ASSEMBLY BILL 206
SECTION 11

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DECEMBER 2019

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ACKNOWLEDGEMENTS

The Nevada Division of Public and Behavioral Health would like to thank the following individuals for their contributions to this planning process:

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INTRODUCTION

In 2018, the Nevada Commission on Homeland Security approved a shift in policy due to an increase in emergency situations within the state. The increase reached a critical point during 2017 where the state experienced several emergencies resulting in Presidential Major Disaster Declarations and a mass shooting in Las Vegas. Assembly Bill 206, of the 80th Session of the Nevada Legislature, is a result of the action taken by the Commission to move toward a model that includes preparation, response, recovery and resilience.

ASSEMBLY BILL 206, SECTION 11

During the 80th (2019) Session of the Nevada Legislature, Assembly Bill 206 (AB 206) was enacted to amend Chapter 232 of NRS by adding Section 11 (Sec. 11.), which requires the Department of Health and Human Services (DHHS) to develop a written plan to address the state's behavioral health needs in an emergency or disaster. Sec. 11. reads as follows:

1. The Department shall develop a written plan to address behavioral health needs in an emergency or disaster. Such a plan must, without limitation:

(a) Prescribe a process for assessing the need for behavioral health resources during and after an emergency or disaster based on the estimated impact of the situation and the estimated depletion of resources;
(b) Ensure continuity of services for existing patients with a mental illness, developmental disability, or intellectual disability during an emergency or disaster;
(c) Prescribe strategies to deploy triage and psychological first aid during an emergency or disaster;
(d) Identify opportunities for the rendering of mutual aid during an emergency or disaster;
(e) Prescribe procedures to address the behavioral health needs of first responders during and after an emergency or disaster; and
(f) Prescribe measures to aid the recovery of the behavioral health system after an emergency or disaster.

2. On or before December 31 of each year, the Department shall:

(a) Review the plan developed pursuant to subsection 1 and revise the plan as necessary; and
(b) Transmit the plan to the Chief of the Division of Emergency Management of the Department of Public Safety.

3. As used in this section:

(a) “Disaster” has the meaning ascribed to it in NRS 414.0335 - A “disaster” is an *occurrence or threatened occurrence* for which, in the determination of the Governor, the assistance of the Federal Government is needed to supplement the efforts and capabilities of state agencies to save lives, protect property, and protect the health and safety of persons in this state, or to avert the threat of damage to property or injury to or the death of persons in this state.

(b) “Emergency” has the meaning ascribed to it in NRS 414.0345 - An “emergency” is an *occurrence or threatened occurrence* for which, in the determination of the Governor, the assistance of state agencies is needed to supplement the efforts and capabilities of political subdivisions to save lives, protect property, and protect the health and safety of persons in this state, or to avert the threat of damage to property or injury to or the death of persons in this state.

PURPOSE

The purpose of this plan is to serve as a framework to address Nevada’s behavioral health needs in an emergency or a disaster (emergency/disaster). The plan is intended to be an evolving, adaptable, scalable, and open-ended process reflective of the type, nature, severity, and duration of the emergency/disaster and of the needs and capabilities of the affected local communities and jurisdictions (communities). The plan draws heavily from the Federal Emergency Management Agency’s (FEMA) *National Disaster Recovery Framework* (p. i) (June 2016), which emphasizes pre-emergency/pre-disaster preparedness:

> A community’s ability to accelerate the recovery process begins with its effort in pre-disaster preparedness, including coordinating with whole community partners, mitigating risks, incorporating continuity planning, identifying resources, and developing capacity to effectively manage the recovery process, and through collaborative and inclusive planning processes. Collaboration across the whole community provides an opportunity to integrate mitigation, resilience, and sustainability into the community’s short- and long-term recovery goals.

PREPARATION

The Division of Public and Behavioral Health (DPBH) has designated a Statewide Disaster Behavioral Health Coordinator who will work collaboratively with representatives from the local communities, tribal governments, and state agencies to ensure the plan is *community-driven*, scalable, and flexible. DPBH dedicated the position for overall coordination purposes in recognition that the local communities will need support to implement the plan and the state will need a central point of contact specific to the plan.

(A) PRESCRIBE A PROCESS FOR ASSESSING THE NEED FOR BEHAVIORAL HEALTH RESOURCES DURING AND AFTER AN EMERGENCY OR DISASTER BASED ON THE ESTIMATED IMPACT OF THE SITUATION AND THE ESTIMATED DEPLETION OF RESOURCES

The DPBH coordinator will partner with the Division of Emergency Management (DEM) and the Public Health Preparedness Program (PHP) to begin the assessment process by working collaboratively with the local communities and the tribal governments to develop culturally-diverse, community-based assessment teams (CATs) (SAMHSA, 2003a; SAMHSA, 2005).

In following the principle of engaged partnership, the CATs will use a collaborative, whole-community approach to build on the work already being accomplished in the local communities; to ensure the process is inclusive of the natural helping community and healers; and to ensure all Nevada communities have an opportunity to participate in the assessment and in the statewide behavioral health emergency and disaster planning process. In particular, the CATs will make an effort to reach out to: government and tribal entities; first responders (responders); behavioral health care providers; peer-to-peer support networks; self- and mutual-help groups (e.g., Alcoholics Anonymous (A.A.), Dual Recovery Anonymous (D.R.A.), SMART Recovery, Women for Sobriety); crisis call centers; information and referral organizations; the Deaf and Hard of Hearing communities; the faith-based community; behavioral health licensing bodies; advocacy groups (e.g., the National Alliance on Mental Illness (NAMI)); and cultural organizations.

The CATs will develop a community-based communications plan specific to the behavioral health needs assessment. Community-based communications means to listen and react to the community's concerns and needs; to reach out to isolated or hard-to-access community segments (e.g., people who are experiencing homelessness, people who have mobility issues); to include the community in key decisions; and to give the community an active role in the response (CDC, 2018).

