



ESF 8 – FUNCTIONAL ANNEX

King County Disaster Behavioral Health Plan

Version 2.1 2016

Record of Changes

Version No.	Description of Change	Date Entered	Posted By
2	Further operationalization of most plan components.		A. Kelmore, Response Planning Manager
2.1	Quick revision to change references from RSN to BHO	September 29, 2016	A. Kelmore, Response Planning Manager

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I. Introduction

When discussing disaster response, people often focus on physical injuries and any damage to property and infrastructure. However, behavioral health issues (which include mental health needs and substance abuse) may actually be the main area of concern in a population following any major disaster. While the major physical injuries and ailments will likely be identified and addressed soon after an incident, people will continue to arrive at medical settings with unexplained symptoms for months or even years. The majority of people will respond to a major disaster with resiliency, but most will also experience shorter term emotional reactions such as anxiety; sadness; difficulty with memory, decision-making and focus; irritability; anger; and difficulty with sleep and eating. Self-medication with alcohol or drugs will increase, as will family conflict and aggression. This will occur widely in the general population and must be addressed, along with the needs of the chronic severely mentally ill, those actively abusing substances, and those with ongoing addiction issues.

Disaster behavioral health is not a new field. It has been studied in some form, and with a different name, for centuries. However, in recent years, with more evidence about the specific effect of disasters on the physical and behavioral health of those involved, communities have recognized the need to have a plan addressing the behavioral health needs of residents.

Attachment:

Intro 01 Glossary and Acronyms

II. Purpose

The King County Disaster Behavioral Health Plan (“the plan”) outlines a concept of operation to achieve an evidence-informed approach toward an effective disaster behavioral health response and recovery for King County. It will be used to coordinate and implement disaster behavioral health response within the community, and was prepared by Behavioral Health and Recovery Division (BHRD) of the Department of Community and Human Services (DCHS) with support from Public Health Preparedness as a part of the King County ESF 8 plan. This plan is meant to address the needs of current behavioral health services clients as well as those who may require disaster behavioral health services.

III. Scope

The plan seeks to:

- Support continuity of service for existing patients with chronic behavioral health conditions.
- Deploy triage and psychological first aid services to identify and mitigate the development of diagnosed behavioral health conditions
- 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

This is an all-hazards plan, and can be activated in response to any incident that is expected to affect people with existing behavioral health conditions, as well as incidents that are expected to result in a significant increase in stress and newly diagnosed behavioral health concerns.

A successful disaster behavioral health plan will address:

- Provision of disaster behavioral health services to the community
- Monitoring psychological and medical status of those involved or affected by an incident
- Ensuring that comprehensive stress management strategies and programs are in place and available to all emergency responders, support personnel, and healthcare workers
- Maintaining situational awareness of behavioral health needs
- Coordination with State, Tribal, and local medical, behavioral health, substance abuse, and public health officials to determine current assistance requirements
- Options for geographically dispersed teams to provide assistance to local communities if transportation options may be reduced (e.g. after a large earthquake)
- Provision of disaster behavioral health services to affected persons
- Provision of incident site counseling support services
- Mobilization of behavioral health specialists for pediatrics
- Creation of teams with specialized experience to address needs of different cultures and populations, with a special focus on including known and trusted community members
- Provision of crisis counseling and behavioral health services for first responders and other emergency workers

This plan is likely to be activated in conjunction with other plans, such as the Mass Fatality and Family Assistance Operations plan, Regional Shelter Operations Annex or the Medical Countermeasures Dispensing plan.

IV. Situation Overview

Current Services Available via the Public Behavioral Health System

Through the public mental health system, agencies contracted with King County provide many services. There are 317 residential mental health treatment beds available within the county, with 97 percent full on average. In a given year, 42,000 patients receive outpatient mental health treatment. 3,500-4,000 clients seek assistance with opioid dependence on an annual basis. In terms of alcohol and other chemical dependencies, 8,000 receive outpatient treatment annually. However, according to SAMHSA, about 20 percent of U.S. adults experience mental illness each year.¹

King County Demographics and Diversity

King County Washington is the 14th most populous county in the US, with two million people. King County represents 28.6 percent of Washington State's population, and as the largest population center in the State poses many opportunities and challenges.

¹ More information can be found on King County's website: <http://www.kingcounty.gov/depts/health/data.aspx>

The County includes Seattle, 38 other incorporated cities, and 19 school districts. It is home to one of most diverse zip codes² and the most diverse school district in the nation.³ Immigrants and refugees from all over the world, including Asia, the Horn of Africa, Central America and the former Soviet Union, reside in King County. 2010 Census data show more than 1 in 3 residents is a person of color, increasing to almost half among children. The county, especially the southern suburbs, includes several cities and school districts in which racial minorities are now the majority population. One out of every five residents (over 420,000 adults and children) now lives below 200% of the federal poverty level⁴.

Twenty-three percent of residents speak a language other than English, and 19% are foreign-born. Public Health has identified three language tiers⁵ to reflect the language needs of Limited-English Proficient populations. This information will be consulted when the plan is activated to get a better sense of interpretation services needed. When deciding on interpreter services and translations by location and populations involved in the incident, staff will refer to the King County language maps in the Public Health Translation Manual⁶.

V. Planning Assumptions and Priorities

- Public Health and DCHS will make every reasonable effort to make services available and accessible to people throughout the county.
- The existing infrastructure is not sufficient to provide support to all who need assistance for behavioral health conditions; an emergency or disaster will only make this situation worse, both immediately after the incident and for the long term.
- Continuity plans are in place to allow outpatient providers to continue to serve their existing populations.
- People who already take medications for mental or behavioral health conditions will need uninterrupted access.
- Public Health will rely on evidence-based tools for disaster behavioral health triage and psychological first aid.
- When available and needed, PsySTART will be the primary triage method used to determine the need throughout the county.
- As resources will be limited, priority for treatment will be given to those who are the highest risk of harm.
- Psychological First Aid (PFA) will be necessary but will not be sufficient treatment for all people affected by the incident. While Psychological First Aid will be helpful in the first few days, a subset of the population will need more robust interventions as time continues.
- In addition to PFA, it will be helpful to train individuals in other interventions, such as mindfulness/relaxation, cognitive behavioral therapies and trauma focused interventions for those who, as a result of the incident, have newly diagnosed behavioral health disorders.

