Northern Regional Behavioral Health Emergency Response Plan

Annex to Local Emergency Operations Plans in Carson City, Churchill, Douglas, Lyon, and Storey Counties

Adopted by the Northern Region Behavioral Health Policy Board on _____.

PLAN ADMINISTRATION

The Regional Behavioral Health Coordinator (RBHC) or designee(s) from the local Behavioral Health Task Forces (BHTFs) will coordinate the review, revision, and re-promulgation of this plan every two years or when changes occur, such as lessons learned from exercises or events and/or legislative change. Periodic reviews will be done in collaboration with regional partners. Changes to this plan will be approved by local Emergency Managers (EM) and/or designees.

Plan Adoption

Signatures below indicate the EM or his/her designee has formally adopted this regional plan as an annex to the local Emergency Operations Plan (EOP) in each county within the Northern Behavioral Health Region.

Date	County	Name	Title	Signature
	Carson			
	Churchill			
	Douglas			
	Lyon			
	Storey			

Plan Distribution List

Copies of the BHERP will be provided to the following jurisdictions, agencies, and persons electronically, unless otherwise indicated. Updates will be provided electronically, when available. To request an electronic copy of the plan, contact Jessica Flood, Regional Behavioral Health Coordinator, at jessica@nrhp.org.

Agency	Department/Title
Carson City Fire Department Carson City Manager's Office	Emergency Manager – Sean Slamon City Manager – Sharon Landers
Carson City BHTF	Chair(s) - Nicki Aaker/ Mary Jane Ostrander
Churchill County	EM - Mike Heidemann County Manager - Jim Barbee
Churchill BHTF	Social Services - Shannon Ernst
East Fork Fire District Douglas County	EM - Todd Carlini County Manager – Patrick Cates
Douglas County BHTF	Chair – Taylor Allison (Partnership Douglas County) Vice-Chair– Debbie Posnien (Suicide Prevention Network) Karen Whit- Social Services
Lyon County	County Manager/EM – Jeff Page
Lyon County BHTF	Human Services – Shayla Holmes

Storey County	EM - Joe Curtis County Manager - Austin Osborne
Storey County BHTF	Chair - Erik Schoen (Community Chest)

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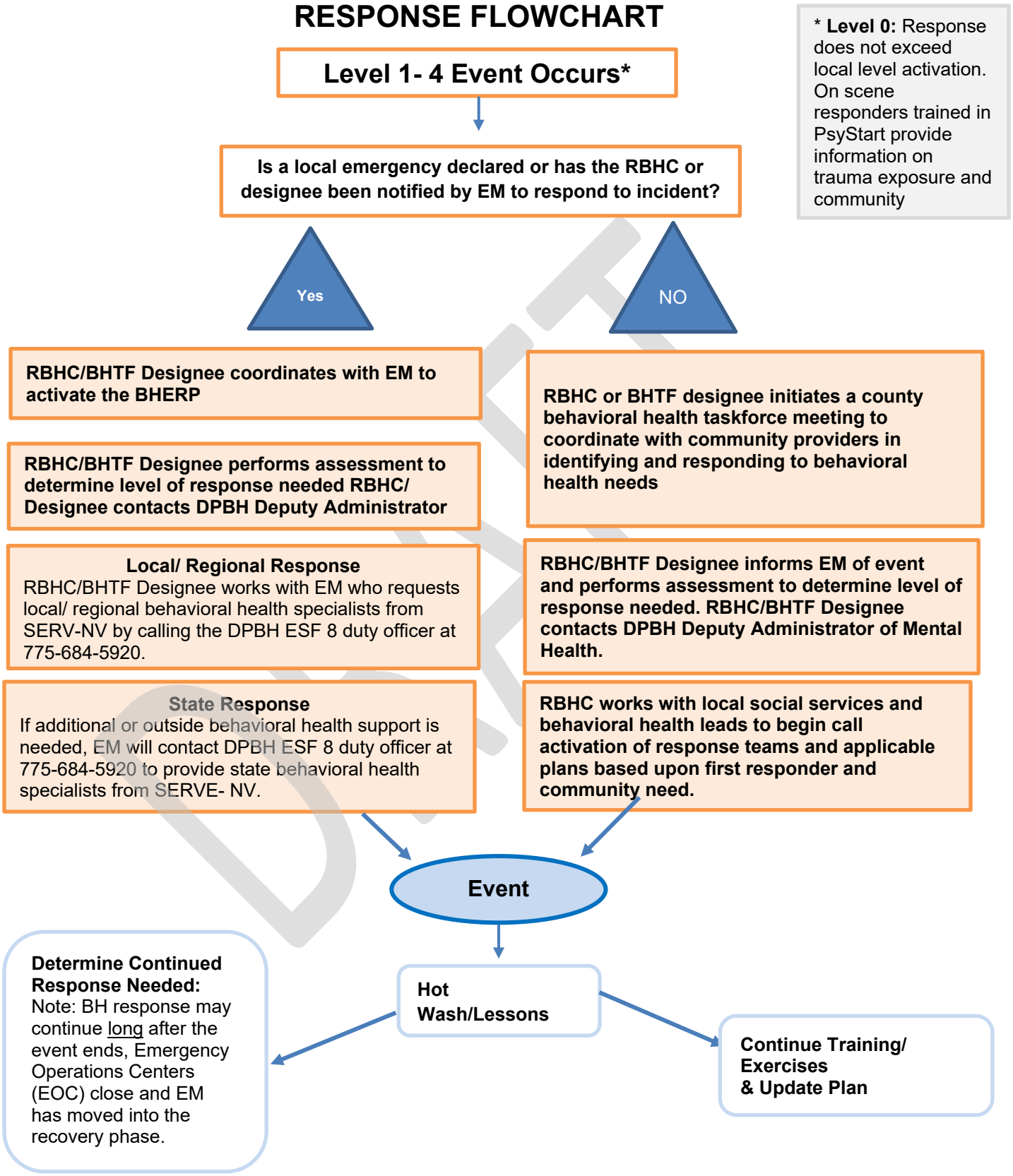
EXECUTIVE SUMMARY

Disaster behavioral health is an integral part of the overall public health and medical preparedness, response, and recovery system. Behavioral health factors directly and indirectly influence individual and community risks, health, resilience, and the success of emergency response strategies and public health directives. The Northern Regional Behavioral Health Emergency Response Plan (BHERP) is a supplemental plan to overarching local plans to establish the preparedness framework for localized, county-wide, or catastrophic emergencies affecting counties in the Northern Behavioral Health region, and the people it serves. It is a comprehensive emergency management tool prepared in coordination with local EM agencies and consistent with the Federal Response Framework. This reference provides guidance, direction, and coordination for emergency and crisis behavioral health support to first responders, survivors, families, or visitors. This plan is considered an all hazards plan which means that planners prepare for response to a full range of threats and dangers but with a focus on the specific incidents most likely to occur in their area (Federal Emergency Management Agency [FEMA], 2010a). (SAMHSA).

Recognizing that the plan is a lengthy narrative, and in support of other Regional plans, there are attached functional annexes which address specific response; job action sheets; and, check lists /assessment forms for easy access during a specific incident or plan activation.

All individuals involved in behavioral health response are encouraged to read and become familiar with the entire plan and acquaint themselves with how it intersects with local EOPs and other State guidance.

RESPONSE FLOWCHART



* **Level 0:** Response does not exceed local level activation. On scene responders trained in PsyStart provide information on trauma exposure and community

SECTION 1: INTRODUCTION

Section 1 establishes the framework within which this Behavioral Health Emergency Response Plan (BHERP) exists and how it fits into existing plans.

1.1 WHOLE COMMUNITY PLANNING

In concert with local EOPs, this plan follows the "Whole Community" planning concept which is based on the recognition that it takes all aspects of a community to effectively prepare for, protect against, respond to, recover from, and mitigate against disasters. In behavioral health, just as in other emergency responses, this includes all emergency management partners, both traditional and nontraditional, such as volunteer, faith-based and community-based organizations; the private sector; and the public, including survivors of an incident. In this sense, we must plan for a wide variety of impacts to the communities within the Region. This BHERP attempts to address, at least in general terms, a wide variety of operational concerns throughout the Region.

