existing plans often fall far short of being current and having maximum utility.

PLAN REVISIONS CURRENTLY IN PROCESS

Some of the areas in which States are focusing their revisions include:

- Enhancing the use of a consistent planning template compliant with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO);
- Considering the use of the Incident Command System (ICS) because the SMHA must operate within the ICS to respond to a Federally declared emergency;
- Addressing regional disasters;
- Increasing attention to terrorism and bioterrorism;
- Enhancing training for SMHA staff in incident command;
- Addressing storage and maintenance of plans in multiple locations as well as in computer file format and notebook format;
- Expanding integration of regional mental health planning with regional and community emergency management;
- Addressing the evacuation of SMHA facilities and development of surge capacity in facilities;
- Revising long-standing CCP training to add or expand on the topics of terrorism, child and adolescent issues, multicultural components, and post-disaster substance abuse treatment and prevention needs;
- Expanding training to others (including SEMAs), and refining databases on specific and/or specialized skills existing within the State;
- Modifying State emergency plans to ensure mental health-related responsibilities are included under the SMHA and not (inappropriately) under other State agencies;
- Revising the State mental health plan to include more content on health, substance abuse, bioterrorism, the President's Homeland Security Advisory System, the State Department of Education, spiritual community involvement; racial and cultural competence; outreach to non-State organizations involved in disaster mental health; and State planning and advisory bodies; and
- Revising existing systems to include more standard forms and to incorporate biennial review and updating of the plan.

It became clear in the development of this document that resources—both human and financial—are key elements to successful planning and implementation. Few States, however, have even a single person whose full-time responsibility is disaster and emergency mental health. Most States rely on leadership from a single person who devotes 5 percent to 50 percent of his or her time to this type of activity.

PART TWO

The Planning Process

According to Albert Ashwood, Director of the Oklahoma Department of Civil Emergency Management, all-hazards planning can be summed up in two points, "The process is where the real plan comes through," and, "Until mental health, health, and emergency management make [coordinated planning] a priority, little will happen."

There seems to be a consensus that the process of planning is nearly as important as the content of the plans. Individual and organizational relationships among interested parties are formed and solidified, planning responsibilities of the SMHA and others are established, and multiple plans are integrated during the process.

States benefit from an honest assessment of the resources available to them to establish and maintain a plan at the beginning of the planning process. Sound planning and the effort needed to keep plans current require resources and ongoing commitment. Few organizations will have the resources to accomplish everything they desire, but most will be able to delineate at least the basic elements of a plan.

In addition, the scope of a State's disaster mental health response will have an impact on financial and human resources as well as on existing programs. These considerations should be incorporated into the planning process. For example, intensive outreach and case finding will result in the identification of more individuals in need of assistance, necessitating additional funding and personnel. Some victims, while typically in the minority, will develop significant mental health problems. Planning should include an assessment of the ability of the State mental health infrastructure to absorb additional individuals in need of services.

Effective plans are exercised, modified, and updated regularly. If a plan is developed and not kept alive and vital, it will have limited value. For that reason, it is important to develop a plan that is meaningful but also fairly basic, so that it can be maintained and updated regularly.

BENEFITS OF THE PLANNING PROCESS

Nearly all reviewed States identified positive outcomes for the process of developing and implementing disaster mental health plans. Some of these outcomes are listed below.

- Having plans in place and having a good working relationship with the SEMA make it easy to modify the plans because there is an established structure and mutual trust.
- A strong commitment from the Commissioner resulted in positive planning and plan outcomes.
- The planning process enhanced relationships with the Red Cross and resulted in the development of crisis response teams, which assist emergency personnel in times of emotional instability.
- The planning process enhanced collaborations with other State and county agencies.
- The process allowed and facilitated completion of a Statewide needs assessment, increased information available online, and garnered support of the SEMA.
- The process resulted in the establishment of full-time positions in the SMHA devoted to disaster preparedness, response, and recovery.

LIMITATIONS, BARRIERS, AND CHALLENGES IN DEVELOPING AND IMPLEMENTING PLANS

Some of the systemic limitations and barriers to adequate planning (identified through phone interviews) include:

- Lack of human and financial resources to do the work;
- The "back burner" status of disaster mental health planning when the public mental health system struggles with inadequate staff and funding for basic mental health services;
- Little political will to focus on disaster mental health over many years, once a disaster passes;
- Mental health being overlooked in favor of safety and security concerns;
- Less than optimal mental health planning because of the barriers to ensuring that mental health concerns are reflected in the policies, practices, and planning of public safety, disease control, and law enforcement officials. These barriers may include lack of state mental health agency resources, organizational separation, and lack of knowledge about and appreciation for the importance of behavioral health issues and impacts;
- Emerging local and regional mental health groups (e.g., new

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Err on the side of over-inclusion rather than leaving some portion of the system out. If key players are left out, the value of their contribution could be lost and valuable time and human resources may be expended to mend fences and/or cope with resistance to the process or product.

advocacy groups, local and State critical incident management groups, etc.), as well as local and regional safety and security groups (e.g., groups organizing for community security, groups marketing security equipment, and plans for individuals and businesses, etc.), with little knowledge of State disaster and disaster mental health infrastructure;

- The lack of collaboration and consistency among federal departments and agencies and corresponding State departments and agencies receiving disaster and terrorism funding—SAMHSA/CMHS, the Department of Justice, the Centers for Disease Control and Prevention, and the Health Resources and Services Administration were specifically mentioned; and

- The lack of well-defined, studied and easily implemented programs in disaster mental health that can be adopted widely.

GETTING THE PLANNING PROCESS STARTED

It will be helpful to keep in mind the following contextual and fundamental guidelines before formal planning begins. Remember that each State differs from others in its planning and disaster history, its structure, and its resources for preparedness activities. States will need to adapt the following guidelines to their unique situations and may find it useful to prioritize these elements. The unifying essential characteristics of these guidelines are good preparation and a diplomatic process sensitive to strengths, challenges, and other priorities.

The Context of Planning

- Secure support for planning at the highest possible level of State government (e.g., the Governor's Office or at the Cabinet level).

- Plan developers should know the culture of the State government and the major players before starting. (Table 3 contains a listing of some suggested major players). For example, will making changes and establishing new collaborations be easy and/or valued? Are the major agencies/organizations involved seeking change, or are they likely to try to maintain the status quo? Is this planning taking place in the context of fiscal expansion or contraction? The SMHA is typically part of a larger State response and recovery effort and it often functions under SEMA's authority. It is important to know who is responsible and/or in charge of the larger operation.

- Exactly how planning occurs—considering the variables delineated above—is not well documented at the national level. It is anticipated that as plans emerge and as the process becomes documented more completely by the State Disaster Mental Health Coordinators, more State-specific guidance will be developed and disseminated.

Process Guidance

- Try to anticipate problems from the start.

- Err on the side of over-inclusion rather than leaving some portion of the system out. If key players are left out, the value of their contribution could be lost and valuable time and human resources may be expended to mend fences and/or cope with resistance to the process or product.

- Have a leader, but share the work. Without someone to guide and oversee this process it frequently becomes the victim of other emerging priorities. At the same time, workload and differential expertise and authorities demand that the work be shared.

- Keep reminding participants of the benefits of the effort.

- Appreciate and acknowledge the concerns/constraints/expertise of others.

- Involve representatives who can make decisions for their agencies/departments/organizations. Enormous amounts of time and energy can be wasted when decisions must wait for clearance, which can be lengthy, or if decisions or components are later changed because the planning participant lacked authority.

- Encourage agencies/departments/organizations to do what they do best.

- Keep expectations and timelines realistic.

- Understand that in many ways the process is as valuable as the product. The teamwork developed in the planning process will be the teamwork you depend on in the disaster response efforts.

RECOMMENDATIONS FROM THE FOCUS GROUP

When the focus group for this project convened, members identified several parts of the planning process they felt were important to successful outcomes. They offered the following suggestions and observations about the process of developing plans.

The Preplanning and Early Planning Stages

- Much information already exists and is readily available. While comprehensive, all-hazards plans are scarce, most States have existing and emerging plans that can be very helpful. Officials should review the plans of other States with an eye toward identifying those elements that might be applicable in their State. Some examples of elements derived from States' plans are included throughout this document.

- Literature, available through a wide variety of sources commonly known to State emergency coordinators, should be utilized to support and assist the planning process. For example, numerous preparedness publications are available from FEMA (*See Part IV for contact information*). Meeting with the SEMA at the beginning of the planning process can be useful in a variety of ways, including gaining access to preparedness aids/documents that the SEMA has found helpful in the past. The SMHA will likely find some of these resources more helpful than others.

Understand that, in many ways, the process is as valuable as the product. The teamwork developed in the planning process will be the teamwork you depend on in the disaster response efforts.

TABLE 1:

SAMPLE COMPARISON OF ELIGIBILITY AND SERVICES

AGENCY	TYPE OF EVENT	WHO IS ELIGIBLE?	WHAT IS PROVIDED	WHEN PROVIDED
FEMA/CMHS Crisis Counseling	•Natural or human caused disaster •Must have Presidential declaration	•Anyone living, working, or in the declared area at the time of the disaster	•Outreach, short-term counseling, referral, and psychoeducational activities provided by mix of professionals and trained paraprofessionals	•Typically for about a year following a disaster •Does not provide long-term treatment
Red Cross Mental Health Services	•Any emergency •Special authorities in transportation emergencies	•Anyone in affected areas •Can provide services to families outside disaster area	•Counseling and referral by licensed mental health professionals	•Typically only for a few days/week following the event
Office for Victims of Crime	•Criminal acts only (including terrorism)	•Crime victim's location not critical	•Variety of advocacy and other services including support for short- and long-term mental health services	•As long as necessary

The information in Table 1 is an example of how definitions of eligibility vary as a function of the type of event and funding source in the mental health arena. Each State will want to consider carefully the types of events that may occur, what definitions apply, and who will provide the relevant services to the various victims. In addition to the groups listed in the table above, other potential providers/supporters of post-disaster mental health services may include health insurance programs, employee assistance programs, and faith-based services.

■ In addition, different providers of services have different definitions of services, as well as who is eligible for these services—specifically in regard to mental health interventions. For example, three major national providers/supporters of disaster mental health services include CMHS (operating this program for FEMA), the American Red Cross, and the Office for Victims of Crime (*See Part IV for contact information*). The information in Table 1 may be useful in understanding service provider similarities and differences.

■ It is important to acknowledge that other State departments and agencies may be further along in planning and preparedness than the SMHA. Other State agencies

may be very helpful while the mental health disaster plan is being developed.

- Along with understanding organizational differences in terms of eligibility and services, as mentioned above, SMHAs will enhance collaborations if they make an effort to understand new administrative and operational terminology, especially from the SEMA and FEMA, as they begin the planning process. The establishment of common definitions is also important, and each State will be able to determine which of those common definitions are important to establish. Examples may include shared incident definitions, common command and control definitions, and administrative terms.

- It is important to consider the intended audience(s) for the plan as the process begins. This may vary from State to State and it may be necessary for States to prioritize their audiences, as it is difficult for a plan to meet fully the needs of everyone. Factors affecting priority setting may include financing, politics, structure, extent, and nature of operational responsibilities, etc. Audiences may include the SMHA, SEMA, other State agencies and departments, the governor, State legislature, components of the larger mental health system, State and local Red Cross chapters, and the Federal government. Planners will want to consider how much of the plan they want to make available (on the SMHA's Web site, for instance) to the general public. A wide distribution of parts of the plan may be useful, while other parts (i.e. portions identifying potential targets for terrorism) may warrant a narrower distribution.

