Ventura County Behavioral Health Advisory Board

Finalized at the General meeting of June 18, 2018

VISION

A society where equity exists in the provision and funding for behavioral health services. Mental wellness is achieved by Ventura County Behavioral Health's commitment to ensure that every client receives appropriate housing, whole person care which includes, but is not limited to, behavioral health services, a primary care physician, preventive and dental care, and the elimination of the stigma that surrounds Behavioral Health clients.

MISSION

The mission of the Behavioral Health Advisory Board is to advocate for members of the community living with mental illness and/or substance use disorders and their families. This is accomplished through the assessment of data, support, review and evaluation of evidence-based treatment services provided and/or coordinated through the Ventura County Behavioral Health Department, with consumers, community and stakeholder involvement.

OBJECTIVES FOR FY 2018-19

1. Advocate for effective assessment and referral for individuals in crisis at the Hillmont Psychiatric Center in cooperation with local hospitals and law enforcement, with particular emphasis on developing a Crisis Stabilization Unit and increasing inpatient beds, both public and private, within the community.
2. Advocate for increased services to the older adult population.
3. Identify opportunities for cannabis education and awareness.
4. Identify strategies, including advocacy, to address gaps in services for the Transitional Age Youth (TAY) population related to mental health and substance abuse treatment, housing options, work and volunteer opportunities, and the justice system.
5. Advocate for the availability of psychiatric hospital beds in the county for the pediatric population.

INTRODUCTION AND SUMMARY

for discussion at the BHAB General Meeting of July 16, 2018

- All levels of government within the United States and all people within this nation must demonstrate their concern for the safety and protection of children within their homes, their communities and their schools. It is unfathomable to accept mass shootings and active shooter situations as the new norm within our schools. Safety with respect to the protection from mass shootings must also be a concern for transitional age youth, adults and older adults as well. It is imperative that the sanctity of human life be a high priority concern for everyone in this nation. No child should ever have to go to school fearful of being murdered by an active shooter in the classroom. Nor should any parent send their children to school fearing that every morning they say good-bye to their children as they leave to go to school may be the last time they see their children alive. This is not only a mental health issue, but it has also become a public health matter. We as a people can do better than this.

- It has been predicted that the older adult population in California is expected to surge, being referred to as the "silver tsunami". The Ventura County Behavior Health Department and Human Services Agency must intensify their planning efforts to address the needs of individuals age 60+ that are forecast to increase by 73 percent in Ventura County by 2030 as compared to 2010. Specific emphasis should be placed on the behavioral health needs of this growing population including addressing the need for providing inpatient psychiatric beds in Ventura County.

- The prevailing treatment philosophy for individuals with substance use disorders is to require those seeking care to recognize that they have a problem and seek care on their own volition. In light of the opioid and heroin epidemics being experienced in our communities, that philosophy needs to change if progress in effectively addressing these behavioral health and healthcare issues can be achieved. Serious outreach and engagement programs must be set in place if progress is to be achieved. VCBH Alcohol and Drug Programs must look at ways to accomplish this. Without an enhanced effective outreach and engagement program aimed at individuals with substance use disorders not willing to accept treatment, we can only expect the epidemic to remain static or increase.

Challenges and Recommendations in Disaster Mental/Behavioral Health
From June 22, 2018, Los Angeles PowerPoint Presentation (Slides 28 - 32)

Patti Carter, BA, EMT
Public Health Coordinator – Nevada County
Sandra Stark Shields, LMFT, LPCC
Sr. Disaster Analyst – LA County DMH DSU

Challenges for BH/MH Departments

1. **Lack of funding** and dedicated and trained Emergency Management **staff** and Disaster MH/BH expertise.
2. **Integration** of BH staff into the Med/Health Branch, Public Health and Health plans, and into exercises and drills
3. "Psychological Casualty" numbers are **not included in drills** and exercises = no opportunity for BH Departments to practice!
4. ***Need for statewide facilitation to help develop:***
   - ❖ DMH/BH tools for disaster planning and response
   - ❖ Consensus on "required" training – including specific training for BH roles in different types of disasters
   - ❖ Implement CA Public Health & Medical BH Resource Typing Tools
   - ❖ Evidence-Informed BH Intervention Standards
   - ❖ **California (Methadone) Clinic Plan**

What the CALBHB/C can do to help:

1. **Assess the level of Disaster Response Preparedness for your County's Disaster Behavioral Health response:**
   a. How is Mental/Behavioral Health integrated, staffed, funded and supported in your County? On par with Public Health and Health in your jurisdiction? If not, why not?

   b. Professional Emergency Management staff dedicated full time to disaster response planning? Does your county have a Disaster MH/BH Subject Matter Expert?

   c. Current, written disaster plans? Integrated?

   d. Disaster Department Operations Center?
      i. Staff identified for NIMS Roles? Trained? Equipment?
      ii. DOC Activation for minor as well as major disasters? When?

   e. What are the Disaster BH Intervention Standards for those who are least impacted to most impacted? (Beyond PFA and "debriefing")

   f. What is your BH Department's Disaster Mission?

   g. What is the working relationship like with American Red Cross - Disaster Mental Health Services in your County?

   h. What are the BH plans for County staff disaster mental health? (Employee Health and Well Being Unit Leader selected and trained?)