1.2 PURPOSE

The purpose of BHERP is to provide a response framework for emergencies using the "Whole Community" planning concept within the Northern Region. Engagement of diverse community providers is based on the recognition that it takes all aspects of a community to effectively prepare for, protect against, respond to, recover from, and mitigate against disasters. The BHERP provides the framework for how local agencies within the region, in collaboration with State, will respond to a public emergency. This plan provides a framework for organizing the behavioral health response to disasters or large-scale emergency situations. Behavioral health in the Northern Region includes mental health, substance abuse, and addictive behaviors. Emergency behavioral health includes the many interconnected psychological, emotional, cognitive, developmental, and social influences on behavior, behavioral health, and substance abuse, and the effect of these influences on preparedness, response, and recovery from disasters or traumatic events. Behavioral factors directly and indirectly influence individual and community risks, health, resilience, and the success of emergency response strategies and public health directives. Disaster/emergency behavioral health services can help mitigate the severity of adverse psychological effects of the disaster and help restore social and psychological functioning for individuals, families, and communities. This plan is a dynamic document that can be modified to incorporate changing technologies and emerging best practices in behavioral health as well as any changes to State and County plans.

1.3 SCOPE

The BHERP is designed to complement local EOPs and the state Emergency and Disaster Behavioral Health Plan which establishes the preparedness framework for a range of events from severe weather to hazardous material spills to terrorist attacks. Just as the local EOPs

structure the response for County agencies and departments, this plan provides a guide for the integration and/or collaboration between regional agencies including local governments, voluntary organizations, regional and federal partners when indicated to respond to the *behavioral health component* of an event. The all hazards approach to disaster response means the plan can be used in any public emergency and therefore does not address specific scenarios. The plan seeks to provide a consistent outline for disaster mental/behavioral health activities in the region, including, but not limited to:

- Preparedness strategies to support the disaster behavioral health function;
- Mitigation activities to lessen the behavioral health impacts of disasters;
- Activities in response to and recovery from an event with behavioral impacts, and,
- Use of resources to address the consequences of behavioral health impacts.

The BHERP and associated functional annexes seeks to:

- Support continuity of service for existing patients with chronic behavioral health conditions.
- Facilitate ongoing follow up, outreach and community support after an emergency or disaster.
- Facilitate services from agencies that provide behavioral health crisis counseling/intervention, emotional and behavioral services to disasters victims and emergency responders during a significant emergency or disaster.
- Deploy triage and psychological first aid services to identify and prevent the onset of behavioral health conditions from trauma experienced during the emergency or disaster.
- Estimate the scope of acute and long-term impact of an incident on disaster behavioral health needs.
- Create a disaster behavioral health process to achieve the public health goal of the most good for the most people.
- Estimate the need for additional disaster behavioral health assistance.
- Support long-term behavioral health needs resulting from an emergency or disaster.
- Address responder disaster behavioral health.
- Address additional specific disaster behavioral health concerns, including substance abuse prevention, domestic violence prevention, opiate dosing, and stress management.
- Create a comprehensive resource list of responders, agencies, and volunteers.
- Create a plan by which this and other plans can be exercised.

1.4 AUTHORITY

This plan is developed under the authority of the Northern Region Behavioral Health Policy Board and local EM agencies. In the context of this plan, a disaster or major emergency is characterized as an incident requiring the coordinated response of Regional Partners to respond to behavioral health needs for the affected population within the region. This plan is issued in accordance with, and under local EOPs close coordination and support from the local Behavioral Health Task Forces (BHTF). All County plans comply with the provisions of the Nevada Revised Statutes (NRS) Chapter 414, which establishes the authority for jurisdictions to establish an Emergency Management Organization (EMO) and appoint an "Emergency Management Director" who will be responsible for the organization, administration, and operation of the EMO (NRS 414.090). EMOs within the Region are consistent with the National Incident Management System (NIMS) and procedures supporting NIMS implementation and training for the region will be developed and formalized by the regional partners' respective EM, or corresponding position. The EM or designee within behavioral health, will implement the appropriate plan based on the activation and resources needed.

SECTION 2: SITUATION AND PLANNING ASSUMPTIONS

Section 2 of the BHERP builds on the scope discussion in Section 1 by profiling the Northern region's risk environment, identifying specific planning considerations, and describing the predicate assumptions underlying the plan. This section ensures that, while taking an all hazards approach to emergency management, the plan is tailored to the unique behavioral health risks faced by the region.

2.1 SITUATION

Disasters are associated with a continuum of mental health impacts including post-traumatic stress disorder, generalized anxiety disorder, acute stress disorder, major depression, panic disorder, and substance use disorder. Disasters are also associated with a wide range of impairments including work, home, community and school functioning. For those with pre-existing mental conditions disasters can exacerbate difficulties and some may lose access to their life sustaining medications, routine counseling, and other stabilizing processes. Rates of domestic violence, substance use disorders, and child abuse may also increase.

Additionally, wide-ranging behavioral as well as mental health impacts of catastrophic incidents have been demonstrated in various types of public health emergencies, including loss of credibility for public health, other government authorities, societal structures, lack of adherence with mandatory quarantine measures, massive price inflation and complete supply chain depletion due to panic buying of critical supplies.

Serious overload on healthcare systems and hospital inundation by concerned citizens can occur. These impacts act as stressors, are indicators of mental health stress, or impede government response.

2.2. HAZARDS

The BHERP is designed to be an all-hazards guide to regional emergency behavioral health response operations. However, users of this plan should be informed of the hazards within the Northern region. The local EM agencies utilize a threat and hazards identification and risk assessment (THIRA) to develop a county-specific ranking of these natural phenomena and manmade threats. Based on magnitude (potential for life, economic, and/or property loss), duration, area affected, distribution of impacts, frequency of occurrence, and vulnerability of the population and/or infrastructure, the distribution of hazards is below. For behavioral health response and to provide continuity of response, the same hazards will be assumed.

The table below lists the hazards profiled in Quad-County Hazard Mitigation Plans:

Table 1 - Hazard Profiles Summary

Hazards	Carson City	Douglas County	Lyon County	Storey County	Churchill County
Acts of Violence	X				X
Avalanche	X			X	
Drought		X			X
Earthquake	X	X	X	X	X
Floods	X	X	X (includes Dam/Canal failure)	X (includes Dam/Levee Failure)	X
Hazardous Materials Events	X		X	X	X
Infectious Disease/Epidemic	X	X	X	X	
Infestation (Invasive species)			X		
Land Subsidence and Ground Failure			X	X (includes caving ground/mining collapse)	X
Landslide	X		X		
Seiche	X	X			
Severe Weather	X	X	X (includes heat, hail and thunderstorms, windstorm)	X (includes snow, ice, windstorm, hail)	X(windstorm, winter storm)
Terrorism/WMD	X		X	X	
Utility Loss	X				
Volcanic Activity	X	X			
Wildland Fire	X	X	X	X	X

2.3. VULNERABLE POPULATIONS

This plan recognizes that while all sectors of the population may be affected by an emergency/disaster, there are certain populations that are more vulnerable to the social, health, economic, or other impacts of such events.

Populations	Description
People with Existing Behavioral Health Issues	Those individuals who depend on outpatient/inpatient behavioral health services including psychiatric and substance abuse disorders An estimated 20% of the population experiences mental illness, 5% of the population experiences serious mental illness, 17% of youth experience a mental health disorder.
First Responders	Those who are designated or trained to respond to an emergency especially law enforcement, fire, EMS, and healthcare.
Female Gender	Those who may be pregnant and single parenting
Incarcerated	The Northern Region has multiple prisons and jails with the following average inmate populations: Carson City Jail: 200 (average) Churchill County Jail: 53 (average) Douglas County Jail: 85 (average) Northern Nevada Corrections Center: 1,619 (capacity) Warm Springs Corrections Center: 525 Juvenile Detention Centers:
Homeless/Unsheltered/ Living In Poverty	Those who live in a place that is not meant for human habitation. Homeless: (From Rural Nevada Continuum of Care 2020 Point in Time Report): Carson City: • Sheltered: 62 • Unsheltered: 43 • Motel: 423 • School: 355

	Churchill: • Sheltered: 9 • Unsheltered: 24 • Motel: 4 • School: 111 Douglas: • Sheltered: 2 • Unsheltered: 2 • Motel: 18 • School count: 124 Lyon: • Sheltered: 3 • Unsheltered: 98 • Motel: 18 • School: 276 Storey: • Sheltered: 0 • Unsheltered: 1 • Motel: NA • School: 13 <u>Living in Poverty</u>: • Carson City: 6,458 • Churchill: 2,871 • Douglas: 3,930 • Lyon: 5,831 Small Area Income and Poverty Estimates, U.S. Census Bureau, Office of Statewide Initiatives, 2019
Congregate Care	Placement settings that consists of 24-hour supervision in highly structured settings such as group homes, childcare institutions, residential treatment facilities, transitional housing, etc.
Children	(0–17 years of age) • Carson City: 11,082 • Churchill: 6,128 • Douglas: 8,442 • Lyon: 11,972 • Storey: 522 (Nevada State Demographer's Office, 2019)
Access and Functional Needs (The Americans with	• See Nevada instant atlas