- SMHAs vary widely in their flexibility and adaptability to emergency and disaster situations. A candid appraisal of these characteristics can help ensure that expectations of the system in the wake of such an event are realistic. The extent to which a State engages in assertive outreach, for example, will have a significant impact upon the number of people they find with both disaster-related stress as well as preexisting mental disorders. It is important to acknowledge this issue in the preparedness stage in the context of such factors as the State's ability to obtain and/or re-deploy resources (and for how long), absorb additional caseload, and sustain expanded expectations.

- It is far better to develop relationships prior to an event than attempting to forge them during an event.

- It is important to identify specifically who will have responsibility for putting the plan together and to update this information on a periodic basis. This person must have a sound understanding of the SMHA, the legal responsibility for response and recovery operations, and knowledge of where this responsibility falls within the State emergency plan.

- Key partners in disaster planning may already have experience dealing with the SMHA. That experience may have been positive or negative, it may have been general or specific to a single issue, and it could have occurred recently or in the distant past. It is helpful to learn what those experiences are and the type of impression the person may have left. One may identify attitudes and perspectives through this process that may be important during the collaboration process. Ask around to determine if division and/or departmental initiatives may have preceded the current effort and existing plans and relationships must be taken into consideration.

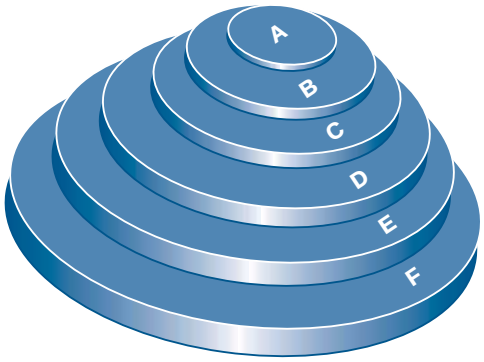
- Others will participate in the planning process more readily if they see some benefit to their organization or operation following an event. Mental health planners should identify how others will benefit from collaboration with the SMHA. As an example, a local mental health agency or school that does not have staff trained in large-scale crisis response may benefit by having staff trained as part of the preparation effort. In addition, the planning process will enable these organizations to better know and understand each other, thereby opening doors to collaborations outside the disaster context.

- It is important to identify the mission of the planning process, the purpose(s) of the plan, and the legal obligations of the SMHA, early on.

- Viewing mental health concerns in a public health context that is broader than direct service interventions (e.g., counseling, debriefing, etc.) is one of many benefits derived from approaching

FIGURE 1:

POPULATION EXPOSURE MODEL (DeWolfe)



A	Seriously injured victims • bereaved family members
B	Victims with high exposure to trauma • victims evacuated from the disaster zone
C	Bereaved extended family members and friends • rescue and recovery workers with prolonged exposure • medical examiner's office staff • service providers directly involved with death notification and bereaved families
D	People who lost homes, jobs, pets, valued possessions • mental health providers • clergy, chaplains, spiritual leaders • emergency health care providers • school personnel involved with survivors, families, of victims • media personnel
E	Government officials • groups that identify with target victim group • businesses with financial impacts
F	Community-at-large

the planning process and the plan from a public health perspective. Terrorist events have made public health a national security issue and few in the public health sector have managed to see the benefits of including mental/behavioral health as part of this system. Like mental health, public health shares the same interest in primary, secondary, and tertiary prevention. So there is much to be gained from a close collaboration between the SMHA and the public health agency in the areas of preparedness and response. The requirements of State health agencies regarding smallpox vaccination, as an example, provide an opportunity for collaboration. Federal guidelines require health departments to establish plans for dealing with the mental health consequences of an outbreak. Some SMHAs have used this requirement to engage the public health authorities on a variety of issues including consultation on risk communication.

■ Defining the victims is not an easy process, as many people who are exposed to most large-scale events are impacted. Even though people may be negatively affected, not all will need, accept, or necessarily benefit from various interventions. Definitions also may differ depending on the type of event—especially the difference between natural disasters and terrorist events (i.e. victims of terrorist events are *crime* victims and may therefore be eligible for services and resources not available in natural disasters). Some States have identified groups that represent primary populations who *must* be served (e.g., adults with severe mental illness; children and adolescents with severe emotional difficulties) and then identified other populations who can be served *if* possible or *if* additional resources are available.

In the priority-setting process, both research and practical experience points to exposure as a prime predictor of the development of psychological sequelae. Figure 1 is an illustration of exposure categories.

It generally is agreed that all who experience a disaster are somehow affected by it. However, a number of groups warrant specialized approaches and services, even if they're not at great risk, including,

but not limited to, children, those with pre-existing mental disorders, disaster and emergency workers, the frail elderly, and racial and cultural minorities. An excellent summary of the empirical research, including a discussion of risk and status factors, can be found at http://www.ncptsd.org/facts/disasters/fs_range.html.

- Membership on a planning group should be given careful consideration. A State may opt to establish a consistent team that will develop the plan. Others may opt for a "core team" that includes all who are legally mandated to be involved, and a larger "adjunct team" that includes the core team as well as representative of any other agency that has an interest. Texas has developed a unique model of a Crisis Consortium representing a number of State agencies (*See excerpt at right*).

Structural Considerations

- Ideal plans identify a clear decision making structure and articulate the authority of each plan participant.

- Both State and local mental health agencies can best exert influence and respond to changing events if they are represented in State and local Emergency Operations Centers.

- The SMHA can play a valuable "gate-keeping" role if the plans incorporate it. These can include distribution of mental health provider resources and management of research interests.

AN EXCERPT FROM THE TEXAS MODEL
[TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION, (TDMR, 2002)]

The role of the State Crisis Consortium is to coordinate, manage, and ensure the credibility of services provided and eliminate the duplication of services to victims following a catastrophic event. The State Crisis Consortium is a unique and innovative element in disaster response and recovery and is comprised of the following core programs:

The Texas Department of Mental Health and Mental Retardation's Disaster Assistance and Crisis Response Services program is the lead agency in the coordination of the State Crisis Consortium and provides assessment and evaluation of the immediate long-term mental health needs of victims and responders, immediate crisis counseling and mental health services to victims and responders, and coordinates federal Crisis Counseling and Training programs following federally declared disasters.

The Texas Department of Public Safety Psychological Services Division provides peer support and victim services to responders and their families including short-term counseling and referral.

The Texas Department of Health Critical Incident Stress Management Network provides for the pre- and post-incident stress management and educational support to emergency service workers and their primary support systems, and provides support after any situation faced by personnel that causes them to experience unusually strong emotional reactions.

The Office of the Attorney General Crime Victim Services Division provides for crime victim compensation services if the event is criminal in nature. The Consumer Protection Division provides support, protection and recovery from consumer fraud and deceptive practices following disaster or critical events.

TABLE 2:

EXAMPLES OF STATE LEGISLATION GEARED TOWARD DISASTER RESPONSE PLANNING

LOUISIANA R.S. 39:1494.1 SOCIAL SERVICE CONTRACTS	MINNESOTA 9575.0670 EMERGENCY APPOINTMENT
A. Contracts for social services may be awarded without the necessity of competitive bidding or competitive negotiation only if director of the office of contractual review determines that any one of the following conditions is present. The using agency shall document the condition present and such documentation shall be part of the contract record submitted to the office of contractual review. (6) An emergency exists which will not permit the delay in procurement necessitated by the request for proposal procedure given in R.S. 39:1503. Such emergency shall be determined by the director of the office of contractual review.	Whenever an emergency exists that requires the immediate services of one or more persons and it is not possible to obtain such persons from appropriate registers, the appointing authority may appoint a person or persons without consideration of other provisions of this chapter governing appointment, except as provided in parts 9575.1410 to 9575.1450. Such appointments normally shall be limited to no more than 45 working days during any calendar year for the same person; however, such appointment of the same person can be extended to 67 working days. STAT AUTH: MS s 256.012 HIST: 12 SR 458; 22 SR 45

- In States with both regional and central SMHA offices, identifying the respective roles and responsibilities of each is a very important part of the planning process.

- Plans should include clear documentation on how to access Federal resources through State structure. In the past, some SMHAs have had a better understanding of the Federal administrative process to obtain funding than of the State process required to obtain and distribute these funds. In some cases, this has resulted in unnecessary delays in funding. To reduce delays and other setbacks, the following questions should be considered: Under what circumstances can a State apply for the Federal Crisis Counseling program? Through which internal State processes and paths do these decisions and processes flow? How do Federal funds flow from the Governor's Office to the SEMA, to the SMHA, and on to vendors?

SMHAs may find it useful to review their individual State laws with an eye toward needs (such as speedy hiring, rapid contracting, and the ability to reprogram funds) that are common in disaster situations. In some cases, States may consider policy changes, either themselves, or in concert with other State disaster response entities, that will allow for these urgent activities. Table 2 contains examples of relevant legislation from Louisiana and Minnesota.

- The important relationship between the SMHA and the health agency can benefit from the creation of a formal Memorandum of Understanding (a legal document which details the two agency's potential collaboration) established during the planning process.

Recommended Planning Participants

Involvement of, and collaboration with, a wide variety of both public and private agencies and organizations is strongly encouraged. Partnering with some or all of the organizations listed in Table 3 is recommended.

Planners may find it useful to sort groups into categories such as those having legal responsibility for planning, those whose responsibilities are primarily response, and those who might serve best as advisors. In addition, as noted earlier, most States will want to prioritize these groups based on factors such as centrality to the SMHA disaster mission and a State's political, structural, and financial context.

TABLE 3:

RECOMMENDED PLANNING PARTICIPANTS

☐ Agencies serving the elderly	☐ Local and State military resources
☐ Agencies serving people with disabilities	☐ Managed behavioral health care companies
☐ CISM teams	☐ Managed care organizations
☐ Community systems (all responsible agencies)	☐ Media conduits
☐ Crime victim advocates	☐ Medical provider communities
☐ Daycare	☐ National Guard and other military
☐ Department of Education	☐ Public safety agencies
☐ Department of Veterans Affairs	☐ Red Cross
☐ Faith community	☐ Salvation Army
☐ Head Start	☐ School systems
☐ Health authority	☐ Social services
☐ Hospital systems	☐ Substance abuse professionals
☐ Large employer	☐ Unions
☐ Law enforcement	☐ Vocational rehabilitation services

As noted earlier in this document, the scope and depth of a given SMHA's investment in this planning process will vary depending on a number of factors, especially human and fiscal resources. The scope of the above list may seem beyond the resources of some. Each SMHA is encouraged to be realistic about its resources and assess priority linkages in their State. Some of the entities on the above list may not be involved in initial planning, but may be incorporated at a later date if time and resources are not available to accommodate all. However, the following list of entities includes core organizations that must be involved in any planning effort.

Essential Planning Participants

■ Involve local mental health agencies in planning from the beginning.

■ Seek the collaboration between the SMHA and the SEMA—perhaps the most important collaboration within State government. Planners should note that SEMA plans are already in place and that SMHA planning should be integrated into those existing plans.

