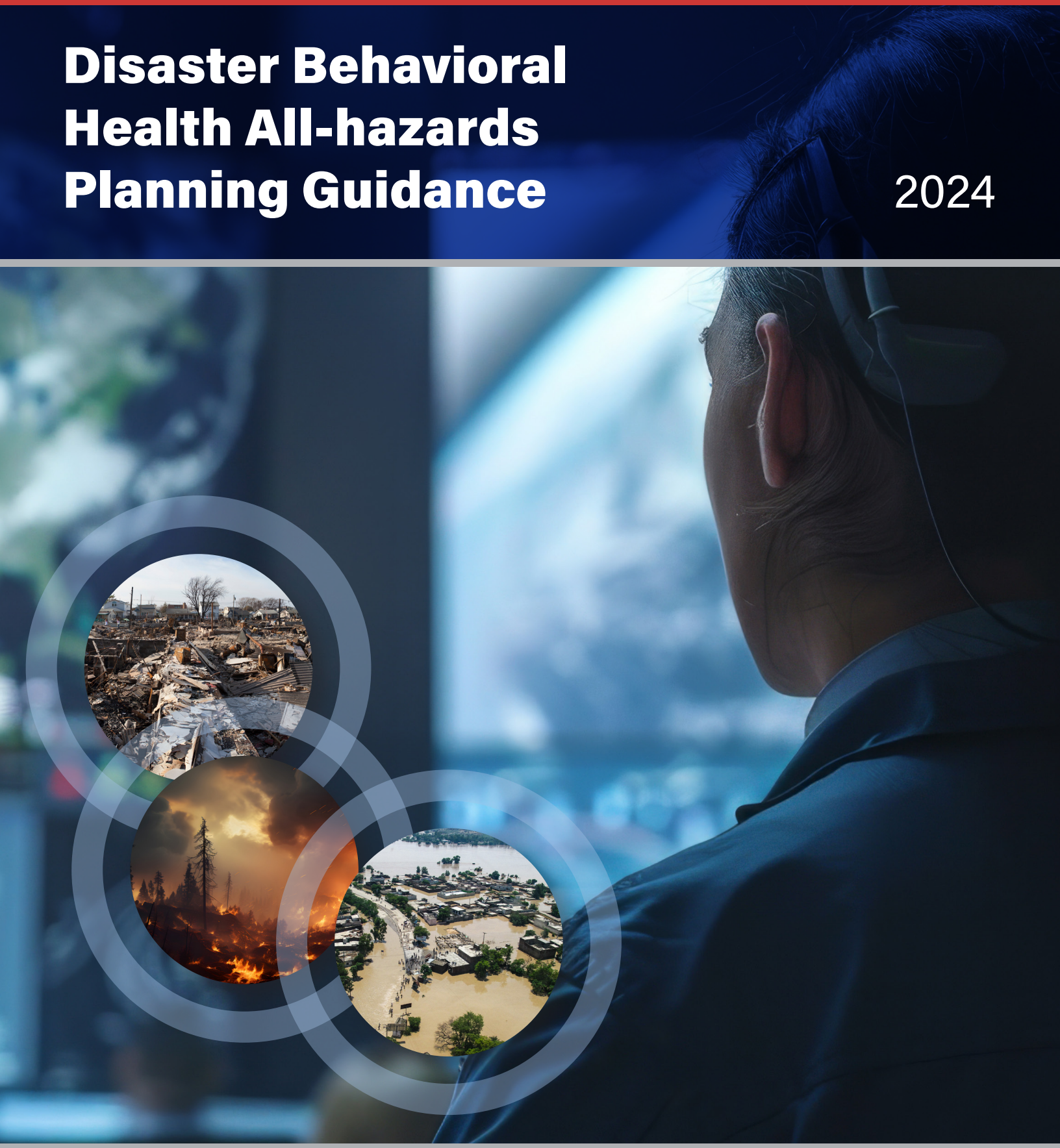
Disaster Behavioral Health All-hazards Planning Guidance

2024



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Substance Abuse and Mental Health Services Administration

Disaster Behavioral Health All-hazards Planning Guidance

Substance Abuse and Mental Health Services Administration

Center for Mental Health Services

Disaster Behavioral Health All-hazards Planning Guidance

Acknowledgments

Disaster Behavioral Health All-hazards Planning Guidance was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) under contract number 75S20322D00056/75S20224F41001 with SAMHSA, U.S. Department of Health and Human Services (HHS). Nikki Bellamy, Ph.D., served as the contracting officer's representative.

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Recommended Citation

Substance Abuse and Mental Health Services Administration: *Disaster Behavioral Health All-hazards Planning Guidance.* Publication No. PEP24-01-031. MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2024.

Originating Office

Disaster Behavioral Health Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857, SAMHSA Publication No. PEP24-01-031. First released 2003. Updated 2024.

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Publication Number PEP24-01-031
First released 2003. Updated 2024.

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Following the terrorist attacks of September 11, 2001, the Substance Abuse and Mental Health Services Administration (SAMHSA) began organizing efforts to support state all-hazards disaster behavioral health plans. These efforts led to the published Mental Health All-Hazards Disaster Planning Guidance *document in 2003. The original planning document was produced by the National Association of State Mental Health Program Directors and the National Technical Assistance Center for State Mental Health Planning. More than 20 years later, SAMHSA and the SAMHSA Disaster Technical Assistance Center (DTAC) have supported the publication of this updated guidance based on the current environment, lessons learned, and best practices in the field. This document is informed by the previous guide, a SAMHSA DTAC series on promising practices in disaster behavioral health planning, and new emergency planning guidance.*

Introduction

Disasters impact all of us. In March of 2020 the World Health Organization declared COVID-19 a pandemic, a public health emergency that impacted most of us personally in one way or another (Cucinotta & Vanelli, 2020). The 2023 global search results in Google highlight how disasters impact us, with 9 of the top 10 news searches related to a type of disaster, including hurricanes (3), wars (2), mass shootings (2), a tragedy at sea, and an earthquake (Google, n.d.). In our interconnected world, if we have not been directly impacted by a disaster, we probably know somebody who has. With a 24-hour news cycle and the impact of social media, stories of a disaster's impact seem closer to home than ever before.

In addition to the physical destruction and loss of life that can be caused by disasters, the Substance Abuse and Mental Health Services Administration (SAMHSA) recognizes that disasters can also leave people with feelings of emotional distress:

> *Feelings of anxiety, constant worrying, trouble sleeping, and other depression-like symptoms are common responses to disasters before, during, and after the event. Many people are able to "bounce back" from disasters with help from family and the community, but others may need additional support to cope and move forward on the path of recovery. Anyone can be at risk, including survivors living in the impacted areas and first responders and recovery workers (SAMHSA Disaster Distress Helpline, 2023b).*

To promote resilience and assess disaster survivors for additional behavioral health support needs, the U.S. Department of Homeland Security (DHS) and the U.S. Department of Health and Human Services (HHS) have agencies, offices, and programs that promote the mental health and well-being of people impacted by disaster. Other executive departments, including the U.S. Department of Education and the U.S. Department of Justice under the Attorney General, also administer programs to support those impacted by a disaster or traumatic event.

To make this guidance document as helpful as possible to your specific planning role, we will highlight both how things fit together and where you might fit within the big picture. Because the picture is so big—and growing—we will aim to look at disaster behavioral health (DBH) efforts throughout the United States, with the intent of piecing together disparate approaches and efforts into a more complete summary.

Before we begin, we want to pause and emphasize the following:

- All disasters are local. We have done our best to underscore this throughout the document. Federal, state, territory, tribal, and insular area resources should assist in the local response and recovery.
- Everyone who experiences a disaster is affected by it in some way.
- Federal programs, offices, guidance, and grants will change over time. In this guidance, we pull together many moving pieces as we see them working and benefiting DBH planning today. It is important to pay attention to changes over time to remain informed.
- Where we have used the term "state" by itself, it most likely represents states, U.S. territories, and federally recognized tribes.
- The term "disaster" is defined broadly throughout this document to include natural disasters, public health emergencies, acts of terrorism, and incidents of mass violence.
- In this guide we follow SAMHSA's definition of disaster behavioral health (DBH). SAMHSA defines DBH as the understanding and provision of mental, emotional, and substance use services to and interventions for persons and communities impacted by disasters. DBH encompasses the delivery of behavioral health and stress management interventions to address and promote mental health, reduce substance misuse, and foster resilience and recovery.

Why We Plan

According to Forbes, between January 2013 and January 2023, 88.5 percent of all U.S. counties declared a natural disaster, including 95 percent of the 200 most populated counties (Gusner, 2023).

Due to extreme weather events, the scale, impact, and frequency of disasters is increasing. We might be familiar with the communities we support today, but tomorrow is always full of new challenges and opportunities. Populations change, housing developments spread, weather patterns can be unpredictable, new public health issues may arise, and the people and organizations we coordinate with may change. For these reasons and more, planning is an ongoing process that is never quite finished. Plans are living documents, expected to change over time. Planning partners will also change, requiring ongoing relationship building, coordination, and learning to keep plans relevant and useful. As Dwight D. Eisenhower put it, "Plans are nothing; planning is everything" (1957, p. 818).

No single agency owns the entire disaster behavioral health (DBH) response or recovery on their own. Planning ensures that we coordinate with federal, state, and local partners—in government, nonprofit, private, and volunteer capacities—to best prepare to support people's well-being following a disaster. The third version of the Federal Emergency Management Agency (FEMA) *Comprehensive Preparedness Guide (CPG) 101* places extra emphasis on planning with private and nonprofit organizations, adding that relationship building is just as important as the resulting planning document (FEMA, 2021). The planning process helps to forge and maintain the relationships needed for a swift and successful response when events happen. Steady engagement and information-sharing among agencies, leaders, and community members are key to ensuring collaboration in addressing the unexpected aspects of a disaster. To help achieve coordination across partners in different sectors, whole-community approaches and outcomes have become measures for success in the field of emergency management.

In addition to the natural benefits of planning, there are also federal, state, and local legal and regulatory requirements that mandate it. The FEMA CPG 101 is the foundational document for developing state, local, tribal, territorial, and insular area emergency operations plans (EOPs) in the United States. The CPG 101 helps operationalize Presidential Policy Directive 8 (PPD-8, 2011), calling on federal departments and agencies to coordinate on disaster preparedness as a shared responsibility. As another example, Section 416 of the Robert T. Stafford Relief and Emergency Assistance Act authorizes the President to provide crisis counseling assistance and training after a disaster, which is the foundation for the FEMA Crisis Counseling Assistance and Training Program (CCP) (2024). And Section 501 of the Public Health Service Act (Public Law 78-410) authorizes the Secretary of Health and Human Services, through SAMHSA, to act immediately under emergency circumstances requiring a behavioral health response, and this is the foundation for the SAMHSA Emergency Response Grant (SERG) (Emergency Response Criteria, 2002). At SAMHSA's discretion, a SERG can be used to provide new substance use and mental health prevention, treatment, and recovery services in response to an event or to replace services destroyed by a disaster (Mental Health and Substance Abuse Emergency Response Procedures, 2001; Mental Health and Substance Abuse Emergency Response Criteria, Interim Final Rule, 2001; Mental Health and Substance Abuse Emergency Response Criteria, Final Rule, 2002). Typically awarded in cases where an incident has occurred but there is no Presidential major disaster declaration, the SERG is considered funding of last resort and cannot supplant or replace existing funds (Mental Health and Substance Abuse Emergency Response Procedures, 2001).

There are also grants, contracts, and reimbursement clauses that require disaster planning.

- In 2016 and 2019 the Centers for Medicare & Medicaid Services (CMS) published rules to establish national emergency preparedness requirements outlining coordination with federal, state, tribal, regional, and local emergency preparedness systems (CMS, 2023). The 17 provider types under the rule include community mental health centers, psychiatric residential treatment facilities, hospitals, intermediate care facilities for individuals with intellectual disabilities, rural health clinics, and federally qualified health centers.
- The Centers for Disease Control and Prevention (CDC) and the Administration for Strategic Preparedness and Response (ASPR) have oversight of the Public Health Emergency Preparedness (CDC, 2023b) cooperative agreement and Hospital Preparedness Program (ASPR, n.d.-a), respectively. These programs require disaster planning and forming coalitions with other organizations in the healthcare system. Although mental health and substance use treatment and recovery service centers are not required members of these coalitions, communities will benefit from voluntary participation in regional coalitions.

- FEMA has the Emergency Management Performance Grant (EMPG), which provides preparedness resources for state, local, tribal, and territorial emergency management agencies. This funding may support threat assessments, trainings, exercise development and delivery, and EOPs that promote equity and support the needs of underserved, at-risk communities (FEMA, 2023a).

Finally, we plan in order to meet the needs of our community, of our neighbors, of people we have been given the opportunity to—or chosen to—serve. On that note, let's talk about planning in today's environment.

Environmental Scan

A review of the current DBH landscape identified various issues and trends that should be considered during the all-hazards planning process.

Social Connection Promotes Positive DBH Outcomes

In 2023 the U.S. Surgeon General issued an advisory, *Our Epidemic of Loneliness and Isolation*. The report highlights better health and disaster outcomes with higher levels of social connection and the benefit of neighbors knowing and helping one another in disaster and emergency events. With this information, how can public behavioral health models of support to communities include aspects of social cohesion and promote community efficacy within an environment of smaller social networks and less social connection?

DBH Outreach and Access Must Be Equitable

Disasters and public health emergencies often affect populations unequally and inequitably, and the tools and resources necessary for response and recovery may not be readily available to all. Federal agencies have recognized this, with strategic plans from SAMHSA, CDC, and FEMA prioritizing the advancement of equity initiatives and measures (SAMHSA, 2023e; CDC, 2022; FEMA, 2023c).