Disabilities Act defines a **disability**, with respect to an individual, as a physical or mental impairment that substantially limits one or more of the major life activities such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working)	
Seniors	Individuals aged 65+ (Particularly those with physical health conditions and/or socially isolated) • Carson City: 11,938 • Churchill: 4,280 • Douglas: 13,646 • Lyon: 11,518 • Storey: 1,282 (Nevada State Demographer's Office, 2019)
Veterans	Carson City: 4,890 Churchill: 3,368 Douglas: 4,645 Lyon: 6,179 Storey: 444 (Unpublished data from the US Dept of Veterans Health Administration, 2016, Office of Statewide Initiatives)
People with Disabilities	Office of Statewide Initiatives (2018)
Intellectual /Developmentally disabled	Need data
Rural/Frontier Populations	Percent population residing in unincorporated area: Carson City: 0% Churchill County: 65.6% Douglas County: 100% Lyon County: 58.3% Storey County: 100%

2.4 BEHAVIORAL HEALTH RESPONSE PLANNING ASSUMPTIONS AND PRIORITIES

The following assumptions are applicable to emergency/disaster response for behavioral health and are not all inclusive:

- All emergencies and disasters have some level of behavioral health needs. In disasters, for every 1 injury there may be 4-5 psychological injuries. The level of behavioral health resources deployed to the response will normally be initiated at the City or County jurisdiction level with additional requests for support being forwarded to State Emergency Operations Center – Emergency Support Function (ESF) 8.1 desk, when appropriate.
- Major emergencies/disasters affect the mental wellbeing of responders and victims. Responders are likely to be affected by both the incident and by interactions with those who experience trauma, and thus will require assistance relevant to their experience. This may be different from the needs of the general public. These individuals may not realize that they need assistance.
- Behavioral health response will be a continual planning and assessment process, conducted by Behavioral Health Task Forces (BHTFs).
- Current research indicates that alcohol and other substance use may increase during and/or after a disaster, potentially causing problems for persons already in recovery.
- People who already take medications for mental or behavioral health conditions will need uninterrupted access.
- Behavioral Health will rely on evidence-informed tools for disaster behavioral health triage and psychological first aid.
- Mass casualty events, particularly those that involve chemical, biological, radiological, nuclear, or explosive (CBRNE) or emerging infectious diseases, are expected to affect the population significantly, resulting in new incidences of clinical disorders and distress symptoms.
- Disaster mental/behavioral health workers will triage, assess, provide early psychological first aid, crisis counseling and make referrals, consistent with their level of training and scope of practice.
- Common clinical approaches for standard therapy may not be appropriate for disaster mental health responses. Psychiatrists, psychologists, and counselors who currently practice in community agencies or private practice will need training in disaster mental health approaches and the Nevada Crisis Standards of Care as part of their preparation to volunteer.
- Behavioral health workers should have a certain level of cultural competency in order to provide quality care, especially given the fact that many populations have

experienced significant trauma in their past. Culturally and linguistically appropriate services will be made available for vulnerable populations.

- Children are a high-risk group in disasters. In order to be successful, behavioral health interventions for children need to be evidence-based and targeted to children.
- Because of exposure to media coverage of the incident, those not directly exposed to the incident may require disaster behavioral health services.
- The community's anxiety may be decreased by recognition that things are not being hidden from them, along with good information about how to deal with various aspects of any disaster.
- Disaster mental/behavioral health resources will vary by operational area, community, and disaster circumstance. These resources, which together may be seen as constituting a "disaster system of care", will include public mental/behavioral health agencies, public health agencies, EMS agencies, schools, volunteer organizations, hospitals, and others
- Existing systems that provide mental/behavioral health services may be damaged, disrupted, or overwhelmed during an emergency. Mental health clinics, schools, places of worship, group homes, hospitals, nursing homes, ambulatory care centers, and other facilities, which provide mental/behavioral health care and support for affected populations, may be damaged or destroyed or may be overwhelmed providing such support.
- Long-term recovery planning must be factored in from the beginning of the disaster.

SECTION 3: CONCEPT OF OPERATIONS

3.1 ACTIVATION

The need to activate some or all components of this plan will be dictated by the specifics of the incident. A few coordinating activities during small, isolated incidents such as an apartment fire may be sufficient and prevent the need to activate the plan officially, although components of the plan may still be operational. The plan will be activated to address the needs that come with large, widespread, or prolonged incidents. It may also need to be activated in response to incidents occurring outside of the Northern Region, or before anniversaries of traumatic events.

3.1.1 Levels of Activation

Activation Levels	Decision Points	Number of Behavioral Health Specialists Needed on scene
Level 0 (Readiness)	Approximately less than 10 survivors or ongoing informal response	First responders able to triage event and provide community resources
Level 1	Approximately 10 survivors/fatalities with approximately 30 family members	2 PSA volunteers, 1 clinician, 1 volunteer contacting/ coordinating resources
Level 2	10 – 25 survivors/fatalities with approximately 75 family members	5 PSA volunteers, 2 clinicians, 1 volunteer contacting/coordinating resources
Level 3	26 – 50 survivors/fatalities with approximately 200 family members	10 PSA volunteers, 4 clinicians, 1 volunteer contacting/ coordinating resources
Level 4	50+ survivors/fatalities with over 200 family members	20 PSA volunteers, 6 clinicians, 1 volunteer contacting/ coordinating resources

3.1.2 Deployment

Activation will be determined based on if a local emergency has been declared or the RBHC or BHTF designee has been notified by the EM to respond to the incident, or if the incident is identified through community providers or other sources.

If a local emergency has been declared or the RBHC or BHTF designee has been notified by the EM to respond, the RBHC and BHTF will fill local/regional ESF 8.1 position in local emergency operation centers (EOCs). If awareness of the incident arises from community providers or other sources, the RBHC or designee will coordinate with the EM on the incident. In both scenarios, the RBHC or designee will then coordinate with DPBH by contacting the DPBH deputy administrator for behavioral health and informing them of the incident. The RBHC or designee will then initiate a BHTF meeting in the county or counties affected to perform an assessment, determine the risk level, and plan resource deployment accordingly. Resources, including volunteers, will be activated first at the local and regional levels, and then at the state level if needed.

3.1.3 Local Activation

Behavioral health emergency response activities within the Region are undertaken immediately after an incident has occurred/been acknowledged. Level 0 responses For levels 1-4, regional partners can request the activation of the BHERP through a local EM agency and is able to request support during an emergency response if their internal resources have been exhausted. Upon request for activation, the County EM or designee, will follow activation processes outlined in local EOPs which will include notifying the RBHC or BHTF designee. When activation occurs, providing incident information to response partners is critical. Prompt notification of response partners is likely to reduce incoming requests for information from multiple sources and allow response partners to anticipate the need for additional resources to support the affected jurisdiction(s). If behavioral health representation is requested at the county level, the RBHC or designee will report to the local EOC(s) to coordinate mental health emergency response operations.

Support to the community is categorized in the following functional areas:

- Notification process
- Assessment of mental and behavioral health needs
- Volunteer requests and credentialing process as necessary
- Psychological first aid or crisis counseling intervention services, if required
- Community awareness and outreach
- Follow Up Response after Incident

3.1.4 State Activation

In the event the local resources cannot meet the response needs, the RBHC or designee will provide a request to the State Emergency Operations Center ESF 8.1 staff, with a courtesy notification to the Statewide Behavioral Health Coordinator at the Division of Public and Behavioral Health (DPBH), to coordinate appropriate mental health resource response into the affected area(s). The EM may make this request directly and simply notify the RBHC or designee. Upon request, any additional resources shall be provided by DBPH, and are addressed in the DPBH Emergency Operations Plan (EOP). These resource requirements primarily involve ESF 8-1 staffing. These resources may range from a single individual to a behavioral health facility in the immediate area of the emergency, to the activation of one or more BH Regional Response Teams/Community Assessment Teams from other counties or facilities. If DEM requests representation from DPBH at the SEOC, the Statewide Behavioral Health Coordinator or designee will report to the SEOC.

3.1.5 Federal Activation

In the event the state resource cannot meet the response needs, the State Emergency Operations Center ESF 8.1 staff may request the Crisis Counseling Assistance and Training

Program (CCP). The CCP program is a federally funded supplemental program administrated by the U.S. Department of Homeland Security (DHS) Federal Emergency Management Agency (FEMA). Section 416 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. § 5183 authorizes FEMA to fund mental health assistance and training activities in areas that have been declared a major disaster by the President. The mission of the CCP is to assist individuals and communities in recovering from the effects of natural and human-caused disasters through the provision of community-based outreach and psychoeducational services. The CCP supports short-term interventions that involve assisting disaster survivors in understanding their current situation and reactions, mitigating stress, developing coping strategies, providing emotional support, and encouraging linkages with other individuals and agencies that help survivors in their recovery process.