The CATs will actively reach out to their respective localities by using community-based communications that solicit participation through methods such as in-person regional and community gatherings, focus groups, forums, meetings, and online surveys. Further, in recognizing that English is a second language for some people who have communication disabilities, the CATs will partner with organizations and state agencies to ensure communication is provided in American Sign Language and through vlogs; which are video-taped blogs that can be shared within the particular communities.

Each CAT will conduct at least a rudimentary (depending on capability and funding mandates), community-specific, emergency/disaster behavioral health needs assessment. The assessment will focus on the community's greatest emergency/disaster threats and hazards and will identify critical behavioral health resource gaps. The assessment will include six

components: 1) identify the specific threats and hazards, 2) identify the populations and estimate the number of people who are at risk of needing behavioral health services as a result of the particular threats and hazards, 3) identify the behavioral health resources needed to address each threat and hazard, 4) estimate the impact each threat and hazard will have on the behavioral health system during and after the emergency/disaster, 5) estimate the depletion of behavioral health resources during and after each threat and hazard, and 6) establish behavioral health capability targets by considering the resources required to address the impact of each threat and hazard.

The CATs will use state and local data to identify their unique populations at-risk of developing behavioral health conditions after an emergency/disaster. These include:

- Children;
- Female gender - especially pregnant and parenting women;
- First responders - especially law enforcement, emergency medical technicians and firefighters;
- Older people - in particular those with physical health conditions or those who are socially isolated;
- Ethnic minorities - especially people who are non-English speaking or who have linguistic barriers;
- People with intellectual or developmental disabilities;
- People with pre-existing psychiatric or substance abuse disorders; and
- People living in poverty, including those who are experiencing homelessness.

In addition to the at-risk populations identified above, Glickman (n.d.) determined the behavioral health care needs of culturally Deaf (and Hard of Hearing) people has many parallels with the behavioral health care needs of other linguistic, social, or cultural minorities. As such, the CATs must address the specialized language and communication requirements of people who are Deaf or Hard of Hearing and must ensure they are represented in the process; this can be accomplished by working with the Nevada Aging and Disability Services Division (ADSD).

The CATs may use the Federal Emergency Management Agency's (FEMA) Threat and Hazard Identification and Risk Assessment (THIRA) process for this purpose (FEMA, May 2018). Many state, local, and tribal partners already use the THIRA to conduct their assessments since FEMA requires grant recipients to use this method to qualify for Emergency Management Performance Grant funding.

(B) ENSURE CONTINUITY OF SERVICES FOR EXISTING PATIENTS WITH A MENTAL ILLNESS, DEVELOPMENTAL DISABILITY, OR INTELLECTUAL DISABILITY *DURING* AN EMERGENCY OR DISASTER

Continuity planning is central to a behavioral health organization's ability to continue operating and providing services during and after an emergency/disaster. Continuity planning includes, but is not limited to: determining the organization's critical service functions; identifying key staff to continue those functions; proactively developing partnerships to share needed resources; determining alternative service sites; maintaining clinical and operational records; and preparing for financial resiliency.

There are a number of state and federal regulations in place to help ensure continuity of services for behavioral health programs that serve patients with mental illnesses, developmental disabilities, or intellectual disabilities during an emergency/disaster. Regulations include:

- Each state behavioral health agency includes continuity of services in their Emergency Operations Plan.
- Under the Protecting Access to Medicare Act of 2014, Program Requirement 2.a.8: Availability and Accessibility of Services, all Certified Community Behavioral Health Clinics are mandated to have a continuity of operations/disaster plan in place.
- The Joint Commission and the Commission on Accreditation of Rehabilitation Facilities (CARF), both which accredit behavioral health programs, require programs to have continuity of care plans in place in order to be accredited.
- As regulated through the U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response, behavioral health treatment programs that are part of the regional health care coalitions receiving federal funding under the 2019 Pandemic and All-Hazards Preparedness and Advancing Innovation Act are required to ensure continuity of care for at-risk individuals. Per this Act, at-risk individuals are people with access-based and functional-based needs that may interfere with their ability to access or receive medical care before, during, or after an emergency/disaster.
- The Centers for Medicare and Medicaid Services requires organizations registered with Medicare as Community Mental Health Centers, Federally Qualified Health Centers, Rural Health Centers, and Intermediate Care Facilities to develop and implement emergency plans to follow in the event of a natural disaster or other emergency.

The DPBH coordinator will assist the behavioral health programs to develop, or review, their individual continuity of operations plans (COOPs). The coordinator's assistance will be provided as requested by the individual programs. Once the individual COOPs are established, the coordinator; the behavioral health programs; DEM; and PHP will collaborate

to align the individual COOPs with those of other behavioral health programs, local jurisdictions, the state, federal coordinating agencies, and voluntary organizations that provide behavioral health services (e.g., American Red Cross; Salvation Army; faith-based organizations).

The COOPs will identify each program's essential functions and staff that will be needed during an emergency/disaster in order for the entity to: continue providing vital services to its clients; meet specific regulations or laws; maintain onsite safety of its clients, visitors, and staff; and support the essential functions of federal coordinating agencies. To assist in this process, the Substance Abuse and Mental Health Services Administration (SAMHSA) has outlined a number of essential and general functions to guide *all behavioral health programs,* and it has listed additional essential functions to guide *specific types of behavioral health treatment programs* (SAMHSA, TAP 34, 2013, pp. 43-55).