■ Establish a relationship with the largest employers in the State. These employers may have special needs following a disaster, resources that could be helpful following a disaster, and plans that should be coordinated with the State plan. In some cases, these large employers may be potential targets for terrorism.

■ Identify potential mental health resources. Sources might include:

• Veterans Administration hospitals and clinics—often have significant numbers of mental health professionals well-trained in trauma work;

• Academic institutions—faculty and student health services may have resources;

• Professional associations—State chapters may be able/willing to identify/train their members to serve;

• State-operated services—State mental health provider institutions/agencies in unaffected areas may be able to deploy staff to areas of need; and

Most disaster responses utilize mental health professionals as well as trained para-professionals. The mix of responders may vary depending on the type of incident, source of funding, availability of professionals, and duration of the recovery. It is important to identify potential resources and to consider the initial and ongoing training needs of everyone. A list of resources is included in Part IV of this publication.

A response is only as good as the responders. A plan must be in place to ensure physical and psychological support for mental health workers as well as staffing depth to ensure ongoing operational capacity.

- The Red Cross is active in nearly all emergencies and disasters, providing general post-disaster services and specialized mental health services. Through a partnership with the National Highway Traffic Safety Administration, the Red Cross has taken the lead in serving families of victims in transportation emergencies and disasters. The development of coordinated planning with the Red Cross is essential. Without such agreements, the potential for misunderstandings, inefficient use of mental health resources, and organizational conflict is increased. SAMHSA's recently established Disaster Technical Assistance Center (DTAC) is collecting helpful examples of these agreements for State planners to utilize (*See Part IV for contact information*). The Red Cross has chapters in counties and cities throughout the United States. In addition, each State has a lead chapter responsible for developing mental health planning. A copy of each State's plan is on file at the Red Cross national office. The Red Cross trains mental health professionals with appropriate licenses and credentials in basic Red Cross procedure, and these individuals are promoted commensurate with their experience. By the time a major disaster happens, they should have a clear idea of how to work with State and local representatives.

- As noted earlier, one of the most significant relationships is the one between the SMHA and the State health agency. This link is especially critical in the areas of terrorism involving chemical, nuclear, or biological weapons.

- A relationship based on expertise and trust should exist between SMHA public information staff and their counterparts in emergency management.

- Most SEMAs have established links with other State departments as well as interstate collaboration for events that cross borders or might activate mutual aid agreements. SMHAs might explore opportunities to build upon those existing emergency management relationships as they plan. Specific suggestions include: learning about the existence of SEMA interstate collaborations; assessing the relevance of existing collaborative arrangements for disaster mental health response; identifying opportunities for the SMHA to collaborate; contacting SMHA counterparts in other jurisdictions; and sharing relevant portions of the SMHA plan or planning process to promote coordination/collaboration following an event. Participation in multi-jurisdictional exercises also can be very beneficial. Contact the SEMA Individual Assistance Officer to discuss existing partnerships and to create a Memorandum of Understanding (MOU) or other mutual aid agreement that could serve as a starting point for similar agreements benefiting the SMHA plan.

- Most SMHAs work closely with consumers and family members in their routine activities. These groups can contribute an

important perspective to disaster planning and response as well. Representatives from other vulnerable populations such as children, the aged/geriatric population, and those who are hard of hearing or deaf can also contribute. It is known from years of disaster mental health experience that these groups have special needs following disasters (although they may not be at higher risk for development of mental disorders). In addition, they may be receiving services through multiple organizations that may be part of the planning process for the SMHA plan (e.g., schools, health care facilities, etc.). Including representatives from these groups in the planning process can help ensure that planning proceeds in a manner that incorporates their particular needs.

Response Logistics

- Establish a system for notification and call-up of key response staff as events occur.
- Ensure access to areas where staff is needed by issuing proper identification and establishing a method to easily identify mental health workers (e.g., baseball caps, labeled T-shirts). In some States, the SEMA has issued SEMA badges to SMHA employees.
- Prior to an event, establish a plan for deployment of mental health personnel. Mutual aid agreements for deploying mental health personnel from one jurisdiction to another should be considered. A Statewide deployment plan should detail the specific agencies involved as well as the method of deployment for these agencies. Careful consideration should be given to the availability of resources and the backfilling of temporary vacancies, as well as transportation, communication, and safety issues. In particular, communication systems (cell phones, "ham" radios, etc.) should provide redundancy to ensure capability if infrastructure has been destroyed. Do not oversimplify this critical procedural element of the plan.
- Be sure that SMHA leadership understands the incident command system and establishes plans for immediate mental health activities as part of unified incident command.
- Clarify how communications will take place and the reporting expectations. The use of preexisting forms is recommended.

Planning for Post-event Issues

- It would be helpful to have a common and nationally consistent definition of what constitutes the responsibility of the SMHA for mental health response and recovery after a disaster. It is a challenge for key State leaders outside the SMHA to understand the nature of disaster mental health services and how these services differ from traditional mental health services, because most SMHAs focus primarily (sometimes exclusively) on those with the most serious mental health disorders.
- Public education following an event is critical. Many victims will require nothing more than information that reassures and provides anticipatory guidance and meaningful advice about what can be done to reduce and/or manage disaster-related stress. Consistency in these messages is critical.
- A response is only as good as the responders. A plan must be in place to ensure physical and psychological support for mental health workers as well as staffing depth to ensure ongoing operational capacity.
- There often is significant lag time between the decision to implement services and the actual implementation. States should develop a mechanism to expedite the implantation of services so the process is unencumbered by procedural delays.

PART THREE

Plan Content

In creating this document, extensive consideration was given to whether States should be encouraged to follow a common approach or to create their own design and content. No current authority requires States to adopt a single, uniform conceptual model; there is merit to unique approaches. However, there was consensus that States should be encouraged to follow a consistent content format and conceptual model based on the FEMA-supported all-hazards approach, which is being universally utilized by SEMAs. It was agreed this common approach will enhance the integration of SEMA planning and operations as well as cross-State collaboration—both important values in this endeavor. However, within this common model there is significant opportunity for States to devise and implement plans reflecting their particular needs, characteristics, and unique and creative approaches.

It also should be noted that SMHAs vary considerably in the programs that are included in the agency, as well as how they are organized internally. For example, in some SMHAs the tasks of disaster and emergency preparedness and risk management are organizationally separate. This document was developed on the assumption that these two functions are combined. Responsibility for developing various parts of the plan will fall to different parts of the organization in those States where these functions are separate. In all cases, the content should be integrated regardless of which part of the organization has the lead.

There are several basic elements to an all-hazards disaster mental health plan. This section will describe the suggested contents of each element. Appendix A contains a comprehensive matrix to help planners in ensuring that they have included all the relevant information in the plan. In reviewing this matrix, States may find items that

do not apply to their particular situation.

It is worth noting again that not all States will have the resources to develop or sustain a plan that contains all of these elements. This information is meant to serve as a guide—a comprehensive menu for choosing initiatives when formulating an all-hazards disaster mental health plan.

BASIC PLAN ELEMENTS

Several boilerplate elements should be in the introduction of the plan including material such as those listed below:

- A signature page to assure readers that the plan is official;
- A dated title page with a record of changes. It will assure readers that they are reviewing the current version;
- A record of the plan's distribution to ensure that those who need to review and access the plan have done so;
- A table of contents; and
- An optional executive summary may be helpful to those who do not have the time or need to review the entire plan.

To set the stage and context for the more detailed portions of the plan early on, the following elements should be included:

- A statement of the general purpose of the plan;
- General situations and assumptions inherent in the plan. This information should include basic assumptions, such as limits of the SMHA's responsibilities and highest probability scenarios as well as special considerations having significant impact on planning, including vulnerable populations, special facilities, and low probability/high impact events. A matrix capturing some of this type of information has been developed by the Texas Department of Mental Health and Mental Retardation and is included in Table 4. Some States may find it helpful to differentiate hazards into two categories: physical events or damage that is easily identifiable (e.g., flood, school shooting), and events not easily identifiable (e.g., bioterrorism, epidemics, reaction to perceived risk);
- A general concept of operations, including the SMHA's overall approach to an emergency situation; jurisdictional responsibilities; the general sequence of action before, during and following an event; requests for aid, etc. While this section should cover many topics, it is intended to be relatively brief, providing only the most general overview, primarily for readers of the plan who will not need the level of detail contained in the remainder of the plan and for those who may be unfamiliar with the SMHA and its function in disasters. As a broader topic, establishing and implementing a concept of operations is complex and will vary considerably among States. Hopefully, States will share this information with each other and additional discussion and guidance can be provided as more plans are developed and implemented; and

It is worth noting again that not all States will have the resources to develop or sustain a plan that contains all of these elements. This information is meant to serve as a guide—a comprehensive menu for choosing initiatives when formulating an all-hazards disaster mental health plan.

TABLE 4:

TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION DISASTER MATRIX (TDMHMR, 2002)

	LOCAL DISASTERS	STATE DECLARED DISASTERS	FEDERALLY DECLARED DISASTERS
Disaster Definition	A local disaster is any event, real and/or perceived, which threatens the well-being (life or property) of citizens in one municipality. A local disaster is manageable by local officials without a need for outside resources.	A State disaster is any event, real and/or perceived, which threatens the well-being of citizens in multiple cities, counties, regions and/or overwhelms a local jurisdiction's ability to respond, or affects a State-owned property or interest.	A Federally declared disaster is any event, real and/or perceived, which threatens the well-being of citizens, overwhelms the local and State ability to respond and/or recover, or the event affects Federally owned property or interests.
Ownership	Response is by local government, such as a police or fire chief, mayor, or county judge and/or other legal authority of local government.	A State-declared emergency can only be designated by the Governor or his/her designee. Response and recovery is the responsibility of the Texas Department of Public Safety and the Governor's Division of Emergency Management.	A Federally declared disaster can only be designated by the President of the United States. The Governor of a State must request a Presidential declaration of disaster.
Response Required	A response by a Community Mental Health and Mental Retardation Center is not required by the State Authority. The Local Authority may choose to respond if a request is made by local officials and/or a need is evident.	A response may be required depending upon the magnitude, nature, and duration of the emergency or disastrous event. The State Authority may also supplement local resources with State Facility staff and/or other staffing opportunities.	A response will be required and the level of response will be according to actual or perceived need.
Duration of Response	There is no set time duration for response to a local disaster.	The duration of response for this category of disaster is generally for the duration of the event or until it is jointly determined by the State Authority and the Governor's Division of Emergency Management that a response is no longer necessary and/or appropriate.	The duration of response for this type of disaster will be for the duration of the event or until it is jointly determined by the State Authority and the Governor's Division of Emergency Management that a response is no longer necessary and/or appropriate; for the duration of the grant period, if a Federal Crisis Counseling Program is obtained.
Reimbursable?	This type of disaster is not reimbursable.	This type of disaster is not reimbursable. Only under highly unusual circumstances would the State Authority be allowed to apply for contingency funds from the Governor's office.	This type of disaster will be reimbursable only upon request and approval by the State and Federal authorities. If a disaster is approved for "Public Assistance," a municipality may apply for reimbursement. Also, if the State Authority seeks a Federal Crisis Counseling Program grant through the Governor's office, funds for these services will be reimbursable.

- References to specific legal authorities that enable the SMHA to fulfill the elements of the plan or to maintain existing services.