The CCP consists of services focused on preventing or mitigating adverse repercussions of a disaster. This goal is achieved with a public health approach. Beginning with the most severely affected group and moving outward, the program seeks to serve a large portion of the population affected by the disaster. CCP services are community based and take place anywhere survivors are, including, but not limited to, survivor homes, shelters, temporary living sites, and churches and other places of worship. CCP Guidance, Version 5.0 | Page 2 The CCP services include supportive crisis counseling, psycho-education, development of coping skills, and linkage to appropriate resources, while assessing and referring those members of the community who are in need of intensive mental health and substance use treatment to appropriate community resources. The CCP engages community gatekeepers and organizations through direct contact with stakeholder groups, such as unmet-needs committees, and participation in community events in order to facilitate response activities and services to survivors

The CCP funds the following services:
- Individual crisis counseling
- Basic supportive or educational contact
- Group crisis counseling
- Public education
- Community networking and support
- Assessment, referral, and resource linkage
- Development and distribution of educational materials
- Media and public service announcements

3.2 RESPONSE

Based on the information provided by the EM or designee, the RBHC or BHTF designee will complete the assessment tool (See Functional Annex B) to determine the appropriate resources to request to meet the needs of the response. Behavioral health response activities within the region are undertaken immediately after an incident. The response will begin with situation assessment and situation reporting activities. While certain events may not require

the activation of local EOCs, any coordinated behavioral health response to an event will require notification to the County EM or designee. This does not include an individual agency response in their normal course of business/operation. The region's response priorities and processes are defined below:

3.2.1 Response Sites

There are a variety of sites where behavioral health emergency responders may be needed; behavioral health providers are often not needed at the site of the incident. Although it is a common reaction to want to rush to these sites, the assistance that behavioral health responders provide will most likely be needed at other sites where people gather. Response will be dictated by the EM and/or Incident Command and communicated through the RBHC/ designee. Examples of sites where behavioral health response teams may report include the following:

- Family Assistance Centers/Family Support Centers
- Shelters, meal sites, hospitals, schools, police stations, survivors' homes, morgues, business or police barriers/perimeters, etc.
- Mass care sites; mass clinics for immunizations and/or prophylactic medications; sites where first responders and other response workers gather.
- Sites conducive to community education and outreach such as community centers, schools, religious centers, business associations
- Virtual/telehealth sites may be established during infectious disease events or when the community cannot access in-person behavioral health services.

3.2.2 Response Services

As appropriate, on site behavioral health emergency responders will provide these services for individuals directly and indirectly affected by a disaster/emergency according to the following procedure:

- Response will be made upon deployment/dispatch by a) Emergency Response Manager; (b) Incident Commander and/or (c) the Regional Behavioral Health Coordinator or designee from the local Behavioral Health Task Force, acting under direction of the above.
- Personnel deployed should have a fundamental knowledge of trauma and response may include the use of a variety of therapies and techniques to include Psychological First Aid. More complex therapies (performed by licensed clinicians only) may include Trauma Focused Cognitive Behavioral Therapy; Motivational Interviewing; Grief Interventions; and Behavior De-escalation.
- Above clinical response will be made in accordance with and not exceed the individual's expertise, licensure and/or training and in accordance with the risk factor.
- Referral for clinical behavioral health services may also be provided.
- Response will be documented as much as possible and referrals made as necessary.

3.2.3 Response for Homeless

The Rural Nevada Continuum of Care measures homelessness through counting the sheltered and unsheltered individuals in each county on January 30th, 2020 through the annual Point in Time Count for Nevada's rural counties. This is a US Department of Housing and Urban Development (HUD) mandated count of sheltered and unsheltered people experiencing homelessness within a defined geographic area. In this count, individuals considered "unsheltered" were those "with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings". Individuals considered "sheltered" were those enrolled in either emergency shelter or transitional housing at the time of the count.

In incidents that might have an impact on those who are already homeless, individuals may be provided basic emotional and tangible psychological support using interventions such as Psychological First Aid, as needed. Behavioral health responders will work with the other responders and essential functions to identify any additional behavioral health needs. If necessary and as available and appropriate, behavioral health responders will also work to identify needed surge strategies. As existing shelter agencies providing care for the homeless may identify disaster-specific behavioral health needs, they will be encouraged to request assistance via their individual emergency plans. Additionally, needs of the newly homeless after a disaster may be addressed by the recovery plan/annex.

3.3 EVENT ASSESSMENT AND TRIAGE

3.3.1 Overview

Research cited in Nevada's Crisis Standards of Care Overview, shows that between 30 and 40 percent of people directly impacted by a major disaster are at risk of developing new clinically diagnosable mental illness, including depression or post-traumatic stress disorder. Early triage, intervention, and referral to services can reduce the risk of mental health disorders in disaster victims. An important component of managing medical surge following a major disaster is the ability to identify people at high risk for development of behavioral health conditions and managing the demand for services by people who are experiencing a behavioral health crisis.

Upon responding to a disaster, people will be universally screened with the PsyStart (Psychological Simple Triage and Rapid Treatment). This screen will be utilized to identify individuals experiencing a mental health crisis or at risk for chronic mental health disorders and triaging them to the correct mental health services.

3.3.2 Coordination of care and Information Sharing

The safety and privacy of the individual impacted by the event must be ensured throughout the process, as well as the safety of the individual providing the screening. If safety is an immediate concern, call 911 or contact emergency services. There are three levels of Information sharing:

1. **In an emergency:** Providers **can share** patient information with anyone as necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public -- consistent with applicable law and the provider's standards of ethical conduct.[1]
2. Information sharing with disaster relief organization: When a health care provider is sharing information with disaster relief organizations that, like the American Red Cross, are authorized by law or by their charters to assist in disaster relief efforts, it is unnecessary to obtain a patient's permission to share the information if doing so would interfere with the organization's ability to respond to the emergency.
3. Continuity of care: Sharing patient information is also allowable between healthcare providers for connection with and continuity of treatment.
4. Other supports and services: A release of information must be completed to share patient **healthcare** information with non-covered entities. *Healthcare providers can still provide referrals and coordination for other needs not involving healthcare to non-covered entities such as social services without a release of information.*

3.3.3 Screening and Triage

PsySTART screening and triage:

A PsySTART screening (See Functional Annex C: PsySTART Screening Tool) will be conducted on all individuals who are impacted by an emergency or disaster. The PsySTART screening results inform referral to immediate crisis intervention, secondary assessment, enhanced psychological first aid, or promotion of community resilience. The PsySTART has three screening systems for the following populations:

- Adult Victim/ Survivors- available via paper screen
- Youth Victim/ Survivors- available via paper screen or digital app
- First Responders (healthcare/ EMS)- available via paper screen

Psystart will be conducted by trained first responders or volunteers who will provide referrals and information about community resources for individuals who are directly exposed to a disaster or emergency.

Individuals that screen red or purple on the Psystart screen:

[1] https://www.hhs.gov/hipaa/for-professionals/faq/960/can-health-care-information-be-shared-in-a-severe-disaster/index.html

Individuals who are screened to have acute behavioral health response to the emergency/ disaster based upon Psystart and/ or Psychological First Aid require secondary assessment, crisis intervention, casualty support, and advocacy. Must immediately be connected, by the volunteer conducting the screen, with a mental health crisis counselor for further assessment. The volunteer may connect the individual virtually to a mobile team, in person, or the individual may be brought to a family assistance center or other emergency facility. If specialized behavioral health services are unavailable, and the individual screens purple, they must be referred to emergency medical services aligning with normal procedure in responding to mental health crisis and may receive priority status for admission to an inpatient psychiatric facility.

Signs and symptoms:

- Signs and symptoms requiring immediate behavioral health intervention include the individual exhibiting the following: inability to care for himself or herself adequately because of severe emotional distress, severe confusion, disorientation, irrational thinking, inability to be calmed, or severe drug or alcohol intoxication.
- Individuals who are screened and report concerning reactions including unexpected reactions to stress or have family/friends who are concerned about behaviors should be referred to a behavioral health specialist as soon as possible.
- Other risk factors indicating need for urgent behavioral health response include a loss of the individual's family, friend, or pet, witnessing a death or injury, feeling as thought their life was threatened, separation from family or caregiver, or their community is destroyed. Finally, if the individual has no family or community support, has no financial resources, and lacks good coping skills should be referred to a disaster behavioral health as soon as possible.