ESSENTIAL FUNCTIONS FOR ALL BEHAVIORAL HEALTH PROGRAMS

All behavioral health programs, regardless of type, are encouraged to include the following **essential** functions in their COOPs:

- Provide for continuity of leadership, including order of succession and delegation of authority.
- Provide behavioral health emergency services.
- Conduct basic screening, intake, and discharge procedures.
- Provide crisis and relapse prevention counseling and supportive services.
- Reduce the clients' risk of developing traumatic stress by providing stress-prevention guidance (e.g., self-care, reach out to others, minimize media exposure) and by training them on calming and relaxation techniques, etc.
- Pre-arrange for services to be provided in a different facility or location (e.g., another space within the facility, another location of the organization, space borrowed from or shared with another organization, telework, mobile workstations).
- Document any transfer of clients and their records to another agency.
- Track clients affected by any dispersal and evacuation to ensure they continue to receive needed behavioral services or to re-engage them in programming, as necessary.
- Maintain treatment and billing records in accordance with payor and regulatory requirements.
- As resources are available, and based on mandates, provide disaster mental health services to the community as requested by the Emergency Operations Center or the Emergency Support Function #8 Coordinator.
- Plan to use intrastate and interstate mutual aid for essential functions and essential staff, as necessary.

GENERAL FUNCTIONS FOR ALL BEHAVIORAL HEALTH PROGRAMS

In addition to the *essential* functions, all behavioral health programs, regardless of type, are encouraged to include the following non-essential, but important **general** functions in their COOPs:

- Develop multiple means to broadcast alerts to staff and clients (e.g., establish agreements with local television and radio stations to communicate the program's status to the staff and the public, create a communications tree, partner with amateur radio operators).
- Distribute staff emergency contact information in multiple formats.
- Ensure staff have access to interoperable communications systems for when cell and landline phones are inoperable (e.g., cell phones with text messaging capabilities, internet-based telephone accounts, two-way radios).
- Prepare clients for emergency/disasters by providing resources (e.g., trainings, handouts, brochures).
- Prepare for program financial resiliency by: considering how to support client retention though active outreach following an emergency/disaster; informing staff about procedures for enrolling clients in Medicaid under emergency conditions; by educating payors about modified counseling services (e.g., telephone or web-based counseling); by establishing a contingency or reserve fund or a line of credit for unexpected cash flow issues; and by making plans for low revenue after an emergency/disaster (e.g., emergency grant proposal writing).
- Develop resources to manage human capital in advance of an emergency/disaster:

    - Issue a list of social service providers who will be available to support staff with personal emergency needs (e.g., medical assistance, crisis counseling, temporary housing, child care). If necessary, plan to use mutual aid for this purpose.
    - Develop policies that will support staff as they prepare for, and serve during, an emergency/disaster (e.g., training in emergency/disaster self-care, access to phones or the internet, adjusted work schedules, behavioral health support resources).

ESSENTIAL FUNCTIONS FOR *OUTPATIENT TREATMENT* PROGRAMS

In addition to the essential and general functions listed above, all outpatient treatment programs are encouraged to include the following **essential** functions in their COOPs:

- Provide case management activities, such as linking clients to needed resources and helping them obtain any needed medication replacements or refills.
- Provide crisis stabilization, crisis intervention, or other emergency services.

ESSENTIAL FUNCTIONS FOR *RESIDENTIAL TREATMENT* PROGRAMS

In addition to the essential and general functions, all residential treatment programs are encouraged to include the following **essential** functions in their COOPs:

- Provide residential care for patients who do not meet discharge criteria.
- Stabilize patients undergoing nonmedical (social) detoxification.
- Continue medications and supportive counseling to patients to prevent decompensation or escalation of symptoms of behavioral health disorders.
- Coordinate or address patient transportation needs for accessing medical services.
- Provide case management services, as appropriate, to move patients toward discharge readiness.

ESSENTIAL FUNCTIONS FOR *MEDICALLY MANAGED DETOXIFICATION* PROGRAMS

In addition to the essential and general functions, all medically managed detoxification programs are encouraged to include the following **essential** functions in their COOPs:

- Follow established medically-managed detoxification protocols.
- Medically stabilize patients; closely monitor their withdrawal symptoms.
- Transfer patients to an appropriate facility if they require a higher level of medical care than the program can offer; provide residential care for patients who remain at the facility.

ESSENTIAL FUNCTIONS FOR *OPIOID TREATMENT* PROGRAMS

In addition to the essential and general functions, all opioid treatment programs are encouraged to include the following **essential** functions in their COOPs:

- Confirm identities and dose information for patients receiving medication.
- Provide or facilitate access to prescribed or dispensed medications (e.g., methadone, buprenorphine).
- Provide case management to assist with medically appropriate transfer or discharge.

MEMORANDA OF UNDERSTANDING

It is also recommended the COOPs include Memoranda of Understanding (MOU) for mutual aid specific to the essential and general program functions listed. It is particularly important that the MOUs address shared service space and shared staff.

(C) PRESCRIBE STRATEGIES TO DEPLOY TRIAGE AND PSYCHOLOGICAL FIRST AID *DURING* AN EMERGENCY OR DISASTER

The DPBH coordinator will collaborate with the Division of Emergency Management (DEM), the Public Health Preparedness Program (PHP), and the local communities to determine scalable strategies to prepare for and to deploy triage and psychological first aid during an emergency/disaster.

DPBH will formalize Emergency Support Function 8.1 in the agency's Emergency Operations Plan and will partner with DEM, PHP, and the local communities (partners) to ensure any community behavioral health teams are integrated into the statewide disaster plan and are invited to participate in all statewide, full-scale, exercises.

Training is essential in preparing to deploy triage and psychological first aid during an emergency/disaster. As such, the partners will work to ensure triage and psychological first aid strategies are standardized and the practices are evidence-informed or evidence-based. This will be accomplished by adopting a training standard of practice for individuals wanting to participate in emergency/disaster behavioral health.

