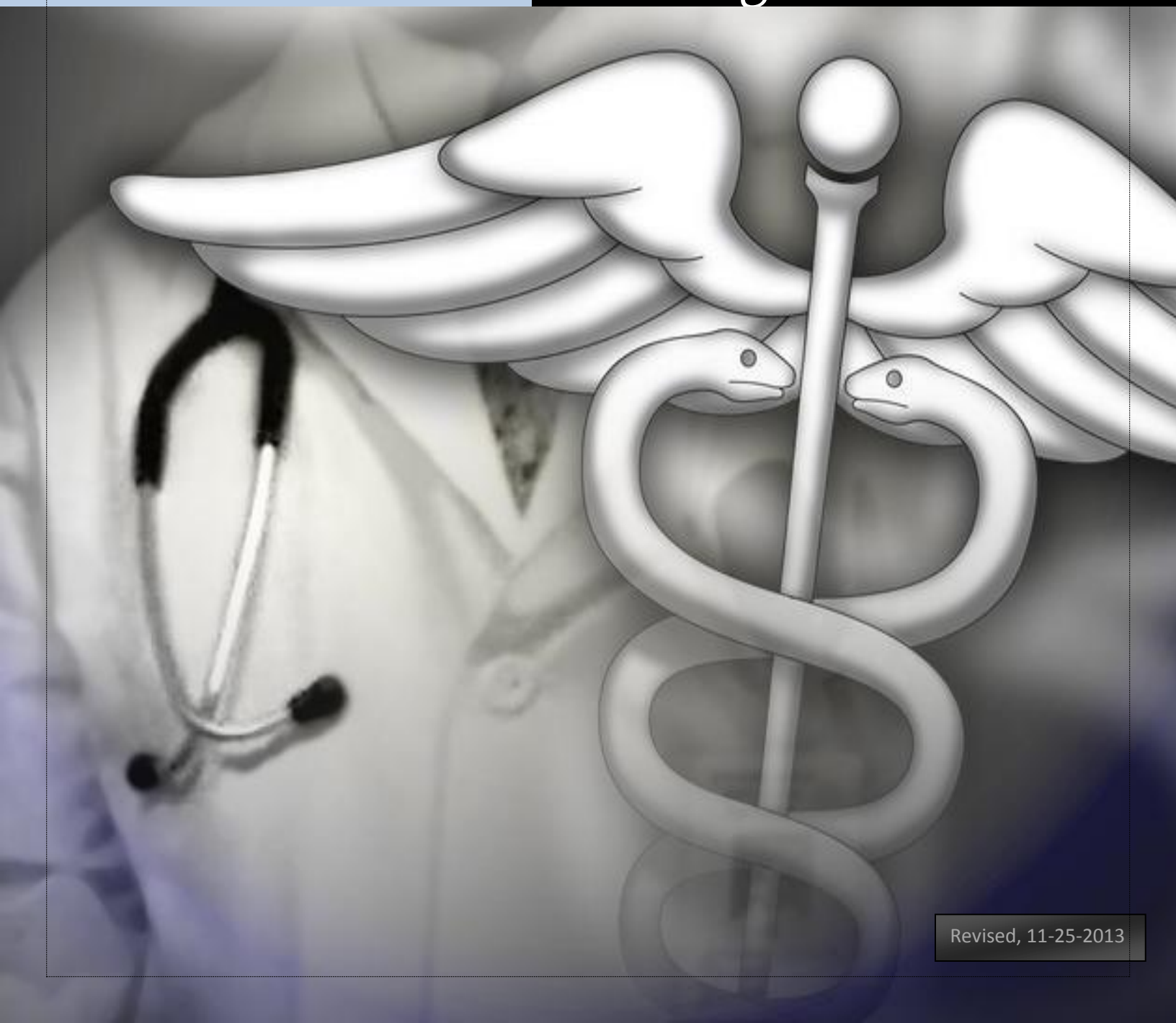
MISSOURI DEPARTMENT OF MENTAL HEALTH

The Behavioral Health Emergency Plan Template for Health Care Organizations



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Preface

The federal government has provided ongoing support to states for all-hazards preparedness including health care preparedness and planning. The mission of the Assistant Secretary for Preparedness and Response (ASPR) Office, established in 2006 under the Department of Health and Human Services, is to: "Lead the nation in preventing, preparing for and responding to the adverse health effects of public health emergencies and disasters."

Funding for the writing and compilation of the resources within the *Behavioral Health Emergency Plan Template for Health Care Organizations* was made possible through the ASPR Hospital Preparedness Program that funds the Missouri Department of Health and Senior Services and its contracted agencies including the Missouri Department of Mental Health.

The Behavioral Health Emergency Plan Template for Health Care Organizations will be shared with hospitals through the Missouri Hospital Association EMResources and will also be placed on the Missouri Department of Mental Health, Coping with Disaster website: www.dmh.mo.gov/disaster under Plans and Competencies. Additionally, Missouri 1 Disaster Medical Assistance Team (MO 1 DMAT), the Missouri Primary Care Association, the Mid-America Regional Council (MARC) and the St. Louis Area Regional Response System (STARRS) will share it within their networks.

Many thanks go to those who reviewed this document including Kathy Hadlock and Paula Nickelson, the Missouri Department of Health and Senior Services, Center for Emergency Response and Terrorism; Derek Collins, North Kansas City Hospital; Debbie Mays, Children's Hospital, St. Louis; Leslie Porth, Jaclyn Gatz and Lois Kollmeyer, Missouri Hospital Association; Janice Pirner, Missouri Primary Care Association; Dan Manley, MARC, Julie Grotemeyer, STARRS; Jill Marie Shugart, MSPH, REHS, LCDR, U.S. Public Health Service ASPR Hospital Preparedness Program (HPP); Rachael Kaul, Division for At-Risk Individuals, Behavioral Health, and Community Resilience (ABC) Office of Policy and Planning Office of ASPR; Mark Thorp and Kevin Tweedy, Missouri 1 Disaster Medical Assistance Team; Department of Mental Health staff who repeatedly offered assistance with the editing of the document included Rebecca Carson, Monica Hoy, and Joan Keenan. A special word of thanks goes to Ronda Findlay who diligently worked to both edit and format the document.

Please feel free to contact me if you have additions that you believe would be helpful to future volumes of this template. This resource is a public document and may be copied, but attributes to the Missouri Department of Mental Health; P.O. Box 687, Jefferson City, Missouri, 65102 would be appreciated.

Jenny Wiley
Coordinator Disaster Services,
Missouri Department of Mental Health
Jenny.wiley@dmh.mo.gov
www.dmh.mo.gov/disaster/

The Behavioral Health Emergency Plan Template for Health Care Organizations

Introduction

The Behavioral Health Emergency Plan Template was developed to assist hospitals and other health care providers in integrating the behavioral/mental health functions into their emergency plans and incident command. The document is designed to serve as a template/checklist.

The National Bio-defense Science Board (NBSB) appointed a Disaster Mental Health Subcommittee that developed the report: Integration of Mental and Behavioral Health in Federal Disaster Preparedness, Response, and Recovery: Assessment and Recommendations.[13] On page five, the report states:

"Effective integration of mental and behavioral health into disaster and emergency preparedness, response, and recovery activities can help build psychological resilience at both the individual and community levels, so that both are better prepared to deal with disaster when it strikes. Integration has the potential to increase the effectiveness of disaster and emergency aid at the height of a crisis and to reduce the severity and extent of long-term health consequences of a disaster."