Services and/or interventions needed: Secondary assessment, crisis intervention, casualty support, advocacy, *and possible inpatient hospitalization*

Resources needed: *Clinicians, MOST/mobile teams, mental health crisis counselor volunteers, hospital emergency room beds (if available), inpatient psychiatric hospital beds.*

Individuals that screen green or yellow on the PsyStart screen:
Will be connected to a volunteer for enhanced psychological first aid to identify additional signs and symptoms or will be provided a handout such as "Listen, Protect, and Connect" (link: https://www.fema.gov/media-library-data/1499092051917-115ad4c12a44f04a93b4a37c17e99211/PFA(1).pdf) with resources specific to the region. If a Psychological First Aid volunteer is not available, the individual will be provided with resources to follow up and a referral will be made to the county social service agency to contact the

individual within 72 hours of the incident to ensure connection with needed resources and behavioral health supports.

Signs and symptoms: Many Individuals may benefit from a behavioral health referral, but the need for referral may be less urgent. Concerning reactions, risk factors, or resilience indicated may include difficulty thinking/concentrating, anxiety nervousness, or has significant physical complaints.

Services and/or interventions needed: Enhanced Psychological First Aid (if available), resource lists and handout to identify additional signs and symptoms

Resources needed: *Peer Support Specialists/Community Health Workers, Psychological First Aid volunteers, crisis call lines*

In all cases, the NAMI Warmline will be available for follow up calls to check in on individuals assess to be at risk for continuing mental health issues the Warmline at 775-241-4212, and provide the person's name and phone number, purpose of the call, and the preferred time to call.

Enhanced Psychological First Aid

With Psystart solely focused on exposure, Psychological First Aid serves as a secondary screening to identify other potential risks and impacts as well as resilience factors. Psychological First Aid is designed to reduce the initial distress caused by a traumatic event and to foster short and long-term adaptive functioning and coping. This intervention fosters community resilience support and promotion of resilience and coping. (Please see Appendix _ for more information the behavioral health screenings and interventions). The Psychological First Aid Screenings will be determined based upon following criteria:

- Reactions to the stress of the event
- Risk factors
- Resilience factors -- or lack of resilience factors.

All three of these factors combined provide a holistic view of the person and his/her needs for psychological first aid and behavioral health referral, and will be utilized to determine the appropriate referral and level of response indicated below as described in the American Red Cross's Psychological First Aid triage model.

3.3.5 Referral Process

On- site referrals: Individuals may be referred to a clinician, MOST/mobile team, or mental health crisis counselor volunteer at a disaster response site.

Virtual referrals: Depending on the nature of the response, individuals may be referred to a clinician, MOST/mobile team, or mental health crisis counselor volunteer through telehealth or telecommunications.

Off- site referrals: Individuals in need of behavioral health services may be referred to a community provider not on-site for behavioral health services.

"Warm hand offs" and continuity of care are necessary for referrals that take place in the community. Actions involved could include calling the provider, ensuring they are able to accept the individual for services, and have availability to see the individual in a reasonable amount of time. Ideally appointments for follow up behavioral health services would be made within 7 days.

3.3.6 Current Services Available via the Public Behavioral Health System

Through the public behavioral health system, there are many public, for profit and nonprofit agencies that provide many behavioral services. To find providers throughout Nevada, please go to: https://behavioralhealthnv.org For a current list of regional and community behavioral health crisis services, see www.NVCIT.org/find-support-in-crisis.

3.4 RESOURCE MANAGEMENT

The RBHC or BHTF designee will utilize the assessment form (See Functional Annex B) to identify local and state assets currently available at the time of the emergency or disaster. Based on the assessment, a need for additional resources may be identified and the RBHC or BHTF designee will need to utilize the resource requesting procedures to formally request additional assets to support the behavioral health response.

3.4.1 ASSET MANAGEMENT

Local assets that may be requested as part of the behavioral health response include behavioral health professionals from the local behavioral health task forces such as clinicians, peer support specialists, community health workers, and psychological first aid trained staff. The RBHC of BHTF designee will work with the local BHTF in each jurisdiction affected to identify the number of each type of asset available to respond during the time of the incident and to potential future incidents. In addition to professional, assets such as crisis call centers that may be used as access points for disaster behavioral health services should be listed on the assessment form for activation.

3.4.2 VOLUNTEER MANAGEMENT

Local Resources
When the RBHC or BHTF designee is contacted he/ she will work with the local EM or designee to coordinate with Quad County Public Health Preparedness (PHP) to request volunteers from Western Region Medical Corps and coordinate with Nevada Division of Public and Behavioral Health's ESF 8.1 desk as needed The skill set being requested would encompass behavioral health support in the form of psychological first aid and other supportive assistance. If clinical support is requested, responders will be fully licensed, credentialed and trained in behavioral health disaster response. The volunteers requested will be managed according to existing local and state emergency response plans.

Local resource requests from Western Region Medical Corps
Requests for volunteers will first be placed with the Western Region Medical Corps to ensure that local resources are utilized first before requests are made at the state level through ServeNV. Western Region Medical Corp is a chapter of the Medical Reserve Corp located in the Quad County Region of Nevada.

SERV-NV
When the need for volunteers exceed local resources, the local EM or designee or Quad County PHP, in coordination with the RBHC or designee, will place a request to the state for volunteers in SERV- NV through the state ESF 8.1 desk. Serve NV is a registry in Nevada's that oversees Emergency System of Advance Registration for Volunteer Health Professionals (ESAR-VHP). The ESAR-VHP is part of a national network of state-based systems, which registers health professionals and verifies their identity and credentials of so that they can more readily volunteer for disasters, and medical and public health emergencies. All volunteers registered in SERVE- NV, have had their licenses, credentials, accreditations, and hospital privileges verified in advance of a public health and medical disaster or emergency.

There are three types of volunteers that may be requested from the Western Nevada Medical Reserve Corps:

1. **General volunteer:**
   General volunteers have not been trained in psychological first aid or other behavioral health trainings. These volunteers can assist in data entry and administrative coordination to assist with decision making.

2. **Psychological First Aid Volunteers:**
   Individuals that are not licensed by a state occupational licensing board (Title 54) play a core role in emergency response through providing screening, support, and connection with needed resources. Those that have received trainings including: PsySTART,

Psychological First Aid, Mental Health First Aid, Crisis Intervention Training etc. are able to screen and identify mental health needs and refer them to clinical behavioral health services as needed. ASSIST suicide prevention training can also strengthen behavioral health response in disasters. (please see appendix ___ for more information on these trainings). Examples of non-licensed behavioral health volunteers may be community members, peers, and members faith-based communities.

3. **Mental Health Crisis Counselor Volunteers**

The Mental Health Crisis Counselor Volunteers (MHCCV) is a group of mental health professionals (Psychologists, Clinical Professional Counselors, Marriage and Family Therapists, Licensed Clinical Social Workers, and Alcohol, Drug and Gambling Counselors) who receive special training as Crisis Counselors in Psychological First Aid. These volunteers can register for regional and state response through SERVE- NV if they take the FEMA ICS 100 and 700 trainings, in order to respond to disaster and emergency situations around the state and provide support and services to survivors, family members, and first responders.

SECTION 4: RECOVERY

Immediately following a disaster/emergency, response operations for saving lives, protecting property, and meeting basic human needs have precedence over longer-term objectives of recovery. However, initial recovery planning, including behavioral health, should commence at once and in tandem with response operations. Recovery components are embedded in every aspect of response and continue after the response activities cease.

4.1 RECOVERY PRIORITIES

Recovery operations are the actions taken to restore vital services, help residents resume self-sufficiency, and help communities return to pre-event or “new normal” conditions. Short-term recovery involves the restoration of critical services such as communications, water supply, sewage service, emergency medical capabilities, and electricity, as well as garbage and debris removal. These functions must occur early in the emergency response to support the life, health, and safety of the population and to support other emergency operations. The EM, designee or other authorized officials may begin to stand down certain aspects of an Incident Command Structure. In many cases, however, the need for response activities around behavioral health may continue or increase as individuals begin to experience the emotional aftermath of an event. The RBHC, designee, and/or response teams will work with the EM to continue to advise of the continued behavioral health need and actions.

4.1.1 DEBRIEFING

Depending on the nature; size; scope; and duration of the emergency/disaster, behavioral health response teams (**as identified/developed by BHTFs**) will provide one-on-one and group debriefings. In this regard, the programs may:

- 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.
- Monitoring will occur and the use of buddy systems/peers will be encouraged by providers.
- BHTFs may also do post-disaster follow-up with victims of the emergency or disaster to ensure they are receiving long-term behavioral health supports. Follow-up may be approximately, 30 days, 90 days, 6 months, and 1 year following the event.

4.1.2 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.

4.1.3 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.