² <http://www.seattletimes.com/opinion/seattles-rainier-valley-one-of-americas-dynamic-neighborhoods/>

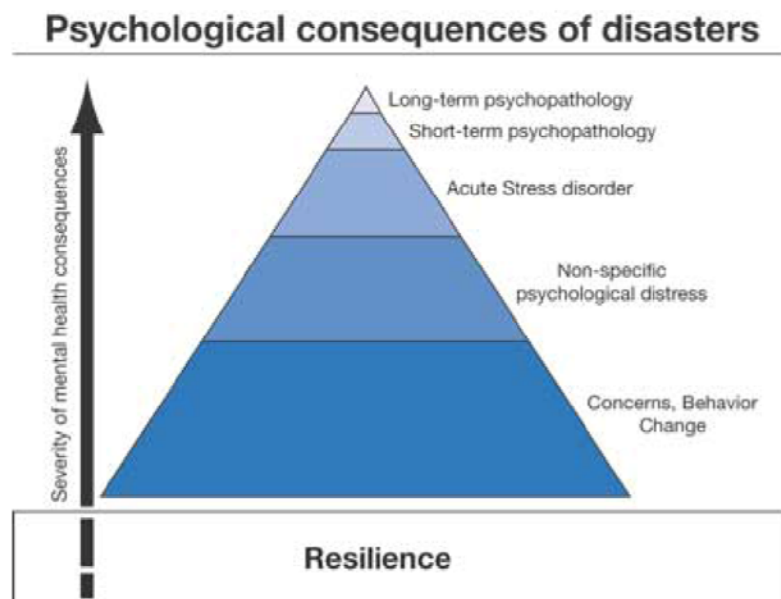
³ Remade in America. Diversity in the Classroom. *The New York Times*. <http://projects.nytimes.com/immigration/enrollment>

⁴ http://www.kingcounty.gov/depts/executive/performance-strategy-budget/regional-planning/benchmark-program/Economy/EC03_Poverty.aspx

⁵ http://www.kingcounty.gov/~media/operations/policies/documents/inf142a0_appxc_languagetiers_intro.ashx

⁶ <http://kingcounty.gov/healthservices/health/languages/~media/health/publichealth/documents/translation/PHTTranslationManual.ashx> Available in Spanish, Vietnamese, Russian, Chinese, Korean and African languages

- 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.
- 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 as part of their preparation to volunteer.
- 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.
- 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.
- Behavioral health workers should have a certain level of cultural competency in order to provide quality care, especially given the fact that many populations in King County have experienced significant trauma in their past.
- Any disaster behavioral health services provided at the incident scene will be closely coordinated with law enforcement and fire services.
- Because of exposure to media coverage of the incident, those not directly affected by the incident may require 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.
- Small incidents may be managed with existing resources; larger incidents will require the activation of the Disaster Behavioral Health plan.



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⁷ Dr. Merritt Schreiber

VI. Decision-Making

A. Criteria

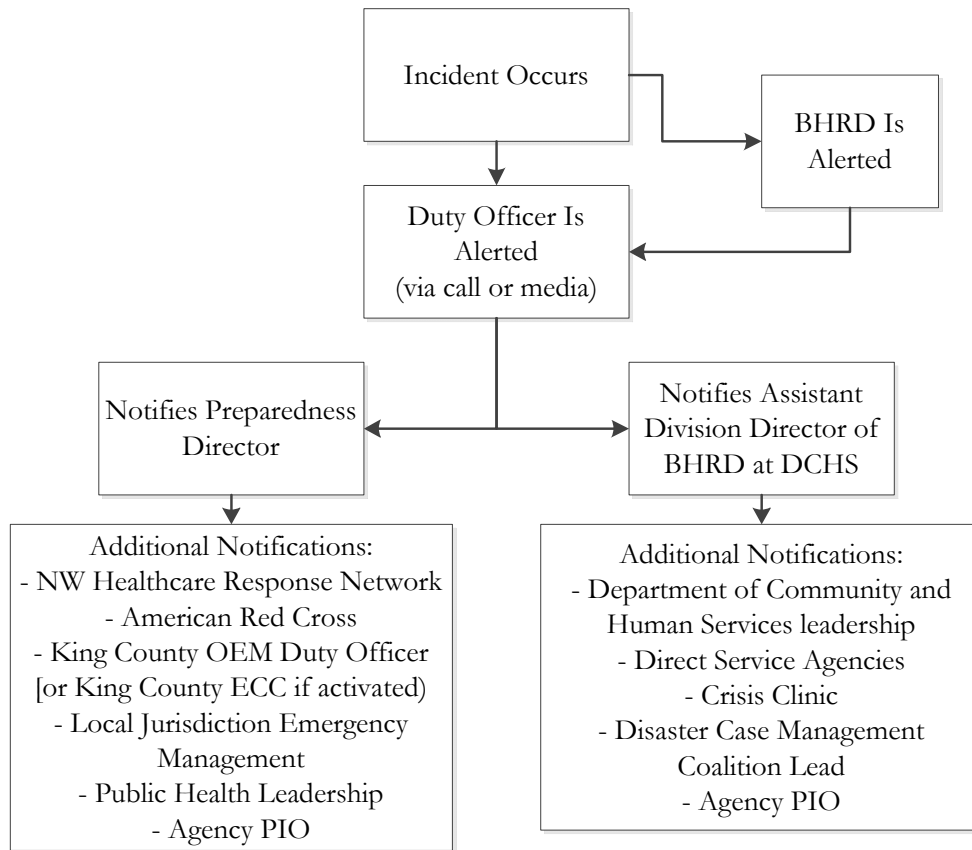
The need to activate some or all components of this plan will be dictated by the specifics of the incident. A few coordinating activities during small, isolated incidents such as an apartment fire may be sufficient and prevent the need to activate the plan officially, although the plan will still provide guidance. 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 King County, or before anniversaries of traumatic events.

B. Notification – Primarily Disaster Behavioral Health Response

While most disaster behavioral health response will be in conjunction with the activation of additional emergency response plans in response to a larger incident, in some cases the only Public Health role will be in activating this plan. When such an incident occurs, the first parties to learn of the incident have the responsibility to notify the Public Health Duty Officer (Duty Officer). When notified, the Duty Officer should be prepared to ask questions to gain situational awareness. The Duty Officer should request information on the estimated number of people involved, as well as any demographic information that could aid in response (such as whether those affected may speak a language other than English, or are existing clients of the behavioral health system).

The Duty Officer will then notify the Preparedness Director and Assistant Division Director for BHRD. The Preparedness Director (or the Duty Officer, at the Director's request) will notify department leadership, the Northwest Healthcare Response Network and other interested partners as needed. The Assistant Division Director will notify the Department of Community and Human Services leadership, direct service agencies they contract with, and Crisis Clinic.

It is important to note that it is likely that the need for disaster behavioral health assistance will come in conjunction with a broader response, so the Duty Officer may not recognize that the incident could have a disaster behavioral health component and may need to request further information and follow-up.



Attachments:
Notification 01 Notification Tree

C. Activation

After notification, the Preparedness Director and the Assistant Division Director, in consultation with other relevant parties, will determine the need to activate components of this plan. If consensus cannot be reached, the default action will be to follow the recommendation of the subject matter expert, in this case the Assistant Division Director. Public Health will take a conservative approach and err on the side of activating the plan and then pulling back should conditions change. Other jurisdictions may request activation of the plan; such requests will be considered in consultation with the Preparedness Director and Assistant Division Director.