However, even as the need for integration is made clear from the highest authorities, there are few resources available to assist with behavioral health planning and integration. One resource that was relied on for this template and which is recommended for audiences is a course entitled: Surge, Sort, Support: Disaster Behavioral Health for Health Care Professionals.[7] The course was funded through the Florida Department of Health and the Health Resources and Services Administration. The World Health Organization documents also provided reliable information to assist in the development of the template. Finally materials from the Hospital Incident Command System (HICS), including organization charts, are used with this template to assist readers in understanding the critical role that mental health plays both within the HICS structure and within the response as a whole in a mass casualty incident. Other types of health care providers should look at both the HICS incident command materials and at the other checklists within this document to see how they fit into their health centers. References for all materials used are included in the reference section of this document.

Federally Qualified Health Care Centers, other outpatient clinics, surgical, orthopedic and dialysis units and other types of medical facilities should consider how a disaster or terrorism

incident will impact them and how they would surge, if needed. That planning includes coordination with other health providers at the community level. Also within their planning, community clinics should consider the behavioral health impacts and how those might impact surge and the services delivered.

Even the smallest critical access or acute care hospitals may provide surge support in disaster, terrorism, and bioterrorism incidents. Still, the smallest hospitals are complex organizations with many facets of service inclusive of emergency operations, inpatient medical services and critical care, dietary, maintenance, social and administrative supports, and security operations. In a devastating incident, each of these and other units will be affected by the psychological impact and trauma caused by the occurrence. Additionally, members of the community will likely surge at the hospital looking for friends and loved ones. The hospital must be prepared to handle both the physical and the psychological casualties of both its staff and its community after a disaster.

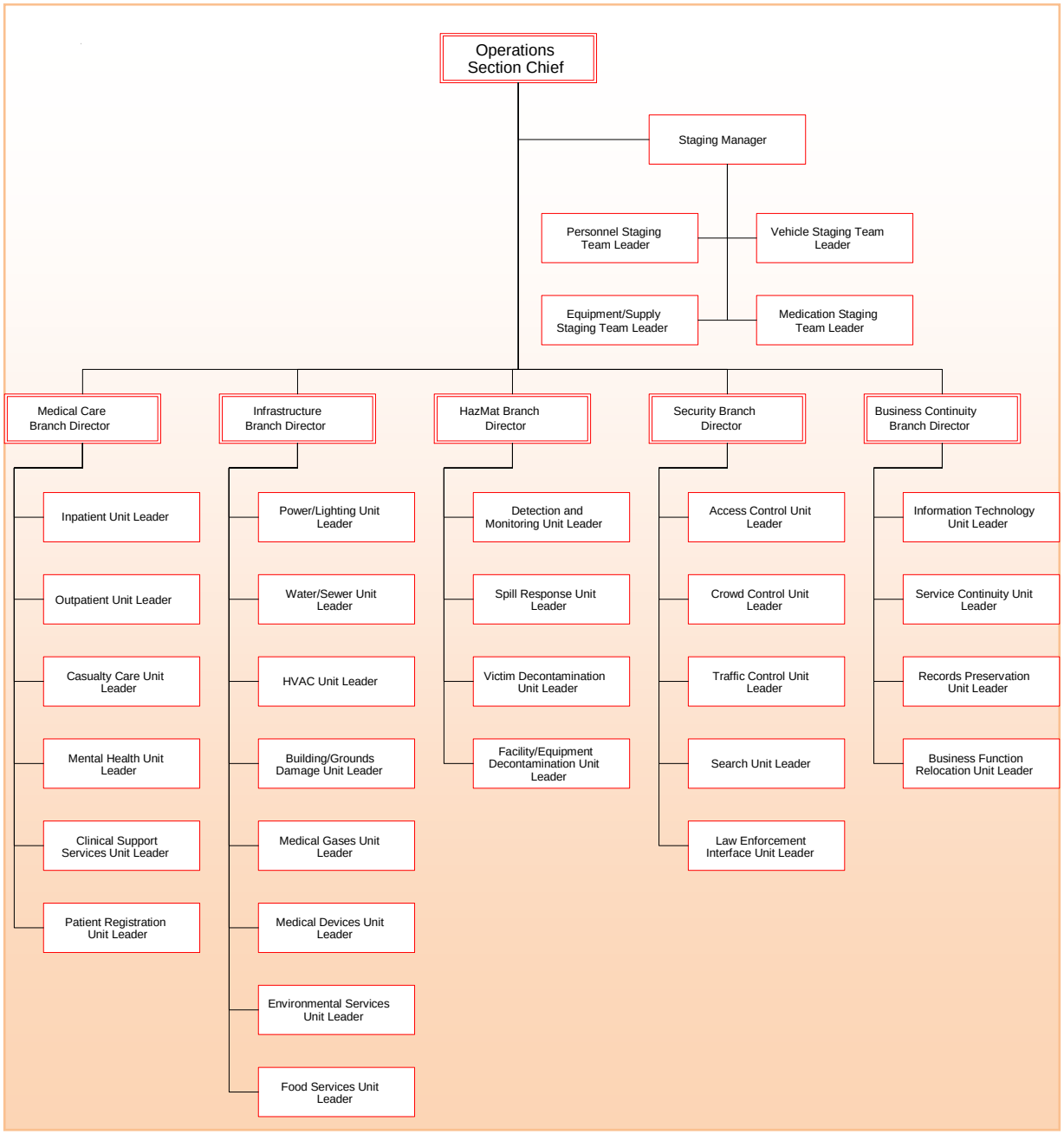
A Concept of Operations

The Institute of Medicine's Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations[11] suggests that a mass casualty disaster mental health concept of operations should be used to enable mental health triage and treatment particularly for those directly exposed to the casualty incident. Concepts of operation generally include the goals, objectives, strategies, responsibilities and authorities, communications, operational processes and ending/close-out processes.

The concept of operations would identify how the behavioral health component fits within the command structure and could use many of the templates developed within this document to assist in developing the appropriate goals, objectives and strategies that would fit within a particular hospital or clinic structure.

Hospital Incident Command System (HICS)

Hospital incident command is a requirement of the National Incident Management System. Incident Command is meant to expand and contract based on the incident. As health care organizations plan for the behavioral health response, they need to consider where it fits within their incident management system. HICS provides the organizational format for mental health services to be placed in Operations under the Medical Care Branch Director. (See next page). HICS also provides a Mental Health Unit Leader Job Action Sheet (Pp. 24 -29) that will assist the mental health unit leader in understanding his/her duties.