2. **Weigh in on proposed legislation:** ***AB2333 – Counties would greatly benefit from having a dedicated Disaster Mental/Behavioral Health Director*** *in the appropriate state agency tasked with Public Health, Medical response, or Emergency Management to facilitate statewide BH disaster response planning and to help with the development and implementation of BH Guidance (EOM and Resource Typing), Tools, Training, and integration with the Public Health and Medical disaster response systems.*

Disaster Preparedness & Recovery

Mental/Behavioral Health Issues/Gaps and Planning and Response

CALBHBC – Los Angeles

Friday - June 22, 2018

Howard Backer, MD, MPH

Director, California Emergency Medical Services Authority

Patti Carter, BA, EMT

Public Health Coordinator – Nevada County

Merritt D. Schreiber, Ph.D.

Professor of Clinical Pediatrics – Harbor UCLA MC

Sandra Stark Shields, LMFT, LPCC

Sr. Disaster Analyst – LA County DMH DSU

Topics we will Discuss

- Disaster-Related MH/BH Spectrum: Individual Needs & Appropriate Levels of Care
- The place of Mental/Behavioral Health in the Structure of Emergency Response Organizations (State and Local)
- Challenges and Recommendations in Disaster Mental/Behavioral Health Planning and Response

Disaster-Related MH/BH Spectrum: Individual Needs & Appropriate Levels of Care

Sandra Stark Shields, LMFT, LPCC

Sr. Disaster Analyst – LA County DMH DSU

Overview – Disaster Mental Health

*"Disasters can occur naturally (such as tornadoes, hurricanes, earthquakes, floods, wildfires, mudslides, or drought) or be human-caused (such as mass shootings, chemical spills, or terrorist attacks). Preparing for, responding to, and recovering from disasters and traumatic events **is essential** to the behavioral health (mental health and substance use) of individuals and communities. When people experience a disaster, they may experience a variety of reactions ... most people show **resilience** after a disaster..."* SAMHSA https://samhsa.gov/disaster-preparedness

*"A number of risk factors make it more likely that someone will have more **severe or longer-lasting stress reactions** after disasters..."* https://www.ptsd.va.gov/public/types/disasters/effects_of_disasters_risk_and_resilience_factors.asp

Some Disaster MH History

- Cerritos Air Crash in 1986 was the watershed event

- 1992 Disaster Mental Health function established at the American Red Cross in the wake of Hugo and the Loma Prieta Earthquake
  - ***DMH/BH Departments entered the disaster response business more proactively at that time as well***

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California – Many Large Disasters!

- 2017 **Wildfires** Historic levels of death and destruction = 1.2 million acers destroyed, 10, 800 structures, killing 46 people. Thomas fire was the *largest recorded wildfire in CA* (Washington Post)
- **Floods** – Oroville Dam, Sonoma, Mendocino, Guerneville, Ventura, Santa Barbara, Los Angeles
- **Public Health disasters** (Hepatitis A, Exide, Sativa Water, etc) = always a BH impact!
- **Shootings** - Las Vegas Shooting (also Waterman/San Bernardino) = *Care of Employees* a big factor

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Disaster Mental Health - Assumptions

- Most reactions to disaster are **common and expected**
- Most people are **resilient** and will **recover on their own** ***but some will require follow up.***
- Disaster MH interventions can help facilitate recovery and mitigate long-term psychological challenges (e.g., depression, anxiety, PTSD).
- American Red Cross *provides crisis intervention -- but not long term BH treatment.*
- ***County BH/MH departments are <u>tasked</u> with providing crisis and longer term BH/MH services***

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58 BH/DMH Departments in CA

- Each County is different
- Not all departments have dedicated disaster planning staff, professional emergency managers, and/or Disaster BH expertise
- Not all counties have the same disaster BH Mission, evidence-informed BH interventions, trained staff, integration into Medical and Health plans, or partnerships (such as with the American Red Cross)

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Where are Disaster Mental Health Services Provided?