Incident Type	Definition	Examples
Level 3: Contained, with limited community impact (plan may or may not be activated)	An incident that has a specific geographic location that is not expected to expand deeper into the community.	Apartment fire
Level 2: Contained, with wide community impact (plan activated)	An incident that has a specific geographic location but is expected to expand into and affect the community	School shooting, one-site terrorist attack

Incident Type	Definition	Examples
Level 1: Not contained, with wide community impact (plan activated)	An incident that has multiple locations and affects the community	Earthquake, terrorist attack with multiple sites. Prolonged severe weather may also be considered.

Service or Plan Component	Level 3	Level 2	Level 1
Incident Assessment	X	X	X
Resource Identification	X	X	X
Resource Deployment	X	X	X
Continuity of Care	X	X	X
Coordination of Referrals	X	X	X
Coordination of Scene Assistance (Following an Incident)	X	X	X
Coordination of Scene Assistance (Incident Anniversary)		X	X
PsySTART		X	X
Coordination of Follow-Up Care Resources		X	X
Responder Support		X	X
Post-Demobilization Assistance		X	X
Crisis Counseling Program Application			X
Coordination of Long-term Monitoring			X

Activation of the plan requires that Public Health concurrently activate Health and Medical Area Command (HMAC), per the guidelines found in the ESF 8 Basic Plan, as well as the Emergency Communications Plan. The Basic Plan governs the day-to-day tasks of Public Health emergency response and enables Public Health to support the tasks outlined in the Disaster Behavioral Health plan. While it is understood that staffing levels may be stretched, especially if the activation of this plan takes place during a major incident affecting other aspects of the healthcare system, the Area Commander is responsible for ensuring that HMAC staff members are assigned to serve as the main point of contact for implementing each piece of this plan, and ensuring that the other responsible parties implement their relevant components.

D. Command and Control

During a local, regional, state, national or international event that affects King County, or results in the need to coordinate King County resources, Public Health will activate HMAC to support operations. HMAC will serve as the overall coordinating entity for ESF 8 agencies (as outlined in the ESF 8 Basic Plan), with local Emergency Operation Centers (EOCs) and the King County ECC serving as the entities to provide or secure additional resources from the state and federal government.

Public Health will provide the staff to serve as Area Commander for the HMAC activation if disaster behavioral health is only one component of a larger ESF 8 response. If the incident does not have other ESF 8 components beyond behavioral health, the Department of Community and Human Services will provide staff to serve as Area Commander.

E. Key Decision Points

Topic	Decision Point
Command and Control	<ul style="list-style-type: none"> Will Public Health or the Department of Community and Human Services serve as Area Commander?

	<ul style="list-style-type: none"> • Who else needs to be briefed on the decision to activate this plan?
Finance and Administration	<ul style="list-style-type: none"> • What staffing is needed and where will they come from? • How will costs of activating this plan be tracked?
Planning	<ul style="list-style-type: none"> • What information do we need to gather and share?
Communications	<ul style="list-style-type: none"> • What is the public information strategy?
Equity	<ul style="list-style-type: none"> • What is the impacted population and what considerations should we undertake in determining the suitability of resources deployed?
Operations	<ul style="list-style-type: none"> • Which disaster behavioral health response strategies would be most appropriate given the specifics of the disaster and the population involved? • What resources should we deploy to implement these strategies?
Logistics	<ul style="list-style-type: none"> • What resources such as facilities, communications/IT equipment, food and lodging, transportation, are needed to support staff and volunteers involved in the behavioral health response, and how can these resources be quickly mobilized?

VII. Concept of Operations

A. Activation and Set-up

When the plan is activated, the Preparedness Director and the Assistant Division Director will determine whether the HMAAC needs to be opened as well. In some instances – namely Level 3 events – it is possible that staff can perform work at their desks. However, for Level 2 and Level 1 events, HMAAC will open a physical space where Preparedness staff and BHRD staff will work together under incident command.