Operations Section Chief
Staging Manager
Personnel Staging Team Leader
Vehicle Staging Team Leader
Equipment/Supply Staging Team Leader
Medication Staging Team Leader
Medical Care Branch Director
Infrastructure Branch Director
HazMat Branch Director
Security Branch Director
Business Continuity Branch Director
Inpatient Unit Leader
Outpatient Unit Leader
Casualty Care Unit Leader
Mental Health Unit Leader
Clinical Support Services Unit Leader
Patient Registration Unit Leader
Power/Lighting Unit Leader
Water/Sewer Unit Leader
HVAC Unit Leader
Building/Grounds Damage Unit Leader
Medical Gases Unit Leader
Medical Devices Unit Leader
Environmental Services Unit Leader
Food Services Unit Leader
Detection and Monitoring Unit Leader
Spill Response Unit Leader
Victim Decontamination Unit Leader
Facility/Equipment Decontamination Unit Leader
Access Control Unit Leader
Crowd Control Unit Leader
Traffic Control Unit Leader
Search Unit Leader
Law Enforcement Interface Unit Leader
Information Technology Unit Leader
Service Continuity Unit Leader
Records Preservation Unit Leader
Business Function Relocation Unit Leader

Our Nations Resilience Paintings:

By: Edmund Earle, Age 16
A child is offering support to an elderly woman who appears frail and overcome as seen in her reclining position and the distant look in her eyes. The young boy appears strong with his arm outstretched to hold her mask in place. The setting is somber, a brick wall with nowhere to turn. Despite their fear, the expectation of recovery and survival appears ever so subtly in the almost halo-like image of light surrounding the figure's heads.
Center for the Study of Traumatic Stress: http://ournationsresilience.org/paintings.shtml "Teachers Guide for using Painting as a Medium to Develop Resilience and Convey Hope:" http://ournationsresilience.org/teachersguide.shtml

Surge Capacity

Surge capacity represents the ability to manage a sudden, unexpected increase in patient volume that would otherwise severely challenge or exceed the current capacity of the health care system.[3] According to Surge, Sort, Support,[7] (p. 21) "surge capability is the ability of the health care system to manage patients who require specialized evaluation or intervention."

HOSPITALS

Depending on the incident, surge may occur in several different ways. When there are medical causalities, patients may self-transport, be brought to the hospital by Emergency Medical Services (EMS) or, as in the case of the Oklahoma City bombing or the Joplin, Missouri EF5 tornado, be transported to area hospitals by Good Samaritans. Less severe causalities usually arrive at the hospitals first, followed by EMS and individually transported patients. Those arriving by ambulance are usually the most severe. However, when ambulances are unable to get into areas, patients needing all levels of care may be transported by any means available. Additionally, family members will soon arrive at the hospitals looking for injured family members including separated children. In considering the behavioral health assistance that may be offered in this type of a causality incident, the behavioral health team needs to work

with the rest of the Incident Command staff in their planning efforts. Most hospitals will have planned for this type of surge by evaluating the capacity and capability of the emergency room, considering where triage may take place, handling those with less serious injuries, and designating space for family members inquiring about missing relatives. Hospitals may consider assigning very experienced medical staff to these areas or at least teaming more experienced staff with less experienced staff as part of a support system.

Explosions whether from an incident like a natural gas leak or from a terrorist bombing are likely to stress any responding hospital's surge capacity in both the emergency room and possibly the burn unit. In bioterrorism or accidental hazardous material spills, the hospital may also be overwhelmed with persons concerned that they have been exposed to the chemical or biological agent. Each type of hazard may present diverse surge challenges and distinct behavioral reactions that the hospital or other health care provider will need to consider in its planning.

Some nerve agents may cause neurological damage that mimic psychiatric illness. Persons presenting with psychological symptoms will need to be screened to determine if their symptoms are due to neurological effects of the chemical agent or if the symptoms are a psychological effect. The book, Chemical and Biological Terrorism: Research and Development to Improve Civilian Medical Response,[6] (p. 168), discusses potential neurological effects. "…Signs of central and peripheral nervous system poisoning include apathy, mood liability, thought disorders, sleep disorders, and delusions and hallucinations, in addition to psychological stress sequelae."

After decontamination and medical evaluation, those who are fearful and distressed should be monitored in a separate room by a combination of medical and behavioral health staff. Those who decompensate can be returned to a higher level of care. Those who do not show further signs of illness can be monitored, and given information about what to watch for along with a phone number to call if they have further concerns after leaving the hospital. This follow up will ease the concerns of those experiencing anxiety, letting them know that professionals care about their well-being and that there are resources to assist them further if needed.

There are several behavioral responses to consider when assessing patients:

1. Fear and acute anxiety may be expected after a traumatic incident particularly after a bioterrorism or chemical attack. Psychological casualties may be four to ten times greater than physical casualties. In the 1995 sarin gas attacks on the Tokyo, Japan subway, almost 80% did not have chemical exposures or injuries. Of 5,510 seeking medical treatment, 12 died, 17 were critically injured, 1,370 suffered mild injuries and 4,000 had no medical injuries. [8]

2. Persons may present at the emergency room with multiple unexplained physical symptoms (MUPS) that are of psychogenic origin.[19]

3. Occasionally, a cluster of persons may arrive presenting with similar psychosomatic symptoms and a common belief regarding the nature of their exposure, called mass psychogenic illness (MPI).

4. Individuals may misinterpret real physiological symptoms due to common causes (allergies, etc.) as evidence that they have been exposed to a dangerous agent. [1]

COMMUNITY CLINICS

If citizens are not badly hurt, they may surge to local clinics that they know and trust. Clinics may also be at capacity and beyond in a critical incident and in the weeks/months following the incident as they follow-up with patients released from the hospital. Clinics need to be attuned to the behavioral health impact on these patients and how it may impact their physiological well-being. Planning should include an incident command structure, surge planning and behavioral health follow-up planning. Most patients will report to their local physicians rather than following up with mental health specialists in the days after an incident. Clinics may explore how to partner with behavioral health specialists (including mental health and substance abuse specialists) in their geographic areas if they do not have these specialists already on their staff.

EMERGENCY MEDICAL SERVICES (EMS) AND OTHER FIRST RESPONDERS

Even though scenes may be chaotic and responders must work as quickly as possible, EMS, police, fire, and other first responders have the opportunity to reassure injured persons. Adults and children may become frightened that they will die even when they do not have life threatening injuries. A word of comfort and developmentally appropriate information can assist in alleviating these fears. For example, "We are here to help you and will take you to the hospital where you can get further help to begin the healing."

Persons who have access and functional needs may have additional requirements. For example, a person who uses a wheel chair will need to have his chair transported to the hospital in order to maintain his independence once he begins to heal. A person, who has autism, may need the emergency responder to speak calmly using concrete phrases and allowing extra time for the individual to respond. The responder will also need to know to check the person's wrist or arm for a tattoo or a bracelet that identifies the person as having an autism spectrum disorder while keeping in mind that not all people with autism spectrum disorders will have identification. Some people with autism do not show indications of pain, so checking thoroughly for injuries is important. Information about working with persons with different kinds of access and functional needs can be found in a booklet entitled, Tips for First Responders, and is available through the Missouri Department of Mental Health, or at the website: http://dmh.mo.gov/docs/diroffice/disaster/Tipsbrochure6thEdition.pdf

ILLNESS VERSUS INCIDENT

Mass illness that could occur in pandemic flu or other infectious illness brings enormous challenges to both the health system surge and to the psychosocial reactions of the community. The surge of ill persons may overwhelm health care organizations. Staff and/or families of personnel may be ill. Resources may be limited due to the limited capacity for supply caused by the illness.

The article, "Prioritizing 'Psychological' Consequences for Disaster Preparedness and Response: A Framework for Addressing the Emotional, Behavioral, and Cognitive Effects of Patient Surge in Large Scale Disasters," [12] (Pp. E2-E3) identifies five triggers associated with psychological reactions among survivors. They are restricted movement, limited resources, trauma exposure, limited information, and perceived personal or family risk. The authors reiterate that these triggers apply across all hazards. All of these triggers may be present during a pandemic or other large-scale infectious disease outbreak.

Panic is rare in disasters, but is more likely to occur if persons believe that there is no escape. The medical community needs to be aware of the importance of communication to the public, particularly in instances where the public might perceive a lack of resources for medical treatment such as vaccines, anti-viral medications, or ventilators.[7] (p. 77)

Community members, who have not contracted the illness, may be afraid to be around those who are ill or who treat the ill. Individuals and families may voluntarily isolate or practice social distancing at the urging of health care providers. Risk communication will be essential to direct citizens to appropriate care and self-care within their own homes. Both the community and health care personnel may witness the illness and death of citizens, co-workers, and family members.