Federal efforts are underway to expand understanding of disaster equity. For example, SAMHSA contributed to an interagency collaboration led by the HHS Administration for Children and Families to expand understanding of disaster equity, including clarifying the definition of disaster equity in a statement by the ACF's Office of Human Services Emergency Preparedness and Response as "the provision of community-specific services and resources for disaster survivors that are accessible, and culturally and linguistically tailored to mitigate disparities in health and well-being and support resilience" (2023). Stevan Hobfoll, a DBH researcher who led identification of five essential elements of immediate and mid-term mass trauma intervention that have had a global impact on disaster response (Hobfoll et al., 2007), noted in an interview (Dückers, 2013) that these principles are still the "basics" in the field of DBH, but a key issue in achieving them is access to resources and interventions, and access may be unequal and inequitable. To learn more about diversity, equity, and inclusion in disaster planning and response, you can visit the SAMHSA Disaster Technical Assistance Center (DTAC) web page on the topic.

Guidance on Climate Change Mitigation and Adaptation Is Critical

FEMA's second strategic goal for 2022–2026 is to lead whole of community in climate resilience (FEMA, 2023d). Climate change has made disasters more frequent, more intense, and more destructive—also increasing the time it takes for communities to recover. SAMHSA and partner agencies and offices within HHS, including the HHS Office of Climate Change and Health Equity (OCCHE), are working together to help behavioral healthcare professionals and organizations increase capacity to mitigate and adapt to the effects of climate change (Assistant Secretary for Health, 2022). In 2023, SAMHSA included language in its application and guidance materials for state behavioral health block grants to recognize the heightened risk people with mental illness and substance use disorders face due to climate change (SAMHSA, n.d.-a). SAMHSA also offers a web page with information about climate change and health equity, including health impacts of climate change and strategies for disaster response and increasing resilience. SAMHSA DTAC (n.d.) has developed and collected tools and resources to support extreme weather and climate-related disaster planning in the SAMHSA DBHIS. You can access these resources by going to the SAMHSA DBHIS home page and selecting the filter Climate Change in the category of Disaster Type. You can also find SAMHSA DTAC resources

at the part of its website dedicated to climate and disaster behavioral health, including a page for disaster behavioral health professionals and a page for the public.

Workforce Development and Resilience Are Key

It takes a special workforce to prepare for and respond to disasters. Large-scale disasters and public health emergencies (such as the COVID-19 pandemic) ask for a tremendous amount from this workforce. Add to this the public criticism these professionals may endure when society is looking for someone to blame in the wake of a disaster, and their resilience may be tested to the limits. The need for a robust disaster response workforce is great, but it must be accompanied with appropriate training, agreed-upon competencies, and an organizational structure that promotes staff well-being and resilience. These goals connect to FEMA's (2023e) objective of strengthening the emergency management workforce. Online trainings to help disaster and emergency responders improve their awareness and understanding of the behavioral health effects of disasters are also available from SAMHSA DTAC (2024a).

New U.S. Residents Need Greater Outreach

Due to wars, instability, and persecution in other parts of the world, the United States has seen an influx of immigrants, migrants, asylum seekers, and refugees. These newcomers may be unaware of disaster response and recovery norms and approaches, requiring additional education, unique outreach approaches, and culturally informed practices in providing psycho-education and support. For example, the CCP can provide DBH support to everyone in an impacted and declared county, regardless of legal status. It will be important to have your community assessment drive outreach to all impacted survivors. High-quality resources you can read and share with disaster survivors who are new to the United States include materials from the National Child Traumatic Stress Network (NCTSN), which offers resources about refugee trauma and immigrant, migrant, and asylum-seeking children and families. You may also want to identify and connect with your state's refugee coordinator and refugee health coordinator, professionals who have generally been designated by your state in coordination with the U.S. Department of Health and Human Services' Administration for Children and Families' Office of Refugee Resettlement. These coordinators may be able to provide more information about organizations serving people new to the United States and resources available to people of various immigration statuses.

Accurate Information Must Be Channeled Through Modern Systems

Both information and misinformation can spread quickly following a disaster, leading to confusion. Health systems that do not communicate with one another can lead to disruption, delay, or misalignment in patient care. Conversely, fast and efficient data collection and public health messaging can save lives. Accessing U.S. Census, CDC, Agency for Healthcare Research and Quality (AHRQ), and SAMHSA baseline health data—in addition to frequent and comprehensive assessments after a disaster hits—can promote more equitable response and recovery. An emphasis on data modernization and improved information sharing is also an important focus of the emergency management community. It is a complicated and costly issue to tackle but must be a part of any discussion on whole-community response and recovery. Better systems can promote more efficient recovery for disaster survivors and lead to more accurate outcome measures and data for future research on topics of disaster preparedness, response, and recovery.

The 988 Suicide & Crisis Lifeline system—previously known as the National Suicide Prevention Lifeline established in 2005—offers 24/7 call, text, and chat access to skilled crisis counselors who can help people experiencing suicidal crisis or emotional distress. Since July 2022, states have received funding to transition to the new three-digit dialing code (988 for call, text, or chat), which directs people to the modernized resource (n.d.-b). The previous Lifeline phone number is still active, in case it is still being promoted by older information resources. You should consider including referral to 988 in protocols for triage when someone is showing signs of unresolved distress or thoughts of suicide. The SAMHSA Disaster Distress Helpline (DDH) (2023a) is also available for call or text at 1–800–985–5990. SAMHSA DDH crisis counselors can offer support to survivors experiencing concerns related to mental illness and substance use, and at any point after disaster from the acute post-disaster period through long-term recovery. They are trained in Psychological First Aid (PFA), an evidence-informed approach to helping disaster survivors discussed in greater detail in the Disaster Interventions section of this guide.

Why "All-hazards"?

This guide offers a planning approach to address all hazards, or the various types of incidents that may affect your area. Several policies and laws that help structure emergency management and disaster planning in the United States call for an all-hazards approach. These include Homeland Security Presidential Directive-5 (2003), the Public Health Service Act (Public Law 78–410, 1944), and the Pandemic and All-Hazards Preparedness Act of 2006 (PAHPA, Public Law 109–417, 2006) and its reauthorizations (ASPR, n.d.-d).

An all-hazards plan (AHP) must be capable of responding promptly to requests for assistance from a variety of government and nongovernmental entities in the context of potential or actual natural, human-caused, accidental, or technological emergencies or disasters. AHPs provide an all-discipline, comprehensive framework for coordinated response and recovery activities in all types of disasters and emergencies. AHPs should include planning for response, short-term recovery, and long-term recovery. Typically AHPs will also have underlying assumptions, including the possibility that one or more disaster events may be happening during the same period of time.

All too often, emergency planners focus on lessons learned from the last disaster they experienced to build their disaster plan. Using an all-hazards approach helps planners think about a variety of possible and probable disaster events, based on what has happened in the past, evaluation of disasters that could happen in a particular geographic area, and information about unanticipated disasters that should be included, even if there is a perception that the probability of those events occurring seems small.

Several resources may be helpful to you in developing AHPs, including the Federal Emergency Management Agency Preparedness Toolkit, Emergency Preparedness and Response section of the website of the Centers for Disease Control and Prevention, and SAMHSA's *Technical Assistance Publication (TAP) 34: Disaster Planning Handbook for Behavioral Health Service Programs*.

An Overview of Disaster Behavioral Health

During a DBH response, responders often need to reach survivors using community outreach strategies. Most people who are coping following a disaster do not see themselves as needing mental health services and are not likely to seek them out or request them.

Additional key concepts of DBH include the following:

- No one who sees a disaster is untouched by it.
- Most people pull together and function during and after a disaster, but their effectiveness is diminished.
- Disaster stress and grief reactions are common responses to an uncommon situation.
- Many emotional reactions of disaster survivors stem from problems of living brought about by the disaster.
- Survivors may reject disaster assistance of all types.
- Survivors may increase use of alcohol and other substances following a disaster.
- Disaster mental health assistance is often more practical than psychological in nature.
- Disaster mental health services must be uniquely tailored to the communities they serve.
- Mental health workers need to set aside traditional methods, avoid the use of mental health labels, and use an active outreach approach to intervene successfully in disaster.
- DBH providers should recognize the effects of substance use and incorporate prevention, treatment, and recovery resources into their programs.
- Survivors respond to active, genuine interest and concern.
- Interventions must be appropriate to the phase of disaster recovery.
- Social support systems are crucial to recovery.

Disasters are complicated. Remember to always deploy as part of an integrated response system. Self-deployment of unaffiliated responders can create another layer of chaos in an already complex environment (SAMHSA DTAC, 2023).

Relevant Terminology

Traditional mental health and substance use treatment and recovery services support people with behavioral health conditions, and services often are provided by clinicians within offices or facilities. Diagnosis and case management may be part of this treatment.

Day-to-day behavioral health crisis response services are a specialized set of services that occur outside of traditional behavioral health treatment settings, and are often provided at a person's home or other places in the community. They aim to reduce unnecessary emergency department visits, inpatient hospitalizations, and engagement with law enforcement for people experiencing a behavioral health crisis. These services most often focus on immediate response to people who may be in distress and experiencing acute mental illness or substance use conditions. Training, such as Mental Health First Aid, focuses on building capacity in diverse communities to support people who may be experiencing mental illness or substance use disorders.

In comparison, the goals of disaster crisis counseling services focus on supporting people who may be in early stages of shock immediately after a disaster event, or who may be experiencing displacement and other stressors due to the disaster event. Disaster crisis counseling focuses on the tools of Psychological First Aid (PFA), stress reduction, psycho-education, and, if needed, linkage to other levels of care within the behavioral health system. These services are based on DBH, which SAMHSA describes as understanding and provision of mental, emotional, and substance use services to and interventions for persons and communities impacted by disasters. DBH encompasses the delivery of behavioral health and stress management interventions to address and promote mental health, reduce substance misuse, and foster resilience and recovery. Figure 1 shows the different, but complementary, behavioral health services that may be part of the continuum of care in disaster-impacted communities.

Figure 1. Elements of Continuum of Care in Disaster-affected Communities

Traditional Treatment	Crisis Response Services	Disaster Crisis Counseling
• Office-based. • May involve diagnosis and treatment of a mental health or substance use condition, as well as identification of strengths, coping skills, and supports for recovery. • May focus on longer-term goals. • Validates experiences associated with distress that have brought the person to treatment. • Keeps records, charts, case files, etc.	• Crisis lines accepting all calls and dispatching support based on the assessed need of the caller. • Mobile crisis teams dispatched to the location of the person in crisis. This can require 48–72 hours in some large metro areas. • Crisis receiving and stabilization facilities serve everyone coming through their doors from all referral sources. • Not a replacement for ongoing behavioral health treatment and recovery services. • Reduce unnecessary emergency department visits, inpatient hospitalizations, and engagement with law enforcement for people experiencing a behavioral health crisis.	• Home- and community-based. • Involves identification of strengths and coping skills. • Counsels on disaster-related issues. • Validates common reactions and experiences. • Does not collect identifying information. • Referral, as needed, to traditional behavioral health services.
Mental Health First Aid (MHFA) training is commonly recommended to paraprofessionals for the recognition of mental illness and substance misuse issues in the populations they serve.*		Psychological First Aid (PFA) is the evidence-informed approach recommended for use by disaster responders in the immediate phase of response and recovery.*

* Keep in mind that disasters can exacerbate existing mental health and substance use disorders, so understanding both models may be helpful.
Sources: SAMHSA DTAC, 2024b; SAMHSA, 2023a

Several connected but unique terms are used in our field. They all center around the behavioral health and well-being of disaster survivors, with slight variations in meaning and context.

Disaster mental health: Provision of prevention, outreach, screening, triage, PFA, education, and referral services for individuals and groups who have had or may have had exposure to an all-hazards incident (Military Health System, 2019). In response to Hurricane Andrew in 1992, the American Red Cross mobilized disaster mental health personnel in what is considered by some to be the first implementation of a disaster mental health team post-disaster (Everly, 2021).

Disaster behavioral health: The field of disaster behavioral health (or DBH) integrates principles from psychology, psychiatry, social work, and public health to provide comprehensive support to individuals and communities affected by catastrophic events and recognizes the importance of integrating psychological services during and after disasters to support individuals and communities in coping with trauma, stress, and grief. The field of DBH is an integral part of overall public health and medical preparedness, response, and recovery systems, and includes integration of behavioral health medical expertise along with broader disaster behavioral health specialists as part of mass care emergency response.

Behavioral health: Behavioral health is "the promotion of mental health, resilience, and wellbeing; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities" (SAMHSA, n.d.-b).

Psychosocial support: Psychosocial support is the process of facilitating and strengthening resilience within individuals, families, and communities to recover from and adapt to critical adversities with potentially damaging long-term impacts. Psychosocial support thus promotes the restoration of social cohesion and infrastructure (International Committee of the Red Cross, 2018).

Mental health and psychosocial support: Any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder (Inter-Agency Standing Committee [IASC], 2007).

Disaster emotional care: Disaster emotional care providers offer comfort, support, and resources to individuals, families, and communities throughout all phases of the disaster cycle (National Voluntary Organizations Active in Disaster [NVOAD], 2020).

Disaster spiritual care: Disaster spiritual care is a sustaining care that assists people in drawing on their own inner and external religious or spiritual resources. In the context of a disaster, spiritual care providers respond to the need for spiritual meaning and comfort by providing accompaniment, compassionate care, individual and communal prayer, and appropriate ritual (NVOAD, 2020).

Substance use disorder (SUD): A health condition characterized by a cluster of cognitive, behavioral, and physiological symptoms that describe an individual's compulsive use of a substance despite significant adverse impacts associated with the use (American Psychiatric Association, 2022).