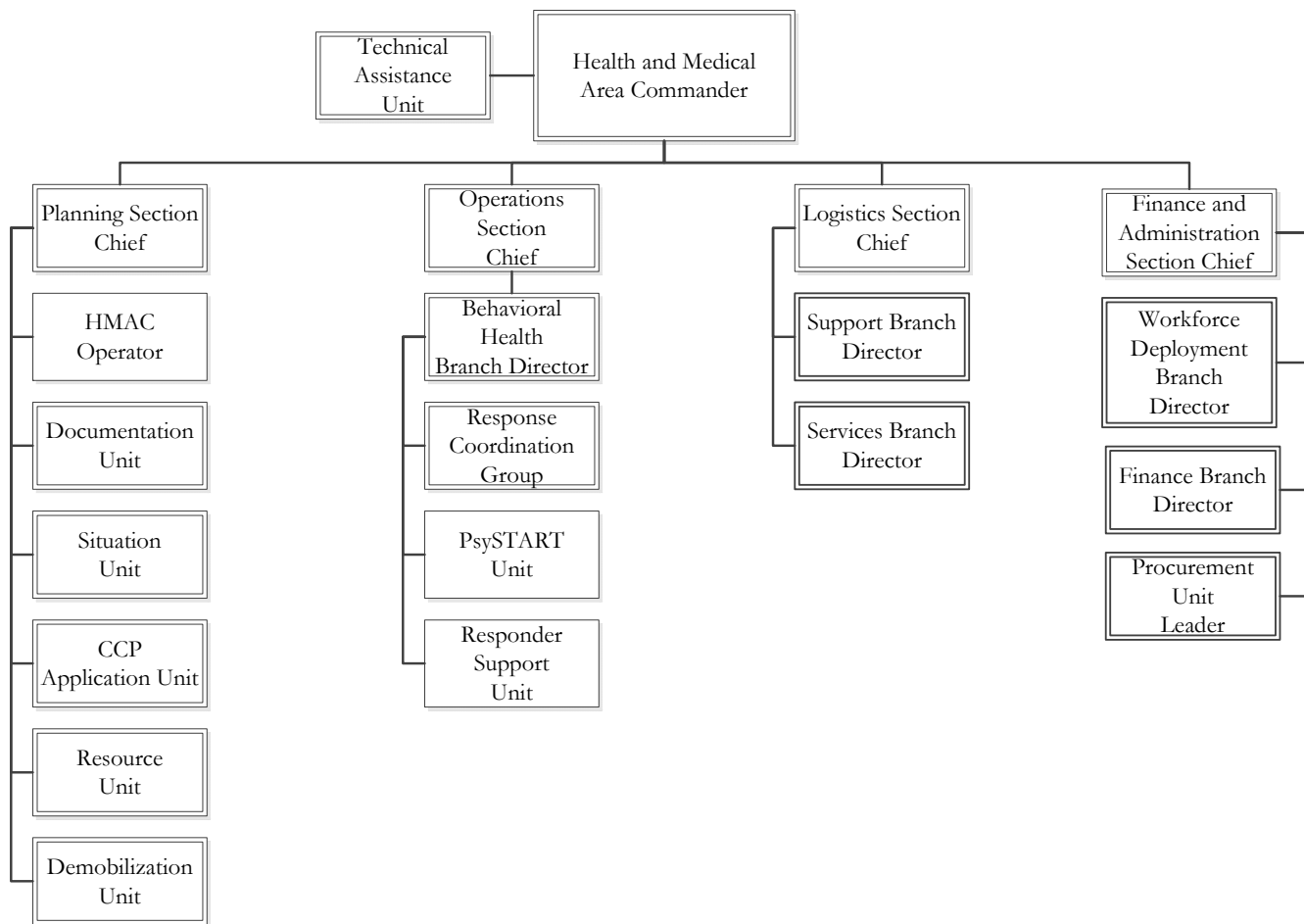
B. Organizational Structure

In a Level 3 Incident, HMAAC will likely not need to be activated, but will be available to provide support to BHRD as needed. However, for Level 2 and Level 1 incidents, HMAAC will activate with the following organization. All roles may not be filled at all times, and some staff members may fill multiple roles depending on the size of the incident.

Attachments:

ORG 01 Behavioral Health Org Chart

ORG 02 Behavioral Health Service Areas Org Chart



C. Types of Incidents and Responsibilities

The responsibilities listed below are specific to disaster behavioral health response; they are not meant to include all possible emergency response tasks that the listed organizations may undertake, nor are they meant to imply that they are focused exclusively on disaster behavioral health response.

Level 3 Incident

When a Level 3 incident occurs, the American Red Cross (ARC) will likely be the primary response agency. Ideally the Duty Officer will be notified as well, and at that point will follow notification protocols outlined above. The ARC will also notify the Crisis Clinic, which notifies the Behavioral Health Organization (BHO) of a request for response. The BHO will perform a needs assessment to determine the number of people affected, how individuals may need assistance, the benefit of group debriefings, the need for on-site response or phone support. Once the BHO identifies these resources, they will communicate that information to the Crisis Clinic. At the same time, the ARC will provide referral information to victims, who will call the Crisis Clinic. The Crisis Clinic will determine whether the caller is a current behavioral health client. If so, the caller will be referred to their current provider for crisis services; if not, the caller will be referred to the appropriate resource. HMAC will be available to offer support as needed, which will likely come in the form of logistics.

ARC

The ARC will likely send a Disaster Action Team to the scene of a Level 3 incident. Such teams include volunteers trained in Psychological First Aid.

- Contact 911 or incident command on scene if anyone is expressing desire to harm self or others
- Request mental health assistance from ARC chapter for less critical mental health needs to assist with stabilization and assessment
- Make referrals to SAMHSA Disaster Distress Helpline or to Next Day Appointments via Crisis Clinic

Community Behavioral Health Clinics

Unless the incident has taken place at or near where most of the agency's clients live (e.g. an apartment building that houses many people with behavioral health needs), it is unlikely that continuity of care will be the biggest concern.

- Provide care for clients affected by the incident
- Make staff available for new clients via Next Day Appointments⁸
- Deploy relevant mobile assets as requested
- Provide assistance to other clinics if they are being disproportionately impacted

Public Health Reserve Corps

- Serve as volunteers in shelters

Hospitals and Healthcare Systems

Unless the incident has a large number of injuries, no one hospital should be disproportionately affected by the incident.

- Provide care to patients
- Offer support to family and friends of patients

Attachment:

Level 03 Process and Responsibilities

Level 2

In a Level 2 incident, Public Health will activate Health and Medical Area Command until more information is available to determine the breadth of behavioral health needs. The Duty Officer will follow the notification tree as indicated above, and the Preparedness Director and BHRD Assistant Division Director will determine which components of the plan to activate. Main areas of focus during Level 2 incidents are Next Day Appointments, PsySTART, and determining what information the Planning Section will need to collect.

ARC

- Provide mental health staff to shelters and community locations as requested
- Triage shelter clients using PsySTART (if activated by Public Health)
- Make referrals to Next Day Appointments or SAMHSA Disaster Distress Helpline

Community Behavioral Health Clinics

- Provide care for clients affected by the incident

⁸ Next Day Appointments are not funded by Medicaid

- Make staff available for new clients via Next Day Appointments for the short term
- Provide assistance to other clinics if they are being disproportionately impacted
- Work with Disaster Case Managers to create plans of care for newly qualifying clients (e.g., Medicaid clients via Apple Health Plan)

Crisis Clinic

- Manage Next Day Appointment system
- Triage new callers using PsySTART (if activated)

Disaster Case Management

- Connect individuals to services such as behavioral health, housing and transportation

Hospitals and Healthcare Systems

- Provide care to patients
- Triage any new patients using PsySTART (if activated and part of facility's triage plan)
- Work with Disaster Case Managers (within system or from Disaster Case Management Coalition) to create plans of care for qualified clients (e.g., members of insurance plans accepted by the facility)
- If applicable, deploy behavioral health staff to the scene or other locations (e.g. community meetings) at Public Health's request if hospital or healthcare system approves
- Offer support to family and friends of patients

Northwest Healthcare Response Network (NWHRN)

- Alert facilities to activation of PsySTART via WATrac if requested
- Support hospitals and the healthcare system as needed

Private Practice

- Provide care to existing patients
- Deploy to the scene or other locations (e.g. community meetings) at Public Health's request
- Work with Disaster Case Managers to create long term plans of care for qualified clients (e.g., members of insurance plans accepted by the practitioner)

Public Health Reserve Corps

- Serve as volunteers in shelters or at community events

Attachment:

Level 02 Process and Responsibilities

Level 1

In a Level 1 incident, Public Health will activate HMAC to address many components of response, in addition to disaster behavioral health. The Duty Officer will follow the notification tree as indicated above, and the Preparedness Director and BHRD Assistant Division Director will determine which components of the plan to activate, although it is likely that all components will be needed at some point. Some facilities may not be functional; others may be operational but not easy to access via regular

transportation routes. This incident type will require the collection of detailed information of the breadth of impact within the community.

While some of the tasks below are similar to the tasks during Level 2 incidents, the biggest difference (other than stretched resources) is that it will take some time for the organizations to check in on their own staff and assess the status of their internal operations. This may take as many as three or four days, which will delay the availability of disaster behavioral health services for at least that long. During this time the MOU among Opiate Substitution Treatment providers will allow dosing to one another's clients, as described below.