- Wherever disaster **survivors/clients** are:
  - Shelters
  - Service Centers (established temporarily in community settings)
  - LACs, FAC's, Community meetings
  - Hospitals, Public Health PODs
- Wherever disaster **responders** are:
  - Shelters
  - Service Centers
  - Emergency Operations Centers (EOC)

Type of BH/MH Staff Who Respond

- Licensed MH Professionals, Nurses
- Registered MH Interns, etc
- *No paraprofessionals are used for mutual aid (county to county deployments) but Counties can choose to use them*
- Counties might consider adding Certified Drug and Alcohol Counselors for tasks within their scope – but *not* as Disaster Mental/Behavioral Health responders.
- Spiritual Care providers can "partner" with BH

Common BH/MH Field Interventions

- Psycho-education Model
  - Community Meetings
- Psychological First Aid
- Crisis Intervention
- Crisis Counseling
- Linkage, Advocacy and Referrals into the County MH system (for longer term counseling services)

Severity vs. Treatment – Not "One size fits all"

Severity	Treatment
Resiliency	Nothing ➡ PFA
Concerns, Behavior Change	PFA, Psycho-Education, Support systems
Non-specific psychological distress	Assessment, Crisis Counseling, etc
Traumatic Bereavement, Acute Stress Disorder	Short Term counseling – TF-CBT, etc
PTSD, Depressions, Anxiety, Panic, etc	Long Term (trauma) treatment/psychotherapy

County Staff Impact

- *Mission of Disaster Mental/Behavioral Health ALSO includes support for County staff*
- Employee Health and Well Being Unit Leader position in the County EOC should be added.
- Services beyond Employee Assistance Program (EAP) will be needed for disasters impacting staff.
- Rules on access to Victim of Crime Services for Employees were changed after the Waterman/San Bernardino shooting

Disaster-Related MH/BH Spectrum: Individual Needs & Appropriate Levels of Care

Merritt D. Schreiber, Ph.D.
Professor of Clinical Pediatrics – Harbor UCLA MC

Behavioral Health and Medical/Health (ESF 8) Mutual Aid System

Howard Backer, MD, MPH, FACEP

Director, Emergency Medical Services Authority

Spectrum of Behavioral Health Response

- Evaluation of mental health needs
- Existing mental health problems
- New stress response among public
- Stress response among rescuers
- Psychiatric medications and Drug rehabilitation
- Response to public health and disaster messaging
- Support health care and shelter operations

So Cal Catastrophic Earthquake Estimate (8 county region affected, 2010)

Pre-existing mental health needs:

- 7% of general population is on medication for a diagnosed mental health disorder
- 1,146,239 severely mentally ill adults and severely emotionally disturbed children
  - Dept State Hospitals in affected region
    - Patton State Hospital patient population = 1287
    - Metropolitan State Hospital population = 1041
- 72hr involuntary hold (5150) average = 200 / day

Response Principles Public Health and Medical (ESF-8)

- Standardized Emergency Management System (SEMS) compliant
  - ➢Local Operational Control and Response
  - ➢State Responsible for Resource Assistance
  - ➢Federal support for resources, management
- Coordinate/integrate private and public partners
- Mutual aid based on needs and requests
- Need is immediate with resource gap
- Recovery is much longer than initial response

Medical Health Operational Area Coordination (MHOAC) Program
Health & Safety Code 1797.153

- County health officer and local EMS administrator or their joint appointee
- 17 Functions – may be delegated
- Single Point of Contact for coordination with the RDMHC/S, EMSA and CDPH
  - Situation Status Reporting
  - Resource Requests

17 functions of the MHOAC (HSC 1797.153)

(1) Assessment of immediate medical needs.
(2) Coordination of disaster medical and health resources.
(3) ...patient distribution and medical evaluations.
(4) Coordination with inpatient and emergency care providers.
(5) Coordination of out-of-hospital medical care providers.
(6) Coordination and integration with fire agencies personnel, resources, EMS.
(7) Coordination of non-fire based prehospital EMS.
(8) ...establishment of temporary field treatment sites.
(9) ...surveillance and epidemiological analyses of community health status.
(10) ...food safety.
(11) ...exposure to hazardous agents.
(12) ...mental health services.
(13) ..public information health and medical protective actions.
(14) ...vector control services.
(15) ...drinking water safety.
(16) ...management of liquid, solid, and hazardous wastes.
(17) ...control of communicable disease.