Disaster Reactions and Interventions

Everyone person who experiences a disaster is affected by it in some way, but people are not all affected in the same way. Common disaster reactions can vary by age, culture, previous exposure to other disasters or traumatic events, social cohesion, and overall life experience (among other factors). Although disaster reactions will not look the same for every person affected by a disaster, the following tables list common disaster reactions and interventions by age group. In the field of DBH, we say that these are "common reactions to an uncommon situation."

Table 1. Disaster Reactions and Interventions: Preschool

Disaster Reactions and Interventions					
Age Group	**Behavioral Reactions**	**Physical Reactions**	**Emotional Reactions**	**Cognitive Reactions**	**Intervention Options**
Preschool (1–5)	• Clinging to parents or familiar adults • Helplessness and passive behavior • Avoidance of sleeping alone • Increased crying	• Loss of appetite • Stomachaches • Nausea • Sleep problems or nightmares • Speech difficulties • Tics • Resumption of bed-wetting or thumb-sucking	• Anxiety • Generalized fear • Fear of the dark • Irritability • Angry outbursts • Sadness • Withdrawal	• Preoccupation with disaster • Poor concentration • Recurring dreams or nightmares	• Give verbal reassurance and physical comfort • Clarify misconceptions repeatedly • Provide comforting bedtime routines • Help with labels for emotions • Avoid unnecessary separations • Permit child to sleep in parents' room temporarily • Demystify reminders • Encourage expression regarding losses (deaths, pets, toys) • Monitor media exposure • Encourage expression through play activities

Table 2. Disaster Reactions and Interventions: Childhood

Disaster Reactions and Interventions					
Age Group	**Behavioral Reactions**	**Physical Reactions**	**Emotional Reactions**	**Cognitive Reactions**	**Intervention Options**
Childhood (6–11)	• Decline in school performance • School avoidance • Aggressive behavior at home or school • Hyperactive or silly behavior • Whining, clinging, or acting like a younger child • Increased competition with younger siblings for parents' attention • Traumatic play and reenactments	• Change in appetite • Headaches • Stomachaches • Sleep disturbances or nightmares • Somatic complaints	• Fear of feelings • Withdrawal from friends or familiar activities • Fears triggered by reminders • Angry outbursts • Preoccupation with crime, criminals, safety, and death • Self-blame • Guilt	• Preoccupation with disaster • Poor concentration • Recurring dreams or nightmares • Disorientation or confusion • Flashbacks • Questioning of spiritual beliefs	• Give additional attention and consideration • Relax expectations of performance at home and at school temporarily • Set gentle but firm limits for acting out • Provide structured but undemanding home chores and rehabilitation activities • Encourage verbal and play expression of thoughts and feelings • Listen to child's repeated retelling of traumatic event • Clarify child's distortions and misconceptions • Identify and assist with reminders • Develop school program for peer support, expressive activities, education on trauma and crime, and preparedness planning

Table 3. Disaster Reactions and Interventions: Pre-adolescence and Adolescence

Disaster Reactions and Interventions					
Age Group	**Behavioral Reactions**	**Physical Reactions**	**Emotional Reactions**	**Cognitive Reactions**	**Intervention Options**
Pre-adolescence and Adolescence (12–18)	• Decline in academic performance • Rebellion at home or school • Decline in responsible behavior • Agitation or decrease in energy level, or apathy • Risk-taking behavior • Social withdrawal • Abrupt shift in relationships	• Appetite changes • Headaches • Gastrointestinal problems • Rashes • Complaints of aches and pains that don't seem to have a physical cause • Sleep problems	• Loss of interest in peer social activities, hobbies, or recreation • Sadness or depression • Anxiety and fearfulness about safety • Resistance to authority • Feelings of inadequacy and helplessness • Guilt, self-blame, shame, and self-consciousness • Desire for revenge	• Preoccupation with disaster • Poor concentration • Recurring dreams, nightmares, or flashbacks • Disorientation or confusion • Questioning of spiritual beliefs • Difficulty setting priorities • Difficulty making decisions • Loss of objectivity	• Give additional attention and consideration • Relax expectations of performance at home and school temporarily • Encourage discussion of experience of trauma with peers and significant adults • Avoid insistence on discussion of feelings with parents • Address impulses to act recklessly • Link behavior and feelings to the disaster event • Encourage physical activities • Encourage resumption of social activities, athletics, clubs, etc. • Encourage participation in community activities and school events • Develop school programs for peer support and debriefing, special student support groups, hotlines, chat support numbers, and drop-in centers

Table 4. Disaster Reactions and Interventions: Adults

Disaster Reactions and Interventions					
Age Group	**Behavioral Reactions**	**Physical Reactions**	**Emotional Reactions**	**Cognitive Reactions**	**Intervention Options**
Adults	• Sleep problems • Avoidance of reminders of the disaster • Excessive activity level • Protectiveness toward loved ones • Crying easily • Angry outbursts • Increased conflicts with family • Hypervigilance • Isolation, withdrawal, or shutting down	• Nausea • Headaches • Fatigue or exhaustion • Gastrointestinal distress • Appetite change • Somatic complaints • Worsening of chronic conditions	• Shock, disorientation, and numbness • Depression or sadness • Grief • Irritability or anger • Anxiety or fear • Despair or hopelessness • Guilt or self-doubt • Mood swings	• Preoccupation with disaster • Poor concentration • Recurring dreams, nightmares, or flashbacks • Disorientation or confusion • Questioning of spiritual beliefs • Difficulty setting priorities • Difficulty making decisions • Loss of objectivity	• Provide supportive listening and opportunity to talk about experience and losses • Ensure access to emergency medical services • Provide frequent rescue and recovery updates and resources for answers to questions • Assist with prioritizing and problem solving • Help family to facilitate communication and effective functioning • Provide information on traumatic stress and coping, children's reactions, and tips for families • Provide information on criminal justice procedures and roles of primary responder groups • Provide crime victim services • Assess and refer, when indicated • Provide information on referral resources • Provide information on substance misuse self-help (for self, family, friends)

Table 5. Disaster Reactions and Interventions: Older Adults

Disaster Reactions and Interventions					
Age Group	**Behavioral Reactions**	**Physical Reactions**	**Emotional Reactions**	**Cognitive Reactions**	**Intervention Options**
Older Adults	• Withdrawal and isolation • Reluctance to leave home • Mobility limitations • Relocation adjustment problems	• Worsening of chronic illnesses • Sleep problems • Memory problems • More susceptibility to hypothermia and hyperthermia • Physical and sensory limitations (sight, hearing) that interfere with recovery	• Depression • Despair about losses • Apathy • Suspicion • Agitation or anger • Fears of institutionalization • Anxiety about unfamiliar surroundings • Embarrassment about receiving "handouts"	• Preoccupation with disaster • Poor concentration • Recurring dreams, nightmares, or flashbacks • Disorientation or confusion • Questioning of spiritual beliefs • Difficulty setting priorities • Difficulty making decisions • Loss of objectivity	• Provide strong and persistent verbal reassurance • Provide orienting information • Ensure physical needs are addressed (water, food, warmth) • Use multiple assessment methods, as problems may be underreported • Assist with reconnecting with family and support systems • Assist in obtaining medical and financial assistance • Encourage discussion of traumatic experience and losses and expression of emotions • Provide crime victim assistance • Provide information on substance misuse self-help (for self, family, friends)

Adapted from SAMHSA, 2000.

The FEMA CCP emphasizes that DBH responders should screen for, but not assume, that disaster survivors have a diagnosable mental disorder following a disaster. As described in the preceding tables, many people will experience reactions to stress during and after a disaster. Smaller proportions of disaster survivors will experience the disaster as traumatic. Some will also have experienced trauma before the disaster. Disaster responders should be familiar with the following concepts related to trauma and disaster, as they may have implications for how DBH and other disaster-related services are planned and provided.

Trauma

SAMHSA (2023b) defines trauma as "an event, series of events, or a set of circumstances an individual experiences as physically or emotionally harmful or threatening, which may have lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being." SAMHSA notes that trauma may affect an individual, a community, or a culture.

DBH professionals, practitioners, and volunteers should know what trauma means because:

- People may experience trauma as part of a disaster. Also, people you work with and serve may have had lived experience of trauma before the disaster.
- Trauma may have consequences for health, including behavioral health.
- If not designed thoughtfully, systems of care may accidentally trigger reexperiencing of trauma or other intensely difficult feelings or experiences in people with trauma, and so it is important for systems of care to be trauma-informed.

You can learn more about trauma-informed approaches to care in SAMHSA's *Practical Guide for Implementing a Trauma-Informed Approach* (2023b). Designed for organizations and systems, the guide explores trauma and its prevalence, describes trauma-informed approaches, and suggests steps for planning, implementing, evaluating, and sustaining trauma-informed approaches. You can also learn more about trauma-informed care from SAMHSA's *Treatment Improvement Protocol (TIP) Series No. 57: Trauma-Informed Care in Behavioral Health Services* (2014).

Resilience

People use the word "resilience" in many ways. They may use it to refer to individual resilience or community resilience. In the *Federal Plan for Equitable Long-Term Recovery and Resilience for Social, Behavioral, and Community Health*, federal agencies offer a shared definition:

> *The capacity of people, communities, and systems—including families, households, organizations (e.g., healthcare institutions), businesses, enterprises, and infrastructure—to equitably adapt, prepare, and recover from episodic, persistent, and layered stressors and shocks to thrive together.*

In addition, FEMA has published *National Resilience Guidance* with a working definition of resilience as "the ability to prepare for threats and hazards, adapt to changing conditions, and withstand and recover rapidly from adverse conditions and disruptions."

FEMA's National Resilience Guidance emphasizes that strengthening resilience requires a collective approach. Addressing resilience from only one perspective or through only one lens will not be successful. Equally important is the need to consider the interdependence of all facets of resilience such as climate, ecosystem, social, economic, infrastructure, and disaster resilience. A key goal of the work you do in DBH planning involves engaging communities. Because some populations in the United States have less access to resources than others, it is important in to plan with communities to support resilience across diverse populations and to adapt policies and program design, when possible, to support equity and whole-community approaches to disaster planning. Disaster resilience planning aims to ensure that all the populations in a disaster-affected community will have access to the resources they need before, during, and after disasters.

Disaster Interventions

From early to mid-term stages of DBH support, the foundational article Five Essential Elements of Immediate and Mid-Term Mass Trauma Intervention: Empirical Evidence (Hobfoll et al., 2007) is used to inform intervention and prevention efforts following disasters and mass violence. The article identifies several principles that intervention and prevention efforts should include and promote in the disaster-affected community:

- A sense of safety
- Calming
- A sense of self-efficacy and community efficacy
- Connectedness
- Hope

The authors note that these principles should be core to both individual and community-focused interventions, and they provide both public health and individual/group measures for each principle.

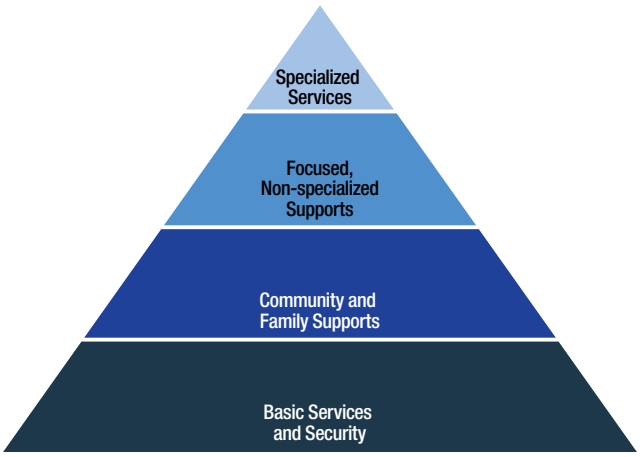
The early intervention PFA (National Child Traumatic Stress Network, n.d.-a) is informed by the empirical evidence and five principles noted above. The IASC's (2007) Guidelines on Mental Health and Psychosocial Support in Emergency Settings also connects to these principles within their approach and intervention pyramid (Figure 2).

Did You Know? Spotlight on SPR

The National Center for PTSD and National Child Traumatic Stress Network also developed an intervention called Skills for Psychological Recovery, or SPR. While PFA is intended for use in the days and weeks following disaster, SPR addresses needs of survivors of trauma, including disaster trauma, in the weeks and months following the incident, as the community moves from response to recovery. SPR involves helping disaster-affected individuals and communities develop and strengthen core skills to lower stress and cope effectively. Learn more from

- The *Skills for Psychological Recovery Field Operations Guide*
- The SAMHSA DTAC *Supplemental Research Bulletin* with an inventory of DBH interventions

Figure 2. Intervention Pyramid for Mental Health and Psychosocial Support in Emergencies



Source: IASC, 2007.