Managing the behavioral health reactions will include planning for the needs of patients, staff, and their families. It will mean:

- Addressing fears head on with education and risk communication.
- Educating staff regarding grief and bereavement reactions; how to support grieving co-workers and management of the workload will be fundamental.
- Preplanning for sensitive ways to address issues such as anger, fear, exhaustion and resolving ethical issues in critical incidents.
- Identifying staff care strategies including ways to support those with less social support
- Providing grief information, and self-care information via written fact sheets
- Planning for recovery and support groups for after the illness/incident

According to the Institute of Medicine's Guidance for Establishing Crisis Standards of Care for use in Disaster Situations,[11] (Pp. 52-53), the increase in demand for health care services along with the decrease in the available resources to provide needed care will result in the implementation of a variety of "surge capacity" strategies along a continuum of care from conventional capacity to contingency and then crisis capacity. Even though every attempt may be made to maintain usual and customary medical practices with conventional standards of care, catastrophic disasters such as Hurricane Katrina may force health care organizations into crisis capacity. Implementing crisis capacity standards of care may cause internal conflict for medical staff used to providing high standards of care and could cause ethical dilemmas. It is important for health care providers to drill and practice strategies that would be used in both contingency and crisis capacity standards of care[11] (p.54). Exercising these responses will assist providers in the mental and physical preparation needed to handle crisis standards of care.

Psychological Triage

Patients will be medically triaged in the field and may be triaged again once they arrive at the hospital. Those who are less injured, but still needing attention should be separated from the more serious patients to:

- Monitor their level of acuity and provide psychological support and information
- Prevent overexposure to difficult scenes of patients with more serious injuries
- If indicated screen for dangerousness to one's self or others

Those with more serious injuries, but stable, and those in critical condition will receive medical interventions first. These groups of patients may need psycho-education, support and psychological interventions when they are admitted to the hospital and are medically stabilized. Besides providing the traditional chaplain and social work services, hospital-based mental health professionals and related service individuals will need training regarding common reactions, psychological first aid, how to assist in disaster and terrorism incidents, and when to refer for long-term best practice substance abuse and mental health interventions such as trauma-focused cognitive behavioral therapy.

Those patients who are dying may be medically triaged to a palliative care area. Not only can appropriate care continue, but appropriately trained nurses, clergy and professional mental health workers can support the individuals and their family members. If patients begin to respond, they may be reevaluated and moved out of palliative care to other areas of the hospital.

Family members of decedents will need information and support to assist them through the grief and trauma they experience. Some persons who experience the trauma and see persons badly injured or killed may experience complicated grief and need additional mental health assistance or referral. The hospital or clinic may be their first contact to information that will assist them in understanding their reactions and assessing if they might need behavioral health assistance in the future.

When family members are present at a person's death, they should be allowed time to be with the deceased at the place of death if possible. In chaotic crisis situations this can be difficult if not preplanned, but a few minutes of respectful presence can make a difference in grief responses later for family members. The hospital morgue itself should not be a viewing area. (Also see Temporary Morgue Operations, page 18)

Isolation – Quarantine

Isolation

All patients admitted to hospital isolation units should be screened for mental health issues with continued reassessments. Patients are at increased risk for higher rates of anxiety and depression. Additionally, a person's self-esteem and sense of control are lower.[9]

Patients may enter isolation with a preexisting mental health or substance abuse diagnosis or may have a developmental disability. In these cases it will be necessary to continue ongoing treatment through existing providers (including methadone provision), if possible, or to work with the providers so that necessary treatment can be taken over by the hospital. It is possible that patients who are actively abusing substances and could be at risk for withdrawal may enter isolation. Part of the assessment should include questions about pre-existing conditions. However, staff should also be aware that patients may be reluctant to answer the questions and staff should be prepared to provide increased observation. Procedures should also include suicide protocols.

The appendices in the book, Behavioral Health Guidelines for Medical Isolation,[5] provides a summary of isolation precautions, a policy and procedure template, sample suicide precautions protocols, and screening resources that may be useful to health care organizations.

Communication will be critical to ease a patient's and his/her family's concerns and to assist them in understanding the process of isolation. For example, patients may feel that staff persons are afraid to be around them. For staff this might translate to less time due to the extra protection of donning Personal Protective Equipment (PPE) before entering the patient's room. It might also be difficult to communicate through facemasks or respirators and the

equipment may be hot and cumbersome. Communication should include verbal, brief, simple statements; repetition in written form and conveyance of the communication to family /guardians when appropriate. Persons who are stressed have difficulty in retaining information, so providing communication in as many formats as possible will assist. Protocols for interpretation and translation need to be in place for persons who are hard of hearing, deaf, or speak another language. Health care workers should be sensitive to the patient's and the patient's family's preferred means of communication.

All hospital personnel also need to be provided accurate information regarding the contagion and hospital precautions. Information should be released to the patient, the patient's family and hospital staff before being released to the public.

Communication needs to include the family and the community who may worry about ongoing risk, contamination, etc., particularly in high-profile cases. The family may also begin to cut themselves off from other family members and support systems if not provided the proper information. Hospitals may need to work with their local public health agencies to make appropriate information known to the public, such as precautions, exposure, and accurate information that will decrease worry and enhance knowledge.[5]

Those who work directly in the isolation unit should be provided behavioral health supports, including the ability to communicate with their family through phone, computer, etc. Anticipating and assisting in the provision for their families' needs relating to child, older adult or pet care and basic needs for food, medicine, etc. will assist staff in remaining on the job. Supervisors and mental health workers should monitor staff's well-being and insist that they take meal breaks, regularly scheduled breaks during the shift, and should provide for rotations as much as possible from more stressful to less stressful duties within the unit. A quiet environment where staff can retreat for phone calls, rest, etc., can be helpful.

Quarantine

The article "SARS Control and Psychological Effects of Quarantine"[10] describes a web-based survey of 129 quarantined health care workers and other citizens regarding the control of Severe Acute Respiratory Syndrome (SARS) by widespread voluntary quarantine measures. Frustrations by persons asked to voluntarily quarantine include:

- lack of information regarding infection control measures, modes of transmission and prognosis
- lack of contact with public health officials
- lack of support that they had expected; (p. 1208)
- Incomplete knowledge of rationale for quarantine (p.1211)

The instruments used for the survey were self-report validated scales.[20] The study showed that the duration of the quarantine was significantly related to increased PTSD symptoms. Responders described a sense of isolation because of the mandated lack of social and physical contact with family members. Confinement without the ability to shop for basic necessities and items such as thermometers and prescribed medications enhanced their isolation. Respondents also believed that people were reacting differently to them following quarantine including avoiding them, not calling them or inviting them or their families to events. The authors report that the data show that quarantine can result in considerable psychological distress in the forms of PTSD and depressive symptoms. Other types of anxiety symptoms were not studied. Respondents' informational needs ranged from failed expectations that the Public Health Agency would check up on them, to lack of information from their employers and a lack of support from other health care professionals. Additionally, the nature of the information provided was not detailed enough to suit them. Examples of inadequate information includes lack of precautions to take regarding infection control; inconsistencies in information; information provided too late; onset of symptoms and what should be considered serious; prognosis and ongoing health problems after recovery from SARS; and, mode of transmission (Online Appendix to the study)

Personal Protective Equipment (PPE)

Essential Elements of Respiratory Protection[15] provides a guide in graphical format of the elements that medical providers should consider in respirator practices. Information includes potential effects on patients and on medical providers when respirator use is required.