Organization and assignment of responsibilities in times of emergencies relate to the following components:

- Identification of tasks (both within the SMHA and outside) to be performed and positions and organizations responsible for carrying out these tasks. Documentation of tasks may use the FEMA-suggested format (defines objectives, characterization of the situation, general plan of action, delegation of responsibilities, information on resources, and administrative support necessary to accomplish tasks including descriptions of treatment responsibilities). Additionally, one of the most important assignments to clarify is responsibility for modifying and updating the disaster mental health plan;

- Tasks related to other departments and agencies, such as FEMA, SAMHSA/CMHS, and the Justice Department (victim rights and assistance);

- Integration of preparedness and coordination of operations with other important components of State and local government, such as health agencies, substance abuse agency, criminal justice agencies, law enforcement, fire and rescue, and agriculture (including the extension service and veterinary services); and

- Connection with State emergency plan and Federal response plan (the SMHA's plan must be consistent with the expectations of these two important plans in the likely event that an incident that activates the SMHA plan also activates other State and Federal plans).

An appropriate response may be ensured by adequate preparation of the following administrative issues (using documentation expected from FEMA and CMHS may help if funding from these sources is anticipated):

- Record keeping for program activities (which services are being provided to whom, and by whom);

- Record keeping of expenditures and obligations. In the course of a response, the SMHA may incur significant, atypical expenses, such as car or generator rentals. It is important before an incident to have a means of documenting these types of expenditures to ensure that future problems are minimized and reimbursable expenses are accurately documented;

- Record keeping for human resource utilization. This is important not only for potential reimbursement, but for planning to ensure adequate staffing as well;

- Expected format, frequency, and content of situation reports. Again, this information is critical, especially in the early parts of a response, to justify resources and to project service, fiscal, and human resource needs. Situation reports can also serve as

In the course of a response, the SMHA may incur significant, atypical expenses, such as car or generator rentals. It is important before an incident to have a means of documenting these types of expenditures to ensure that future problems are minimized and reimbursable expenses are accurately documented.

A process to provide continuous information flow to planners and managers is also critical because of the rapidly changing environment that characterizes large-scale disasters.

important political resources as SMHA and other State leaders present the status of response to others; and

- Management of volunteer services. Development of a plan to address use of volunteers prior to an incident will help ensure that human resource levels and skills are appropriate to service needs. Many States have learned difficult lessons about the management of well-intentioned but unneeded and/or inappropriate volunteer resources. The SMHA should consider the use of a volunteer coordinator position in large-scale disasters/events. This position/function would centralize decision making and control of voluntary mental health assistance. Pre-disaster, the plan should include a decision tree for use by the voluntary utilization function to ensure consistency in the selection and deployment of unsolicited assistance.

During the preparation stages, it is important to consider the following key logistics issues:

- Arrangement for support (food, shelter, etc.) needed for the mental health operation, including the ability of the mental health operation to be self-supporting for at least 72 hours. Operations can quickly be compromised if staff must rely on others during this critical and often chaotic period;

- Arrangement to repair and/or replace essential equipment (such as radios, computers, phone service); and

- Arrangement for personnel to access the areas where they are needed. The most heavily impacted areas are not accessible without proper credentials and transportation in the early hours after a disaster. The SMHA should work closely with the SEMA to assure that essential mental health staff members are able to get to where they need to be. It is important to ensure that these credentialing arrangements are included in both the SEMA and SMHA plans. Transportation of mental health workers may need to be jointly planned in cases where mental health staff need to be transported by resources outside the SMHA (e.g., the National Guard). As noted earlier, familiarity with the incident command system (ICS) will make planning for access and exit easier.

A necessary but challenging activity for content planning is ongoing needs assessment. Critical questions to consider are listed below:

- *How are needs to be assessed?* Is there a needs assessment tool? Who is responsible for compiling the assessment? What is the process for implementing recommendations?

- *Who will be served?* Are original assumptions still accurate? Is information being collected with respect to the extent of exposure, degree of personal impact, and demographic characteristics? CMHS Crisis Counseling guidance may be helpful in making this assessment.

- *How will they be served?* What services are available; what are needed? Are requests for services

being answered in a timely manner?

- *How are needs changing?* Are the needs of some satisfied so that resources can be redeployed? Are there emerging groups? Are geographical areas of need emerging?

An assessment with these types of questions is critical for resource management, establishing program priorities, documentation of effort, and long-range planning. A process to provide continuous information flow to planners and managers is also critical because of the rapidly changing environment that characterizes large-scale disasters. The CMHS needs assessment formula is included in Table 5.

INTEGRATING ACTIVITIES WITH THE STATE PLAN

- The availability of medications, and where they need to be located are special mental health concerns. The plan should address the transportation of medications to where they are needed, as well as the safeguarding of their administration, recording, and storage.

- When—in the assessment of the local agency or the SMHA—the requirements of events exceed the service capacity of the responsible jurisdiction, mutual aid agreements with other jurisdictions (e.g., counties, States) can be very helpful and are strongly encouraged. The plan should document the existence and scope of such agreements.

TABLE 5:

CMHS NEEDS ASSESSMENT FORMULA (CMHS, 2000)

B. Needs Assessment Formula. **Using the CMHS Needs Assessment Formula (located below) estimate the number of persons you will serve in each designated area (fourth column of the following table). Attach a CMHS Needs Assessment Formula sheet for each designated area.**

CMHS Needs Assessment Formula for Estimating Disaster Mental Health Needs

This is an estimate for the following disaster area:_____

Date of Report:_____ **Completed by:**_____

LOSS CATEGORIES Type of Loss	NUMBER OF PERSONS Number	ANH Multiply by ANH[1]	RANGE ESTIMATED At-Risk Multiplier (Percent)	TOTAL Number of Persons Targeted Per Loss Category
Dead			100	
Hospitalized			35	
Non-hospitalized injured			15	
Homes destroyed			100	
Homes with "major damage"			35	
Homes with "minor damage"			15	
Disaster unemployed			15	
(Other loss—specify)			10	
Total estimated persons in need of Crisis Counseling services (add total column)				

[1] *ANH means **A**verage **N**umber of persons per **H**ousehold. This figure can be obtained on a county/parish/area basis from the Census Bureau. If the State is unable to determine the ANH for an area, then use the average figure of 2.5.*

To make the response and recovery activities both more efficient and to reduce vulnerability to litigation, the plan should address the following legal issues prior to the event:

- Knowledge and understanding of State licensing laws. Are there waiver provisions during emergencies for recognition of those licensed in other jurisdictions?
- Informed consent, confidentiality of conversations with victims, and records kept by service providers; and
- Liability (How is personal, professional, and organizational liability addressed? In what ways are service providers vulnerable? Are there legal provisions for waiving certain contracting/ procurement rules during emergencies?).

FUNCTIONAL ANNEX CONTENT

State emergency plans typically contain a series of functional annexes. Annexes are typically parts of a plan that begin to provide more detailed direction and information. Planning in these areas should focus on assignment of responsibilities, key tasks, and specific actions that should be taken. The annexes described in this section follow the FEMA all-hazards annex components and will be reflected in most SEMA plans. They are general in nature and apply to many, if not most, types of events that would activate the plan. Planning related to specific types of events, also as reflected in the FEMA all-hazards approach, is discussed in the next section.

Communications

Functional and reliable communication is frequently a problem following major events. In some types of disasters, the event itself may compromise communications, (i.e. cell phone transmitters were located atop the World Trade Center buildings) or they may become so over utilized that they are of little use. These issues can be a major concern for SMHAs as they typically rely on existing communications systems to assess the status of existing programs and emerging needs, as well as to deploy and track mental health resources. During planning stages, the following key elements of communication should be considered:

- Identify situational assumptions such as the types of situations that might occur and the types of communication necessary (e.g., telephone and data transmission). Close integration with the SEMA will be helpful in this activity;
- Identify methods of communication among key sites such as the SMHA and psychiatric facilities, community treatment facilities, State emergency management, hospitals and clinics, and sites where victims may be sheltered and mental health staff may be stationed. A good communication plan begins with the assurance that the SMHA is on the notification list of the Governor's Office and State emergency management when emergencies occur;
- Identify alternatives when planned communications fail, as well as the availability of personnel with the technical expertise to make and keep communications functional. Plans should include multiple options for communications; and
- Identify risk is communicated in emergency situations has a significant psychosocial impact. While the primary responsibility typically lies outside the SMHA, the SMHA has much to contribute to this process and therefore the description of the SMHA role in risk communication should be clear.

Public Information

Communication with the public is an important part of all emergency responses. It ensures that those affected by an event, or at risk of being affected, take appropriate action to mitigate adverse effects. This function assumes even greater significance in mental health. Everything communicated to the public, how it is communicated, and by whom it is communicated can exert a significant effect on the psychosocial experience of the event. State and local SMHAs should work closely with the SEMA's public information officer, since this position is typically responsible for this function during State and federally declared emergencies. Key elements of an optimal public information plan are listed below. More detailed information is available in *Communicating in a Crisis: Risk Communication Guidelines for Public Officials* (U.S. Department of Health and Human Services, 2002).

Identification of Responsibility

- It is important to identify key roles and policies, such as the designation of the SMHA liaison(s) to the media and restricting media access to other personnel.

- Public information materials should exist prior to an event (e.g., fact sheets, guidance on how to access services, guides to coping). These materials should be available in a variety of languages.

- Identification of experts in trauma and disaster/emergency mental health by the SMHA, prior to an event, will significantly reduce the likelihood that the SMHA will have to locate and assess expertise in the midst of a response and will increase the likelihood that the SMHA can exercise some control of the messages given.

- Establishing relationships with the local media prior to an event will help ensure that mental health is considered in coverage and may reduce the potential for the media to seek out or accept mental health information from sources unconnected with the response. Existing SMHA media relationships may be helpful. Briefing the media on the planning process and the importance of accurate information about behavioral sequelae may be an opportunity for mental health promotion and problem prevention. Relationships with reporters who cover health issues may be especially productive.

Warning: Mobilization Related to Internal Mental Health Systems

It is important that the SMHA receive as much information as possible, as early as possible, when an event occurs or is likely to occur. The SMHA, therefore, must have mechanisms in place to mobilize the mental health response. Key elements in this process include:

- The SMHA and local mental health agencies should be linked to the SEMA warning and notification system/process;

- The plan should identify methods and procedures for notifying staff, facilities, service providers, and others, as appropriate in a given State;

- The plan should include policies and procedures for SMHA offices and facilities, such as sending staff home, holding staff in place, recall of staff who are off duty, and evacuating facilities. In some States, these functions are controlled by the SMHA risk management unit rather than those involved in disaster preparedness. In those States, it is important that these two parts of the organization integrate their plans; and

- Warning and mobilization of those outside the SMHA also are important roles of the SMHA. Plans should identify groups with special needs (such as those who have mental disorders who are also deaf) and include plans to notify the larger mental health system (e.g., counties, contract providers) as well as private sector mental health resources.

It is important that the SMHA receive as much information as possible, as early as possible, when an event occurs or is likely to occur. The SMHA, therefore, must have mechanisms in place to mobilize the mental health response.

Caring for large numbers of displaced victims is a major, complex part of disaster planning. While mental health does not have primary responsibility in this area, it is common to find the SMHA playing a secondary, supportive role.