The partners will develop and implement a standardized, statewide initial and refresher training plan to deliver the recommended psychological first aid and crisis counseling classes. In addition, the partners will work to expand the state's triage and psychological first aid capability by recruiting and training community-based peer supporters, the faith-based community, and other natural community helpers and healers. The training plan will address standards regarding cultural sensitivity, appropriate crisis-situation interactions with culturally diverse groups, and appropriate interactions within the context of the cultural considerations (SAMHSA, 2004; SAMHSA, 2005). The partners will also collaborate with the Nevada Commission for Persons who are Deaf and Hard of Hearing and with representatives from the Deaf and Hard of Hearing communities to ensure the strategies are culturally and disability sensitive.

The DPBH coordinator, DEM, and PHP will support the local communities to develop comprehensive behavioral health mobilization and deployment plans and related protocols in order for the entities to quickly and efficiently identify, process, mobilize, and deploy staff during an emergency/disaster. The plans will include operational protocols to address the spontaneous self-deployment of volunteers during an emergency/disaster (CDC, January 2019; FEMA, October 2017; Herrmann, 2005; SAMHSA, 2003b).

As needed, the DPBH coordinator will work with the local communities to establish intrastate mutual aid MOUs in order to quickly deploy or receive triage and psychological first aid during

an emergency/disaster. The DPBH coordinator will work with the other partners to develop and disseminate an intrastate mutual aid behavioral health resource inventory.

The DPBH coordinator will work with the professional licensing boards covered in State of Nevada, Assembly Bill 534 (AB 534), Sections 18-23 (2019) to develop deployment strategies specific to professionals licensed by the particular boards. This legislation authorizes the Governor to suspend certain licensure requirements in response to an emergency/disaster; requires certain professional licensing boards to maintain lists of licensees trained in the treatment of short- and long-term mental and emotional trauma; and requires said boards to provide those lists to a governmental entity responding to an emergency/disaster. The coordinator will disseminate information about this resource to the communities.

The partners will begin developing a triage and psychological first aid communication strategy to assist with mobilizing deployment resources and services across the systems. The strategy will include working with behavioral health crisis support providers, such as Crisis Support Services, and with behavioral health information and referral organizations, such as Nevada 2-1-1. Both entities have disaster response plans that can be activated to assist local communities during an emergency/disaster, and both have the capability to serve as accurate, reliable, and coordinated communication links between the state, federal, local, and tribal governments and the public. The strategy will also incorporate Everbridge, which is DHHS's mass notification system. DHHS provides Everbridge for all DHHS employees and volunteer crisis counselors *who opt to participate* in the program.

In preparation to deploy triage and psychological first aid services during an emergency/disaster, and to build capacity, DHHS uses the State Emergency Registry of Volunteers-Nevada (SERV-NV). The resource is a web-based network of state-based systems used to register, qualify, and credential Nevada's volunteer health care professionals before an emergency/disaster. The system complies with the Emergency System for Advanced Registration of Volunteer Health Professional Guidelines. The DPBH coordinator will work with the other partners to promote SERV-NV across the state and to develop a coordinated recruitment strategy.

During an actual emergency/disaster, the local communities and the state will activate their unique predetermined triage and psychological first aid deployment protocols and processes as outlined above.

(D) IDENTIFY OPPORTUNITIES FOR THE RENDERING OF MUTUAL AID *DURING* AN EMERGENCY OR DISASTER

DPBH and many other governmental and non-governmental entities have behavioral health interstate and intrastate mutual aid agreements and systems in place to provide a variety of resources, facilities, services, and supports to the communities during an emergency/disaster:

- The Nevada Intrastate Mutual Aid System, as authorized by NRS 414A (2015), allows the Nevada Department of Public Safety, Division of Emergency Management to coordinate the provision of equipment; services; or facilities owned or organized by the state or its political subdivisions for use in the affected communities upon request of the duly constituted authority of the areas during the response to, and recovery from, an emergency/disaster.
- The Nevada Emergency Management Assistance Compact, as authorized by NRS 415 (2018), complies with the nationally adopted Mutual Aid Agreement to provide for mutual assistance between the states entering into the compact. As such, this compact provides a resource for the rendering of mutual aid at the local level. DPBH will ensure this information is disseminated across the system.
- As noted in Section (c), DHHS manages the SERV-NV volunteer registry which can be used to provide behavioral health mutual aid services across systems.
- The Nevada Division of Child and Family Services (DCFS) has a behavioral health coordinator who works with the Vegas Strong Resiliency Center (VSRC) and maintains a list of available emergency/disaster response behavioral health and supportive services providers within Nevada and other states and communities. DPBH will collaborate with DCFS and VSRC to incorporate this list into a behavioral health resources list to be disseminated across the system.
- The Nevada Hospital Association and participating hospitals within the geographical boundaries of the state have a mutual aid agreement to share resources during disasters. Those resources include personnel, equipment, supplies, pharmaceuticals, and transfers of patients.

While the above mutual aid partnerships are already in place, there are several areas where DPBH and its partners can work to develop additional mutual aid capabilities. This includes helping low-resource communities to develop or formalize partnerships and to identify cross-system opportunities for mutual aid. It involves collaborating with disability-focused entities, such as the Nevada Commission for Persons who are Deaf and Hard of Hearing and the Commission on Services for Persons with Disabilities. It also entails working with the criminal justice system to identify opportunities to collaborate and to provide mutual aid across systems. FEMA (2017) provides guidelines about how to develop mutual aid agreements. The resource covers types of mutual aid agreements, key elements of mutual aid agreements, and key elements of mutual aid operational plans.

E) PRESCRIBE PROCEDURES TO ADDRESS THE BEHAVIORAL HEALTH NEEDS OF FIRST RESPONDERS *DURING* AND *AFTER* AN EMERGENCY OR DISASTER

PREPARING FOR AN EMERGENCY/DISASTER

Responders who are exposed to disasters are at an increased risk of acute stress, post-traumatic stress disorder, and a number of other emotional problems. As such, it is critical for the behavioral health community to be prepared to address the behavioral health needs of its responders. In this regard, preparation incorporates the principles of *engaged partnership* and *readiness to act*. Through the principle of an *engaged partnership*, DPBH and the local communities will adopt a preventive perspective to address the behavioral health needs of responders. Through the *readiness to act* principle, DPBH and the local communities will be prepared to act by anticipating and managing the responders' risk of developing behavioral health issues; this will be accomplished through targeted planning and by providing specific education and training.