ARC

- Deploy mental health staff to shelters and community locations as requested
- Triage shelter clients using PsySTART (if activated)
- Make referrals to Next Day Appointments or SAMHSA Disaster Distress Helpline

Community Behavioral Health Clinics

- Provide care for existing clients
- Make staff available for new clients via Next Day Appointments for the short term
- Provide assistance to other clinics if they are being disproportionately impacted
- Work with Disaster Case Managers to create plans of care for newly qualifying clients (e.g., Medicaid clients via Apple Health Plan)

Crisis Clinic

- Manage Next Day Appointment system
- Triage new callers using PsySTART (if activated)

Disaster Case Management

- Connect individuals to services such as behavioral health, housing and transportation

Health and Medical Area Command

- Medication Support

Hospitals and Healthcare Systems

- Provide care to existing patients
- Triage any new patients using PsySTART (if activated and part of facility's triage plan)
- Work with Disaster Case Managers (within system or from Disaster Case Management Coalition) to create plans of care for qualified clients (e.g., members of insurance plans accepted by the facility)
- If applicable, deploy behavioral health staff to the scene or other locations (e.g. community meetings) at Public Health's request
- Offer support to family and friends of patients as resources allow

Northwest Healthcare Response Network (NWHRN)

- Alert facilities to activation of PsySTART via WATrac if requested
- Support hospitals and the healthcare system as needed

Private Practice

- Provide care to existing patients
- Deploy to the scene or other locations (e.g. community meetings) at Public Health's request
- Work with Disaster Case Managers to create long term plans of care for qualified clients (e.g., members of insurance plans accepted by the practitioner)

Public Health Reserve Corps

- Serve as volunteers in shelters or at community events

Attachment:

Level 01 Process and Responsibilities

D. Evidence-Based Treatment

Personnel deployed through the Plan should have a fundamental knowledge of trauma, and should be licensed mental health providers. There are many evidence-based practices that they could use to provide care for those affected by the incident necessitating the activation of this plan; when determining which staff to make available, we would encourage facilities to choose those with experience in one or more of the following practices:

- Cognitive Behavioral Therapy
- Trauma-Focused Cognitive Behavioral Therapy
- Motivational Interviewing
- Grief Interventions
- Behavior De-Escalation

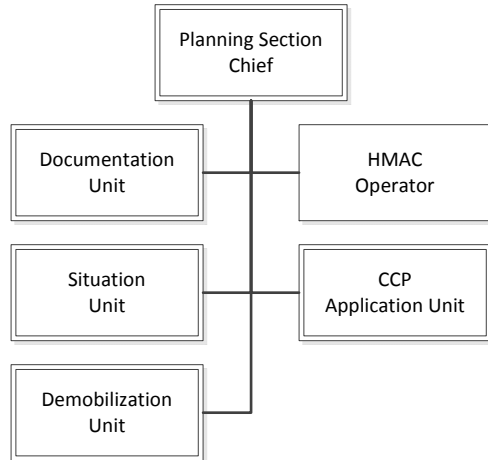
E. Command Staff

Job action sheets and other relevant information for command staff, including Area Commander, Liaison Officer and Safety Officer can be found in the HMAC Procedures Manual.

Technical Assistance Unit (Level 2 or Level 1 incident)

Should incident-specific Subject Matter Experts (SMEs) be needed, they will be located in the Technical Assistance Unit as part of command staff. These SMEs may be asked to provide input on the types of interventions to be offered for specific population groups, including responders, children, behavioral health consumers, and people with disabilities. They may also be able to provide incident-specific (e.g. biological terrorism or school shootings) expertise. They will also be tasked with providing technical assistance to Communications staff to frame appropriate public messaging.

F. Planning Section



Public Health, with support from BHRD, will provide staff for the Planning Section, with disaster behavioral health resource and information analysis focused in the Situation Unit. In addition to the tasks outlined in the ESF 8 Basic Plan and HMAC Procedures Manual, the Planning Section Units will take on the additional tasks described below.

Documentation Unit

- Create a map of the incident area and available disaster behavioral health resources within King County.

Situation Unit

- Use PsySTART (if activated) to develop a common operating picture of numbers of victims, levels and types of risk factors, aggregated by site, defined area or county-wide depending on the incident.⁹
- Use WATrac to assess availability of the BHO response assets. If WATrac is down or as a redundancy, this Unit will also email all BHO agencies on the contact list a form to complete to assess available response assets.
- In concert with the Operations Section, identify mutual aid needs projections by comparing needs to available resources.

Demobilization Unit

- Work with the Operations Section to identify scope of outstanding disaster behavioral health needs and who will maintain responsibility for fulfilling future requests for disaster behavioral health resources.

CCP Unit (Level 1 incident only)

The Crisis Counseling Program¹⁰ (CCP) is a FEMA funding mechanism for providing longer-term behavioral health assistance, including:

⁹ The PsySTART system allows administrators to pull detailed and extensive reports that will serve this purpose.

¹⁰ <https://www.fema.gov/public-assistance-local-state-tribal-and-non-profit/recovery-directorate/crisis-counseling>

- 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

This funding is secured via an application that the State submits. The CCP Unit will be responsible for putting together an application letter. As soon as it becomes apparent that this might be a possibility, the Planning Section chief should request that the Area Commander contact the state Emergency Management Division and state Department of Health to ensure that they do not submit a CCP request without first speaking with BHRD and Public Health. HMAC will work through the King County Regional Communications and Emergency Coordination Center to prepare the application for submission, which will be sent to the State to send to the federal government.¹¹¹²

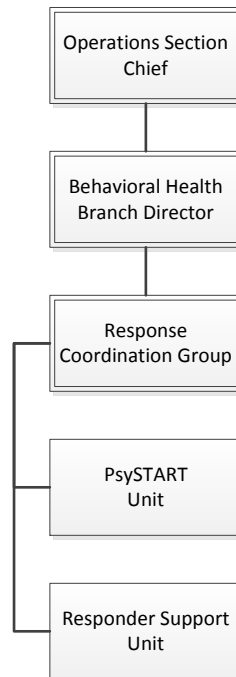
Attachments:

- Planning 01 Essential Elements of Information for Behavioral Health
- Planning 02 Available Resources Spreadsheet
- Planning 03 WATrac Resource Availability Survey Questions
- Planning 04 Sites Needing Assistance
- CCP 01 Application Packet
- CCP 02 Toolkit

¹¹ <http://www.dhhr.wv.gov/healthprep/programs/behavioralhealth/Documents/FEMA%20CCP%20Toolkit.pdf>

¹² <http://media.samhsa.gov/DTAC-CCPToolkit/intro.htm>

G. Operations Section



In all levels of incidents warranting a disaster behavioral health response, BHRD will provide staff to serve in the Behavioral Health Branch of the Operations Section, including the Behavioral Health Branch Director (likely the Assistant Division Director for BHRD). This Branch is responsible for managing the Response Coordination Group, PsySTART Unit, Responder Support Unit, and Crisis Clinic's participation in the response.