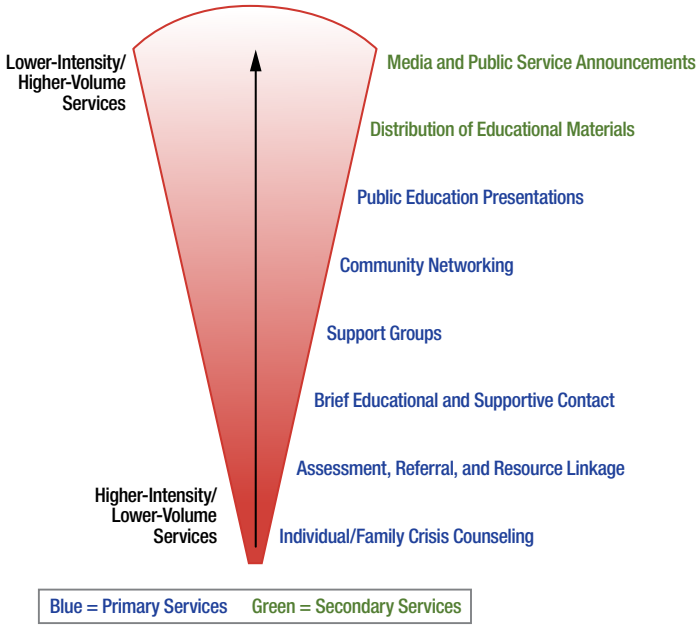
In addition to being informed by the five essential elements described above, PFA is also a widely adopted, evidence-informed framework for supporting disaster-affected communities. In 2006, the National Child Traumatic Stress Network and the National Center for PTSD co-authored a manual that lists eight core actions of PFA:

- Contact and engagement
- Safety and comfort
- Stabilization
- Information gathering
- Practical assistance
- Connection with social supports
- Information on coping
- Linkage with collaborative services

Since that time, other versions of PFA have been developed by organizations such as the World Health Organization, American Red Cross, Johns Hopkins University, HHS, the National Association of County and City Health Officials, the University of Nebraska Public Policy Center, and more. There are versions for paraprofessional disaster responders, educators, community religious professionals, public health and healthcare staff, and others. This is important to note, as professional and paraprofessional staff and volunteers who can provide PFA after being trained to do so may come from various fields and sectors; they may include mental health professionals, hospital staff, partners in voluntary organizations active in disaster (VOAD), and Medical Reserve Corps (MRC) volunteers.

The CCP—a federal grant program implemented by FEMA and administered and overseen by SAMHSA—bases its crisis counseling activities around the PFA model. The CCP's mission is to assist individuals and communities in recovering from the psychological effects of disasters through the provision of community-based outreach and educational services. Figure 3 shows the range and intended reach of CCP services in the community. Services requiring more time and specificity which are provided for smaller populations are included toward the bottom of the graphic, while services requiring less time and specificity to particular populations appear toward the top of the graphic.

Figure 3. Range of CCP Services



In the Disaster Behavioral Health Interventions Inventory issue of a research newsletter produced by SAMHSA DTAC, the *Supplemental Research Bulletin* (2022a), disaster interventions are categorized by the time in which they should be administered after a disaster (early, intermediate, and long-term). Web-based and mobile app interventions are also listed, in addition to service delivery models and telephone/hotline resources.

Keep in mind the following:

- Behavioral health needs will vary by the scope, size, and severity of the disaster.
- People who experience direct disaster exposure are not the only people affected. People in their households and families will be affected as well. In some disaster situations, the whole community is affected, even if they were not physically in the location of the disaster events at the time of the disaster.

- To prevent burnout in response workers:
  - Set the tone by relating to workers with respect and valuing their contributions.
  - Foster connections between and among workers, helping them build a sense of team cohesion.
  - Help workers understand the meaningful nature of their work and how they contribute to the team.
  - Ensure that lines of communication are clear.
  - Establish clear lines of authority and responsibility so everyone knows who reports to whom. This reduces confusion and uncertainty, which can help lower stress. Clearly define individual roles and reevaluate them if the situation changes.
  - Provide sufficient staffing to prevent responders from becoming overworked or overwhelmed.
  - Encourage responders to take breaks and rotate staff across the more complicated assignments. Prioritize allowing each responder to get enough sleep on a regular schedule (SAMHSA DTAC, 2022b).

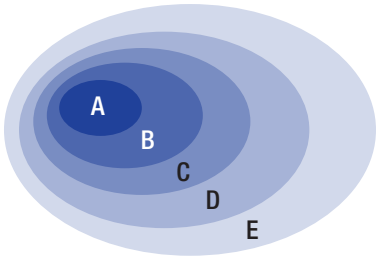
Additional suggestions are provided in SAMHSA's *A Guide to Managing Stress for Disaster Responders and First Responders.*

Disaster Models To Inform Planning

Population Exposure Model

The HHS (2004) publication *Mental Health Response to Mass Violence and Terrorism: A Training Manual* introduced the Population Exposure Model as a way to think about which groups might be affected in a disaster and how to prioritize outreach and services for those most impacted. At its core is the principle that those "who are most personally, physically, and psychologically exposed to a trauma and the disaster scene are likely to be affected the most" (HHS, 2004, p. 12). Figure 4 shows the model, its levels of exposure, and the populations that may fit within the exposure levels. The overall goal in using this model is to help determine the impact and behavioral health service needs for each group.

Figure 4. Population Exposure Model

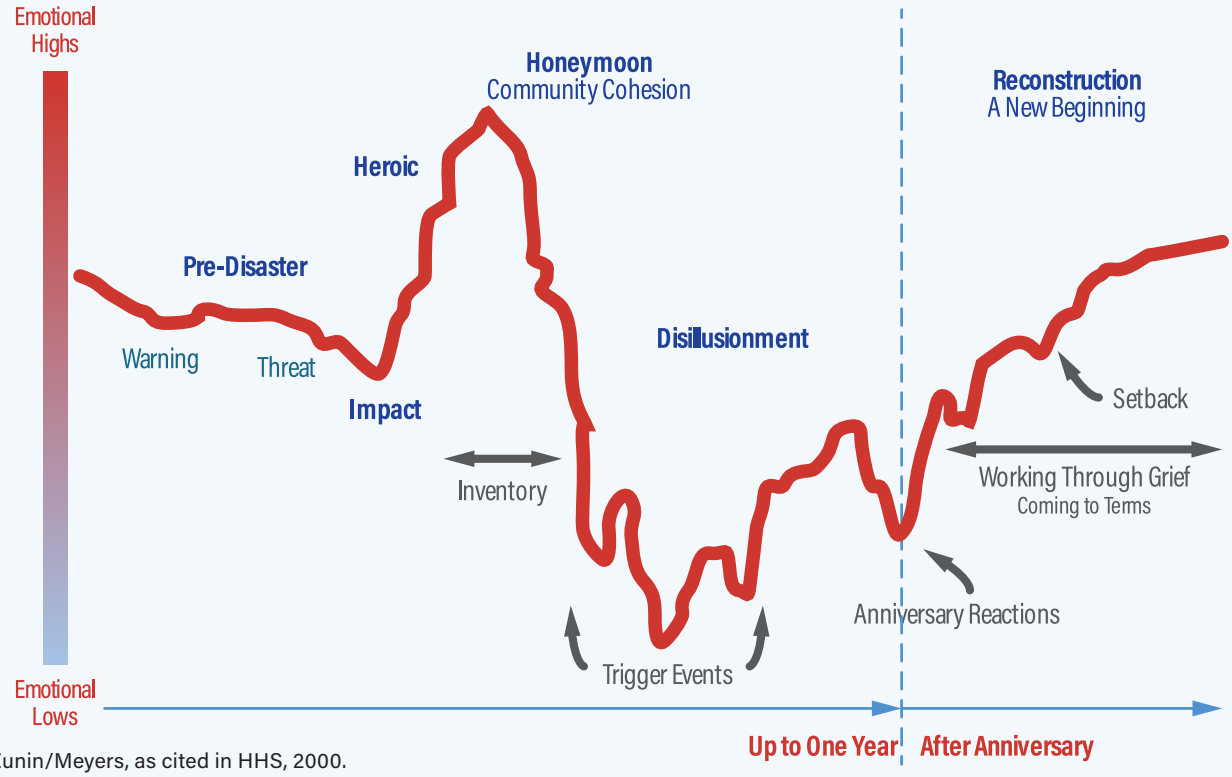


A	Injured survivors, bereaved family members
B	Survivors with high exposure to the disaster or evacuated from disaster zones
C	Bereaved extended family and friends, first responders
D	People who lost homes, jobs, or possessions; people with preexisting trauma; special populations; disaster responders
E	People affected by the disaster from the larger community

Phases of Disaster Model

In thinking about DBH service delivery planning, another helpful model to review is the Phases of Disaster Model (Figure 5) (HHS, 2000). This model illustrates the collective community's response to a disaster, and the emotional highs and lows that may come over time. It helps prevent us from thinking about recovery as a linear process and considers the range of factors affecting individuals and a community days and months after a disaster's impact. This model can also help a disaster planner anticipate and plan for successive phases in recovery.

Figure 5. Phases of Disaster Model



Source: Zunin/Meyers, as cited in HHS, 2000.

Note: The timeline of these phrases may differ in the context of different types of disasters.

Typical Phases of Disaster—Collective Community Reactions

Pre-disaster phase:

- Disasters with no warning can cause feelings of vulnerability, lack of security, and loss of control; fear of future unpredicted tragedies; and inability to protect yourself and your family.
- Disasters with warning can cause guilt or self-blame for failure to heed warnings.

Impact phase:

- Reactions can range from shock to overt panic.
- Initial confusion and disbelief are followed by a focus on self-preservation and family protection.

Heroic phase:

- Many survivors exhibit adrenaline-induced rescue behavior, as well as high activity with low productivity.
- Risk assessment may be impaired.
- There is a sense of altruism.

Honeymoon phase:

- Disaster assistance is readily available.
- Community bonding occurs.
- Many are optimistic that everything will quickly return to normal.
- Crisis counseling program staff members can establish program identity, gain access to survivors, and build relationships with advocacy groups.

Disillusionment phase:

- Stress and fatigue take a toll.
- Optimism turns into discouragement.
- Need for substance use services may increase.
- The larger community returns to business as usual.
- Demand for crisis counseling services may increase as individuals and communities become ready to accept support.

Reconstruction phase:

- Individuals and communities begin to assume responsibility for rebuilding their lives.
- People begin adjusting to new circumstances.
- There is a recognition of growth and opportunity.

Model for Adaptive Response to Complex Cyclical Disasters

The Model for Adaptive Response to Complex Cyclical Disasters was developed out of a collaboration involving Vibrant Emotional Health, the Group for the Advancement of Psychiatry, and Decision Point Systems (2022). It aims to capture the impacts of disasters on communities when more than one disaster is occurring at the same time, as happened during the COVID-19 pandemic.

This model introduces a revised "Phases of Disaster," from anticipation, to impact, adaptation, and growth and recovery.

Anticipation

- This phase is characterized by threat and anticipatory anxiety immediately preceding the impact phase.
- The level of anticipation and preparation may be high, depending on the nature of the disaster.
- If there is no anticipation, with an initial, sudden onset event, this phase is brief.
- If there are intervals between cycles which allow for preparation, or ebbs and flows of intensity, this phase may be relatively calm.
- It is key to make the most of the opportunities available during this time for recuperation, integrating lessons learned, triage, and preparation.

Impact

- This phase is intense and characterized by an extreme focus on survival.
- People and groups may have little ability to assess overall impact beyond the immediate line of sight.
- The psychological impact of this phase is largely defined by the degree of exposure to the disaster and uncertainty of survival.
- Isolation and lack of knowledge of the fate of loved ones in this phase amplify the risk of negative impact to individuals.

Adaptation

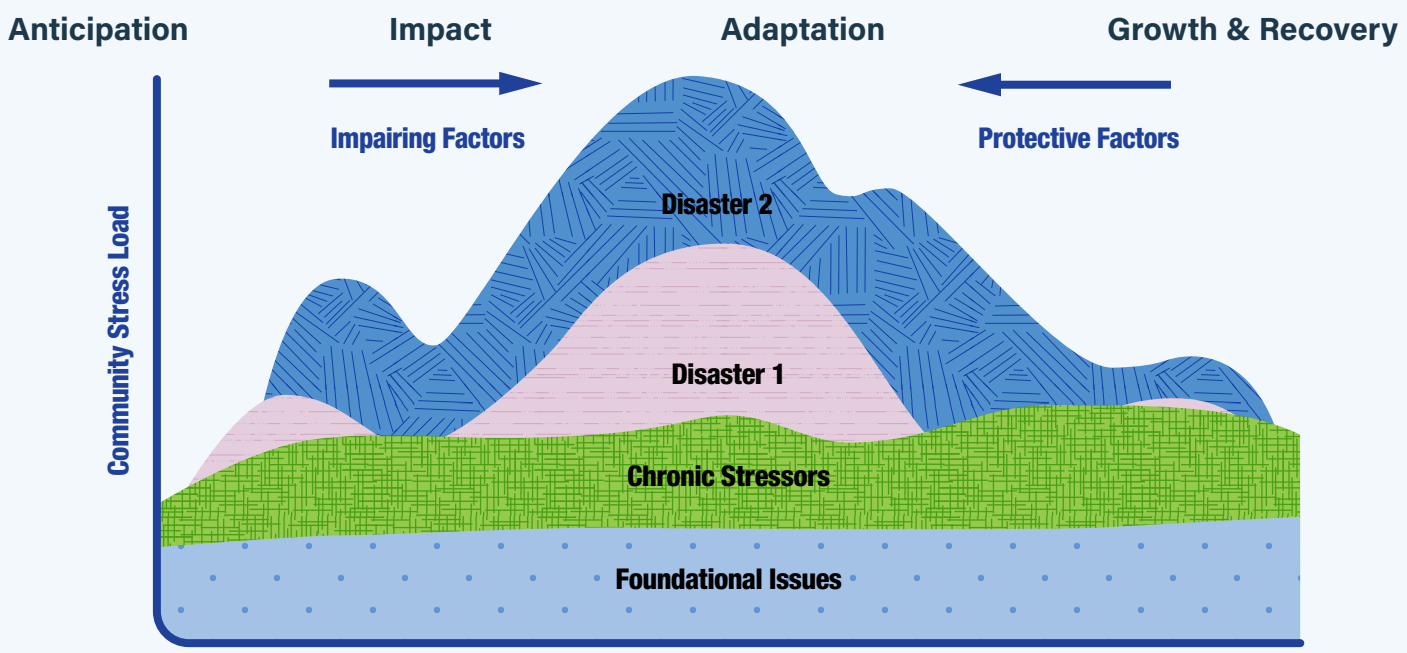
- This phase begins within 24 to 48 hours of the impact phase.
- It is characterized by feelings of relatively greater safety and stability and the opportunity to begin acute recovery.
- There is an initial sense of altruism, followed by potential disappointment, anger, and resentment.
- Initially, energy is high, and people are grateful to have survived the disaster and work hard to help each other.
- Next, individuals and communities realize the limits of disaster assistance and people may feel abandoned, especially given delays in aid or inequities in its availability.