Planning

The local communities will develop policies for the organizational care of responders during and after an emergency/disaster. This includes writing strategic plans, developing clear written protocols, and working with DPBH to address the stigma, misunderstanding, and perceptions about responders who use behavioral health services.

Education

With support from DPBH, DEM, PHP and with free federal resources, the local communities will provide pre-emergency/pre-disaster education for responders on topics such as stress management; coping skills; self-care; personal vulnerability; burnout; and compassion fatigue. In addition, the local behavioral health programs will address the behavioral health needs of their responders in employee handbooks and orientations and will provide information and materials (e.g., brochures, handouts) relating to when and where to seek assistance.

Training

DPBH, DEM, PHP, and the local communities will partner to enhance the statewide public and private-sector responder-capacity by expanding the standardized psychological first aid and crisis counseling trainings. The partnership will also work to develop the capability to offer training for employee assistance program (EAP) professionals on how to provide responder-specific psychological first aid and crisis counselling. In addition, the partnership will work to establish a network of peer-to-peer support teams trained in crisis response that can be mobilized when local peer-support providers are involved in responding to an emergency/disaster and are not available to assist their own responders.

DURING AN EMERGENCY/DISASTER – LOCAL COMMUNITY PROGRAMS

The local community programs will follow the principle of *scalable, flexible, and adaptable capabilities*; the principle allows a community to adapt its response to an emergency/disaster based on the nature, size, scope, and duration of the event. As such, the local community programs will:

- Follow protocols to use the community-specific mass notification system to alert, mobilize, and deploy behavioral health providers in order to quickly respond to the needs of responders.
- Provide confidential, one-on-one crisis interventions and assistance any time during the emergency/disaster, as requested by the responder.
- Monitor responders throughout the emergency/disaster and provide outreach, confidential peer support, and make and facilitate referrals to an EAP or to other behavioral health programs for responders who show obvious signs of distress and who want help. The programs will use intrastate or interstate mutual aid, as necessary.

DURING AN EMERGENCY/DISASTER – LOCAL COMMUNITY-RESPONDER SUPERVISORS

Depending on the nature; severity; and duration of the emergency/disaster, each supervisor of the local community responders will:

- Actively manage responder stress and functioning by continually checking on the responders and by providing them with real-time support.
- Remind responders how to monitor themselves and their peers for stress and how to obtain assistance if they need it.
- Provide brochures and handouts on the potential normal reactions and behavioral health consequences of an emergency/disaster, including how to manage stressors and when and where to seek assistance.
- Ensure enough staff are available from all levels of the organization, including administration; supervision; and support. Design shift schedules and mobilize backup support to ensure the responders only work 12 hours, with 12 hours off. Mandate the responders take time off. Whenever possible, rotate responders among low-, mid-, and high-stress tasks. Delegate the responders' regular work to others so they do not attempt to respond to the emergency/disaster in addition to maintaining their usual workloads. Use intrastate or interstate mutual aid, as necessary.
- Nurture team support and create a responder buddy system so they can support each other and can check on each other's stress reactions during and after an emergency/disaster.
- Provide regular stress-reducing activities, such as music; movies; meditation; and yoga.
- Help reduce responder isolation by providing access to email, the internet, and telephones.

- Address responder concerns about personal and/or family risks.

AFTER AN EMERGENCY/DISASTER

The local community behavioral health programs will monitor responders who meet certain high-risk criteria. This includes those who: are survivors of the emergency/disaster; have experienced personal trauma or loss; have regular exposure to severely affected individuals or communities; have pre-existing conditions; and have multiple stressors, such as having responded to multiple disasters in a short period of time.

Debriefing

Depending on the nature; size; scope; and duration of the emergency/disaster, the local community program will provide one-on-one and group debriefings. In this regard, the programs will:

- Conduct a confidential, one-on-one demobilization debriefing session with each responder at the time of their **demobilization** and provide information about how to communicate with their family about their work.
- Conduct a confidential, one-on-one, intermediate debriefing session with each responder **within 72 hours** of the emergency/disaster.
- As available, provide small, homogenous critical incident stress debriefing groups for the responders **within 24 to 72 hours** of the emergency/disaster. The groups should follow a standardized curriculum and should be staffed by teams of trained behavioral health specialists and peer support specialists (Davis, J., 2013; Mitchell, J., n.d.; US Army Corp of Engineers, n.d.).
- **Approximately 30 days** post-emergency/disaster, conduct a confidential one-on-one follow up debriefing session with each responder.

As necessary, the program will use intrastate or interstate mutual aid to provide staffing for this purpose.

Defusing

As with debriefing, depending on the nature; size; scope; and duration of the emergency/disaster, the local community program will provide small critical incident stress defusion groups **8 to 12 hours** post-emergency/disaster. The program will use intrastate or interstate mutual aid to provide staffing for this purpose, as necessary.

The program will also create on-going formal and informal opportunities for the responders to discuss their experiences, critique the operation, receive support, and to receive formal recognition for their services.

Monitoring

During each debriefing or defusing encounter with a responder, the behavioral health staff will provide formal recognition of the person's service (US Army Corp of Engineers, n.d.) and will monitor the person for behavioral health needs. Not all responders will need or want additional supports. For responders needing and wanting additional supports, the behavioral health staff will make and facilitate referrals to the EAP or other behavioral health programs, to peer-to-peer support networks, or to self- and mutual-help groups (e.g., A.A., D.R.A., SMART Recovery, Women in Sobriety). The program will also provide family information sessions and family support services; as necessary, the program will use intrastate or interstate mutual aid for this purpose.