4.1.2 Ongoing community support

A core assumption of behavioral health emergency response is that behavioral health effects may occur long after the event. In the recovery phase, the resiliency center, coordinated by the Quad County Multi-Agency Coordinating Counsel, will identify individuals who are experiencing post-traumatic stress or other behavioral health issues and refer them to identified community providers.

For incidents that do not have a resiliency center, local human service and community support agencies will provide referral coordination to behavioral health services to support the individual during crisis or when in need.

SECTION 5: MITIGATION AND PREVENTION

All those individuals that participate in the emergency behavioral health response activities should participate in preparedness and mitigation activities. These would include state and local sponsored trainings and exercises (See Functional Annex E and H) with a goal to ensure readiness and education on best practices in emergency behavioral health response as well as ensure maximum coordination with other Emergency Response Functional areas. Participants should also ensure a familiarity with local EOPs and their role in the response protocols.

Training is essential in preparing to deploy triage and psychological first aid during an emergency/disaster. As such, community partners, identified and assisted through the BHTFs, 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.

BEHAVIORAL HEALTH FUNCTIONAL ANNEXES

FUNCTIONAL ANNEX A: Contact Lists

State contacts

Position	Name	Contact

DHHS Senior Advisor on Behavioral Health		
Division of Public and Behavioral Health Deputy Administrator contact		
Duty officer		

Regional contact:

Position	Name	Contact
Regional Behavioral Health Coordinator	Jessica Flood	775-203-1287

Local contact:

Carson City

Position	Name	Agency	Contact
BHTF Lead (may be designee for RBHC)			
Social Services Branch Director			
BHTF			

Churchill County

Position	Name	Agency	Contact
BHTF Lead (may be designee for RBHC)			
Social Services Branch Director			
BHTF			

Douglas County

Position	Name	Agency	Contact
BHTF Lead (may be designee for RBHC)			
Social Services Branch Director			
BHTF			

Lyon County

Position	Name	Agency	Contact
BHTF Lead (may be designee for RBHC)			
Social Services Branch Director			
BHTF			

Storey County

Position	Name	Agency	Contact
BHTF Lead (may be designee for RBHC)			
Social Services Branch Director			
BHTF			

FUNCTIONAL ANNEX B: Behavioral Health Needs Assessment

1) Identify the specific threats and hazards:

a. Has an emergency been declared? □ yes □ no

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

Estimate of people at risk of needing behavioral health services:

- □ Level 1 (10 survivor/ fatalities with approximately 30 family members)
- □ Level 2 (10-25 survivor/ fatalities with approximately 75 family members)
- □ Level 3 (26-50 survivor/ fatalities with approximately 200 family members)
- □ Level 4 (50 + survivor/ fatalities with approximately 200 family members)

Populations at risk of developing behavioral health conditions after an emergency or disaster:

- □ 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.

3) Identify the behavioral health resources needed to address each threat and hazard

- □ Level 1: 2 PSA volunteers, 1 clinician, 1 volunteer contacting/ coordinating resources
- □ Level 2: 5 PSA volunteers, 2 clinicians, 1 volunteer contacting/coordinating resources
- □ Level 3: 10 PSA volunteers, 4 clinicians, 1 volunteer contacting/ coordinating resources
- □ Level 4: 20 PSA volunteers, 6 clinicians, 1 volunteer contacting/ coordinating resources

4) Assess the behavioral health resources available in the county by type registered in Serv- NV and in BHTF list.

Serve- NV
_____ Psychological First Aid volunteer
_____ Psychological First Aid volunteer
_____ Mental health crisis counselor volunteer

Local BHTF list:
_____ Psychological First Aid trained staff
_____ Community Health Worker/ Peer Support Specialist
_____ Mental health crisis counselor volunteer
_____ Clinician
_____ Case manager
_____ CIT trained officers
_____ MOST team

5) Has an access point (site) to behavioral health services been established? __ Yes/__ No. If so, what type?

- ☐ Family Assistance Center
- ☐ Call Center
- ☐ Shelter
- ☐ Other: _____

6) Based on the Assessment above, list the resources that still need to be requested by type:

Volunteer Resources		**Access Point (Site) Resources**		**Other Resources**	
Type	**# Needed**	**Type**	**# Needed**	**Type**	**# Needed**
General		Call Center		Phones	
Psychological First Aid		Family Assistance Center		Computers	
Mental Health Crisis Counselors		Shelter		Translators	
Other (Please Specify: _____		Other (Please Specify: _____		Other (Please Specify: _____	

FUNCTIONAL ANNEX C: Behavioral Health Triage Screens for Community Providers and First Responders

PsySTART for Victims/Survivors

PsySTART Victim/survivor system provides:

- Real time situational awareness of a tiered system of mental health risk using a rapid triage tool completed in a few seconds by psychological first aid trained volunteers.
- Provides geo coded information that is end user scalable at the individual site level (i.e. hospital, shelter, clinic, mobile team), county, region or statewide, depending on informational requirements
- Realtime “decision support” at the individual/clinical and population level
- First known data(surveillance) driven disaster mental health Incident Action Plan leveraging real time PsySTARTTM evidence base metrics.
    - Conforms to “crisis standards of care” by informing allocation of scarce mental health resources to those at greatest risk by ethical, evidence-based risk protocol
    - Includes “floating triage algorithm which matches risk to available resources based on actual resources available.
- Provides a common operating picture of population level risk levels specific to EVD or other PH emergencies

o Those isolated
o Quarantine including family members, co-workers etc.
o Worried well” including neighbors, co workers, other family members o Those experiencing loss of loved ones from EVD or other PH

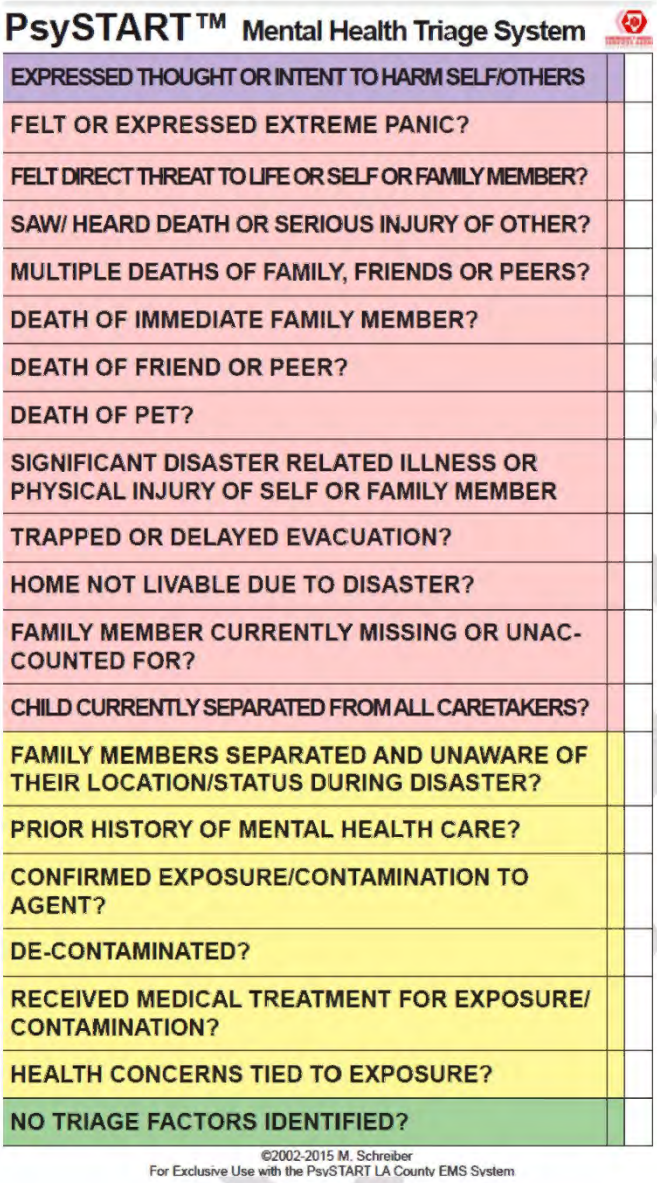
emergencies
Used to support requests for Federal Stafford Act Mental Health Support by providing numbers at risk, sources of risk and locations including separate information for children.