Growth & Recovery

- This phase is marked by a restoration of previous or new routines, accompanied by the feeling of things being "back to normal" or part of a "new normal."
- Temporary response teams are disbanded, and resources are replenished.
- The trajectory of this phase is highly dependent on the intensity of disaster experiences, social support, availability of resources, and conflict within and between subcommunities.

A second part of the Model for Adaptive Response to Complex Cyclical Disasters is the Community Stress Load Threshold (Figure 6), which is useful as a visualization of how the response community can strengthen **protective factors** and address **impairing factors** to stay below the load threshold.

Figure 6. Model for Adaptive Response to Complex Cyclical Disasters: Community Stress Load Threshold



Acute Stressors

Health crisis, economic crisis, environmental crisis, and police-community conflict (Disaster 1 & 2)

Chronic Stressors

Violence, poor population health, housing instability, lack of political representation, and population loss

Foundational Issues

Unemployment, low trust in institutions, intergenerational poverty, discrimination, etc.

To explore the full model, please visit https://marccd.info.

The Planning Process

Benefits of the Planning Process

As stated in the introduction, the process of planning and establishing relationships with other responders is just as important as the production of the resulting plan. Some specific benefits are as follows:

- Having a good working relationship with the state emergency management agency (SEMA) with mutual trust and an established response structure makes it easier to modify plans in the future.
- The planning process can enhance relationships with other response partners and VOADs such as the American Red Cross.
- The planning process enhances collaborations with other state and county agencies.
- The planning process facilitates the completion of threat and hazard identification and risk assessments.
- The planning process requires buy-in from senior leadership. Exposure to planning and response requirements may help encourage the allocation of part- or full-time staff hours for this purpose.

Limitations, Barriers, and Challenges in Implementing Plans

There are also challenges to developing and implementing plans, including:

- The lack of allocated staff time and financial resources for the work
- A low prioritization of disaster planning, as other work tasks and projects may seem more pressing and have more visibility to the community being served
- Planning for a disaster disruption by an already stretched workforce and behavioral health system, which may feel overwhelming
- Behavioral health being overlooked in favor of safety and security concerns
- Staff turnover in both your agency and in partner agencies, requiring a reestablishment of relationships and knowledge transfer
- The lack of well-defined behavioral health services and interventions, which can make implementation and plan adoption difficult
- Limited nature, or absence, of behavioral health response and recovery elements in disaster exercises with state partners

Getting Started

Understanding Existing Plans, Resources, and Authorities

Federal NIMS and ICS Structures

Homeland Security Presidential Directive-5 (2003) directs federal agencies to adopt the National Incident Management System (NIMS) and encourages others involved in disaster planning and preparedness to do the same—state, local, tribal, and territorial governments; private sector organizations; critical infrastructure owners and operators; and nongovernmental organizations (NGOs) involved in incident management and support (FEMA, 2020).

Adopting NIMS means to adopt the principles, structures, and processes that link all responders together to promote a coordinated response that is greater than the response capacity from any single agency. Adopting a common planning and response vocabulary and structure also promotes a timely and effective response, especially when timelines matter.

NIMS also includes the structure of the Incident Command System (ICS), as well as the structure for an Emergency Operations Center (EOC). Understanding how all these systems and structures fit together and who your response team will be ultimately helps you develop a NIMS training plan.

Think about your response personnel for a moment. Are they making high-level decisions on behalf of the organization and in coordination with other entities? Do they have a seat within the EOC? Are they in leadership positions with oversight responsibilities? Or are they responding at a shelter, supporting the impacted community? Their role and level of coordination with other responders will dictate what level of training will best equip them for a response.

For planning purposes, you should be thinking in terms of what a particular position needs to know to be able to interact and collaborate with other responders using the same vocabulary and approach. NIMS establishes these qualifications for incident personnel in the *National Incident Management System Training Program* guide, with the ICS training progression of courses outlined below as an example (FEMA, 2020).

Table 6. Qualifications for Incident Personnel

NIMS Titles and Qualifications			
Responder Type	**Course Name**	**Type**	**Target Audience**
All incident personnel	IS-100 Introduction to ICS	Computer-based 3 hours	Emergency managers/responders
	IS-700 Introduction to NIMS	Computer-based 3 hours	Emergency managers
Incident personnel with leadership responsibilities (courses above, plus. . .)	IS-200 Basic ICS for Initial Response	Computer-based 4 hours	Response personnel at the supervisory level who are involved with emergency planning, response, or recovery efforts
	IS-800 National Response Framework, An Introduction	Computer-based 3 hours	All personnel involved in whole community national response efforts
Incident personnel designated as leaders/ supervisors (courses above, plus . . .)	G0191 EOC/ICS Interface	Course delivered by individual agencies/ jurisdictions	For emergency management and response personnel to begin developing an ICS/EOC interface for their communities
	ICS-300 Intermediate ICS	Course delivered by individual agencies/ jurisdictions	Personnel who require advanced ICS knowledge
	ICS-400 Advanced ICS	Course delivered by individual agencies/ jurisdictions	Training in managing large, complex incidents or events

Note: Some responder types may be advised to complete additional courses based on role (see NIMS training program document for more information) (FEMA, 2020).

Understanding the same vocabulary and structures is important to be able to work and communicate within your own state, but it is also crucial when supporting a disaster response inside a different state. Governor-declared states of emergency or disasters allow for a system of assistance known as the Emergency Management Assistance Compact (EMAC). This system allows for personnel, equipment, and commodities support, and EMAC membership includes all 50 U.S. states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and the Northern Mariana Islands (Emergency Management Assistance Compact, n.d.).

Resources are deployed through the SEMA. As part of this process, it may be helpful to become familiar with NIMS resource typing and the behavioral health-related position qualifications that may be required in a mutual aid request.

For example, in a search of positions related to the field of behavioral health, the following personnel resources are published within FEMA's Resource Typing Library Tool (DHS, n.d.).

Table 7. Behavioral Health-related Positions and Teams in FEMA's Resource Typing Library Tool

ID	Type	Name	Resource Category	Primary Core Capability
12-509-1220	Position Qualification	Behavioral Health Chaplaincy Specialist	Medical and Public Health	Public Health, Health Care, and Emergency Medical Services
12-508-1186	Resource Typing Definition	Behavioral Health Community Services Team	Medical and Public Health	Public Health, Health Care, and Emergency Medical Services
12-509-1221	Position Qualification	Behavioral Health Specialist	Medical and Public Health	Public Health, Health Care, and Emergency Medical Services
12-509-1222	Position Qualification	Behavioral Health Team Leader	Medical and Public Health	Public Health, Health Care, and Emergency Medical Services
12-509-1081	Position Qualification	Social Worker	Medical and Public Health	Public Health, Health Care, and Emergency Medical Services
2-508-1041	Resource Typing Definition	Critical Incident Stress Management Team	Incident Management	Public Health, Health Care, and Emergency Medical Services

These personnel positions and teams may have additional requirements (e.g., education, experience, certifications), but taking a closer look at the training requirements for the behavioral health position individual resource types in Table 8, completion of the following courses is required.

Table 8. Training Requirements by Behavioral Health Position

FEMA's Resource Typing Library Tool: Training Requirements by Behavioral Health Position			
Social Worker	**Behavioral Health Team Leader**	**Behavioral Health Specialist**	**Behavioral Health Chaplaincy Specialist**
IS-100: Introduction to the ICS, ICS-100	IS-100: Introduction to the ICS, ICS-100	IS-100: Introduction to the ICS, ICS-100	IS-100: Introduction to the ICS, ICS-100
IS-200: Basic ICS for Initial Response, ICS-200	IS-200: Basic ICS for Initial Response, ICS-200	IS-200: Basic ICS for Initial Response, ICS-200	IS-200: Basic ICS for Initial Response, ICS-200
IS-700: NIMS, An Introduction	IS-700: NIMS, An Introduction	IS-700: NIMS, An Introduction	IS-700: NIMS, An Introduction
IS-800: National Response Framework, An Introduction	IS-800: National Response Framework, An Introduction	IS-800: National Response Framework, An Introduction	IS-800: National Response Framework, An Introduction
Psychological First Aid (PFA) Training (minimum 4 hours)	Psychological First Aid (PFA) Training (minimum 4 hours)	Psychological First Aid (PFA) Training (minimum 4 hours)	Psychological First Aid (PFA) Training (minimum 4 hours)
	ICS-300: Intermediate ICS for Expanding Incidents	IS-368: Including People with Disabilities and Others with Access and Functional Needs in Disaster Operations	IS-368: Including People with Disabilities and Others with Access and Functional Needs in Disaster Operations
	ICS-400: Advanced ICS for Command and General Staff – Complex Incidents	IS-505: Religious and Cultural Literacy and Competency in Disaster	IS-505: Religious and Cultural Literacy and Competency in Disaster

SAMHSA's *Disaster Planning Handbook for Behavioral Health Service Programs* is another resource that can guide your development of a comprehensive, scalable, and flexible disaster plan.

Additional Training Information

Remember to make a training plan, and track training completion for yourself and others if you oversee a response team. FEMA recommends completing refresher training every 3 years or as new course versions are introduced.

Once you have completed the introductory NIMS/ICS training and determined what additional in-state training you will require, consider whether any other training might be helpful for your planning or response role. Additional courses you may want to consider include the following (FEMA, 2023f):

- Basic or advanced public information officer (PIO) training if you would be an agency spokesperson following a disaster, beginning with **IS-29.a: Public Information Officer Awareness**
- Continuity of operations (COOP) training if your planning role includes disaster operations planning, starting with **IS-1300: Introduction to Continuity of Operations**
- Homeland Security Exercise and Evaluation Program (HSEEP) training if you want to better understand the exercise design and evaluation process, starting with **IS-120.c: An Introduction to Exercises**
- **IS-244.b: Developing and Managing Volunteers**
- **IS-366.a: Planning for the Needs of Children in Disasters**
- **IS-368.a: Including People With Disabilities in Disaster Operations**
- **IS-505: Concepts of Religious Literacy for Emergency Management**

If you, or someone within your agency, are the DBH coordinator for the state, you will also want to ensure that your state has the capacity to support the FEMA CCP if Presidentially declared emergencies or major disasters are common or possible in your area. Either SAMHSA or SAMHSA DTAC will announce the availability of the CCP courses when they become available:

- **Crisis Counseling Assistance and Training Program: Training of Trainers**
- **Crisis Counseling Program Grant Application Training**

Training Links

- Computer-based training opportunities through the FEMA Emergency Management Institute: https://training.fema.gov/emi.aspx
- NIMS: https://www.fema.gov/emergency-managers/nims
- HSEEP: https://www.fema.gov/emergency-managers/national-preparedness/exercises/hseep
- State, territory, and tribal training coordinators (for guidance and assistance related to training): https://cdp.dhs.gov/contact/saa
- ICS Resource Center: https://training.fema.gov/emiweb/is/icsresource/index.htm

Emergency Support Functions (ESFs) and Recovery Capabilities

The FEMA National Response Framework (NRF) builds upon NIMS to help "align key roles and responsibilities across the nation" (DHS, 2019). The NRF outlines core capabilities necessary for an effective response. The NRF also introduces Emergency Support Functions (ESFs) as coordinating structures in response. Below is a list of the federal ESFs. Highlighted are ESF #6 and ESF #8, the two primary ESFs responsible for coordinating to support behavioral health needs.

Table 9. Federal ESFs

Federal Emergency Support Functions	
ESF #1	Transportation
ESF #2	Communications
ESF #3	Public Works and Engineering
ESF #4	Firefighting
ESF #5	Information and Planning
ESF #6	Mass Care, Emergency Assistance, Temporary Housing, and Human Services
ESF #7	Logistics
ESF #8*	Public Health and Medical Services
ESF #9	Search and Rescue
ESF #10	Oil and Hazardous Materials
ESF #11	Agriculture and Natural Resources
ESF #12	Energy
ESF #13	Public Safety and Security
ESF #14	Cross-sector Business and Infrastructure
ESF #15	External Affairs

*ESF #8 is the lead support function for behavioral health.

The latest version of ESF #8 describes supporting behavioral health care and behavioral health needs by way of direct services and referrals (DHS, 2016a). As the whole community is needed to respond to emergencies, ESF #6 also has a large part to play in supporting behavioral health needs. Mass care services can include crisis counseling and other short-term psychological support to disaster survivors, and several VOADs have disaster mental health and/or disaster emotional or spiritual care support teams that can support DBH ESF #6 activities as requested.

The National Disaster Recovery Framework is guided by eight key principles. One of these principles is "psychological and emotional recovery," with the acknowledgment that recovery happens at different levels—within individuals, families, social networks, and communities. The Health and Social Services core capability addresses behavioral health and is tasked with promoting well-being for the whole community. This occurs in coordination and with support from NGOs, often in the form of VOADs, long-term recovery groups (including unmet needs committees), or community organizations active in disaster (DHS, 2016b).

An important part of response and recovery within planning is also worker safety and health. At the federal level, there is a plan annex on this topic (DHS, 2013), with one of the annex's purposes consisting of providing technical assistance and support for the maintenance of psychological resiliency of response and recovery workers.