Effect on the public and patients

In describing the effects of a respirator on the tasks performed by workers, the New Jersey Center for Public Health Preparedness (NJCPHP) diagram illustrates physical impacts including mobility, sensory impacts on the worker including vision, hearing, smell and touch and their ability to communicate. In considering these physical impacts on the worker, one must also ascertain effect on the patient and patent's family if they are unable to understand communication, read body language, or comprehend why a worker may not be attending to them in the way that they would want. It may also create fear in those without respirator protection.

During SARS and the 2009 H1N1 pandemic, the public chose to wear facemasks and even respirators due to fears. Protection may be limited or non-existent if facemasks or N95 respirators are not worn correctly. Health care organizations provided public education about

the usefulness of those with the illness wearing facemasks to protect those around them, rather than vice versa.

Effects on Workers

Essential Elements of Respirator Protection,[15] "Impacts to Worker Health, 5:" describes the psychological stressors during use: claustrophobia; breathing difficulty; increased cardiac stress/decreased cardiac output; and, psychosomatic syndromes. After use of a respirator some workers may experience post traumatic stress.

Persons may be required to wear respirators who are not commonly assigned respirators in their regular course of work such as hospice workers, local public health agencies, long term care, psychiatric or developmental disability facilities, mass care and others.

Essential Elements of Respirator Protection,[15] "Work Area Surveillance, 12" describes additional mental health stresses, "Workers may experience one or more generalized symptoms of panic or anxiety disorder. Experience shows that people often express worry about health effects from substances to which they may have, or could have been exposed."

Sweating	Feelings of losing control	Dizziness
Shortness of breath	Palpitations	Claustrophobia
Nausea	Disorientation	Loss of concentration

The article recommends ensuring that buddy systems are established in high risk situations to ensure that workers are paired and remain in visual, voice or signal contact with one another at all times. It also suggests that one or more workers should be located outside the high hazard area to provide effective emergency rescue if needed.

Additionally, work rates and task completion rates may indicate a change in work conditions that might not otherwise be apparent if not monitored. These rates of completion could signal issues with the equipment or with physical or mental stressors.

Decontamination

Decontamination is the process of cleaning the body to remove chemical, radiological or biological materials. Most hospitals have a plan established to decontaminate persons. Clinics may have to call in a hazmat team to assist if they do not have facilities for decontamination.

Anyone going through the decontamination process is likely to have worries and fears regarding the substance they were potentially contaminated with and any long lasting effects of the contamination. Information should be given to all about the contaminant, possible symptoms

Our Nation's Resilience Paintings
By: Jenny Sage, Age 18
A boy cares for his dog during a bioterrorist attack. The boy and dog are on equal ground during this difficult time. The boy is protecting and caring for his dog, making certain that his dog has a mask. They look at each other eye to eye with serious but calm gazes. Behind them stand biohazard workers. The contrast between the black background and the bright yellow areas on the workers' uniforms suggests a sense of hope shining through from the darkness of terrorism

and a phone number in case they have concerns once they leave the decontamination site if not admitted. They should also be provided information about potential psychological reactions and information about how to care for themselves and others.

INDIVIDUALS WHO MAY NEED EXTRA ATTENTION DURING DECONTAMINATION

An individual that is decontaminated or is worried that he may need to be decontaminated may be at risk of behavioral health reactions. Responders at the hospital or scene should consider individuals with access and functional needs that may need assistance in the decontamination process and who may also need to have necessary support equipment decontaminated or replaced. These may include the frail elderly.[7]

Other persons who may need individualized attention include older individuals exposed to the World War II Concentration Camps, particularly those camps with gas chambers disguised as showers. Youth reaching the age of puberty may be especially concerned with having to disrobe and shower, especially if in front of others. Children should be accompanied by those who know them and developmentally appropriate information provided to the adult. Children are also especially susceptible to hypothermia (their bodies lose heat faster than adults) and need to be dried and warmed quickly so that there are not further complications. Children and adults who have been sexually abused may be at higher risk for behavioral health implications. Meeting the basic needs of clothing (even a hospital gown or a long t-shirt) and warmth immediately after decontamination may assist in reducing the trauma.

Family Assistance Center

Family Assistance Centers (FAC) serve to reunite missing family members, help family members locate deceased relatives, help with funeral arrangements, and provide spiritual and emotional support. In the early hours after a mass casualty incident, the hospital may be responsible for fulfilling some of these needs until an FAC can be established.

As hospitals monitor their visitors during a mass casualty or surge incident, they may identify a need for a family assistance center. In most cases the hospital would work with their community and local emergency operations center to request the establishment of a FAC.

The FAC may assist with gathering information from survivors regarding missing persons or persons who may be deceased. Professional interviews will be conducted by funeral directors, law enforcement or others trained to obtain identifying or ante mortem information. Professionals such as forensic pathologists, mortuary specialists, mental health, genetics, internet technology, security and other specialized professionals will staff the FAC and work with mortuary operations.

Tasks the hospital may consider in assisting individuals include planning for escort services if the family needs to go to a different area of the hospital for services or outside of the hospital to the FAC. Persons appointed to these roles need to be caring individuals with training, but do not have to be professional mental health workers.

The hospital may wish to identify if it has employees or volunteers that could be of assistance to the FAC such as medical personnel, social workers, chaplains, etc. These persons could provide an intermediary role for family members between the hospital and the FAC.

Temporary Morgue Operations

A careful assessment of staff who will be assigned to temporary morgue operations will be needed. These staff may see bodies in different states of decomposition and with different injuries from what they had previously experienced. It is also possible for staff working in the temporary morgue or directly assigned to logging the personal effects of individuals to view personal items that remind them of their own family members, such as, a picture, or a piece of jewelry or clothing. Training and exercising for assigned staff will be essential to help them prepare for the physical requirements and assist in building resilience to endure this type of assignment. Most exercises and drills end at the surge impact; therefore, drilling the morgue operations using adult and child dummies will add a needed element to hospital plans and exercises.2 (Pp. 13-6)

Providing staff with high quality Personal Protective Equipment (PPE) and other equipment, appropriate fit-testing and a buddy system for monitoring each other's PPE and other physical and mental safety concerns will assist in lessening the worries of staff about possible exposure in an incident. Education and drills should be carried out regarding performing fit-testing for respirators and providing information about the use of bleach and splash protection with the brands of PPE used in the temporary morgue. Operational debriefings should be scheduled during drills/exercises and during an actual incident to assess operations and any ongoing issues. Assigned supervisors will assess staff reactions, rotations, and other elements consequential to their well-being.

Developing trained, ready and resilient staff will assist them in healing from the psychological and social effects after a mass casualty/mass fatality occurrence. All staff involved in drills, exercises and actual incidents should be given written psycho-educational materials regarding potential reactions and information about how to obtain assistance through their Employee Assistance Program or other local resources if needed.

Psychological First Aid

Psychological First Aid[22] is an evidence-informed modular approach to help persons of all ages in the immediate aftermath of disaster and terrorism. It is designed to reduce the initial distress caused by traumatic incidents and to foster short and long-term adaptive functioning and coping. It is applicable in diverse settings including health care settings such as clinics, hospitals, local public health agencies, and other emergency response settings in the field where health care and mental health workers may be deployed.