Evacuation

Events may cause evacuation of large or small portions of a State. In all cases, evacuations have had significant effects both on direct SMHA operations as well as on potential service sites. Integration with SEMA planning is essential, as always. In most cases, the SMHA will not have direct responsibility, except in their own facilities, but evacuation can have significant impact on all involved, including staff. Planning considerations follow:

- It is critical that SMHA evacuation plans are integrated with State emergency management plans;
- Clearly established plans are needed for the evacuation of SMHA offices and facilities. *Responding to the Needs of People with Serious and Persistent Mental Illness in Times of Disaster* (U.S. Department of Health and Human Services, 1996) may provide useful ideas in planning for the needs of those in State facilities;
- Alternate sites should be established to conduct vital SMHA activities. Emergency managers typically describe these sites in terms unfamiliar to those in mental health. Sites in place, unused for any other purpose, and capable of being fully functional during emergencies, are called "hot sites." Those sites with some functionality, but also used for other functions in non-emergency times are called "warm sites." And those existing sites that do not become active until an event occurs are called "cold sites;" and
- The plan should include provisions for mental health services at shelters and mass care facilities.

Mass Care

Caring for large numbers of displaced victims is a major, complex part of disaster planning. While mental health does not have primary responsibility in this area, it is common to find the SMHA playing a secondary, supportive role. Typically, the Red Cross has the lead in mass care, but the SMHA may be asked to provide support in terms of ongoing needs assessment, staffing for shelters or places where families await information on the status of loved ones, and referral of those identified as suffering from serious psychological reactions. When planning ideas for the SMHA role in mass care, be sure to confirm:

- Documentation of coordination with the SEMA mass care plan; and
- A description of linkages between the SMHA, the Red Cross, and National Voluntary Organizations Active in Disasters (*See Part IV for contact information*).

Many SMHAs have had experience with mass care. States are encouraged to utilize State-to-State consultation regarding mass care preparations. For example, most of the Gulf States have well-established evacuation plans that have significant mass care components. The SAMHSA Disaster Mental Health Technical Assistance Center (DTAC) can provide technical assistance on this topic (*See Part IV for contact information*).

Health and Medical

While health and medical response is only part of the SEMA plan, it is the heart of the SMHA plan. For this reason, SMHAs should pay particular attention to the content of this annex in the SEMA plan and ensure that planning is integrated. The SMHA plan will be far more comprehensive and detailed with respect to behavioral health issues. It is important that the SEMA be briefed on its content when the SMHA plan is complete so that the SEMA is aware of the scope, depth, and limitations of SMHA responsibilities and resources.

When reference is made to the SMHA in State emergency management plans, it probably is included in the Health and Medical Annex. Typically, the emergency management plan will task the SMHA with providing crisis counseling services and/or caring for people with serious mental illness who are within the SMHA service system. Some State emergency management plans describe additional functions. For the purposes of the SMHA's disaster plan, the following points are suggestions for integration with the emergency management plan, as well as for other significant roles the SMHA can play.

- The plan should document coordination with the State emergency management plan, especially in the areas of staffing, logistics, costs, and availability of pharmaceuticals.
- The SMHA plan should include mental health services and consultation as part of the State's emergency medical plan. Typically, this part of the State's emergency management plan will reflect utilization of Veterans Administration resources (which offer a considerable number of mental health professionals skilled in dealing with psychological trauma.) The State plan also will use Emergency Support Function Number 8 (ESF-8), an item under the Health and Medical Annex of the Federal Response Plan. ESF-8 addresses the availability of services provided by the National Disaster Medical System (NDMS), a joint Federal-medical response capability involving the U.S. Public Health Service, the Veterans Administration, the Department of Defense, and FEMA (*See Part IV for contact information*). ESF-8 also mandates the provision of mobile medical teams for deployment in major emergencies. There are several types of these ESF-8 specialty teams including mental health professionals in addition to general medical teams.
- The plan should contain clearly identified roles in the areas of services and consultation to primary victims, secondary victims (those not directly impacted by injury, death, and destruction but who are nevertheless experiencing disaster related stress), response and recovery workers (fire, police, rescue, morgue), incident command leadership and staff, and to other State agencies and departments (such as health epidemiology, education, and social services).
- The plan should document coordination with the Red Cross disaster mental health services.

Resource Management

The purpose of the Resource Management Annex is to ensure that the SMHA documents the means, organizational structure, and process through which it will locate, obtain, allocate, and distribute necessary resources during an emergency. Several key considerations are listed below.

- As noted earlier, a number of issues arise related to personnel, including how will personnel be notified, mobilized, transported, and deployed in the context of a changing response environment?
- The plan should describe how communications and other emergency equipment would be obtained, distributed, and maintained (including repairs).
- The plan should describe the mass care supplies needed to sustain SMHA resources should they be isolated or need to remain at their service locations.
- Mutual aid agreements within the State should be described in the event that local resources are not sufficient.
- As noted earlier, response efforts can be made more efficient and effective with a plan for managing unsolicited offers of assistance, as well as solicited volunteers.
- The Resources Management Annex should describe the nature of and process for obtaining resources from other States and the Federal government.
- The plan should document policies and procedures for maintaining financial and legal accountability.

HAZARD-SPECIFIC PLANNING

There is a need to plan for the specific and sometimes unique aspects of different events in the context of plan content applicable to nearly all types of events. Events may have unique characteristics with special resulting psychosocial consequences that have significant implications for the SMHA (i.e. slow-rising, long-standing flooding may result in delayed reconstruction or repair to homes, which may further result in victims spending longer periods of time in shelters or with friends and families. This can generate additional individual and family stress).

Some types of events are accompanied by significant government regulations that directly affect response and recovery, which may result in or affect psychosocial sequelae. For example, the locations in which suspected terrorist events occur are considered crime scenes. This may result in delayed body recovery and release of surviving victims. It also may result in recovery workers becoming witnesses in criminal proceedings. These special factors can have a significant impact on the course and timing of psychological recovery.

Hazard-specific planning by the SMHA also should occur in the context of similar planning by the SEMA. The SEMA workers will have performed significant and detailed risk assessments that can be utilized by the SMHA. This planning will also include identification of events when an agency other than emergency management (e.g., the FBI or military) is in control of the response. Plans should include identification of types of risks, as well as geographic areas that are believed to be at risk. Not all States are susceptible to the same risks, and different portions of States may be at greater or lesser risk for different types of events. In addition, the SMHA may have facilities in high-risk areas or facilities to be used as backup facilities.

A detailed listing of the types of risks a State may experience is included in Appendix A.

Terrorism

Planning for the consequences of terrorist acts presents numerous challenges. The national experience and the experience of most individual States is limited, and there are many types of potential terrorist acts to consider during planning. The scientific knowledge about the psychological and medical aspects of some types of terrorist acts, especially bioterrorism, is not as precise and complete as needed. Because so much emphasis currently is being placed on preparing for a wide variety of terrorist incidents, the planning environment is changing rapidly—with new laws, guidelines, and key players emerging constantly.

In some cases the SMHA plan could reference the SEMA plan. Consider using excerpts from the SEMA plan to add detailed context to situational assumptions and HazMat considerations. There may also be reluctance to put some material in a plan that is posted on the Web or is otherwise easily accessible to a very wide audience. Again, taking the SEMA's lead may be the best strategy. With these factors in mind, the SMHA plan for terrorism should be developed by being informed of the following issues.

- An understanding of potential hazards such as chemical, biological, nuclear/radiological, explosive, cyber, or combined events. Many types of events might stem from these overall classifications. States with rural areas and agribusiness industries should also include Foreign Animal Diseases (FADs) that may be introduced accidentally or criminally. Planning should reflect the types of events that the SEMA has included in their plans.
- Identification of potential targets that reflect or are consistent with those identified by the SEMA (e.g. chemical manufacturing plants or nuclear power generating facilities). This will not only ensure that there has been SMHA and SEMA communication on these potential targets, but also that planning between the two agencies is consistent.
- Situational assumptions of the SEMA plan including environment (e.g., prevailing winds), populations and population centers, urbanicity, infrastructure (water, sewer), transport patterns (roads, railways), airports (public, private, military), trains/subways, government facilities (non-military), military installations, recreation facilities, and facilities containing hazardous materials, as well as other high-risk targets such as financial institutions, universities, hospitals, research

institutes, schools, and daycare centers. By completing a description of situational assumptions, the SMHA will ensure that planning is consistent with the SEMA, while considering where needs may arise, what mental health resources may be at risk, and where to place preparedness priorities.

- Description of the SMHA's terrorist incident management protocol, with special attention to aspects where incident management may be different than in other types of disasters.

- Reflection of the State emergency plan's modeling of potential releases of hazardous materials or biological agents. This again will increase the potential for SEMA/SMHA plan coordination, as the SMHA will be able to identify specific scenarios (e.g., evacuations, decontamination sites, etc.) that may generate special mental health needs, assess vulnerability of mental health service sites, identify alternative sites, evaluate the deployment of mental health resources, etc.

- Documentation of how incident management by the SMHA reflects the roles of other State and various Federal agencies and resources.

- Description of how the plan's consequence management reflects the involvement of various Federal components (such as FEMA, SAMHSA/CMHS resources, Office for Victims of Crime in the Justice Department, and Safe and Drug Free Schools in the Department of Education).

- A description of the State emergency plan in cases in which terrorist events trigger different response, authorities, and policies within the functional annexes described in the previous section.

- Identification of links to health and medical entities to assist in screening potential victims for mental disorders and psychogenic symptoms, functional impairment, substance abuse, etc. One of the great concerns following a bioterrorist incident is the rapid utilization of health and medical resources not only by those who have been exposed but also by those who believe they have been exposed. This is an area in which close collaboration in the planning and response phases among the SMHA, the health agency, local hospitals, and other health care facilities is paramount.

- Links with the health agency for surveillance, screening, consultation, intervention planning, and risk communication. In events with major public health implications, the State health agency will have a lead role. The valuable role that the SMHA can and should play in the activities described is often not understood by the State health agency. Collaboration in the planning process can result in enhanced response by both the SMHA and the health agency.

- A description of the SMHA's authority in risk communication and response. As noted before, this is an area in which collaboration between the SMHA, the health agency, and the State emergency management public information structure is critical.

Planning for the consequences of terrorist acts presents numerous challenges. The national experience and the experience of most individual States is limited, and there are many types of potential terrorist acts to consider during planning.

Plans should reflect the fact that mental health providers typically are not first responders to HazMat incidents. When they are deployed to the site and are present at the site, their safety should be a prime concern to planners and administrators.

■ Plans should reflect the fact that mental health providers typically are not first responders to HazMat incidents. When they are deployed to the site and are present at the site, their safety should be a prime concern to planners and administrators. Adequate preparation should be undertaken to ensure safety, such as training on proper use of safety equipment and protective gear. Without preparation mental health providers quickly and easily can become part of the population needing health, medical, and mental health services.

Continuity of Operations for the State Mental Health Agency

No organization can mount a response to a disaster if the fundamental operations of that organization are not functioning. SMHAs are no exception. Additionally, preexisting and ongoing responsibilities of the SMHA do not stop, even when disaster strikes. As a result, part of a meaningful plan are provisions that will enable the SMHA to continue its essential functions when disaster strikes through a Continuity of Operations Plan (COOP). In many States, these issues will be addressed in documents separate from the SMHA's disaster plan. In some States, they will be integrated as part of the disaster plan. In any case, there is certainly a role for disaster planners in preparing for worker stress issues inherent in any situation that would activate a COOP. To ensure continuity of essential operations, the following points should be addressed.