State-level Regulations and Structures

The federal ESFs may or may not align with local, state, tribal, territorial, or insular area jurisdiction models, as ESFs can be tailored to meet specific risks and requirements. Recovery models may also differ based on need and recovery structure. The models chosen will ultimately impact which representatives may be at a state or local EOC representing a particular ESF or recovery capability.

Your government structure will also be a factor in disaster response and recovery planning. It will determine where authorities rest and how implementation and integration of planning occurs.

As a reminder, all disasters are local. For cascading levels of support to be readily available if needed, however, local, state, and federal plans still need to be using the same vocabulary and understanding the request processes and resources available at the higher-level tiers of support.

When a disaster occurs, local resources are first used to respond to the disaster event. A disaster may be declared at the local level to activate that jurisdiction's EOP. If local capabilities are overwhelmed, then local officials may request assistance from the state level, where the governor can declare a state emergency, allowing for state-level resources to assist. If additional resources are needed, the governor may ask the President for an emergency declaration or major disaster declaration. Other steps in the disaster declaration, such as completing preliminary damage assessments, may also be part of this process to quantify the disaster's impact and damages.

Legal and regulatory authority at the state level includes:

- State statutes that address who, and what type of responder, will respond after any type of disaster event.
- Membership in EMAC, which applies to all 50 states and U.S. territories. This arrangement gives states the ability to request assistance from other states following large-scale disasters and provides liability protection to states that come in to assist. This is an important way to legally receive assistance from another state.
- Governors' executive orders that detail state agencies' duties for all matters relating to emergency management. These are like Presidential directives and are often issued soon after the disaster's impact. Often, in declaring a disaster, the governor will issue an executive order mandating that all executive-level state agencies work on that disaster. These executive orders also include the identification of state authorities for DBH.
- States also have a comprehensive emergency management plan that mirrors the NRF.

Identifying Partners in Plan Development and Implementation

At the outset of planning, gather support from the highest levels of state government to ensure that the planning, integration, and implementation processes are successful. Ensure that you fully understand your unique government structure, the culture of your government, and the contributors who need to be at the planning table. Where might pain points or bottlenecks in the planning process occur, and how can you avoid those by getting the appropriate people and agencies involved from the beginning? Keep in mind that the planning process—and establishing relationships with other disaster response entities and personnel—are just as important as published planning documents.

Ask yourself the following questions:

- Who is the intended audience for this plan, and are they part of the planning process?
- Whom do I want to already have an established working relationship with once a disaster strikes?
- With whom do I already have, or want to have, a memorandum of understanding (MOU) or a mutual aid agreement (MAA) for a disaster response?
- Who has experience writing, integrating, and implementing plans?
- Who has experience working with leadership at the state mental health agency, in emergency management, in public health, and with NGOs?
- What are the benefits for other organizations participating in the planning process with me, and how am I conveying that on a regular basis?
- What are the legal authorities under which my plan is being written, and how am I getting input from the right people to ensure that I am meeting those requirements?
- Am I viewing DBH response as one part of a statewide comprehensive response? If so, how am I ensuring that all the various response pieces fit together?
- What will the structure for the planning committee be, and how will decisions be made?
- How will responders be activated? Do I fully understand resource capabilities within a state volunteer database or Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), within regional MRC networks, and from the broader network of DBH response entities (ASPR, n.d.-b, n.d.-c)?

Consider including the following entities in Table 10 as planning participants.

Table 10. Suggested Planning Group Participants

- ❑ Agencies serving older adults
- ❑ Agencies serving people with disabilities and access and functional needs
- ❑ Critical Incident Stress Management teams
- ❑ Crime victim advocates
- ❑ Childcare networks
- ❑ Department of Education
- ❑ Department of Veterans Affairs
- ❑ Faith community networks
- ❑ Head Start
- ❑ Health authority
- ❑ Hospital systems
- ❑ Large regional employer
- ❑ Law enforcement
- ❑ Local and state military resources
- ❑ Managed behavioral healthcare companies
- ❑ Managed care organizations
- ❑ Media channels
- ❑ Medical provider communities
- ❑ Public health agencies
- ❑ Public safety agencies
- ❑ VOAD partners (e.g., American Red Cross, Salvation Army)
- ❑ School systems
- ❑ Social services
- ❑ Substance use disorder treatment professionals
- ❑ Unions
- ❑ Vocational rehabilitation services

Adapted from HHS, 2003.

Throughout disaster planning, response, and recovery processes, it is important to engage leaders at all levels in order to build and develop relationships, ensure effectiveness of response and recovery, and build equity into all phases of disaster planning and preparedness, response, and recovery. You can find information and tools for doing so in FEMA's *Achieving Equitable Recovery: A Post-Disaster Guide for Local Officials and Leaders*.

Conducting a Pre-event Needs Assessment and Risk Assessment

Data Sources and Formal Assessments

There are several tools that can help inform our planning, and we should not wait until a disaster hits to become familiar with them. These tools and resources can provide you with baseline data related to information such as social vulnerability, demographics, and pre-disaster behavioral health utilization.

The CDC Agency for Toxic Substances and Disease Registry (ATSDR) offers a Social Vulnerability Index using census data to help identify communities that may need support before, during, or after disasters (2024). This tool is updated every 2 years.

ATSDR defines social vulnerability as "potential negative effects on communities caused by external stresses on human health. Such stresses include natural or human-caused disasters, or disease outbreaks. Reducing social vulnerability can decrease both human suffering and economic loss."

CDC's Community Assessment for Public Health Emergency Response (CASPER) resources may assist you in gauging community well-being following a disaster. These tools help standardize the assessment procedures in disaster response, with questions that can be tailored to meet critical information needs. Ideally, behavioral health-related questions can be incorporated to inform ongoing needs assessments in recovery (CDC, 2019b).

The U.S. Census Bureau also has resources available for disaster planning and recovery in the form of their Emergency Management Hub. The portal provides access to demographic, economic, and resilience information for areas impacted by significant emergency events in the United States, including territories (U.S. Census Bureau, 2024).

In addition, SAMHSA (2023d) has a Substance Abuse and Mental Health Data Archive that has a variety of datasets related to substance use and mental health treatment utilization, including emergency department visits. This data can provide a baseline for behavioral health utilization pre-disaster to help measure potential behavioral health impacts in the months following the disaster.

Also available are several climate assessment tools, many of which focus on climate-related disasters, social determinants of health, and other data relevant to DBH planning. For example, the HHS Office of Climate Change and Health Equity offers the Climate and Health Outlook Portal, which provides maps with forecasts for the current month for heat, wildfires, and drought at the county level across the United States, as well as places with substantial proportions of residents with risk factors associated with these hazards.

The HHS Environmental Justice Index (EJI) also may be helpful. It is the first national, place-based tool designed to measure the cumulative impacts of environmental burden through the lens of human health and health equity.

Hazard-specific Considerations

As discussed in the previous section, several tools and resources may be helpful to you in planning. Along with tools and resources to aid in health and behavioral health needs assessment, there are tools to help you understand disaster hazards faced by the jurisdiction for which you are planning. The U.S. Global Change Research Program's Climate Mapping for Resilience and Adaptation includes an assessment tool that allows users to access data at the census tract, county, or tribal area level showing projections for drought, wildfire, and flooding, as well as extreme heat. The National Oceanic and Atmospheric Administration's State Climate Summaries include 21st century projections for U.S. states in relation to temperature, extreme weather, and climate-related disasters. FEMA's National Risk Index combines data on social vulnerability with risk for 18 natural hazards, including extreme weather and several types of disasters. The index shows risk at U.S. county and Census tract levels. Users can access the index as an interactive map or via database downloads. Other tools for hazard vulnerability and risk assessment can be found in the article "Resources for Disaster Behavioral Health Planning," which begins on page 14 of a DBH planning-related edition of the SAMHSA DTAC quarterly newsletter, *The Dialogue*.

If participating in a Health Care Coalition, a Hazard Vulnerability Assessment (HVA) may be used to identify risks. This process also involves ranking risks by public health consequences. Other risk assessment processes include the Threat and Hazard Identification and Risk Assessment (THIRA) for FEMA preparedness grants. Public health and emergency management partners may coordinate these assessments with other state and local organizations as required in cooperative agreement and grant guidance.

SAMHSA defines natural disasters as "large-scale geological or meteorological events that have the potential to cause loss of life or property" (SAMHSA Disaster Distress Helpline, 2023c). Severe storms and floods are the most common types of natural disasters in the United States. Other types include tornadoes, hurricanes and tropical storms, wildfires, earthquakes, and drought. COOP planning considerations are important in natural disasters, as property impacts may hit your facilities and hinder service provision. These types of disasters can also impact transportation routes and the ability to reach affected areas.

Human-caused disasters (SAMHSA Disaster Distress Helpline, 2023c) including incidents of mass violence and terrorism (SAMHSA Disaster Distress Helpline, 2023b), can cause loss of life and property. These incidents may also require evacuations from dangerous environments and reunifications in safe spaces. Common reactions to incidents of mass violence include feeling overwhelming anxiety, trouble sleeping, and other depression-like symptoms. Impacts from this type of disaster may vary based on the nature of the event and experiences during and after the event. Publications such as *Tips for Young Adults: Coping With Mass Violence* (2022a) are available from SAMHSA, and the National Child Traumatic Stress Network (n.d.-b) has a variety of resources on both violence and terrorism.

Increasingly, a focus is being placed on addressing slower-moving climate events that do not meet conventional definitions of disaster, such as the effects of extreme heat and drought. There is growing recognition that more people die in extreme heat than in any other type of extreme weather event. However, disaster declarations are often determined by the costs incurred to rebuild infrastructure. To meet the needs of communities during extreme heat events, disaster and emergency managers are looking for ways to incorporate resources related to

extreme heat as part of disaster mitigation, preparedness, response, and recovery. In 2024, the United States is publishing its first-ever National Heat Strategy, and resources are expanding across federal, state, local, territorial, and tribal agencies. SAMHSA and other federal partners participate in the National Integrated Heat Health Information System (NIHHIS) and provide related resources on Heat.gov.

SAMHSA DTAC has developed related resources, including *Tips for People Who Take Medication: Coping With Hot Weather*, a tip sheet to help individuals and communities consider their level of risk in hotter weather and foster health and resilience. In addition, SAMHSA DTAC has produced a collection of high-quality resources regarding climate events and included these resources in its SAMHSA Disaster Behavioral Health Information Series. To access climate-specific resources, select Climate Change under Type of Disaster from the menu on the left side of the page. Also, SAMHSA DTAC offers the Climate Change and Disaster Behavioral Health Planning Tool, which DBH planners can use in weaving consideration of climate events into overall DBH planning and preparedness.

In addition, CDC has developed new heat health resources for a variety of at-risk populations, including guidance to clinicians regarding specific medications and their effect on people during extreme heat. Extreme heat events occur on their own and are sometimes coupled with other types of disasters and emergencies, due to blackouts or other cascading disaster impacts. It is important to increase awareness about the effects of extreme heat among the general population and individuals and communities affected by mental health and/or substance use conditions. People with serious mental illness, serious emotional disturbance, and substance use disorder are disproportionately affected by the negative health effects of extreme heat.

A third disaster category to consider is technological hazards. Technological hazards are complex as they can be triggered by natural hazards or from a human cause. Types include transportation incidents, industrial pollution, dam failures, factory explosions, fires, chemical spills, biological hazards, and radiological and nuclear hazards. In response to a technological threat accidentally introduced into the environment, you can expect a hazardous material—or HAZMAT—response from first responders. When the hazardous agent has been weaponized for deliberate release, the incident may be classified as a CBRNE (chemical, biological, radiological, nuclear, and explosive) incident. As you would expect, the behavioral health impacts from these types of disaster will be varied. The SAMHSA DBHIS has a "disaster type" filter for technological disasters.

Biological disasters often lead to public health emergencies that can be especially difficult to contain as multiple regions might be affected simultaneously. Exposure can result in acute or chronic health conditions. Biological hazards can also cause a lot of fear if the infectious pathogen affecting people is unseen. Response workers may be required to use personal protective equipment to minimize exposure to illness (Occupational Safety and Health Administration, n.d.). You should work closely with your health department to plan for and respond to these types of incidents and consider how you might be able to support messaging and provide resources related to fear. SAMHSA offers publications such as *Coping With Stress During Infectious Disease Outbreaks* (2014a) and *Talking with Children: Tips for Caregivers, Parents, and Teachers During Infectious Disease Outbreaks* (2020).

Find out more about different disaster types and the behavioral health impacts they may have at the Types of Disasters section of the website of the SAMHSA Disaster Distress Helpline. The National Child Traumatic Stress Network offers information at its website about behavioral health impacts of disasters on children and families. Specific sections focus on hurricanes, tornadoes, wildfires, terrorism and violence, and other disaster types. Also, the SAMHSA DBHIS features DBH resources related to specific types of disasters; to access these resources, navigate to the main SAMHSA DBHIS landing page and select one of the disaster types from the menu on the left.

Writing, Testing, Activating, and Deactivating the Plan

Writing the Plan

Hopefully, this guidance has provided insight into how to write a DBH plan. The appendix of this document includes a DBH plan template checklist. Planning "from scratch" can be a laborious process, and finding templates and previous versions of your agency's planning documents may help expedite your plan development. If you work for an agency other than the one that maintains your jurisdiction's plan, you should coordinate with that agency on plan development and updates. The website USA.gov offers an online database of state and territory emergency

management agencies, and FEMA maintains a Search Your Location web page where you can find state, territory, tribal, and local emergency management contacts and information.