- Provides a decision support tool for mental health workers who follow up on those at higher risk who need secondary assistance and provides

  o “Solution focused crisis intervention” using the triage information to guide practical crisis intervention, assign individuals based on need (for example those experiencing loss of loved one could be matched with chaplaincy support or those trained in grief)

- Provides first known metric to identify “worried well” trends which can then inform targeted risk communication or other crisis management strategies specific to areas and populations expressing concerns in health care settings

Example of Triage



PsySTART™ Mental Health Triage System	
EXPRESSED THOUGHT OR INTENT TO HARM SELF/OTHERS	
FELT OR EXPRESSED EXTREME PANIC?	
FELT DIRECT THREAT TO LIFE OR SELF OR FAMILY MEMBER?	
SAW/ HEARD DEATH OR SERIOUS INJURY OF OTHER?	
MULTIPLE DEATHS OF FAMILY, FRIENDS OR PEERS?	
DEATH OF IMMEDIATE FAMILY MEMBER?	
DEATH OF FRIEND OR PEER?	
DEATH OF PET?	
SIGNIFICANT DISASTER RELATED ILLNESS OR PHYSICAL INJURY OF SELF OR FAMILY MEMBER	
TRAPPED OR DELAYED EVACUATION?	
HOME NOT LIVABLE DUE TO DISASTER?	
FAMILY MEMBER CURRENTLY MISSING OR UNACCOUNTED FOR?	
CHILD CURRENTLY SEPARATED FROM ALL CARETAKERS?	
FAMILY MEMBERS SEPARATED AND UNAWARE OF THEIR LOCATION/STATUS DURING DISASTER?	
PRIOR HISTORY OF MENTAL HEALTH CARE?	
CONFIRMED EXPOSURE/CONTAMINATION TO AGENT?	
DE-CONTAMINATED?	
RECEIVED MEDICAL TREATMENT FOR EXPOSURE/ CONTAMINATION?	
HEALTH CONCERNS TIED TO EXPOSURE?	
NO TRIAGE FACTORS IDENTIFIED?	

PsySTART for First Responders

PsySTART Responder Self Triage System Public Health Emergencies

Provider a focus on health care worker resilience across pre-incident, response and recovery phases in public health emergencies.

- Evidence based, non-stigmatizing PsySTART *self triage* system that builds on responder resilience and gives the responder information on their own acute or cumulative risk and provides those charged with responder safety and health real time situational awareness on levels of risk and resilience.
- Uses the the Anticipate. Plan. Deter Responder Resilience System that is pre-event stress inoculation, personal resilience plan building, creating team member to team member social support and training in the PsySTART responder system as a comprehensive package of pre-event, response and recovery stress management for emergency health care workers. PsySTART responder and Anticipate Plan Deter can be used on emerging infectious disease threats, EVD and other public health emergencies as an all hazards responder mental health and safety approach.
- PsySTART responder is a component of APD responder resilience and will be provided as a training to all participating agencies employing first responders including Emergency Management Services/ Fire and hospitals, and will cover the following components.

• ***Anticipate*:**

- Pre-incident “stress inoculation”
- Stressors that may be encountered
- Situations you might encounter – Crisis care
- Stigma
- Impact of stress on responders

• ***Plan:***

- Develop personal “resilience plans”
- Build on strengths available now
- Enhance social support

Deter:

- Activate individual/team resilience plans
- PsySTART Responder Self Triage System Real-time Situational Awareness
- Linkage to local resources for responder critical events

PsySTART™ Responder System

WITNESSED SEVERE BURN, DISEMBERMENT, OR MUTILATION?	
EXPOSURE TO PATIENTS SCREAMING IN PAIN/FEAR?	
WITNESSED PEDIATRIC DEATH(S) OR SEVERE INJURIES?	
DID YOU WITNESS AN UNUSUALLY HIGH NUMBER OF DEATHS?	
FORCED TO ABANDON PATIENT(S)?	
UNABLE TO MEET PATIENT NEEDS?	
RESPONSIBLE FOR EXPECTANT TRIAGE DECISIONS?	
DIRECT CONTACT WITH GRIEVING FAMILY MEMBERS?	
ASKED TO PERFORM DUTIES OUTSIDE OF CURRENT SKILLS?	
DID YOU EXPERIENCE HAZARDOUS WORKING CONDITIONS (such as extreme shift length, compromised site safety/security, or other issues)?	
INJURY, DEATH, OR SERIOUS ILLNESS OF COWORKERS?	
UNABLE TO RETURN HOME?	
WORRIED ABOUT THE SAFETY OF YOUR FAMILY MEMBERS/ SIGNIFICANT OTHERS/PETS?	
UNABLE TO COMMUNICATE WITH FAMILY MEMBERS/SIGNIFICANT OTHERS?	
HEALTH CONCERNS FOR SELF DUE TO AGENT/TOXIC EXPOSURE (Infectious Disease, Chemical, Radiological, Nuclear, etc.)?	
AT WORK, WERE YOU INJURED OR BECAME ILL AND TREATED?	
DIRECTLY IMPACTED BY INCIDENT AT WORK OR AT HOME? If yes, advise your employee health and well-being unit leader.	
FELT AS IF YOUR LIFE WAS IN DANGER?	
I AM NOT RECEIVING SUFFICIENT SUPPORT FORM OTHERS	
NO TRIAGE FACTORS IDENTIFIED?	

FUNCTIONAL ANNEX D: Job Action Sheets

Regional Behavioral Health Coordinator
Job Action Sheet

Position Assigned to:

_____

You Report to:

_____

Site:

_____

Job Shift(s):

_____

You Supervise:

_____

Suggested Training: Familiar with EOC Operations, IS-100, IS-200, NIMS 700 or equivalent, IS-300 and IS-400.

Mission: The Regional Behavioral Health Coordinator position may be activated to coordinate the Behavioral Health Emergency Operations Plan in the Northern Region.

Initial Actions:

- ☐ Sign in on Staff Roster.
- ☐ Obtain badge and vest.
- ☐ Receive briefing from Operations Section Chief.
- ☐ Read this entire Job Action Sheet and clarify authority regarding position assignment.

Specific Job Actions:

- ☐ Activate Social Services Branch Director
- ☐ Initiate and coordinate Psystart assessments and behavioral health response for emergency or disaster in coordination social services branch director
- ☐ Determine resources needed to support Behavioral Health Emergency Operations Plan, including staff, space, supplies, equipment, and system requirements.
- ☐ Contribute to the Incident Action Plan (IAP) by establishing operational priorities and objectives for Core and Secondary service delivery.

- ☐ Provide copies of the IAP to Group Supervisors.
- ☐ Document actions and decisions in Activity Log.
- ☐ Inform Operations Section Chief of response resource requirements.
- ☐ Provide regular briefs to the Operations Section Chief.

Demobilization Duties:

- ☐ Ensure that all forms or reports are completed and turned in to the Operations Section Chief.
- ☐ Work with Operations Section Chief to transition Branch activities to ongoing resiliency operations.
- ☐ Contribute to the consolidated Operations Section After-Action Report.
- ☐ Deactivate the Social Services Branch and close out logs.

Participate in hot wash.

Social Services Branch Director
Job Action Sheet

Position Assigned to:

You Report to:

Site:

Job Shift(s):

You Supervise:

Suggested Training: Familiar with EOC Operations, IS-100, IS-200, NIMS 700 or equivalent, IS-300 and IS-400.

Mission: The Social Services Branch Director position may be activated to support the Operations Section during large or complex incidents to address span of control issues. This position oversees five Groups: 1) Behavioral Health, 2) Call Center, 3) Day Care, 4) Referrals, and 5) Spiritual Support.

Initial Actions:

- ☐ Sign in on Staff Roster.
- ☐ Obtain badge and vest.
- ☐ Receive briefing from Operations Section Chief.
- ☐ Read this entire Job Action Sheet and clarify authority regarding position assignment.

Specific Job Actions:

- ☐ Contribute to the Incident Action Plan (IAP) by establishing operational priorities and objectives for Core and Secondary service delivery.
- ☐ Provide copies of the IAP to Group Supervisors.
- ☐ Document actions and decisions in Social Services Branch Activity Log.
- ☐ Determine resources needed to support Social Services Branch, including staff, space, supplies, equipment, and system requirements.
- ☐ Inform Operations Section Chief of response resource requirements.
- ☐ Provide regular briefs to the Operations Section Chief.

Demobilization Duties:

- ☐ Ensure that all forms or reports are completed and turned in to the Operations Section Chief.
- ☐ Work with Operations Section Chief to transition Branch activities to ongoing resiliency operations.
- ☐ Contribute to the consolidated Operations Section After-Action Report.
- ☐ Deactivate the Social Services Branch and close out logs.
- ☐ Participate in hot wash.

Behavioral Health Group Supervisor
Job Action Sheet

Position Assigned to:

You Report to:

Site:

Job Shift(s):

You Supervise:

Suggested Training: Familiar with EOC Operations, IS-100, IS-200, NIMS 700 or equivalent, IS-300 and IS-400, behavioral health license(s); Crisis Emergency Mental Health training.