■ A statement of goals for the COOP is necessary. The goal in most States is to maintain or reestablish vital functions of the SMHA during the first 72 hours following any event that would compromise or halt normal operations.

■ As in other components, there should be documentation of coordination with the overall State Coop.

■ The plan should identify vital functions, records, and data to be maintained within the first 72 hours.

■ The plan should identify plans related to human resources, such as essential staff, staff notification, and family support. Note that these functions may be different from those described earlier, which focus on disaster-related services. In this case, the concern is with maintaining preexisting SMHA functions and responsibilities.

■ The plan should identify alternate locations for essential operations as well as provide for transportation and staff support (food, rest/sleeping areas, etc.).

■ In case the primary records are destroyed or inaccessible, it is important that duplicate vital records and documents be housed prior to an event in at least one alternate site. These types of records might include the SMHA disaster plan, staff rosters, and vital patient medical records.

SPECIAL PLANNING CONCERNS FOR MENTAL HEALTH

The following list includes elements of the SMHA disaster plan that represent issues of special concern to SMHAs.

As States develop their plans, they may want to personalize the list.

- The description of the SMHA's presence and role in the State emergency management structure. As has been noted, this relationship is central to effective planning and plan implementation. In many States in which this positive relationship exists, it is based upon personal relationships. Committing these relationships to writing can help ensure that the relationship is sustained as key people change.

- Documentation of regional or multi-State planning and coordination. The SMHA should not and cannot plan alone. If a plan is to be effective and support the sharing and flexibility of human and other resources, it must involve other jurisdictions.

- Descriptions of licensing issues in disasters. A variety of licensing-related issues for mental health professionals come into play in emergency and disaster situations. SMHAs are advised to consult with appropriate officials within the State to explore issues including licensing of out-of-State providers, the appropriate scope of practice guidance, and the clarity of the types of disaster mental health activities that require a license.

- Documentation of plans to prepare and support mental health staff during and following deployment under the plan. These plans should include attention to physical and psychological health, special medical needs, and family support. Unfortunately, the needs of the providers frequently are overlooked, or are secondary considerations. Attention to these issues in the planning process can help assure that providers do not become secondary victims in the course of performing their important work.

- Documentation of public sector links with private mental health resources. When disasters occur, the line between public and private mental health concerns is not as clear as in "normal" times. SMHAs will be well-served by pre-event planning and collaboration that explore roles, skills, and availability of mental health resources as well as contract planning.

- Documentation of appropriate links with businesses, corporations, and other private sector interests engaged in planning for behavioral health response and consequences. Business and corporate emergency planning has expanded dramatically in recent years. Some are incorporating behavioral health issues into their plans, though many are not. The SMHA may improve outreach capability and enhance community support by reaching out to these organizations during the planning process.

- Documentation of appropriate planning links with institutions of higher learning. Academic departments may be able to provide specialized expertise helpful in planning and/or actual resources when disasters occur. In addition, their student health services could benefit from information, consultation, or training related to disaster mental health.

- Assurance that SMHA facilities meet the standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or other appropriate standards for disaster and emergency preparedness. Like other organizations, health care facilities have increased their attention significantly to prepare for emergencies. SMHAs should ensure that facilities under their responsibility are prepared. The Joint Commission on Accreditation of Healthcare Organizations (www.jcaho.org) has disaster and emergency guidance that may be helpful.

- SMHA involvement in disaster training and exercises. Short of real disasters, disaster exercises are among the best ways to test plans. SEMAs routinely conduct exercises involving differing event scenarios. SMHAs are advised to make certain that not only the SMHA is involved in these exercises, but also that content related to psychosocial consequences are built into exercise scripts. With proper involvement, the exercises will become more realistic and the SMHA will have the opportunity to learn more from the experience. Following drills, after-action reviews should be conducted to identify "lessons learned" for incorporation into planning and exercise development.

- Description of roles in coordination of research. While not often a common role, the SMHA may play a very helpful and valuable role in helping to coordinate research following an event. The balance between services and research is often a

The response phase will certainly be more efficient, and likely more effective, if procedures can be standardized and shared prior to an event and used consistently during an event. Developing these procedures during an event is time consuming and distracting to the primary mission.

delicate one, especially when balancing the need for increased disaster mental health research and the need to ensure that government entities charged with service provision protect the importance of that mission. The SMHA can play a central role in helping to maintain that balance.

- Plans for data collection and evaluation of programs. The same delicate balances described above apply in the area of data collection and the evaluation of services. Potential problems can be avoided to the extent that data collection and evaluations can be described and agreed upon prior to an incident. SAMHSA currently has seven FEMA/CMHS program guidance documents "developed to ensure consistency in addressing key program issues" in crisis counseling training, including *Recommended Approaches to Evaluation of Crisis Counseling Grant Projects*. The documents are listed on the Web at www.samhsa.gov.

STANDARD OPERATING PROCEDURES AND CHECKLISTS

The response phase will certainly be more efficient, and likely more effective, if procedures can be standardized and shared prior to an event and used consistently during an event. Developing these procedures during an event is time consuming and distracting to the primary mission.

In the planning phase, SMHAs should consider the types of procedures and checklists (e.g., emergency contact numbers) that could be helpful, and develop them during the planning process. The Texas Department of Mental Health and Mental Retardation has created a detailed procedural guide for community mental health centers to use in "pre-disaster preparation and initial response." The guide is available online at www.mhmr.state.tx.us.

GLOSSARY OF TERMS

Plans have large and diverse audiences. Also, a major purpose of a plan is to communicate clearly. For these reasons, States have found it helpful to include a glossary of State-specific, emergency management, mental health, and public health terms as a part of their plan. A sample glossary of acronyms and definitions is included in Appendix C.

PART FOUR

Resources

ORGANIZATIONS

Sources for information and assistance in planning are listed below. The list does not necessarily represent all sources of information nor is inclusion on the list intended to imply an endorsement by HHS or SAMHSA.

FEDERAL

Centers for Disease Control and Prevention
www.cdc.gov
888-246-2675

Federal Emergency Management Agency
www.fema.gov
800-621-FEMA

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov
800-789-2647

U.S. Department of Defense
www.defenselink.mil

U.S. Department of Education
www.ed.gov/index.jsp
1-800-USA-LEARN

U.S. Department of Justice
Office for Victims of Crime
www.ojp.usdoj.gov/ovc
800-627-6872

U.S. Department of Veterans Affairs
www.va.gov

U.S. Department of Health and Human Services
Office of Emergency Preparedness
National Disaster Medical System
800-USA-NDMS
www.ndms.dhhs.gov

PRIVATE

American Psychiatric Association
www.psych.org
703-907-7300

American Psychological Association
www.apa.org
800-374-2721

American Red Cross
www.redcross.org
202-639-3520

Jane's Information Group
www.janes.com
800-824-0768

Joint Commission on Accreditation of Healthcare Organizations
www.jcaho.org
630-792-5000

National Association of Social Workers
www.socialworkers.org
202-408-8600

National Center for Post-Traumatic Stress Disorder
www.ncptsd.org
802-296-6300

The National Child Traumatic Stress Network
www.nctsnet.org

National Emergency Management Association
www.nemaweb.org/index.cfm
859-244-8000

National Voluntary Organizations Active in Disasters
www.nvoad.org
301-890-2119

SAMHSA Disaster Technical Assistance Center (DTAC)
800-308-3515
(Under contract with CMHS/ESDRB)

PUBLICATIONS

The following publications also may contribute to a comprehensive planning effort. Again, the list is not exhaustive; inclusion does not imply endorsement by HHS or SAMHSA.

Bailey, B. E., Hallinan, M. M., Contreras, R. J., and Hernandez, A. G. (1985). Disaster response: The need for community mental health center (CMHC) preparedness. *Journal of Mental Health Administration*, *12*(1):42-6.

Barton, G. M. (1985). Disaster preparedness from an emergency psychiatric perspective. *Emergency Health Services Review*, *3*(2-3):313-23.

Beaton, R., and Murphy, S. (2002, April). Psychosocial responses to biological and chemical terrorist threats and events: Implications for the workplace. *American Association of Occupational Health Nurses Journal*, *50*(4):182-9. Review.

Benedek, D. M., Holloway, H. C., and Becker, S. M. (2002, May). Emergency mental health management in bioterrorism events. *Emergency Medical Clinics of North America*, *20*(2):393-407. Review.

Bowencamp, C. (2000, Fall). Coordination of mental health and community agencies in disaster response. *International Journal of Emergency Mental Health*, *2*(3):159-65.

Call, J. A., and Pfefferbaum, B. (1999, July). Lessons from the first two years of Project Heartland: Oklahoma's mental health response to the 1995 bombing. *Psychiatric Services*, *50*(7):953-5.

Cozza, S. J., Huleatt, W. J., and James, L. C. (2002, September). Walter Reed Army Medical Center's mental health response to the Pentagon attack. *Military Medicine*, 167(9 Suppl):12-6.

Dailey, W. F. (2001, December). Planning for the unthinkable. *Behavioral Healthcare Tomorrow*, *10*(6):SR23-7.

Dodgen, D., LaDue, L. R., and Kaul, R. E. (2002, September). Coordinating a local response to a national tragedy: Community mental health in Washington, DC after the Pentagon attack. *Military Medicine*, *167*(9 Suppl):87-9.

Everly, G. S. (1999, Summer). Toward a model of psychological triage: Who will most need assistance? *International Journal of Emergency Mental Health*, *1*(3):151-4.

Federal Emergency Management Agency. *Are You Ready? A Guide To Citizen Preparedness*. FEMA publication H-34.

Flynn, B. W. (1995). Thoughts and reflections following the bombing of the Alfred P. Murrah Federal Building in Oklahoma City. *Journal of the American Association of Psychiatric Nursing*, *1*(5), 166-170.

Flynn, B. W., and Nelson, M. E. (1998, January). Understanding the needs of children following large-scale disasters and the role of government. *Child and Adolescent Psychiatric Clinics of North America*, 7(1):211-27. Review.

Fraser, J. R., and Spicka, D. A. (1981, Winter). Handling the emotional response to disaster: The case for American Red Cross/community mental health collaboration. *Community Mental Health Journal, 17(*4):255-64.

Hoge, C. W., Orman, D. T., Robichaux, R. J., Crandell, E. O., Patterson, V. J., Engel, C. C., Ritchie, E. C., and Milliken, C. S. (2002, September). Operation solace: Overview of the mental health intervention following the September 11, 2001 Pentagon attack. *Military Medicine*, *167*(9 Suppl):44-7.

Hyams, K. C., Murphy, F. M., and Wessely, S. (2002, April). Responding to chemical, biological, or nuclear terrorism: The indirect and long-term health effects may present the greatest challenge. *Journal of Health Politics, Policy, and Law*, *27*(2):273-91.

Lebedun, M., and Wilson, K. E. (1989). Planning and integrating disaster response. In R. Gist, and B. Lubin (Eds.), *Psycho-social Aspects of Disaster*, 268-279. New York, NY: Wiley.

Lichterman, J. D. (2000, March-June). A "community as resource" strategy for disaster response. *Public Health Reports*, *115*(2-3):262-5.

Lindy, J. D., and Lindy, J. G. (1981). Planning and delivery of mental health services in disaster: The Cincinnati experience. *Urban and Social Change Review*, *14*(2):16-21.