Response Coordination Group

The Response Coordination Group will function like a task force. It will use information from the Planning Section to:

- identify the need for services in the community
- identify the available resources within the community
- match those resources to those in need
- identify and request assistance to fill gaps.

The Group leader and most of the staff should be from BHRD or be others with a relevant clinical background.

A key component of these discussions, especially in Level 2 and Level 1 incidents, will be the need to conserve assets to avoid burning out the resources in the first few days of a possible long-term incident.

Below are specific tasks for which the Response Coordination Group is responsible.

- Incident assessment: In conversation with Technical Advisors, the Equity Liaison, and others with knowledge of the incident, the Response Coordination Group will assess what

behavioral health interventions might be needed, referring to the list of existing Public Mental Health Service providers. This includes determining which services are culturally appropriate for those impacted, and whether specialty services (e.g. pediatric care) are needed. This assessment also includes recommending the activation of PsySTART.

- Resource identification: Using WATrac and conversations with service providers, quickly identify what resources are available to either be deployed or accept referrals.
- Resource deployment: The Response Coordination Group will deploy disaster behavioral health response services to shelters, Alternate Care Facilities, pre-hospital triage points, BHO facilities, Family Assistance Centers, Points of Dispensing, hospitals or large outpatient clinics, or other incident-specific settings.

In the initial incident response, this Group will look to deploy public mental health resources. However, as public mental health becomes overwhelmed, or as clients are identified as having either an existing relationship with a hospital or insurance system, or the ability to privately afford care, the public mental health system will refer these clients back to their regular healthcare provider for continued care.

In order to better facilitate this process, this Group will work with the Planning Section and partners such as ARC to gather information on all locations requesting Behavioral Health assistance. This group will schedule a daily conference call with organizations able to provide staffing support to determine who will be responsible for deploying staff to each location.

Some specific resources include:

- Larger mental health service providers contracted with King County that may be available to provide on-scene care with limited notice given their current on-call systems.
- The Downtown Emergency Services Center Crisis Solutions Center may be requested (by HMAC or by responders on scene) to assist adults in crisis.
- The YMCA Children's Crisis Outreach may be similarly requested to assist children in crisis.

If there is a need identified after business hours or during the weekend that must be addressed quickly, this Group will reach out to these providers directly (and not through WATrac).

- Continuity of care: While it is understood that service organizations will not provide staff for disaster behavioral health response unless they can also manage their regular client case load, in a larger emergency this Group will determine what resources may need to be deployed to existing behavioral health service providers to ensure continuity of care for current clients. This may include working with other service organizations to identify whether they can provide assistance to overwhelmed organizations and their clients.
- Coordination of referrals: The Response Coordination Group, working with Crisis Clinic, may make Next Day Appointments (NDAs) available to those affected by the incident.
 - NDAs: If NDAs are to be used, the Response Coordination Group will request that BHRD create an incident-specific code.

- BHO assets located closest to the incident will be prioritized to reduce the need for victims to travel far.
 - Using information provided by the Planning Section, the Group will determine whether the number of appointments available should be sufficient to address the need in the community.
 - The Crisis Clinic will follow its normal operating procedure for scheduling the NDAs, with the incident-specific code collecting information that will be shared with HMAC every 24 hours to allow the Group to adjust the response as needed. If the number of NDAs needed exceeds the number available, the Group will coordinate with NDA agencies to determine if additional appointments can be made available.
- Coordination of scene assistance (Level 2 Incidents): Scene assistance in these instances may involve deploying disaster behavioral health professionals to the locations where victims are gathering (such as a Family Assistance Center or nearby house of worship), or to scheduled meeting locations such as a town hall or memorial. The Group will work with the HMAC Liaison Officer to connect with relevant parties (e.g. school boards, elected officials) to determine the need for assistance.
 - Coordination of scene assistance (Level 1 Incidents): In order to prioritize assistance, the Group will look at the available information gathered by the Planning Section, including PsySTART information, shelter locations, and the number of people displaced, among other relevant items. The Planning Section will prepare a list of all possible locations for resources to be deployed, as well as a list of available resources, and share this with the Group, which will be tasked with making specific decisions on where resources are needed most.
 - Coordination of follow-up care resources: As the incident develops, the Group will work with the JIC and Crisis Clinic to determine the best options for providing information to those who do not need immediate interventions but who may need assistance in the future. This will include basic education materials and coordination with Disaster Case Management. (See Communications Section)
 - Post-Demobilization Assistance: While the need for disaster behavioral health assistance may decrease over time, certain moments, such as a one month or one year anniversary, may result in an increased need for assistance. As part of the demobilization of HMAC, the Liaison Officer will ensure that the executive of the incident location, such as the school board president or town mayor, is provided with a contact number to request disaster behavioral health assistance at those future events.
 - Coordination of long-term monitoring: Coordination of services such as those provided by the federal government. This will be managed through Recovery Support Function 3 (Health, Social Services and Schools), which should be stood up after the response phase of a Level 1 incident is close to completion.

Attachments:

Response Coordination 01 Next Day Appointment Organizations

Response Coordination 02 MOU for Extending Next Day Appointments

Response Coordination 03 CD Youth Providers

- Response Coordination 04 CD Adult Opiate Treatment Providers
- Response Coordination 05 CD Adult Outpatient Providers
- Response Coordination 06 CD Providers Detailed SA Only
- Response Coordination 07 BHRDD Service Sites
- Response Coordination 08 Faith Based Assistance

References:

City of Seattle Recovery Support Function 3 – Health, Social Services and Education

PsySTART Unit

PsySTART is a rapid triage system that allows the early identification of those who might be at risk for longer term disaster behavioral health issues after an incident. This unit, which is part of the Behavioral Health Group, will be activated if PsySTART is activated. This unit will provide any technical support needed for those using PsySTART.

Attachments:

- PsySTART 01 Implementation and Referral Process
- PsySTART 02 Process Map
- PsySTART 03 Sample Report
- PsySTART 04 FAQ

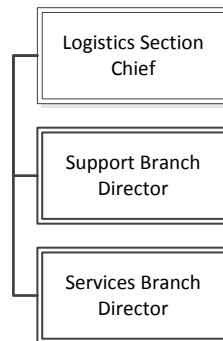
Responder Support Unit

This unit, which is under the direction of the Behavioral Health Branch Director, is tasked with providing support specific to the first and second responders. This may include making appointments with disaster behavioral health service providers available, providing information about their home agency’s employee health and wellness programs, or securing other resources as needed.

Attachments:

- Responders 01 Taking Care During a Response
- Responders 02 Counseling resources for Workforce
- Responders 03 Workforce Preparedness Tips

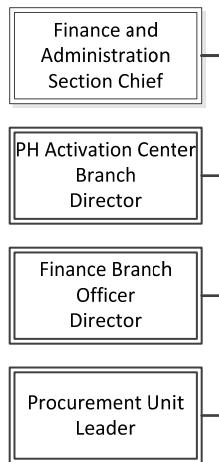
H. Logistics



The HMAC procedures manual outlines in detail the duties of the Logistics Section. This Plan does not require anything beyond the regular duties of securing and managing resources such as facilities,

communications/IT equipment, food, lodging, and transportation, in order to mobilize response operations.