Mission: The Behavioral Health Group Supervisor oversees and coordinates behavioral health services and psychological first aid. This position supervises Behavioral Health Providers and Psychological First Aid Practitioners.

Initial Actions:

- ☐ Sign in on Staff Roster.
- ☐ Obtain badge and vest.
- ☐ Receive briefing from Social Services Branch Director or Operations Section Chief.
- ☐ Read this entire Job Action Sheet and clarify authority regarding position assignment.

Specific Job Actions:

- ☐ Determine resources needed to support Group activities, including staff, space, supplies, equipment, and system requirements and make requests to Social Services Branch Director or Operations Section Chief.
- ☐ Coordinate triage for behavioral health services with Mental Health Crisis Counselor Volunteer.
- ☐ Schedule Psychological First Aid and Behavioral Health appointments
- ☐ Maintain Health Insurance Portability and Accountability Act (HIPAA) compliance as required.
- ☐ Document actions and decisions in Behavioral Health Group Log.
- ☐ Provide regular briefs to the Social Services Branch Director or Operations Section Chief.

Demobilization Duties:

- ☐ Ensure that all required forms or reports are completed and turned in to the FAC Manager.
- ☐ Determine any follow-up to your assignment that might be required and communicate the information to the FAC Manager.
- ☐ Contribute to the consolidated Operations Section After-Action Report.
- ☐ Deactivate the Operations Section Chief Position and close out logs when authorized by the FAC Manager.
- ☐ Participate in hot wash.

Mental Health Crisis Counselor Volunteer

Job Action Sheet

Position Assigned to:

You Report to:

Site:

Job Shift(s):

You Supervise:

Suggested Training: Familiar with EOC Operations, IS-100, IS-200, NIMS 700 or equivalent, IS-300 and IS-400, behavioral health license(s).

Mission: The Behavioral Health Providers deliver care to patients within their licensed scope of practice.

Initial Actions:

- ☐ Sign in on Staff Roster.
- ☐ Obtain badge and vest.
- ☐ Receive briefing from Behavioral Health Group Supervisor.
- ☐ Read this entire Job Action Sheet and clarify authority regarding position assignment.

Specific Job Actions:

- ☐ Conduct behavioral health triage for family members.
- ☐ Deliver behavioral health services according to licensed scope of practice.
- ☐ Coordinate with Death Notifications and Missing Persons Group.
- ☐ Maintain Health Insurance Portability and Accountability Act (HIPAA) compliance as required.
- ☐ Document actions and decisions in Behavioral Health Group Log.
- ☐ Provide regular briefs to the Group Supervisor

Demobilization Duties:

- ☐ Ensure that all required forms or reports are completed and turned in to the Group Supervisor.

- ☐ Contribute to the consolidated Operations Section After-Action Report.
- ☐ Close out logs and patient records when directed to suspend operations.
- ☐ Make behavioral health referrals for transition to resiliency operations.
- ☐ Participate in hot wash.

Psychological First Aid Volunteer
Job Action Sheet

Position Assigned to:

You Report to:

Site:

Job Shift(s):

You Supervise:

Suggested Training: Familiar with EOC Operations, IS-100, IS-200, NIMS 700 or equivalent, IS-300 and IS-400 recommended, Crisis Emergency Mental Health training.

Mission: Psychological First Aid Practitioners provide crisis counseling and support to family members, but are not considered licensed behavioral health providers without valid licensure.

Initial Actions:

- ☐ Sign in on Staff Roster.
- ☐ Obtain badge and vest.
- ☐ Receive briefing from Behavioral Health Group Supervisor.
- ☐ Read this entire Job Action Sheet and clarify authority regarding position assignment.

Specific Job Actions:

- ☐ Conduct Psychological First Aid according to training.
- ☐ Refer family members to Behavioral Health Provider(s) if required.
- ☐ Coordinate with Death Notifications and Missing Persons Group.
- ☐ Maintain Health Insurance Portability and Accountability Act (HIPAA) compliance as required.
- ☐ Document actions and decisions in Behavioral Health Group Log.
- ☐ Provide regular briefs to the Group Supervisor

Demobilization Duties:

- ☐ Ensure that all required forms or reports are completed and turned in to the Group Supervisor.

- ☐ Contribute to the consolidated Operations Section After-Action Report.
- ☐ Close out logs and patient records when directed to suspend operations.
- ☐ Make referrals for services and programs in support of ongoing resiliency activities.
- ☐ Participate in hot wash.

Acronyms and Definitions

ALS	Advanced Life Support
ARC	American Red Cross
BCC	Board of County Commissioners
BEHAVIORAL HEALTH	Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. This includes a range of problems from unhealthy stress to diagnosable and treatable diseases like serious mental illnesses and substance use disorders, which are often chronic in nature but that people can and do recover from. The term is also used to describe the service systems encompassing the promotion of emotional health, the prevention of mental and substance use disorders, substance use, and related problems, treatments and services for mental and substance use disorders, and recovery support. (Substance Abuse and Mental Health Services Administration, 2011a, p. 1, footnote i)
BHTF	Behavioral Health Task Force Policy level multidisciplinary teams (including law enforcement, emergency services, social services, hospitals, treatment provides, peer and advocacy organizations and others) focused on identifying behavioral health gaps and needs and developing solutions to improve the behavioral health system.
BHERP	Behavioral Health Emergency Response Plan
CATASTROPHIC EVENT	
CERT	Community Emergency Response Team
Co-Occurring	Refers to co-occurring mental disorder and substance use disorder.
CAT	Community Assessment Team
CIT	Crisis Intervention Training 40 hour behavioral health and de-escalation training for law enforcement, first responders, and other community providers
COOP	Continuity of Operations
DISASTER	An occurrence of a natural catastrophe, technological accident, or human-caused event that has resulted in severe property damage, deaths, and/or multiple injuries. (Federal Emergency Management Agency [FEMA], 2010a, p. B-3)
EMERGENCY	Any incident, whether natural or human-caused, that requires responsive action to protect life or property
EOC	Emergency Operations Center
ESF	Emergency Support Functions
EM	Emergency Manager
EMS	Emergency Medical Services

Evacuation	
FEMA	Federal Emergency Management Agency
FASTT	Forensic Assessment Services Triage Team Multidisciplinary teams composed of community providers including social services, mental health, and substance use treatment, which provide in-reach into county jails to assist inmates in connecting to needed resources and treatment.
HAZMAT	Hazardous Materials
IC	Incident Commander
ICS	Incident Command System
JIC	Joint Information Center
LARGE SCALE EMERGENCY	
LOCAL (SMALL SCALE) EMERGENCY	
MAJOR DISASTER	
MITIGATION	Those capabilities necessary to reduce loss of life and property by lessening the impact of disasters.
MOST	Mobile Outreach Safety Team Law enforcement and mental health co-responder teams which provide community outreach, assessment, and resource connection for individuals experiencing behavioral health crisis.
NIMS	National Incident Management System
NRP	National Response Plan
NRS	Nevada Revised Statute
PIO	Public Information Officer
RBHC	Regional Behavioral Health Coordinator
REOC	Regional Emergency Operations Center
REMSA	Regional Emergency Medical Services Authority
SIP	Shelter in Place
UC	Unified Command
WCHSA	Washoe County Human Services Agency
WCHD	Washoe County Health District
WCSD	Washoe County School District
WCREOP	Washoe County Regional Emergency Operations Plan

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Behavioral Health Impact on Responders and Medical Providers

Behavioral health strategies should consider the unique impacts and behavioral health consequences of catastrophic public health emergencies on responders and healthcare providers. Responders and healthcare providers may be especially prone to post traumatic stress and other psychosocial impacts. Strategies for addressing the behavioral health needs of these groups should consider the identification, monitoring, and intervention systems tailored toward stress reduction, stress management, and mitigation of posttraumatic stress disorder. Peer-to-peer support, counseling, and other behavioral health support services, such as CISM, may be useful for responders and providers.

Tool (FMHT), and the Alsept-Price Mental Health Scale (APMHS). Mental health triage systems are

Psychological First Aid is based on the understanding that individuals affected by traumatic events will experience a wide range of initial reactions that may cause enough distress to interfere with coping. Psychological First Aid is designed to be used in the immediate aftermath of a traumatic event. Psychological First Aid's basic objective are to establish connection in a compassionate and non-intrusive manner, enhance immediate and ongoing safety and provide physical and emotional comfort' calm and orient emotionally overwhelmed and distraught survivors, identify the survivors immediate needs and concerns, offer practical assistance to help survivors address immediate needs, connect

survivors to social support networks and family, support adaptive coping, provide information, be clear about availability and link survivor to another team or recovery support system.

Annex of Crisis Resource Guide