Loyd, C., Creson, D. L., and D'Antonio, M. S. (1993). A petrochemical plant disaster: Lessons for the future. *Journal of Social Behavior and Personality*, *8*:281-298.

Malilay, J. (2000, October-December). Public health assessments in disaster settings: Recommendations for a multidisciplinary approach. *Prehospital and Disaster Medicine*, *15*(4):167-72.

Mangelsdorff, A. D.(1985, July). Lessons learned and forgotten: The need for prevention and mental health interventions in disaster preparedness. *Journal of Community Psychology*, *13*(3):239-57. Review.

McCarrol, J. E., Ursano, R. J., Wright, K. M., and Fullerton, C. S. (1990). Psychiatric and psychological aspects of the management of catastrophic incidents. *Journal of the U.S. Army Medical Department*, *1*:36-41.

McFarlane, A. C. (1986, December). Long-term psychiatric morbidity after a natural disaster: Implications for disaster planners and emergency services. *Medical Journal of Australia, 1-15*; *145*(11-12):561-3.

National Institute of Mental Health. (2002). *Mental Health and Mass Violence: Evidence-based Early Psychological Intervention for Victims/ Survivors of Mass Violence. A Workshop To Reach Consensus on Best Practices*. National Institute of Health (Publication No. 02-5138). Washington, DC: U.S. Government Printing Office.

Parker, S. G. (2001, March). Establishing victim services within a law enforcement agency: The Austin experience. *OVC Bulletin*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office for Victims of Crime.

Parkes, C. M. (1991). Planning for the aftermath. *Journal of the Royal Society of Medicine*, *84*:22-25.

Pynoos, R. S., Goenjian, A. K., and Steinburg, A. M. (1998, January). A public mental health approach to the postdisaster treatment of children and adolescents. *Child and Adolescent Psychiatric Clinics of North America*, *7*(1):195-210. Review.

REFERENCES

Center for Mental Health Services. (Revised June, 2000). *Needs Assessment Formula* (internal document). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

DeWolfe, D. J. (unpublished manuscript). Population Exposure Model and text excerpted from *Mental Health Interventions Following Major Disasters: A Guide for Administrators, Policy Makers, Planners and Providers*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Federal Emergency Management Agency. (1996). *Guide for All-hazard Emergency Operations Planning, State and Local Guide (SLG) 101*. Washington, DC: FEMA. (*Editor's note: This guide, including Chapter 6, Attachment G, is available for download from www.fema.gov*)

Texas Department of Mental Health and Mental Retardation. (2002, March). *Interim Disaster Plan*. Austin, TX: Texas Department of Mental Health and Mental Retardation

Texas Department of Mental Health and Mental Retardation. (2003). *Common Acronyms and Definitions*. Retrieved February 5, 2003, from www.mhmr.state.tx.us

U.S. Department of Health and Human Services. (1996). *Responding to the Needs of People with Serious and Persistent Mental Illness in Times of Disaster*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

U.S. Department of Health and Human Services. (2002). *Communicating in a Crisis: Risk Communication Guidelines for Public Officials*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service.

Shechet, A. L., and Jordan, C. E. (1993). The Kentucky Post Trauma Response Team: Development of a statewide crisis response capability. *Journal of Social Behavior and Personality*, *8*:267-280.

Silver, T., and Goldstein, H. (1992, June). A collaborative model of a county crisis intervention team: The Lake County experience. *Community Mental Health Journal*, *28*(3):249-56.

Summers, G. M., and Cowan, M. L. (1991, January). Mental health issues related to the development of a national disaster response system. *Military Medicine*, *156*(1):30-2.

Tucker, P., Pfefferbaum, B., Vincent, R., Boehler, S. D., and Nixon, S. J. (1998, February). Oklahoma City: Disaster challenges mental health and medical administrators. *Journal of Behavioral Health Services Research*, *25*(1):93-9.

U.S. Public Health Service. (1999). *The Surgeon General's Call To Action To Prevent Suicide*. Washington, DC: Department of Health and Human Services.

Weisaeth, L., Knudsen, O., and Tonnessen, A. (2002, July 1). Technological disasters, crisis management and leadership stress. *Journal of Hazardous Material*, *93*(1):33-45.

Winget, C. N., and Umbenhauer, S. L. (1982, Winter). Disaster planning: The mental health worker as "victim–by–proxy." *Journal of Health and Human Resources Administration*, *4*(3):363-73.

Appendices

APPENDIX A:

ELEMENTS OF AN ALL-HAZARDS STATE DISASTER MENTAL HEALTH PLAN

APPENDIX B:

LISTING OF FOCUS GROUP MEMBERS

APPENDIX C:

COMMON ACRONYMS AND DEFINITIONS

APPENDIX A:

ELEMENTS OF AN ALL-HAZARDS STATE DISASTER MENTAL HEALTH PLAN

1. Introductory Material	Present	Absent	N/A
A. Signature page			
B. Dated title page			
C. Record of changes			
D. Record of distribution			
E. Table of contents			

2. Executive Summary	Present	Absent	N/A
Summary describing basic plan			

3. Purpose	Present	Absent	N/A
General statement of plan's purpose			

4. Situation and Assumptions-General	Present	Absent	N/A
A. Assumptions (limits of mental health authority, highest probability scenarios, etc.)			
B. Situation (probable impact, vulnerable/special facilities and populations, include low probability/high impact events, etc.)			
C. Include matrix of events if desired			

5. Concept of Operations—General (sequence and scope of response)	Present	Absent	N/A
A. Overview of approach (what should happen, when, who directs?)			
B. Division of responsibility (State, Local, Federal, etc.)			
C. General sequence of actions before, during, after event			
D. Who is authorized to request aid, and in which situations?			

6. Authorities and References	Present	Absent	N/A
Citation of legal authorities and reference documents as appropriate			

7. Organization and Assignment of Responsibilities	Present	Absent	N/A
A. Listing, by position and organization, of the types of tasks to be performed (matrix of primary/secondary/shared responsibilities?)			
B. Documents tasks of SMHA in FEMA format: definition of objective, characterization of the situation, general plan of action, delegation of responsibilities, information on resources and administrative support necessary to accomplish tasks. Includes description of treatment responsibilities (internal/external)			
C. Describes State tasks outside SMHA authority			
D. Tasks related to other governmental levels and organizations (e.g., counties, cities, Red Cross, faith organizations, FEMA, SAMHSA/CMHS, Department of Justice, etc.)			
E. Describes coordination with other components of State and local government health department, substance abuse agency, criminal justice, law enforcement, fire and rescue, agriculture (including extension service and veterinary services), parks and recreation, animal care and control, victims services, social services, education			
F. Ensures connectivity to State emergency plan and federal response plan			

8. Administration, Logistics, Legal	Present	Absent	N/A
A. Administration—Recording and reporting program activities			
B. Administration—Recording and reporting expenditures and obligations			
C. Administration—Recording and reporting human resources utilization			
D. Administration—Expectations of situation reports (format and frequency)			
E. Administration—Recording and reporting of services provided by volunteer agencies			
F. Administration—Management of volunteer offers/services			
G. Logistics—Arrangements for support needs (food, water, fuel, etc.)			
H. Logistics—Provision for self-support for at least 72 hours			

8. Administration, Logistics, Legal (cont.)	Present	Absent	N/A
I. Logistics—Replacement/repair of damaged/destroyed essential equipment			
J. Logistics—Access of personnel to impacted area (criteria method, transportation)			
K. Logistics—Availability, transport, administration, safeguarding, recording medications			
L. Logistics—Existence and scope of mutual aid agreements			
M. Legal—Issues including licensing, informed consent, confidentiality, providers licensed in other jurisdictions, personal, professional, and organization liability, patient records management, waiver of contracting or other procurement rules during emergencies			

9. Plan Development and Maintenance	Present	Absent	N/A
Describes who is responsible for modifications and updating, ensuring coordination with other State emergency planning elements			

10. Communications	Present	Absent	N/A
A. Situation assumptions (types of situations likely to occur—should relate to earlier assumptions, types of communications necessary such as telephone, data, etc.)			
B. Methods of communication among SMHA, local mental health agencies, State psychiatric hospitals, other psychiatric facilities, community-based treatment facilities, State emergency management, regional or field offices, emergency medical services, hospitals and clinics, shelter facilities. Ensure SMHA is on notification list from Governor's Office			
C. Alternatives in the event of failed communication capacity			
D. Availability of technical expertise			

11. Public Information	Present	Absent	N/A
A. Communications strategy			
B. Identification of responsibility			
C. Policies for public information (designation and authority of media liaison[s])			

11. Public Information (cont.)	Present	Absent	N/A
D. Existence of public information material (fact sheets, guides, multiple languages, access to services, distribution of materials, etc.)			
E. Relationship with State emergency office public information officer			
F. Identified means of disseminating information			
G. Identification of experts/resources outside SMHA			
H. Pre-event relationships with media			

12. Warning: Mobilization Related to Internal Mental Health Systems	Present	Absent	N/A
A. Internal—Links with State emergency warning activities			
B. Internal—Describes methods and procedures for notifying staff, facilities, service providers, others as appropriate (link to agency risk management as appropriate)			
C. Internal—Establishes policies and procedures (e.g., sending staff home, holding staff in place, recall of essential staff, facilities evacuation, etc.) for SMHA offices and facilities			
D. External—Identifies groups with special warning needs (e.g., persons who are deaf and have mental illness)			
E. External—Notify mental health system (counties, providers, etc.)			
F. External—Notification of private sector mental health resources			

13. Evacuation	Present	Absent	N/A
A. Plan for evacuation of SMHA offices and facilities			
B. Plan for alternate sites ("hot," "warm," and "cold" sites as appropriate)			
C. Clear linkage with State emergency management evacuation plans and operations			
D. Plan for services at shelters/mass care facilities			

14. Mass Care	Present	Absent	N/A
A. Documentation of coordination with State emergency management mass care plan			
B. Links with Red Cross special populations facilities and other National Voluntary Organizations Active in Disasters			

15. Health and Medical	Present	Absent	N/A
A. Documentation of coordination with State emergency management health and medical plan staffing, logistics, costs, availability of pharmaceuticals			
B. Provision of mental health services/consultation as part of State's emergency medical plan (Emergency Support Function #8, VA resources, etc.)			
C. Roles identified in areas of services/consultation to primary victims, secondary victims, response and recovery workers, incident command, public information, body identification and recovery, mortuary services, other State agencies and departments (e.g., health epidemiology, education, social services, etc.)			
D. Documentation of coordination with Red Cross mental health services			
E. Documentation of coordination with Red Cross health services			

16. Resource Management	Present	Absent	N/A
A. Purpose — Documents means, organization, and process by which SMHA will find, obtain, allocate, and distribute necessary resources			
B. Personnel			
C. Transportation for staff			
D. Communications equipment			
E. Emergency equipment as necessary			
F. Mass care supplies for SMHA resources			
G. Intrastate mutual aid			
H. Management of offers of assistance and invited/uninvited volunteers			
I. Availability of aid from other States and Federal government			
J. Plan for maintaining financial and legal accountability			
K. Resources for initial and ongoing needs assessment			

17. All-Hazards Specific Planning Materials (Natural and Accidental)	Present	Absent	N/A
A. Plan allows for accommodation of unique aspects of hazards			
B. Identifies nature of hazard			