Psychological First Aid (PFA) may be used with patients, their families and for peer care of staff team members. It is consistent with research on risk and resilience following trauma. It does not assume that all survivors will develop severe mental health problems or long term difficulties. PFA is based on an understanding that disaster survivors and others affected by trauma including responders will experience a broad range of early reactions such as cognitive, physical, behavioral, spiritual, and psychological. One does not have to be a mental health professional to deliver Psychological First Aid. It is recommended that compassionate and caring health care responders who represent all areas of expertise in a health care organization be trained to provide PFA.

A free online six-hour PFA course is available at http://www.nctsn.org/trauma-types/natural-disasters. This professionally-narrated course is for individuals new to disaster responses who want to learn the core goals of PFA, as well as for seasoned practitioners who want a review. It features innovative activities, video demonstrations, and mentoring tips from the nation's trauma experts and survivors. CEs and CEUs are offered for physicians and other medical and mental health professionals. More information may be found at the NCTSN website about professional credits. The PFA mobile APP for I-phones is available at http://www.nctsn.org/content/pfa-mobile PFA mobile app for Androids: https://play.google.com/store/apps/details?id=com.nctsn.pfa.mobile

Workforce Support

No one who responds to a mass casualty is untouched by it. [23] Staff preparation before disaster response and staff support systems in place after a disaster are essential to workplace recovery.

Employee support may include training regarding personal and family preparedness and self-care and peer-care. Health Care Organizations (HCOs) may consider communication systems for employees to contact their families. Plans may include assisting with family and pet needs. Investigating how to assist with longer term needs for those personally impacted can aid in retaining employees at critical times. Studying financial options for payment of salaries and keeping employees "whole" for a period of time if the HCO structure(s) sustain damage may be a viable option and has been done by some health care organizations.

Implementing Psychological First Aid as part of the HCO's plan for employees and patients can assist in their short-term and long-term recovery. Offering quiet spaces where employees can go to have a few minutes to decompress and providing educational pamphlets about common reactions, self- help and co-worker support in the weeks following an incident is another method of providing support.

If supportive groups are offered for employees in the aftermath of a mass casualty incident, attendance should be on a voluntary basis. When employees attend, they should not be made to talk and they should be grouped with individuals that have "like" exposure so as not to overexpose them to scenes or information that may cause them more stress.

Making information readily available regarding the HCO's Employee Assistance Program and the services provided can assist in de-stigmatizing counseling assistance. Assess and educate staff about the signs of anxiety, depression and post-traumatic stress disorder. Human Resource policies should address how referrals are to be made for further counseling or medical assistance as needed.

Organizational debriefings that accumulate in an After Action Report are beneficial in ascertaining response actions that went well and actions, policies and procedures that could be improved without assigning blame.

Implementing supervisory strategies that limit on-duty work hours, provide rotations from more stressful to less stressful duties, require breaks away from the scene as practicable, and pair more experienced responders with those less experienced especially in longer term responses will assist employees in remaining rested and attuned to critical details of their jobs.

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Appendix

Page

MENTAL HEALTH UNIT LEADER
JOB ACTION SHEET

Mission: Address issues related to mental health emergency response, manage the mental health care area, and coordinate mental health response activities.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____

Position Reports to: Medical Care Branch Director Signature: _____

Hospital Command Center (HCC) Location: _____ Telephone: _____

Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive appointment, briefing, and appropriate forms and materials from the Medical Care Branch Director.		
Read this entire Job Action Sheet and review incident management team chart (HICS Form 207). Put on position identification.		
Notify your usual supervisor of your HICS assignment.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Appoint mental health team members and complete the Branch Assignment List (HICS Form 204).		
Brief unit team members on current situation, incident objectives and strategy; outline Unit action plan and designate time for next briefing.		
Meet with the command staff and Employee Health & Well-Being Unit Leader to plan, project, and coordinate mental health care needs of patients, their family, and staff. The plan should include addressing the mental health needs of people who arrive at the hospital with concerns that they are or may be victims of the disaster.		

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Participate in briefings and meetings, as requested.		
Communicate with the Medical Care Branch Director and obtain information, as follows: • Type and location of incident. • Number and condition of expected patients. • Estimated arrival time to facility. • Unusual or hazardous environmental exposure. • Location(s) of surge of people (who may or may not be victims of the disaster) who have arrived at the facility or who are calling to ask for assistance (e.g., facility phones, reception area, ED, decontamination area, isolation area, etc.). • Any special circumstances that must be addressed due to the nature of the incident, such as special languages, cultural needs, or security concerns.		
Provide mental health guidance and recommendations to Medical Care Branch Director based on response needs and potential triggers of psychological effects (trauma exposure, perceived risk to staff and family, restrictions on movement, resource limitations, information unavailability).		
Communicate and coordinate with Logistics Section Chief to determine • Available staff (mental health, nursing, chaplains, experienced volunteers, etc.) that can be deployed to key areas of the facility to provide psychological support, and intervention. • Location and type of resources that can be used to assist with a mental health response, such as toys and coloring supplies for children, mental health disaster recovery brochures, fact sheets on specific hazards (e.g., information on chemical agents that include symptoms of exposure), private area in the facility where family members can wait for news regarding their loved ones, etc. • Availability of psychotropic medications (particularly anxiolytics).		
Communicate with Planning Section Chief to determine: • Bed availability in inpatient psychiatry units, if applicable. • Additional short and long range mental health response needs. • Need to provide mental health care guidance to medical community.		
Establish an overall mental health treatment plan for the disaster including priorities for mental health response for patients, families, and staff; staffing recommendations; recommended mental health activities/interventions; resources available and needed; and problems to be addressed in the next operational period.		
Regularly meet with Medical Care Branch Director to discuss medical care plan of action and staffing in all mental health areas.		
Receive, coordinate, and forward requests for personnel and supplies to the Medical Care Branch Director.		

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Request clerical support from the Labor Pool and Credentialing Unit Leader, if necessary.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Documentation Unit.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Communicate and coordinate with Logistics Section Chief on the availability of: • Mental health staff needed to deliver psychological support and intervention • Availability of psychotropic medications (particularly anxiolytics)		
Coordinate with Logistics and Planning Section Chiefs to expand/create a recognized provisional Mental Health Patient Care Area, if necessary.		
Ensure that appropriate mental health standards of care are being followed and mental health needs are being met.		
Establish regular meeting schedule with mental health staff responding to the incident and the Medical Care Branch Director for updates on the situation regarding hospital operation needs.		
Maintain communication with Logistics and Planning Sections to monitor situation updates and maintain information resource availability.		
Communicate with local governmental mental health department, in collaboration with the Liaison Officer, to ascertain community mental health status and assess available resources.		
Participate in development of risk communication and public information that addresses mental health concerns.		
Ensure patient records are being prepared correctly and collected.		
Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques.		
Advise Medical Care Branch Director immediately of any operational issue you are not able to correct or resolve.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Assess environmental services (housekeeping) needs in all mental health care areas; contact the Environmental Services Unit Leader for assistance.		
Report equipment and supply needs to the Medical Care Branch Director and Supply Unit Leader.		
Ensure staff health and safety issues are being addressed; resolve with Medical Care Branch Director and Employee Health and Safety Unit Leader, when appropriate.		
Develop and submit an action plan to Medical Care Branch Director when requested.		
Ensure that patient status and location information is being regularly submitted to the Patient Tracking Officer.		
In collaboration with the Medical Care Branch Director, prioritize and coordinate patient transfers to other hospitals with Transportation Unit Leader.		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Continue mental health care supervision, including monitoring quality of care, document completion, and safety practices.		
Continue to meet regularly with the mental health staff responding to the incident and the Medical Care Branch Director to keep apprised of current conditions.		
Continue to ensure the provision of resources for mental health and recovery, and education to children and families.		
Observe staff, volunteers, and patients for signs of stress and inappropriate behavior. Report concerns to the Medical Care Branch Director and the Employee Health and Well-Being Unit. Provide for staff rest periods and relief.		
Rotate staff on a regular basis.		
Continue to document actions and decisions on an Operational Log (HICS Form 214) and send to the Medical Care Branch Director at assigned intervals and as needed.		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Continue to provide Medical Care Branch Director with regular situation updates.		
Provide staff with situation update information and revised patient care practice standards.		
Continue to ensure mental health needs of patient and family are being met.		
Respond to reports or concerns from other staff regarding signs of staff stress and inappropriate behavior. Report mental health needs of staff to Employee Health and Well-Being Unit.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information.		