I. Finance and Administration



The HMAC procedures manual outlines in detail the duties of the Finance and Administration Section. This Plan requires that staff complete those duties, including tracking response costs, purchasing resources, and identifying and deploying staff. The latter will require assistance from BHRD staff members. The Finance and Administration Section will need to determine the source of liability coverage for all staff participating in the response. It will also be responsible for working with the CCP Unit in the Planning Section to prepare the needed documents for submission.

Deploying Non-Public Health Staff

People want to help after a disaster, and we anticipate that many people who are not already part of the PHRC or organizations contracted to provide care as outlined in this plan will be interested in providing assistance. Public Health is currently exploring options to both ensure the safety of those affected while also making sure that we do not turn away qualified volunteers who could provide care.

Attachments:

F & A 01 Job Action Sheets (in process)

F & A 02 Questionnaire for Organizations Offering Assistance (in process)

References

Workforce Mobilization Plan

J. Continuity of Operations

All involved responding organizations shall develop a continuity of operations plan to address situations in which their primary personnel are unable to serve in their assigned roles for whatever reason.

K. Disaster Case Management

Catholic Community Services (CCS) of Western Washington and The Salvation Army (TSA) partner together to provide disaster case management services at both the local and state-wide level. In King County, disaster case management services (in the county or a city), are activated through the King County Office of Emergency Management. CCS and TSA will alert Public Health when they are

activated, and will provide contact information so that HMAC can remain aware of the behavioral health services available.

HMAC's Planning Section will coordinate with CCS and TSA to avoid duplication of efforts, and to ensure that information on disaster case management services is included in Public Health's messaging.

Within 90-100 days of activation, CCS/TSA will seek to identify local organizations to take over the longer term disaster case management needs of the community, and will share that information with Public Health.

Reference:

Catholic Community Services Org Chart

L. Incident- and Population-Specific Interventions

- a. Psychological First Aid (PFA):
Anyone deployed for disaster response should have an understanding of PFA. It is not a diagnostic tool, but instead exists to help with resilience. There are many different systems, including "Listen, Protect, Connect" and "Look, Listen, Link." As part of the ongoing training related to this plan, Public Health will seek to provide PFA training opportunities to PHRC volunteers, Public Health staff, and volunteers from other organizations (e.g. local CERTs) to develop this skill.
- b. Homeless Assistance: In incidents that might have an impact on those who are already homeless, HMAC will work with Healthcare for the Homeless to identify any additional behavioral health needs. If necessary, HMAC will also work with them 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 city EOCs. Additionally, needs of the newly homeless after a disaster may be addressed by the post-disaster interim housing plan managed by DCHS.
- c. Opiate Substitution Treatment: An MOA exists that allows one OST site to provide doses to other sites' clients should their facility not be available. All OST needs will be managed through that MOA.
- d. Detoxification Treatment: Capacity within the county is very limited, which will need to be considered during response.
- e. Domestic Violence Prevention: Much like any service provider, organizations providing domestic violence prevention should have continuity plans in place to ensure services can continue in a disaster.

Attachments:

Population Specific 01 OPT MOA

M. Demobilization

As the immediate response stabilizes, the Response Coordination Group will speak with the Area Commander to determine a timeline for demobilizing the behavioral health component. Crisis Clinic will also be part of this conversation, as individuals will be referred to the Crisis Clinic with any needs that have not been met, including newly-identified needs for Disaster Case Management. As part of this demobilization, the Response Coordination Group will also identify upcoming milestones (e.g. the six-

month anniversary and one year anniversary) and schedule meetings in advance of those milestones including Public Health Preparedness, Crisis Clinic and BHRD staff to identify behavioral health needs.

N. Code of Conduct

All staff members involved in disaster behavioral health response, including those who are from the public and private sector, paid employees and volunteer staff, contractors, consultants, and others who may be temporarily assigned to perform work or services for the response, must follow the below listed code. All staff shall abide by the code of conduct and behavior policies of their agency or organization.

Disaster behavioral health staff should make every effort to conduct themselves in a discrete and helpful manner, with the traumatic nature of the event and the client's high level of emotional stress in mind.

- Protect the privacy of the clients. Do not share any information or provide access to the media without specific permission from your supervisor and express consent of the families. Follow principles outlined in Health Insurance Portability and Accountability Act (HIPAA) policies.
- Communicate openly, respectfully, and directly with clients in order to optimize services and to promote mutual trust and understanding. Handle conflicts promptly, appropriately and in the correct environment by asking for help and offering positive solutions to problems that are identified.
- Conduct business with integrity and in an ethical manner.
- Be sensitive to an environment where a number of those impacted will be. Refrain from engaging in loud conversations, laughter, and other social conversations in public areas.
- Be sensitive to difference in cultural and religious beliefs during your interactions.
- Clearly identify yourself and your position to those seeking assistance and wear your nametag at eye level.
- Take responsibility and be accountable for your entire job requirements as outlined in job action sheets and organizational policies.

Additionally, those deployed as part of the disaster behavioral health plan will be strictly forbidden from photographing or recording the space or those seeking assistance. Volunteers, staff and contract workers will only be allowed to take pictures in designated areas.

VIII. Communications

Communication with the media and the public about disaster behavioral health is especially important as it has the potential to be overlooked in the initial concerns for life safety after a disaster. In a Level 3 incident, the primary means of getting information to those affected will be through direct contact by staff and volunteers at the scene. However, Level 2 and Level 1 incidents will require coordination among Public Health and DCHS communications staff to ensure that those who have not received direct contact from staff or volunteers (e.g. those who have not sought assistance at a healthcare facility or shelter) receive information to help them manage their behavioral health response.

If King County opens a Joint Information Center (JIC), public information officers and other communications staff will coordinate messaging via that system, as they do with other large or complex incidents. However, if a JIC is not opened (as may be the case in select Level 2 incidents), Public Health and DCHS staff will determine who the appropriate lead is for the incident's communications needs depending on the nature of the incident.

In anticipation of the need to share information quickly, Public Health and DCHS are preparing key messages and brochures that will be made available online and distributed by staff and volunteers during and after an incident. Key messages will also be shared with traditional and ethnic media outlets and via social media to try to reach as many affected community members as possible.

Attachments:

Support 01 Helping Children After Disaster
Support 02 Disaster Mental Health Parent Guide
Support 03 Take Care Emotional Health
Support 04 After the Fire
Support 05 Neighbor to Neighbor PFA
Support 06 Tips for Survivors – What to Expect

References:

Public Health Communications Plan

IX. Organization and Assignment of Responsibilities

The responsibilities listed below are specific to disaster behavioral health response; they are not meant to include all possible emergency response tasks that the listed organizations may undertake, nor are they meant to imply that they are focused exclusively on disaster behavioral health response.