The basic outline of a written disaster plan is as follows:

- Introductory material
- Purpose, scope, situation overview, and planning assumptions
- Concept of operations (CONOPS)
- Organization and assignment of responsibilities
- Direction, control, and coordination
- Information collection, analysis, and dissemination
- Communications and coordination
- Administration, finance, and logistics
- Plan development and maintenance
- Authorities and references

Testing the Plan

If possible, you should be testing your plan before a disaster hits. This can be done through arranging and/or participating in agency-focused exercises and larger regional and state exercises that better inform how well your plan has been integrated into the broader response structure. Activities can—and should—range from simple communication or radio drills to full-scale exercise play. If you feel uncomfortable in these scenarios, it may be helpful to learn more about HSEEP (FEMA, n.d.-a). As a reminder, you can begin to better understand the exercise design and evaluation process by taking FEMA's IS-120.c: An Introduction to Exercises course.

Activating and Deactivating the Plan

The Elements of Successful Disaster Behavioral Health Plans section of this document contains best practices for activating and deactivating plans. Remember, the way you deactivate a plan is just as important as the way you activate it.

Evaluating and Revising the Plan

After-action reviews and other data gathering efforts after a disaster should be used to inform your improvement plan (FEMA, n.d.-b). Because the DBH plan is a living, breathing document, refinement is never finished. Your improvement plan should outline the following:

- The issue or area for improvement
- The corrective action (e.g., training, MOU, increased clarity in language)
- The organization with primary responsibility
- That organization's point of contact
- The start date to begin working on the issue
- The completion date for the issue to be addressed by

There are HSEEP templates that can assist you in this process.

Also, determine and record your strategy for regular maintenance, exercises, and updates to your DBH plan. Maintain engagement with planning partners for the ongoing cycle of editing the plan, testing and implementing the plan, and evaluating and revising the plan.

Elements of Successful Disaster Behavioral Health Plans

In consultation with states, SAMHSA DTAC has identified eight promising practices in DBH planning. These practices have proven helpful to DBH professionals in the field. You can explore these practices through a series of brief videos produced by SAMHSA DTAC, Promising Practices in Disaster Behavioral Health Planning (2019). The next section of this guidance describes the promising practices.

Scalability

To ensure that your plan is scalable, it must be based on NIMS principles and guidelines, including the command-and-control principles of ICS. To ensure scalability:

- Include pre-identified action steps and strategies in your plan.
- Use a basic framework for activation and response.
- Speak to incidents of all types and sizes.
- Include essential features such as chain of command, communication, and authorities.
- Make sure your plan is interlaced and cascades from local to state to federal roles.
- Remember that all disasters are local.
- Remember that your DBH plan should integrate with your broader state, territory, or tribal plan.

Your plan should also include a CONOPS outlining the following:

- Goals and objectives
- Strategies and tactics
- Policies and constraints
- Organizations, activities, and interactions among planning participants and advocacy groups
- A process for implementing your plan
- A process for initiating, developing, and maintaining the plan

In developing standard operating procedures (SOPs), consider the following:

- What capability does the SOP apply to? What need are you addressing by implementing the SOP, and what triggers that need?
- Consider who will use the SOP and what type of information they will need to know.
- What pre-established agreements are in place with other agencies, and are they up to date?

Finally, to ensure that disaster interventions are scalable and tailored, consider these questions in planning for a response to a specific geographical area:

- Does the population include people with serious mental illnesses?
- Is there a large population of children?
- Are you responsible for individuals with substance use disorders or children and youth with serious emotional disturbance?
- What languages are spoken?
- What at-risk populations have been affected (who are they, what department provides services that can support them, and what are their needs)?

Clearly Defined Collaborations and Partnerships

To build an effective partnership, put significant effort into the planning partnership process. Consider these basic steps for building an effective partnership:

- Bring partners together.
- Identify shared values, goals, and objectives.
- Identify a role and function for each partner.
- Get partners on the same page for a crisis response.

Effective partnerships:

- Have an effective leader
- Give potential partners the opportunity to share concerns, fostering a sense of safety
- Have entities with a shared set of goals and outcomes, where all partners see themselves as equals
- Must be measurable—include the basic components of program evaluation to determine whether the partnership is achieving its purpose

Building effective partnerships includes the following key components:

- Define the purpose of the partnership clearly and succinctly. Include the value of the partnership.
- Create clear definitions of each partner's roles in the partnership.
- Define the boundaries of the partnership. When does a role end and a role begin? Who takes the lead, and who provides support and resources?
- Finalize the agreements through an MOU or a similar process.

State partnerships may be with agencies such as emergency management, public health, public education, and NGOs. At the local level, this could include community mental health and substance use providers, schools, nonprofits, victim advocates, private practitioners, and others.

Remember to maintain the partnership through consistent and regular meetings, trainings, and exercises.

Clarity of Financial and Administrative Operations

Indicators of effective financial and administrative operations include the sources and management of funding, but also staffing and communications considerations.

Pre-ICS actions include:

- Recognizing and anticipating the requirement that organizational elements be activated
- Establishing incident facilities as needed
- Establishing common terms, including position titles, facilities, and other resources
- Shifting from oral direction to the written incident action plan

Assessments help you identify gaps that may need to be addressed:

- Specify DBH response and recovery roles. Does everyone know their role?
- Set expectations about the capabilities and resources that will be provided.
- Inventory and categorize resources available for an incident.

- Establish and verify the level of capability needed.

Financial and administrative functions and responsibilities include:

- Documenting resource management (costs incurred)
- Identifying requirements
- Ordering and acquiring resources (procurement)
- Mobilizing resources to the disaster area quickly
- Tracking and reporting (e.g., recording staff time)
- Recovering and/or demobilizing (post-disaster)
- Reimbursing incurred expenses (post-disaster)
- Taking another inventory of resources (post-disaster)

Additional administrative functions include:

- Your communication capacity
- COOP
- Credentialing of responders and volunteers

A Mechanism to Implement a Disaster Behavioral Health Plan

There are seven essential components, and proven strategies, involved in implementing a DBH plan:

1. All-hazards perspective—A plan that can respond to a variety of potential incidents. The plan should anticipate more than a single type of response and be flexible to accommodate events that differ in scale or type.
2. Precise definitions of roles and responsibilities—What services are included, and what is the scope? Who will provide what, and how long will the services be available? If possible, have your response and recovery team reflect the makeup of the state, territory, or tribe, and have useful resources available. Ensure that MOUs are in place.
3. Activation and triggers—Activation process and what triggers/scenarios activate the plan. Consider different launching points for the plan if it can help expedite the process in certain situations.
4. Horizontal and vertical integration of the DBH plan:
    - Vertical—Existing emergency management structure and processes
    - Horizontal—Various governmental organizations and NGOs with mental health and substance use resources
5. Creation and maintenance of resources—DBH responders are the primary resources. Training and exercising are important to ensure preparedness.
6. Specific and reality-based plans—Address what is needed and be realistic about what can be done. The plan should answer **how, who, and when** to be effective.
7. Dynamic plans—Anticipating potential challenges you may encounter in the plan's implementation requires you to include a strategy for responding to changes. Avoid allowing your plan to become stale and outdated. Build in a process for a regular review and a way to make adjustments in response to changing circumstances. Anticipate potential trends to respond to changes over time.

Range and Clarity of Services

In addition to knowing the range of services available within your state, it is important to ground your DBH response approach in an initial and ongoing needs assessment. Key points of the needs assessment include the following:

- Understanding your state. Know who keeps the information you need and where to find it. Baseline indicators can help you determine the type of disruption taking place for individuals and communities.
- A needs assessment is an ongoing process before an incident and throughout recovery. You need to continually redefine the impacted population groups most relevant to each phase of disaster response/recovery. You will find that the volunteer groups and response agencies will vary in each phase of a disaster, and therefore your working partners will vary, and your data points and your needs assessment will change over time.
- The pre-incident planning information informs the DBH incident program design. It is your actual program design that leads to both short-term and long-term interventions.

The needs assessment data should not only support the recovery trajectory of individuals and communities, but also provide a way to design your programs with knowledge of your existing infrastructure. That means knowing your resources, your buildings, your service delivery sites, and whether you can sustain pre-incident service levels. As a behavioral health provider, you may have a lot of people dependent upon your services. It is important to match recovery issues with resource needs, and to match a COOP strategy as you bring on new services. Ask yourself, how will we sustain regular services?

A Description of Logistical Support

A NIMS-compliant logistics section of an effective DBH plan comprises three main areas: personnel, partners, and communications.

Regarding personnel:

- The plan should include a description of your available pool of potential DBH responders.
- In your plan, articulate how you will develop and sustain DBH service delivery capabilities, including how you will accomplish all of the following with responders:
  - Recruitment
  - Screening
  - Training (including cross-training that occurs with other partners)
  - Supervision
  - Retention
- It is important to know how many DBH responders are deployed at any given time, and the status and whereabouts of those personnel.
- There must be clarity in roles, responsibilities, and titles during activation. Clarity in command and control is vital, with a clear check-in and check-out process, and the ability to reach responders quickly to inform them of updates or changing operations.
- How are DBH personnel rotated, backed up, and demobilized?
- Logistics is often thought of as "stuff," but it is also access to tools and resources.
- It may be helpful for DBH responders or team leaders to have access to laptop computers, perhaps enabled with internet access, for communications and web-based resources. Identify whether vehicles, radios, or mobile phones are needed. If on-demand training is part of your response plan, how will that be delivered, and what platforms and equipment are necessary?
- Consider your ratio of supervisors or team leaders to DBH responders or counselors. Outreach should always be done in teams of at least two, and keep in mind that the typical ratio is one supervisor to between three and seven workers.

Definition of Legal, Regulatory, or Policy Authority To Assist Functioning

Questions of authority are best answered well in advance of an actual crisis. Ensuring that legal, regulatory, and policy authority related to DBH have been addressed sufficiently will require input from legal professionals within the state government.

Legal authority should be clearly defined, and you should ask yourself the following questions:

- Under what authority are you developing this DBH plan?
  - Is it under a statute? Is it in a code? Is it under an executive order? Is it a policy within your agency, or included in an MOU or an MAA?
- Who is the lead agency of ESF #8? Are you working with that entity?
- Is your plan being written as a policy for your agency, a stand-alone plan, or as an annex to the state ESF #8 plan? Is it being reviewed internally?

We want to address authority in a disaster response to limit liability. Liability can be mitigated by doing the following:

- Clearly define the roles of your responders. What are you asking them to do?
- Have clear information on the workers' compensation laws for your state in the event of an accident during deployment.
- Include descriptions of the responder's responsibilities, and ensure that they know their "lane."
- Offer training, and incorporate open discussion during your training about the inherent risk in a response.
- Require all responders, including DBH responders, to complete the NIMS ICS training. It helps responders understand the ICS and should be mandated before anyone responds.
- Liabilities may be addressed in statute, which you should consult. Contact your staff attorney, emergency management attorney, or attorney general to see if your state has a Good Samaritan law and whether it would apply within your agency.
- Another way to mitigate liability is to have the DBH response work under the state liability as an asset of the state response. DBH teams can be defined as an asset of the state and work under the state's liability law.

Include concise language when writing policies and procedures for your responders. Your plan should state requirements for individuals who want to participate in a DBH response, including the following:

- Training
- Completion of the required ICS courses
- Medical screening
- Interviews with team leaders and others
- Orientation to a code of conduct or code of ethics

- Under no circumstance should a DBH provider or team self-deploy. Policies should clearly state who, what, and under whose authority the responders will be deployed to a disaster. Policies should also include other agencies with which you will work. What are their roles, and how will you coordinate with them? Have agreements worked out before a disaster.

Ensure the following are also addressed in your DBH plan:

- Liability and confidentiality
- How you will implement MOUs and MAAs when working with other organizations or agencies
- Confirmation that your plan complies with the Health Insurance Portability and Accountability Act, or HIPAA
- Ensure that there is a process for credentialing and dealing with reimbursement issues

Finally:

- Contact your homeland security and emergency management partners, and get copies of all the relevant laws, directives, and policies.
- Contact your legal staff and see what the best option is to get DBH implemented into state statute or to work through existing policy development.
- Find out who your ESF #8 lead is.
- Survey community agencies you currently work with to see if there is a need to formalize those relationships.

A Defined Process for Maintenance, Exercises, and Updates

Identify who is responsible for maintaining and updating the plan, determine a timeline for updates, schedule or attend training and exercises for the plan, and determine the various forms and formats in which the plan will be kept circulated (e.g., paper, electronic).

Also consider the following:

- Keep your plan current by doing the following:
  - Completing a crosswalk of the DBH plan with the existing plans in your jurisdiction
  - Including a process for regular review and updating
- It helps to think of your plan as part of a greater system of emergency planning. If it is to function within that system, it must work with the other response processes with which it will interact.
- Completing a crosswalk of your plan with public health, mental health, and substance use partners will enhance the effectiveness of your plan while avoiding potential conflicts in the field when your plan is implemented.
- Including partners in the planning process is a much easier task than inviting them in after your plan has been developed. Include partners during the planning process to generate buy-in.
- Another benefit to including partners in the planning process is that it becomes a group process, and a group process will generate more ideas and better cooperation. It also creates buy-in among the participants.
- Ensure your DBH plan conforms to legal and regulatory standards:
  - Review your plan with the state emergency management planning section.
  - This step (incorporating standards) must occur before concluding the planning process.
- Maintenance is critical. Your plan must reflect changes in DBH practices.
- A good DBH plan:
  - Provides a timeline for updating the plan
  - Identifies who is responsible for updating the plan
  - Is made accessible by various methods
  - Includes instructions for ongoing exercises and trainings
  - Contains instructions for the rollout of the plan
- Remember to consider and answer the following:
  - How often is the state plan updated, and how often should you update your plan?
  - Who is responsible for updating the DBH plan? This is often the DBH coordinator.
  - How is the plan being made accessible?
    - Remember that a DBH plan functions within a greater response system with multiple moving parts and participants.
    - Each of the planning and response participants must be aware of any changes or revisions to the plan if it's to be implemented effectively.