Demobilization/System Recovery	**Time**	**Initial**
As needs for Mental Health Unit staff decrease, return staff to their normal jobs and combine or deactivate positions in a phased manner.		
Coordinate a plan to address the ongoing mental health needs of patients, families, and staff, in conjunction with the Employee Health & Well-Being Unit.		
Assist Medical Care Branch Director and Unit Leaders with restoring mental health care areas to normal operating condition.		
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
Upon deactivation of your position, brief the Medical Care Branch Director and Operations Section Chief, as appropriate, on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, ensure all documentation and Operational Logs (HICS Form 214) are submitted to Medical Care Branch Director or Operations Section Chief, as appropriate.		
Submit comments to Medical Care Branch Director for discussion and possible inclusion in after action report. Comments should include: • Review of pertinent position descriptions and operational checklists • Procedures for recommended changes • Section accomplishments and issues		

Demobilization/System Recovery	Time	Initial
Coordinate stress management and after-action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools

- Incident Action Plan
- HICS Form 204 – Branch Assignment List
- HICS Form 207 – Incident Management Team Chart
- HICS Form 213 – Incident Message Form
- HICS Form 214 – Operational Log
- Local public health department reporting forms
- Hospital emergency operations plan
- Hospital organization chart
- Hospital telephone directory
- Radio/satellite phone

HOSPITAL INCIDENT COMMAND SYSTEM

August, 2006

Behavioral Health Template

MENTAL HEALTH UNIT LEADER AND UNIT MEMBERS: PREPAREDNESS ACTIVITIES

Recommended Actions	*No Action*	*In Progress*	*Completed (Date)*
Read the emergency operations plan			
Take Incident Command and National Incident Management Courses: 100, 200, 700, 800, 300 and 400			
Learn the HICS forms used by the Mental Health Unit: (HICS 204,207, 213, 214, and other forms used by the hospital in an incident;			
Meet with the Medical Care Branch Director (MCBD) and others the MCBD may assign before an incident to define responsibilities according to the job action sheet.			
Recruit Mental Health Unit members; include mental health, nursing, chaplains, experienced/trained volunteers, etc.			
Plan for the mental health staffing needed based on area, such as emergency room, waiting rooms for family members, unattended children brought to the hospital, persons who have access and functional needs, morgue operations, etc.			
With your supervisor identify other staff who can take the mental health unit leader role to cover all shifts			
Meet with the public information officer to develop risk communication and public information messages that address mental health concerns. See MO Department of Mental Health Disaster Communications Guidebook: http://dmh.mo.gov/diroffice/disaster/CommGuidebkFINAL072210.pdf			
Provide education in psychological first aid, grief and bereavement and other issues that may compound the psychological reactions of staff – consider all staff			
Assist in developing behavioral health scenarios for hospital drills and exercises			
Advocate for persons with access and functional needs to be part of the planning process and drills			
Participate in drills and exercises			
Learn the community: cultures, languages, & special concerns that could complicate the physical and psychological response			
Identify community resources that might assist and how they could help given the hospital's culture and HIPAA: i.e. chaplains, community-based mental health workers, local public health, providers who assist persons with access and functional needs, etc. Develop Memorandums of Understanding as necessary			
Plan for if and how unsolicited volunteers might be used, i.e. serving water, coffee, etc.			

MENTAL HEALTH UNIT LEADER AND UNIT MEMBERS: RESPONSE ACTIVITIES

Recommended Actions	*No Action*	*In Progress*	*Completed (Date)*
Report to incident command			
Follow Mental Health Unit Job Action Sheet			
Meet with the mental health unit teams at least twice a day (beginning and end of shifts) to operationally debrief, assess assignments, rotations, etc.			
Assess crowd control issues such as rumors, perceived lack of resources, etc. Work with Public Information Officer and others to counter incorrect information			
Within ICS access need for requesting a community Family Assistance Center (FAC) be established.			
Assess hospital/medical provider role in the FAC			
Plan for the next operational period			

*Behavioral Health Planning with the Incident Command Team for **SURGE CAPACITY***	*No Action*	*In Progress*	*Completed (Date)*
Review space requirements for surge: • Waiting areas for family members. • Quiet areas for those with fear and anxiety regarding exposure • Space for grieving family members such as chapels, small offices, etc. • Space for palliative care if needed • Designate space for behavioral health staff briefings 2-3 times a day by shift			
Review the staff roster for those with behavioral health credentials that may be assigned in these areas including behavioral health professionals, nurses with psychological experience, chaplains, etc. Be prepared to expand/contract based on the incident			
Plan for ICS briefings including changing resources and updated information for behavioral health staff at change of shift			
Assign behavioral health team members to the medical staffing teams, particularly for the family waiting areas and the surge spaces to accommodate those who are fearful and anxious			
Designate well-trained staff to assist in bereavement areas			
Prepare for persons with mental illness or developmental disabilities who may report to the emergency room and need medical &/or psychiatric evaluation			
Prepare for unaccompanied children, family members and school friends to surge at hospital • Child Life Worker or other behavioral health staff to stay with unaccompanied child until family arrives			

• Provide developmentally appropriate information to child • Provide accurate reunification information to families: ▪ Assess communication process with other hospitals for reunification			
Address the distress among current inpatients and their family members due to the community impact of incident, fears for their own safety, early discharges, overflowing spaces and crowding;			
Assess whether well-trained reassigned staff or volunteers could be assigned supportive roles to meet needs: i.e. serve coffee, water, provide blankets, etc. to those waiting.			
Review security concerns for family areas			
Plan for care of staff members who have dealt with grotesque injuries; been exposed or feared exposure to a biological/chemical agent; dealt with child injuries and death; dealt with multiple deaths. Plan for self-care/staff-care for the mental health workers • Is there an Employee Assistance Plan? • Will staff mental health professionals support staff? • Will outside community assistance be arranged? • Will hospital plan for a combination of these approaches?			
Provide Psychological First Aid training to staff assigned to emergency role (PFA Online course): http://learn.nctsn.org/course/category.php?id=11			
Account for psychological casualties and searching family members in drills/exercises that test surge capacity			
Plan for staff support, such as on-site child, elder, pet care if possible			
Plan for behavioral health support in morgue operations			
Drill/exercise conventional and crisis standards of care response			
Behavioral health should be part of the after action review and contribute to the after action report after drills, exercises and incidents			