- A. Public Health – Seattle & King County
 - Stand up HMAC and activate the sections necessary to support this plan
 - Provide staffing assistance for disaster behavioral health operations and planning sections as needed and mobilize workforce and Public Health Reserve Corps Staff as necessary
 - Assist with coordination of healthcare organizations

- B. Behavioral Health and Recovery Division
 - Serve as lead agency for behavioral health component of any HMAC activation
 - Provide oversight for all aspects of disaster behavioral health response in King County
 - Serve as primary staff for disaster behavioral health operations
 - Provide staff to assist in the planning section and to coordinate BHO assets as needed
 - Coordinate monitoring to assure business continuity for the public mental health system

- C. Crisis Clinic
 - Serve as the central clearinghouse for situational awareness
 - Connect those needing assistance to available services (following PsySTART levels if activated) using NDAs or other services

- D. Community Mental Health Service Providers
 - Share list of available resources and needs via WATrac when requested by the BHO
 - If under contract with DCHS to do so, provide increased NDAs
 - If possible, provide support to other service providers to ensure business continuity
 - Identify and train staff to be available to deploy to incidents and events

- E. Northwest Healthcare Response Network
 - Communicate needed disaster behavioral health support from healthcare to HMAC
 - Provide support to healthcare providers as requested to meet disaster behavioral health needs

- F. Local Hospitals
 - Use PsySTART when alerted by Public Health (via WATrac or other means)
 - Provide behavioral health services to own clients and patients
 - If unaffected by incident, offer support to affected facilities

- G. Local Offices of Emergency Management
 - Request behavioral health assistance from King County either via Public Health Duty Officer or via HMAC (if activated)
 - Refer requests for behavioral health assistance directly to Public Health Duty Officer or HMAC

- H. American Red Cross
 - Provide support on scene to victims of emergencies and disasters
 - Provide staffing to emergency shelters
 - Use PsySTART at shelters as appropriate
 - Identify and train staff and volunteers to be available to deploy to incidents and events

- I. King County Office of Emergency Management
 - Activate the King County Emergency Coordination Center, if necessary
 - Serve as a coordinating entity in brokering additional resources from the Washington State Emergency Management Division or Federal agencies
 - Activate and manage the Joint Information Center (if requested)

- J. Washington State Government Agencies
 - Provide support for requests for additional behavioral health resources
 - Submit application for Crisis Counseling Program (as outlined in the Planning Section overview above)

- K. Community and Faith-Based Organizations
 - Provide spiritual care support to those affected by emergencies and disasters as appropriate
 - Provide human services and disaster case management assistance to those affected by emergencies and disasters as appropriate

X. Training and Exercises

- A. Plan Training
 - Public Health and BHRD staff will receive an orientation of the plan each time significant revisions are made
 - Public Health Duty Officers will receive training on their role in implementing this plan
 - Local emergency managers will receive training on the overall plan as well as on requesting disaster behavioral health assistance for incidents in their jurisdictions

- Staff who may serve as Area Commander in a disaster behavioral health response will complete ICS courses 100, 200, 700, 800, 300, and 400
- B. Community Training
- Psychological first aid training is encouraged for anyone who may provide assistance during an emergency, including staff and volunteers. Public Health Reserve Corps members, CERT members and Citizen Corps members are especially encouraged to complete this type of training.
 - Behavioral health practitioners may be asked to provide training for educators, parents, and caretakers on how to monitor and assist children following a disaster. The training may include common responses by children and teens, suggestions on how to talk with kids, and when to get professional help.
 - Disaster Case Management training is encouraged for those community-based and human service organizations involved in delivering disaster case management services.
- C. Exercises
- Facilitated discussions or table-top exercises will be scheduled at a minimum of once every three years to validate different components of the plan.
 - A functional or full-scale exercise will be held at least once every five years as funding allows or as directed by grant requirements.

XI. Plan Development and Maintenance

- A. Review Process and Plan Update
1. Sections of the plan will be updated as needed based on the evolution of planning activities and partnerships or in coordination with the Regional Improvement Plan after exercises or real world events.
 2. The plan will be provided to partners for review by Public Health when major updates are made.
 3. Following review necessary modifications will be made and a copy will be provided to regional partners.
- B. Maintenance
- The plan will be reviewed every three years or as needed following the process outlined above.

XII. Authorities and References

King County DCHS BHRD is required by County and State regulation to maintain an effective planning, coordination, and response capability for public disaster behavioral health emergencies. As the lead for disaster behavioral health services within ESF 8 in King County, BHRD operates as the primary entity to monitor events of potential negative impact upon public disaster behavioral health from natural and human-generated causes.

BHRD, with support from Public Health, is responsible for ensuring that the systems and procedures necessary to coordinate the department's disaster behavioral health operational response to emergencies or disasters are available.

Relevant References:

1. Homeland Security Presidential Directive # 5, the National Incident Management System (NIMS), 2005

2. Homeland Security Presidential Directive # 21, Public Health and Medical Preparedness, Whitehouse, 2007
3. National Preparedness Goal, Presidential Policy Directive #8, (Whitehouse, 2011)
4. National Health Security Strategy of the United States(HHS, 2009)
5. U.S. Department of Health and Human Services, National Biodefense Science Board, Disaster Mental Health Sub-Committee final report (November, 2008)
6. Washington State All Hazards Emergency Mental Health Plan
7. King County Emergency Support Function (ESF) 8 Basic Plan
8. King County Emergency Support Function (ESF) 6 Plan
9. King county OEM Regional Shelter Operations Annex

XIII. Attachments

CCP 01 Application Packet

CCP 02 Toolkit

FA 01 Job Action Sheets (in process)

FA 02 Questionnaire for Organizations Offering Assistance (in process)

Intro 01 Glossary and Acronyms

Level 01 Process and Responsibilities

Level 02 Process and Responsibilities

Level 03 Process and Responsibilities

Notification 01 Notification Tree

ORG 01 Behavioral Health Org Chart

ORG 02 Behavioral Health Service Areas Org Chart

Planning 01 Essential Elements of Information for Behavioral Health

Planning 02 Available Resources Spreadsheet

Planning 03 WATrac Resource Availability Survey Questions

Planning 04 Sites Needing Assistance

Population Specific 01 OPT MOA

PsySTART 01 Implementation and Referral Process

PsySTART 02 Process Map

PsySTART 03 Sample Report

PsySTART 04 FAQ

Responders 01 Taking Care During a Response

Responders 02 Counseling resources for Workforce

Responders 03 Workforce Preparedness Tips

Response Coordination 01 Next Day Appointment Organizations

Response Coordination 03 CD Youth Providers

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