17. All-Hazards Specific Planning Materials (cont.)	Present	Absent	N/A
C. Identifies areas of high risk			
D. Flooding (flash and slow rising) and dam failure			
E. Hazardous materials (including chemicals)			
F. Hurricane/Tsunami			
G. Fire			
H. Earthquake			
I. Military chemical agents and munitions			
J. Radiological hazards (medical usage, educational institutions, military, manufacturing companies, transport of nuclear material)			
K. Nuclear power plant(s)			
L. Nuclear conflict (war)			
M. Snow/ice			
N. Tornado			
O. Civil unrest/community violence			
P. Agricultural disasters/emergencies			
Q. Immigration emergencies			
R. Tidal wave			
S. Other(s) (specify)			

18. Terrorism	Present	Absent	N/A
A. Describes nature of potential hazards (chemical, biological, nuclear/radiological, explosive, cyber, combined)			
B. Potential targets are identified and/or reflective of State emergency plan			
C. Describes incident management for SMHA			
D. Describes and/or reflects State emergency plan's situational assumptions (environment, populations, urbanicity, infrastructure, transport patterns, airports, trains/subways, government facilities, recreation facilities, military installations, HazMat facilities, other high risk targets such as financial institutions, universities, hospitals, research institutes, schools, daycare centers)			

18. Terrorism (cont.)	Present	Absent	N/A
E. Reflects coordination with State emergency plan's modeling of potential release areas			
F. Incident management reflects roles of other State and Federal roles and resources			
G. Consequence management reflects involvement of various federal components			
H. SMHA plan reflects knowledge of and integration with State emergency plan with respect to warning, communication, emergency public information, protective actions, mass care, health and medical annex, resource management			
I. Describes links to health and medical entities for purposes of assisting in screening potential victims for mental disorders and psychogenic symptomatology, functional impairment, substance abuse, etc.			
J. Describes links with State public health structure for surveillance, screening, consultation, intervention planning, risk communication			
K. Describes SMHA role in risk communication planning and response			
L. Describes SMHA participation in exercises and drills			

19. Continuity of Operations- SMHA	Present	Absent	N/A
A. Contains overview of goals of Continuity of Operations Plan (e.g., to maintain/reestablish vital functions of SMHA during the first 72 hours following an event that would seriously compromise or halt normal operations)			
B. Documents coordination with overall State Continuity of Operations Plan			
C. Identifies vital functions to be maintained within first 72 hours			
D. Identifies vital records/data necessary to function within first 72 hours			
E. Describes plans related to human resources (e.g., essential staff, staff notification, family support)			
F. Describes alternate locations of essential operations			
G. Describes transportation and staff support			
H. Describes alternate vital record/document sites (e.g., assurance of access to disaster plan, staff rosters, patient vital medical records if existing sites are destroyed or inaccessible)			

20. Other Special Planning Concerns	Present	Absent	N/A
A. Description of SMHA's presence and role in State emergency management structure			
B. Documentation of regional or multi-State planning and coordination			
C. Describes various issues around licensing within State, out-of-State providers, scope of practice, etc.			
D. Documentation of plans to prepare and support SMHA staff during and following deployment under plan (physical, health, special medical needs, family support, psychological)			
E. Documentation of plans to prepare and support emergency service responders (e.g., police, fire, hospital emergency department staff, mortuary workers) during and following deployment			
F. Documentation of public sector links with private mental health resources			
G. Documentation of coordination with business and corporations and other private sector interests in planning for behavioral health response and consequences			
H. Documentation of appropriate planning links with institutions of higher learning (academic departments, student health services, etc.)			
I. Provides assurance that all SMHA facilities meet JCAHO or other appropriate standards for disaster and emergency preparedness			
J. Describes SMHA role in crisis and emergency risk communication			
K. Ensures SMHA's role in disaster training and exercises			
L. Describes SMHA's role in coordination of research			
M. Describes SMHA's role in data collection/evaluation/and gatekeeping to balance information needs with victims' needs			

21. Standard Operating Procedures and Checklists	Present	Absent	N/A
A. Contains applicable standard operating procedures			
B. Contains applicable checklists (e.g., emergency contact numbers, lists of facilities, etc.)			

22. Glossary of Terms	Present	Absent	N/A
A. State specific terms			
B. Emergency management terms			
C. Public health terms			
D. Mental health terms			

APPENDIX B:

LISTING OF FOCUS GROUP MEMBERS

NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS ALL-HAZARDS STATE DISASTER MENTAL HEALTH PLANNING EXPERTS FOCUS GROUP MEETING

June 3-4, 2002 • Alexandria, VA

SPONSORED BY:

Center for Mental Health Services,
Substance Abuse and Mental Health Services Administration
National Association of State Mental Health Program Directors

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APPENDIX C:

COMMON ACRONYMS AND DEFINITIONS (TDMHMR, 2003)

COMMON ACRONYMS

Texas Department of Mental Health and Mental Retardation
Disaster Assistance and Crisis Response Services Program
Disaster and Terrorism Mental Health Response and Recovery Plan

A

ABA—American Bar Association

ACE—Automated Construction Estimating

AD—Associate Director

ADAMS—Automated Disaster Assistance Management System

ALE—Additional Living Expense

ARC—American Red Cross

ASCS—Agricultural Stabilization and Conservation Service

B

BFC—Bill for Collection

C

CBFP—Cora Brown Fund Program

CBRA—Coastal Barrier Resources Act

CBRS—Coastal Barrier Resources System

CCP—Crisis Counseling Program

CFR—Code of Federal Regulations

CISD—Critical Incident Stress Debriefing

CMHOvCommunity Mental Health Organization

CMHS—Center for Mental Health Services

CPI—Consumer Price Index

D

DAC—Disaster Application Center

DAE—Disaster Assistance Employee

DARIS—Disaster Automated Reporting and Information System

DD—Damaged Dwelling

DFC—Disaster Finance Center

DFO—Disaster Field Office

DH—Disaster Housing

DHAP—Disaster Housing Assistance Program

DLS—Disaster Legal Services

DLSP—Disaster Legal Services Program

DOB—Duplication of Benefits

DOL- Department of Labor

DRC—Disaster Recovery Center

DRM—Disaster Recovery Manager

DUA—Disaster Unemployment Assistance

DV—Disaster Victim

E

EA—Environmental Assessment

EMI—Emergency Management Institute

EOC—Emergency Operations Center

EOP—Emergency Operating Procedure

ERT—Emergency Response Team

ESDRB—Emergency Services and Disaster Relief Branch

ESF—Emergency Support Function

EST—Emergency Support Team

F

FCO—Federal Coordinating Officer

FEMA—Federal Emergency Management Agency

FHBM—Flood Hazard Boundary Map

FIRM—Flood Insurance Rate Map

FMHA—Farmers Home Administration

FRP—Federal Response Plan

FSR—Final Statistical Report

FY—Fiscal Year

G

GAR—Governor's Authorized Representative

GCO—Grant Coordinating Officer

H

HHS—Health and Human Services

HR—Home Repairs

HS—Human Services

HSO—Human Services Officer

I

IA—Individual Assistance

IFG—Individual and Family Grant Program

IFMIS—Integrated Financial Management Information System

IMS—Information Management Systems

IS—Infrastructure Support

ISP—Immediate Services Program

K

KEN—Knowledge Exchange Network

L

LAN—Local Area Network

M

MRAP—Mortgage and Rental Assistance Program

N

NASMHPD—National Association of State Mental Health Program Directors

NEMIS—National Emergency Management Information System

NEPA—National Environmental Policy Act

NFIP—National Flood Insurance Program

NGO—Non-Governmental Organization

NFIRA—National Flood Insurance Reform Act of 1994

NOGA—Notice of Grant Award

NPSC—National Processing Service Center

NTC—National Teleregistration Center

NVOAD—National Voluntary Organizations Active in Disasters

O

OFA—Other Federal Agencies

OFM—Office of Financial Management

OGC—Office of General Counsel

OMB—Office of Management and Budget

OSD—Operations Support Division

OVC—Office for Victims of Crimes

P

PA—Public Assistance

PDA—Preliminary Damage Assessment

PFT—Permanent Full Time Employee

PIO—Public Information Officer

PO—Project Officer

PP—Personal Property

Q

QC—Quality Control

R

RAA—Request for Allocation Advice

RD—Regional Director

ROC—Regional Operations Center

RP—Real Property

RSP—Regular Services Program

S

SAMHSA—Substance Abuse Mental Health Services Administration

SAP—State Administration Plan

SBA—Small Business Administration

SCO- State Coordinating Officer

SFHA—Special Flood Hazard Area

SMHA—State Mental Health Authority

SMP—Stress Management Program

SOP—Standard Operating Procedure

SSA—Social Security Administration

SSI—Supplemental Security Income

U

UNC—Unmet Needs Committee

USDA—United States Department of Agriculture

V

VA—Veterans Administration

VOAD—Voluntary Organizations Active in Disasters

VOLAG—Voluntary Agency

W

WYO- "Write-Your-Own" Program

Y

YLD- Young Lawyers Division

A

Assistant State Coordinator—DEM employee.

C

Center for Mental Health Services (CMHS)—Part of Substance Abuse and Mental Health Services Administration within the U.S. Department of Health and Human Services.

Crisis Counseling Program (CCP)—Federally funded counseling program.

D

Department of Public Safety-State Police Department.

Disaster Assistance Program—TDMHMR program designed to prepare for, plan and respond to the mental health needs of victims and responders of local, State and Federally declared disasters or emergencies.

Disaster District Chairman—DPS Trooper (normally Lieutenant or above) responsible for incident command in one of six disaster districts (regional level). Coordinates response between State Operations Center and local emergency management.

Disaster Field Office—State or federal disaster operations headquarters.

Division of Emergency Management—a.k.a. Governor's Division of Emergency Management and/or the Texas Division of Emergency Management.

E

Emergency Management Coordinator—Local (city and/or county) individual tasked with ensuring coordination and integration of local resources during a disaster.

F

Federal Coordinating Officer (FCO)—FEMA employee who is in charge of the disaster field office and the disaster or event.

I

Immediate Services Program (ISP)—A 60-day crisis counseling program funded by FEMA.

P

Post Traumatic Stress Disorder (PTSD)—A disorder caused by experiencing traumatic events that result in prolonged anxiety and emotional distress.

R

Rapid Assessment Unit (RAU)—A unit of the DEM that performs initial damage assessments following a disaster or emergency.

Regional Liaison Officer (RLO)—A DEM employee responsible for regions in Texas known as disaster districts.

Regular Services Program (RSP)—A nine-month crisis counseling program that is federally funded through CMHS.

Risk Management—TDMHMR program to protect employees, the general public, and the agency's physical and financial assets by reducing and controlling risk in the most efficient and cost-effective manner.

S

State Crisis Consortium—A collaborative effort of several State agencies to plan for and respond to disasters and emergencies in the State of Texas.

State Coordinator—DEM employee who is the federal counterpart at the disaster field office and in charge of the State's response.

State Emergency Management Council—comprised of 33 State agencies that train for, prepare for, and respond to disaster or emergencies for the State.

State Emergency Response Team (SERT)—Team comprised of State agency representatives that are responsible for rapid deployment and immediate response to disasters and emergencies for the State.

Substance Abuse and Mental Health Services Administration—Agency of the US Department of Health and Human Services responsible for the Emergency Services and Disaster Relief Branch.

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