The program will encourage buddy systems and peer-to-peer support. It will also facilitate ways responders can communicate with each other; this can be accomplished by establishing listservs and/or an online communications platform, by encouraging the responders to share contact information, and by providing peer-to-peer conference calls.

(F) PRESCRIBE MEASURES TO AID THE RECOVERY OF THE BEHAVIORAL HEALTH SYSTEM *AFTER* AN EMERGENCY OR DISASTER

The DPBH coordinator and the local communities will work together to build community health resilience to prepare for and to aid the recovery of the behavioral health system after an emergency/disaster. According to the Office of the Assistant Secretary for Preparedness and Response (ASPR, n.d.), community health resilience is the ability of a community to use its assets to strengthen public health (including behavioral health) and health care systems and to improve the community's physical, behavioral, and social health to withstand; adapt to, and recover from adversity. ASPR provides several strategies to help build resilient communities:

- Strengthen and promote access to public health, behavioral health, health care, and social services; strong day-to-day systems can be better leveraged to support community health resilience during emergencies/disasters. In capable systems, people know how to access care and are not limited by real or perceived barriers to services.
- Promote health and wellness alongside emergency/disaster preparedness. By providing information and education relating to public health; behavioral health; emergency preparedness; and community health resilience, people will be better equipped to face emergencies/disasters, and the behavioral health system will recover quicker.
- Expand communications, collaboration, and social connectedness. Build networks that include an array of behavioral health providers, social service entities, and community stakeholders (e.g., emergency management partners, public health providers, community organizations, faith-based organizations, peer-to-peer networks, self- and mutual-help groups). Work with the networks to expand social connectedness. People are more empowered and inclined to help one another after an emergency/disaster when they are regularly involved in each other's lives.
- Invite at-risk individuals to take an active and meaningful role in the recovery process. Including these individuals helps the system recover, aids the community's resilience, and strengthens the community as a whole.
- Involve and assist programs that serve at-risk individuals to develop robust emergency/disaster plans and COOPs.

In alignment with ASPR's strategy of engaging at-risk individuals and the programs that serve them, the behavioral health programs will work with their clients who are living with serious mental illnesses and with their families to prepare them for an emergency/disaster. This involves working to develop individualized emergency plans, including emergency contact information; a list of medications; and an adequate supply of critical medical and basic household items (Morganstein, 2019).

In expanding on ASPR's strategy of social connectedness, DPBH and the local communities will work together to plan for the recovery of the local behavioral health system by identifying and building on each community's strengths, resources, and capacities, and by developing strong community networks that include, but are not limited to, families; friends; schools; responder peer-to-peer support communities; self- and peer-help communities; and natural community helpers and healers.

To further develop community health resilience, DPBH and the local community partners (partners) will work together to integrate their unique behavioral health resources, activities, and programming into other local sectors (e.g., health care, social services) in order to: eliminate silos, reduce stand-alone services, develop capacity, expand reach, and develop long-term sustainability. The partners will also work to enhance the system's capacity to respond to the surge in behavioral health care needs by providing clinicians and other behavioral health care workers with emergency/disaster-specific education, training, and skill building (Herrmann, 2005). In addition, the partners will develop an intrastate mutual aid behavioral health resource inventory. DPBH will disseminate the inventory to the statewide communities.

In addition, the partners will work to establish a coordinated and unified post-disaster messaging system which will build on any existing state, county, and local crisis communication systems and will include the Nevada Joint Information Center; the Center operates the State Information System where staff with public information responsibilities provide community relations during an emergency/disaster.

Finally, to further prepare for system recovery after an emergency/disaster, DPBH will invite the Nevada Security Awareness Committee (NSAC) to participate in the planning process. NSAC's involvement is critical to ensuring the state will be able to recover its electronic health records and will be able to continue the Medication Management Program.

REFERENCES

Assistant Secretary for Preparedness and Response (ASPR). (n.d.) *National Health Security Strategy and Implementation Plan: 2015-2018* (p. 10). Retrieved from: https://www.phe.gov/Preparedness/planning/authority/nhss/Documents/nhss-ip.pdf

Centers for Disease Control and Prevention (CDC). (March 19, 2018). *Emergency Preparedness and Response. Resources for State and Local Governments.* Retrieved from: https://emergency.cdc.gov/coping/government.asp

Centers for Disease Control and Prevention (CDC). (January 2019). *Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health. Capability 15: Volunteer Management.* Retrieved from: https://www.cdc.gov/cpr/readiness/00_docs/CDC_PubHlthPrepCap_Oct2018_508_Cap15.pdf

Centers for Medicare and Medicaid Services. (2017). *Appendix Z, Emergency Preparedness Final Rule Interpretive Guidelines and Survey Procedures.* Retrieved from: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-29.pdf

Davis, J. (2013). Critical Incident Stress Debriefing From a Traumatic Event: Post-Traumatic Stress Following a Critical Incident. Retrieved from: https://www.psychologytoday.com/us/blog/crimes-and-misdemeanors/201302/critical-incident-stress-debriefing-traumatic-event

Glickman, N., (n.d.) Blog: Language Deprivation and Deaf Mental Health: Introduction to a Webinar. (Blog post). Retrieved from: https://nasmhpd.org/sites/default/files/Glickman_Language_Deprivation_Article.pdf

Emergency Management Assistance Compact, NV. Stat. § 415-010 (2018). Retrieved from https://www.leg.state.nv.us/NRS/NRS-415.html

Federal Emergency Management Agency (FEMA). (February 2006). *Developing and Managing Volunteers: Independent Study.* IS-244.B. Retrieved from: https://training.fema.gov/is/courseoverview.aspx?code=IS-244.b