Behavioral Health Planning for SURGE Capacity for INFECTIOUS ILLNESS	***No Action***	***In Progress***	***Completed (Date)***
Develop measures to address intense grief and loss among the medical community			
Educate staff regarding the potential for angry citizens that may not obtain the level of care they feel they deserve in surge conditions			
Inform staff working in isolation units about the higher rates of anxiety and depression experienced by patients in isolation and ways to assist: empathy, repetition, multiple formats of messages			
Arrange for continued treatment of those with a pre-existing			

behavioral health diagnosis; identify measures to communicate with their behavioral health provider			
Plan for cultural differences and language barriers. (People who speak English as a second language may return to their "language of heart" in stressful conditions).			
Prepare staff to identify patients without strong support systems and how to provide information about available supports, i.e. support groups, faith communities, etc.			
Prepare for family briefings and informational materials to assist family members in healthy practices: • Policies and procedures to guide staff interaction • Consider family's feeling of isolation, guilt, role strain, fears of transmission • Hospital restrictions: PPE, other restrictions including contacts with patients in isolation • Special issues surrounding child patients and family members • Supports for grieving children and other family members			
Additional supports for staff operating the temporary morgue and additional planning for their physical and mental welfare			
Plan with community health providers, organizations and government for an extended response. Include informational warm lines with nurses and mental health specialists			
Provide training on "peer-to-peer" care that anticipates the emotional/behavioral circumstances the medical community will face			
Behavioral health should be part of the after action review and contribute to the after action report after drills, exercises and incidents			

Behavioral Health Planning for PSYCHOLOGICAL TRIAGE	***No Action***	***In Progress***	***Completed (Date)***
Develop process for psychological triage and reassessments throughout the treatment process.			
Evaluate surge spaces to accommodate separation of seriously injured from those less seriously injured to prevent overexposure			
Provide training to medical staff regarding common reactions after a disaster or terrorism incident, when to refer for professional mental health intervention, and suicide prevention.			
Assignment of staff to surge areas and palliative care areas.			
Develop educational materials to provide family members information about traumatic grief reactions			

Behavioral Health Planning for ***ISOLATION***	*No Action*	*In Progress*	*Completed (Date)*
Medical screening and diagnosis includes mental health and substance abuse assessment questions for persons entering isolation			
Develop procedures for increased observation as needed			
Initiate suicide protocols for the isolation unit.			
Educate isolation area staff regarding potential behavioral reactions of persons in isolation. Seek concrete ways to overcome the communication barriers.			
Develop communication policies regarding translation and interpretation for persons who are hard of hearing, or do not speak English			
Behavioral health works with the PIO to determine appropriate messaging to the community and includes other health partners such as the local public health agency in planning to determine consistent accurate messages.			
Ensure that information is released to the patient, patient's family and health care personnel before release to the public			
Give behavioral health supports to personnel working in the isolation unit			
Offer quiet areas for breaks, computers and phones for staff to contact family			
Anticipate staff's family needs and work with community agencies to meet those needs			
Monitor staff's well-being and enforce meal breaks and regularly scheduled breaks			
Provide for rotations as much as possible from more stressful to less stressful duties within the unit			
Behavioral health should be part of the after action review and contribute to the after action report			

Behavioral Health Planning for ***QUARANTINE***	*No Action*	*In Progress*	*Completed (Date)*
Develop plan for support strategies by the health care employer to be used to assist staff who voluntarily quarantine at home			
Determine how the local public health agency, faith communities and other organizations can assist with supporting quarantined staff and their families			
Plan for regular communication with quarantined staff through: phone calls, emails or by using other social networking media			
Provide detailed information early and often for the quarantined			

workers regarding the contagion, symptoms, what should be considered serious, prognosis and lasting health impact.			
Utilize public education materials and public service announcements that result in support for rather than stigmatism of health care workers who are quarantined. Information should include facts about contagion, exposure, etc.			
Behavioral health should be part of the after action review and contribute to the after action report			

Behavioral Health Planning for PERSONAL PROTECTIVE EQUIPMENT (PPE)	***No Action***	***In Progress***	***Completed (Date***
Behavioral health staff develop understanding of the issues and concerns regarding wearing PPE and potential reactions			
Provide staff education about potential stress reactions to PPE and stress management strategies			
Plans for PPE review are established to include: buddy system; correct fit; ongoing monitoring by buddy, behavioral health and medical staff regarding: • Proper fit and wearing • Physical or mental reactions to wearing PPE • Staff rotation, assignment of duties • Work rates and task completion • Emergency rescue provisions			
Behavioral health monitors patients for stress regarding staff with PPE, concerns for communication, isolation, etc.			

BEHAVIORAL HEALTH PLANNING FOR DECONTAMINATION	***No Action***	***In Progress***	***Completed (Date)***
Behavioral health staff understand the decontamination process and concerns for at risk populations			
Psycho-educational materials regarding behavioral health reactions to decontamination and exposure to particular contaminants exist and are readily available (i.e. chemical exposure, radiation exposure, etc.)			
Decontamination plans include privacy as much as possible and covering/clothing for those decontaminated			
Decontamination plans include a footprint for space for behavioral health staff to talk with those decontaminated and provide psycho-educational materials			
Behavioral health staff are assigned to assist with following			

up with individuals who go through decontamination			
If persons present who are assessed not to need decontamination, but who have persistent fears and anxiety, a process exists to refer them to the behavioral health staff for further resources			
Behavioral health staffs work with the PIO to create appropriate messaging. See MO Department of Mental Health Disaster Communications Guidebook: http://dmh.mo.gov/diroffice/disaster/CommGuidebkFINAL072210.pdf			

Recommended ***FAMILY ASSISTANCE CENTER*** *Planning Actions*	*No Action*	*In Progress*	*Completed (Date)*
Identify community organization responsible for establishing the Family Assistance Center (FAC). Resources to contact include the emergency management office or local funeral director or medical examiner offices.			
Identify surge level where hospital would request that a FAC be established			
Assign staff that would assist in FAC if appropriate			
Provide appropriate training, working with the other community agencies that will provide the FAC			
Appoint companions to escort family members as needed to other parts of hospital, to the FAC (especially if family is from out of town) etc. to gain assistance			
Identify any issues for staff accompanying family members including transportation, liability or other legal issues			
Provide psycho-social materials for staff/volunteers that assist family members			

BEHAVIORAL HEALTH PLANNING FOR MORGUE OPERATIONS

Preparedness Activities:

Recommended ***MORGUE OPERATIONS*** *Planning Actions*	*No Action*	*In Progress*	*Completed (Date)*
Assign behavioral health staff and/or chaplains to monitor personnel assigned to morgue operations, all shifts			
Provide education by appropriate personnel: • PPE fit-testing • Buddy system • Normal precautions			

• Splash protection • Information about potential psychosocial staff reactions and available assistance			
Drill/exercise morgue operations including scenarios that could have potential behavioral health impact on staff;			
Provide psycho-educational materials regarding reactions and self-care/stress management including counseling resources available			
After Action Report for drills			

Response and Recovery Activities

Recommended ***MORGUE OPERATIONS*** *Planning Actions*	*No Action*	*In Progress*	*Completed (Date)*
Assign behavioral health staff and back-up staff all shifts			
Provide just-in-time training as needed by appropriate personnel: • PPE fit-testing • Buddy system • Normal precautions • Splash protection • Information about potential staff reactions and available assistance			
Conduct regular staff meetings during each shift to monitor operations and psychosocial impact on staff			
Monitor supervisors and staff for rotations, breaks, emotional reactions			
Behavioral health staff should be involved in the after action meetings and provide further psychosocial educational materials, confidential counseling resources and information at the meetings			
Behavioral health supervisors should monitor and assist the behavioral health staff involved in morgue operations			