Keep in mind the benefits of planning process inclusion:

- Inclusion in the process has an impact on the effectiveness of the outcome.
- The people who get drawn into the process of revising the plan become better educated and updated on how things work.

And always remember that your plan should be a **living, breathing** document.

Planning Resources

Organizations

- Administration for Children and Families, Office of Human Services Emergency Preparedness and Response (ACF, OHSEPR)
- Administration for Community Living (ACL)
- Administration for Strategic Preparedness & Response (ASPR)
- ASPR Technical Resources, Assistance Center, and Information Exchange (TRACIE)
- Centers for Disease Control and Prevention (CDC)
- CDC Division of State and Local Readiness (DSLR)
- Centers for Medicare & Medicaid Services: Emergency Preparedness Rule
- Centers for Medicare & Medicaid Services Emergency Preparedness & Response Operations https://www.cms.gov/about-cms/what-we-do/emergency-response (CMS)
- Emergency Management Institute (EMI)
- Federal Emergency Management Agency (FEMA)
- Health Resources & Services Administration, Emergency Preparedness (HRSA)
- Help Kids Cope mobile app (National Child Traumatic Stress Network)
- Medical Reserve Corps (ASPR)
- National Child Traumatic Stress Network (NCTSN)
- National Institute of Environmental Health Sciences, Disaster Research Response (DR2) Program
- National Voluntary Organizations Active in Disaster (NVOAD)
- Ready.gov
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- SAMHSA Disaster Distress Helpline (DDH)
  - Call or text: 1–800–985–5990
  - Email: ddh@vibrant.org
- SAMHSA Disaster Mobile App
- SAMHSA Disaster Technical Assistance Center (DTAC)
  - Toll-free phone: 1–800–308–3515
  - Email: dtac@samhsa.hhs.gov
  - Website: https://www.samhsa.gov/dtac
- SAMHSA Treatment Locator
- 988 Suicide & Crisis Lifeline
  - Call or text: 988
    Chat: 988lifeline.org
    Línea 988 de Prevención del Suicidio y Crisis (español): 988
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Disaster Behavioral Health Interventions Inventory (2022). *Supplemental Research Bulletin.* SAMHSA DTAC https://www.samhsa.gov/sites/default/files/dtac-disaster-behavioral-health-interventions-inventory.pdf

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Appendix

Disaster Behavioral Health Plan Template Checklist

Based on *CPG 101 Version 3.0*, SAMHSA's prior all-hazards guidance document, and best practices from state DBH plans. Also reviewed for alignment with SAMHSA's *TAP 34: Disaster Planning Handbook for Behavioral Health Service Programs*.

Introductory Material	Description	Included	N/A
Cover Page	Plan title, date, and jurisdiction(s) covered		
Signature Page	With all signatures required		
Record of Distribution	Including internal and external recipients		
Record of Changes	Including when changes were made and to which parts of the plan		
Table of Contents	List of plan sections and pages on which each section begins		

Purpose, Scope, Situation Overview, and Planning Assumptions	Description	Included	N/A
Purpose	A description of the plan's purpose		
Scope	The plan applies to. . . As defined in (code, regulation). . .		
Situation Overview	By way of a hazard assessment process, an analysis of likely threats, hazards, and at-risk populations can be included here. Include a matrix of possible events if desired.		
Planning Assumptions	This section may include an overview of the behavioral health system for plan context. This section might also include definitions of terms, assumptions on the role of DBH, the type of coordination that is expected to occur, what techniques/approaches would be utilized, limits of the mental health authority, and other unique considerations.		

Concept of Operations (CONOPS)	Description	Included	N/A
Methodology for Achieving Plan Goals	Overview of the approach		
Division of Responsibilities	State, local, and federal responsibilities. This should include who has the authority to activate the plan.		
Sequence of Actions	Before, during, and after the incident		
Resource Request Process	Who can request resources and in what situation? Additionally, who will fill the requests and how will additional resources be requested.		
Approach to Meet the Unique Needs of. . .	Examples: Children, people with access and functional needs, people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality		

Organization and Assignment of Responsibilities	Description	Included	N/A
Tasks by Position and Organization	A matrix may be helpful to show tasks that have primary and secondary (or supporting) responsibilities, and tasks with shared responsibilities. Organizational charts (depicting an Incident Command System structure) may also be helpful.		
Coordination and Plan Connectivity	How are you coordinating with other organizations and agencies (federal, state, and local), and their corresponding emergency plans?		
Roles for Unaffiliated Volunteers	Describe roles and responsibilities and how these individuals are incorporated into the emergency operation.		
Maintaining a List of Available and Trained Personnel	How are you collecting this information, tracking it, and keeping it updated?		
Current Notification Rosters, SOPs, and Checklists	Describe how all tasked organizations maintain these so that they can carry out their tasks.		
Mutual Aid Agreements	If in place for sheltering, transportation, relocation, etc.		

Information Collection, Analysis, and Dissemination	Description	Included	N/A
Immediate Information Collection Needs and Priorities	What information will you need for response planning and what are the sources of that information?		
Information Processing	Who will use the information collected and how will it be used?		
Information Sharing	What is the method for sharing information, who will share information, and when will it be shared?		
Long-term Information Needs	What are your ongoing information needs, and how will you collect, analyze, and disseminate information and update strategies based on that information?		

Communications	Description	Included	N/A
Situation Assumptions	Types of situations likely to occur and types of communications necessary such as phone, two-way portable radio, email/text messages, helplines, data, etc.		
Methods of Communication	Methods of communication among state mental health agencies, local mental health agencies, state psychiatric hospitals, other psychiatric facilities, community-based treatment facilities, state emergency management, regional or field offices, emergency medical services, hospitals and clinics, and shelter facilities. Ensure that the state mental health authority is on the notification list from the governor's office. Also consider special communication needs and how your systems ensure accessibility to important messages.		
Alternative Communication Capacity	Alternatives in the event of failed communication capacity		
Availability of Technical Expertise	Expertise in operating communication systems and tools by way of training and testing		

Administration, Finance, Legal, and Logistics	Description	Included	N/A
Administration	Recording and reporting program activities		
Administration	Recording and reporting human resources utilization		
Administration	Expectations of situation reports (format and frequency)		
Administration	Recording and reporting of services provided by volunteer agencies		
Administration	Management of volunteer offers/services		
Finance	Recording and reporting expenditures and obligations		
Legal	Issues including licensing, informed consent, confidentiality, providers licensed in other jurisdictions, personal, professional, and organization liability, patient records management, waiver of contracting or other procurement rules during emergencies		
Logistics	Arrangements for support needs (food, water, fuel, etc.)		
Logistics	Provision of self-support for at least 72 hours		
Logistics	Replacement/repair of damaged/destroyed essential equipment		
Logistics	Access of personnel to impacted area (criteria method, transportation)		
Logistics	Availability, transport, administration, safeguarding, and recording of medications		
Logistics	Existence and scope of mutual aid agreements		

Plan Development and Maintenance	Description	Included	N/A
Plan Responsibility	Assign responsibility for overall planning and coordination to a specific position.		
Plan Training Cycle	Provide a regular cycle of training, evaluating, reviewing, and updating the plan.		

Authorities and References	Description	Included	N/A
Cover Page	Plan title, date, and jurisdiction(s) covered		
Citations	Citation of legal authorities and reference documents as appropriate.		
Provisions for COOP	Provisions for Continuity of Operations (COOP) to ensure that critical functions can be performed.		

Function Annex: The Continuity of Operations Plan (COOP) – This is often kept confidential for safety reasons	Description	Included	N/A
Cover Page	Plan title, date, and jurisdiction(s) covered		
Essential Functions	What essential functions must be maintained or re-established within the first 72 hours of an event?		
Essential Personnel	Which personnel are essential to performing the essential functions?		
Human Resources Plans	Describe plans related to essential staff, staff notifications, and staff/family support.		
Orders of Succession and Delegations of Authority	Outline your orders of succession and delegations of authority for leadership and key decision makers.		
Continuity for Facilities and Communication	Outline strategically located alternate facilities and back-up communication methods.		
Documentation and Records Retention	Describe alternate sites for housing vital records and documents (e.g., the DBH plan, rosters, vital records).		
Testing, Training, and Updating	Outline how you will train staff on the plan, how you will exercise the plan, and when and how you will update the plan.		

Additional Functional Annexes To Consider (for all essential activities that require procedural instructions)	Description	Included	N/A
Communications	How to manage, coordinate, address shortfalls, ensure privacy, make communications accessible, and how notification occurs		
Direction, Control, and Coordination	Initial notification, incident assessment, incident command structure, and Emergency Operations Center functions		
Financial Management	Administrative preparedness procedures, methods for capturing costs and reimbursement, and record keeping required for internal records, grant programs, and funding		
Logistics and Resource Management	Describe resource management (including personnel), transportation, staging, emergency supplies needed, in-state and out-of-state aid and request mechanisms, plan for maintaining financial and legal accountability, and resources for initial and ongoing needs assessments.		
Mass Care (ESF-6)	What DBH considerations occur within mass care? They may already be included elsewhere within your plan. Consider aspects of sheltering, equity in service delivery, disaster resource or recovery centers, and reunification. Also consider accommodations for individuals with disabilities and others with access and functional needs. Which partners do you work with to address mass care needs (e.g., VOAD partners such as the American Red Cross).		
Public Health and Medical Services (ESF-8)	How will you assess and provide mental health and substance use services for those in communities impacted by a disaster? How will you coordinate with the broader public health and medical response? Consider how you will obtain supplies such as personal protective equipment if needed. Also consider whether the disaster qualifies for the Federal Emergency Management Agency Crisis Counseling Assistance and Training Program or other resources. If it does, and the need exceeds local and state capacity, complete and submit the grant application. Also, determine whether you have a role to outline in a mass casualty/ mass fatality incident.		

Additional Functional Annexes To Consider (for all essential activities that require procedural instructions)	Description	Included	N/A
Public Information	Communications strategy, identification of spokesperson(s), prepared and accessible materials/fact sheets/guides, pre-established relationships with agency and state public information officers and media outlets, means of disseminating information, and identification of outside technical experts and resources as needed.		
Recovery	What is the process for post-incident assessments, how will you reach those in need of recovery assistance (including those with disabilities, with access and functional needs, and those who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality)? Consider how you can build local capacity to address DBH needs in recovery.		
Search and Rescue	Do you have any role in supporting people in potential or actual distress, including response personnel?		
Transportation	Do you have a lead or support role following a transportation incident?		
Volunteer and Donations Management	How do you manage unaffiliated volunteers and organizations (if at all)? Do you engage with VOAD partners, and do you have a role in securing, managing, or distributing in kind contributions?		
Worker Safety and Health	How do you support response and recovery worker safety and health from a DBH approach? Do you have a designated role and associated processes for this area of support?		

Annex Implementing Instructions	Description	Included	N/A
Implementing Instructions (sometimes referenced as an appendix or attachment)	Standard operating procedures, maps, charts, tables, forms, checklists, job aids, response protocols, contact information, key addresses, transportation routes, safety and security policies and procedures, etc.		

Hazard- or Threat-specific Annexes	Description	Included	N/A
Hazard- or Threat-specific Annexes	If appropriate, as identified by a threat assessment process, and where a unique and specific response approach needs to be outlined		

Glossary	Description	Included	N/A
Glossary of Terms	If not included elsewhere		

Abbreviations and Acronyms

ACF	Administration for Children and Families
ASPR	Administration for Strategic Preparedness and Response
CCP	Crisis Counseling Assistance and Training Program
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CONOPS	Concept of Operations
COOP	Continuity of Operations
DBH	Disaster Behavioral Health
DHS	U.S. Department of Homeland Security
DMH	Disaster Mental Health
DTAC	SAMHSA Disaster Technical Assistance Center
EMAC	Emergency Management Assistance Compact
EMI	Emergency Management Institute
EMPG	Emergency Management Performance Grant
ESAR-VHP	Emergency System for Advance Registration of Volunteer Health Professionals
ESF	Emergency Support Function
FE	Functional Exercise
FEMA	Federal Emergency Management Agency
FSE	Full-scale Exercise
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HPP	Hospital Preparedness Program
HRSA	Health Resources and Services Administration
HSEEP	Homeland Security Exercise and Evaluation Program
IASC	Inter-Agency Standing Committee
ICS	Incident Command System
IHS	Indian Health Service
MAA	Mutual Aid Agreement
MHFA	Mental Health First Aid

MHPSS	Mental Health and Psychosocial Support
MOU	Memorandum of Understanding
MRC	Medical Reserve Corps
NDRF	National Disaster Recovery Framework
NIH	National Institutes of Health
NIMS	National Incident Management System
NRF	National Response Framework
OVC	Office for Victims of Crime
PHEP	Public Health Emergency Preparedness Program
PFA	Psychological First Aid
PPE	Personal Protective Equipment
PTSD	Posttraumatic Stress Disorder
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	Serious Emotional Disturbance
SERV	School Emergency Response to Violence
SMI	Serious Mental Illness
SPR	Skills for Psychological Recovery
TAP	Technical Assistance Publication
THIRA	Threat and Hazard Identification and Risk Assessment
TTX	Tabletop Exercise
VOAD	Voluntary Organizations Active in Disaster

Publication Number PEP24-01-031

First released 2003. Updated 2024.

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SAMHSA envisions that people with, affected by, or at risk for mental health and substance use conditions receive care, achieve well-being, and thrive.

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