Federal Emergency Management Agency (FEMA). (April 2013). *Continuity of Operations Plan Template for Federal Departments and Agencies.* Retrieved from: https://www.fema.gov/media-library-data/5c4896dd74fd2b18bc900e60935debe9/COOP_Planning_Template.pdf

Federal Emergency Management Agency (FEMA). (June 2016). *National Disaster Recovery Framework, Second Edition.* Retrieved from: https://www.fema.gov/media-library-data/1466014998123-4bec8550930f774269e0c5968b120ba2/National_Disaster_Recovery_Framework2nd.pdf

Federal Emergency Management Agency (FEMA). (October 2017). *National Incident Management System*, *Third Edition.* Retrieved from: https://www.fema.gov/media-library-data/1508151197225-ced8c60378c3936adb92c1a3ee6f6564/FINAL_NIMS_2017.pdf

Federal Emergency Management Agency (FEMA). (November 2017). *National Incident Management System Guideline for Mutual Aid.* Retrieved from: https://www.fema.gov/media-library-data/1510231079545-1fabc7af0e06d89d8c79c7b619e55a03/NIMS_Mutual_Aid_Guideline_20171105_508_compliant.pdf

Federal Emergency Management Agency (FEMA). (May 2018). *Threat and Hazard Identification and Risk Assessment (THIRA) and Stakeholder Preparedness Review (SPR) Guide Comprehensive Preparedness Guide (CPG) 201, 3rd Edition.* Retrieved from: https://www.fema.gov/media-library-data/1527613746699-fa31d9ade55988da1293192f1b18f4e3/CPG201Final20180525_508c.pdf

Herrmann, J. (2005). *New York State County Mental Health Disaster Planning and Response Guide: A Guide for County Directors of Mental Health and Community Services*. Retrieved from: https://www.omh.ny.gov/omhweb/countyguide/countyguide.pdf

Institute of Medicine. (2003). *Preparing for the Psychological Consequences of Terrorism: A Public Health Strategy.* Washington, D.C.: Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK221643/pdf/Bookshelf_NBK221643.pdf

Morganstein, J. (2019). Caring for People with Mental Illness in Disaster. *The Dialogue.* 15(3-4) Retrieved from: https://www.samhsa.gov/sites/default/files/dtac/dialogue-vol-15-issue-3-4.pdf

Nevada Intrastate Mutual Aid System, NV. Stat. § 414A-010 (2015). Retrieved from: https://www.leg.state.nv.us/NRS/NRS-414A.html

Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2019,116 U.S.C. § 905. Washington, Government Printing Office, 2019. Retrieved from: https://www.congress.gov/116/plaws/publ22/PLAW-116publ22.pdf

Protecting Access to Medicare Act of 2014,113 U.S.C. § 1040. Washington, Government Printing Office, 2014. Retrieved from: https://www.congress.gov/113/plaws/publ93/PLAW-113publ93.pdf

State of Nevada. AB 534 (2019). Retrieved from: https://www.leg.state.nv.us/Session/80th2019/Bills/AB/AB534_EN.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA). (2003a). *Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations.* DHHS Pub. No. SMA 3828. Rockville, MD: Center for Mental Health Services. Retrieved from: https://store.samhsa.gov/system/files/sma03-3828.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA). (2003b). *Mental Health All-Hazards Disaster Planning Guidance.* DHHS Publication No. SMA 3829. Rockville, MD: Center for Mental Health Services. Retrieved from: https://www.preventionweb.net/files/1996_VL206606.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA). (2004). *Mental Health Response to Mass Violence and Terrorism: A Training Manual*. DHHS Pub. No. SMA 3959. Rockville, MD: Center for Mental Health Services. Retrieved from: https://store.samhsa.gov/system/files/sma04-3959.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA). (2005). *Mental Health Response to Mass Violence and Terrorism: A Field Guide.* DHHS Pub. No. SMA 4025. Rockville, MD: Center for Mental Health Services. Retrieved from: https://store.samhsa.gov/system/files/sma05-4025.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA). (2013). *Disaster Planning Handbook for Behavioral Health Treatment Programs*. Technical Assistance Publication (TAP) Series 34. HHS Publication No. (SMA) 13-4779. Rockville, MD. Retrieved from: https://store.samhsa.gov/system/files/sma13-4779.pdf

United States Army Corp of Engineers. (n.d.). *Critical Incident Stress Management (C.I.S.M.): Interim Operations Manual.* Retrieved from: https://corpslakes.erdc.dren.mil/employees/cism/pdfs/cism-sop.pdf

ANNEX 1: KEY RESOURCES

American Red Cross Training Services – The American Red Cross provides free disaster training for all volunteers. Trainings are offered online and in-person depending on the course. Access at: https://www.redcross.org/take-a-class/disaster-training

FEMA Community Emergency Response Team (CERT) Training Materials (25) - This site includes a variety of training materials for community emergency response. Access at: https://www.fema.gov/media-library/resources-documents/collections/485

FEMA Emergency Support Function #8 – Public Health and Medical Services - This document provides the mechanism for coordinated Federal assistance to supplement state, tribal, and local resources in response to a public health and medical disaster, potential or actual incidents requiring a coordinated Federal response, and/or during a developing potential health and medical emergency. Access at: https://www.fema.gov/media-library-data/20130726-1825-25045
8027/emergency_support_function_8_public_health___medical_services_annex_2008.pdf

FEMA Ready - This is a Federal Emergency Management Agency public service campaign designed to educate and empower the American people to prepare for; respond to; and mitigate emergencies, including natural and man-made disasters. Access at: https://www.ready.gov/resources

International Society for Traumatic Stress Studies - This site is dedicated to sharing information about the effects of trauma and the discovery and dissemination of knowledge about policy, program, and service initiatives that seek to reduce traumatic stressors and their immediate and long-term consequences. Access at: https://www.istss.org/

Public Health Foundation, TRAIN Learning Network (TRAIN) Affiliates – This is a national learning network that provides a variety of trainings for the health workforce using a centralized training platform. Access at: https://www.train.org/cdctrain/welcome

SAMHSA Disaster Technical Assistance Center – This site helps jurisdictions plan for and respond to behavioral health needs after a disaster. Access at: https://www.samhsa.gov/dtac

SAMHSA Disaster Technical Assistance Center Supplemental Research Bulletin: Disaster Behavioral Health Interventions Inventory – This inventory includes disaster-specific interventions commonly used in the field and are reported in the science- and evidence-based research literature. The inventory identifies early, intermediate, and long-term interventions. Some of the interventions are available via internet-based applications (APPs) or via smart phone APPs. Access at: https://www.samhsa.gov/sites/default/files/dtac/supplemental-research-bulletin-may-2015-disaster-behavioral-health-interventions.pdf

SAMHSA Promising Practices in Disaster Behavioral Health Planning webcast series - This nine-part series discusses various aspects of disaster behavioral health planning, such as

logistics, building partnerships, developing a scalable plan, and financial concerns. Access at: https://www.samhsa.gov/dtac/webinars-podcasts

SAMHSA Psychological First Aid: Tips for Emergency and Disaster Responders - This fact sheet provides tips for emergency and disaster response workers to help disaster survivors cope with the psychological aspects of a traumatic event. It offers strategies for managing intense emotions and promoting a safe, calm environment. Access at: https://store.samhsa.gov/product/Psychological-First-Aid-for-First-Responders/NMH05-0210

SAMHSA Tips for Health Care Practitioners and Responders: Helping Survivors Cope with Grief After a Disaster or Traumatic Event - This tip sheet offers health care practitioners and responders guidelines for communicating with survivors experiencing grief. Access at: https://store.samhsa.gov/system/files/sma17-5036.pdf

State Emergency Registry of Volunteers-Nevada (SERV-NV) – This is a secure, web-based system used to register, qualify and credential Nevada's health care professionals before a major public health or medical emergency. Access at: https://servnv.org/

Technical Resources, Assistance Center, and Information Exchange (TRACIE) - Continuity of Operations (COOP)/ Business Continuity Planning – This site provides public and government entities with mitigation and planning strategies that create resilience and allow services to continue to be provided in the face of a range of challenges. Access at: https://asprtracie.hhs.gov/technical-resources/17/continuity-of-operations-coop-failure-plan/16

U.S. Department of Veteran’s Affairs – This site offers a variety of courses on psychological first aid. Access at: https://www.train.org/vha/home

ANNEX 2: RESULTS OF THE OPEN COMMENT PERIOD FOR AB 206, SECTION 11

From November 21, 2019 through December 21, 2019 the draft plan was open for public comment. While DPBH incorporated many of comments into the plan, the following comments (in no particular order) are open for consideration by a yet-to-be formed statewide AB 206, Section 11 Workgroup:

1. **Comment** – “Adopt guiding principles specific to behavioral health emergency and disaster planning.”

2. **Comment** – “Write the plan based on the disaster recovery continuum from immediate recovery through long term recovery.”

3. **Comment** – “Overall, although there are many comments about ‘stress management,’ there is no attention to what would happen should all providers be unavailable or provision for training in the event of a system meltdown of some kind. This is a possible event, and preparing citizens emotionally and practically for what to do when *no help is available* needs to be added to the plan.”

4. **Comment** – In Section (e) “During an occurrence, add Compassion Fatigue Prevention – Offer debriefing sessions, both group and individual, for crisis behavioral health responders.”

5. **Comment** – “Expand the plan beyond the requirements of AB 206, Section 11.”

6. Regarding - “Psychological first aid and pre-emergency-/pre-disaster education.” **Comment:** “What are best practices?”

7. **Comment –** “Develop disaster behavioral health training core competencies to serve as a framework for all the trainings.”

8. Regarding - “Collaborate with the local communities/jurisdictions to ensure triage and psychological first aid strategies are standardized and based on best practices by adopting a training standard of practice for individuals wanting to participate in disaster behavioral health (Institute of Medicine, 2003). Examples: Introduction to the Incident Command System (IS-100), An Introduction to the National Incident Management System (IS-700.B), Psychological First Aid, and the American Red Cross Disaster Mental Health Fundamentals trainings.” **Comment:** “The training needs to be decided by SME & the state. These courses may not be enough. How often should they be taken – continued? The SME needs input on these trainings.”

9. **Comment** – "Consider a triage type system that may help as we move forward so we utilize the correct level of provider for each patient's issues. The developer looks fairly well versed and it appears to be evidence based https://www.faculty.uci.edu/profile.cfm?faculty_id=5890."

10. Regarding - Section (d) Identify opportunities for the rendering of mutual aid *during* an emergency or disaster, The Nevada Intrastate Mutual Aid System, as authorized by Nevada Revised Statutes (NRS) 414A (2015), allows the Nevada Department of Public Safety, Division of Emergency Management to coordinate the provision of equipment, services, or facilities owned or organized by the state or its political subdivisions for use in the affected areas upon request of the duly constituted authority of the areas during the response to and recovery from an emergency/disaster. **Comment –** "Do they do this at the local level? If they do, we (a local entity) have not seen them."

11. **Comment -** "Need provider input on any recommended interventions and training."

12. **Comment -** "Need to ensure any recommended interventions and treatment are based on best practices."

13. **Comment** – "Add a special populations section (e.g., rural and frontier communities (lack resources, risk urban surge); children (system planning and responses need to be different); deaf and hard of hearing (linguistic, social, and cultural implications); tourists/non-residents (based on the Las Vegas October 1 incident, this population has surge implications); Hispanic population/Spanish-language (cultural and language considerations); tribal communities (cultural and possible language considerations), people who are homeless (many special considerations and complications)."