Regional Disaster Medical Health Coordination (RDMHC/S) Health & Safety Code 1797.152

- Health officer, EMS administrator or medical director, or emergency services coordinator
  - appointed by Directors of CDPH and EMSA
  - RDMHS: shared position by EMSA and CDPH
- Coordinates disaster medical and health resources in the Region
- Manages and improves the Region's medical/health mutual aid and mutual cooperation
- Supports local medical/health response system

The EOM establishes a coordinated system to provide public health and medical resources, e.g., medical equipment and supplies, medical transportation, or healthcare personnel from both the private and public sectors to requesting local jurisdictions impacted by the disaster.
State Emergency Plan 2017

California Public Health and Medical Emergency Operations Manual

JULY 2011

Revision 2018

Emergency Operations Manual

- Strengthens local-state coordination for Public Health and Medical during emergencies
- Builds a common operational framework
- Supports assistance to local governments or Operational Areas
- Describes roles and activities within ESF 8 and coordination with emergency management
- Standardizes operational processes in ESF 8
  - situation status reporting
  - resource requests

County Mental Health Agency (Activities designated in EOM)

- During an unusual event or emergency involving behavioral health
  - Notify MHOAC and necessary agencies
  - Determine resource needs
  - Engage and report to DOC and/or EOC if requested
  - Help provide behavioral health public messaging to community
  - Deploy personnel
  - If Presidential declaration, pursue Stafford Act resources

State Agencies and Resources

- DHCS
  - Division of Mental Health and Substance Use Disorder Services (MHSUDS)
- CDPH
- EMSA
  - Disaster Healthcare Volunteers
  - Medical Reserve Corps mobilization / coord
- Cal OES
- California National Guard
  - 20-30 behavioral health providers
- EMAC (State to state mutual aid)

Federal Resources:

Grants, benefits, technical assistance

U.S. Department Health and Human Services (HHS)

Substance Abuse and Mental Health Services Administration (SAMHSA)

- Crisis Counseling Assistance and Training Program (CCP--with FEMA)
  - Specialized Crisis Counseling Services
  - funds for up to 60 days of services immediately following a Presidential disaster declaration
  - Regular Services Program grant--funds for up to additional 9 months
- Disaster Technical Assistance Center
- Disaster Behavioral Health Information Series
- Disaster Distress Helpline (DDH) – 1-800-985-5990

Federal Resources

- Assistant Secretary for Preparedness (ASPR)
  - NDMS has over 100 deployable mental health personnel
- Commissioned Corps Officers (Surgeon General)
  - 150 Commissioned Corps mental health providers
- American Red Cross
  - 8,000 Licensed mental health personnel plus trained laypersons
  - Services at shelters, service centers, bulk distribution routes, aid stations and temporary evacuation points
- CDC
  - Post disaster surveillance and needs assessment

Challenges and Recommendations in Disaster Mental/Behavioral Health

Patti Carter, BA, EMT

Public Health Coordinator – Nevada County

Sandra Stark Shields, LMFT, LPCC

Sr. Disaster Analyst – LA County DMH DSU

Challenges for BH/MH Departments

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- ***Need for statewide facilitation to help develop:***
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What the CALBHBC can do to help #1

- **Assess the level of Disaster Response Preparedness for your County's Disaster Behavioral Health response:**
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    - ❑ DOC Activation for minor as well as major disasters? When?

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What the CALBHBC can do to help #2

- What are the Disaster BH Intervention Standards for those who are least impacted to most impacted? (Beyond PFA and "debriefing")
- What is your BH Department's Disaster Mission?
- What is the working relationship like with American Red Cross - Disaster Mental Health Services in your County?
- What are the BH plans for County staff disaster mental health? (Employee Health and Well Being Unit Leader selected and trained?)

What the CALBHBC can do to help #3

- ***AB2333 – Counties would greatly benefit from having a dedicated Disaster Mental/Behavioral Health Director*** *in the appropriate state agency tasked with Public Health, Medical response, or Emergency Management to facilitate statewide BH disaster response planning and to help with the development and implementation of BH Guidance (EOM and Resource Typing), Tools, Training, and integration with the Public Health and Medical disaster response systems.*

Want to Learn More About Disaster Mental/Behavioral Health?

- BH Chapter of the **EOM** (Updated)
- ***State of CA M/BH Disaster Framework (December, 2012)*** Developed by consensus – funded by CA HHS Agency and supported by CDPH, CDHCS and EMS Authority in 2011-12: *http://www.cdmhc.org/framework.pdf*
  - "Recommended Actions Steps for Preparedness, Response and Recovery" are helpful for County plans
- **CAMFT – Crisis Response Education and Resources Committee:** http://camft.org/COS/Resource_Center/Crisis_Response_Education_and_Resources/COS/Resources/CRERC/crer.aspx?hkey=935080c5-1345-4a04-a822-493f7bbeaddd

Discussion and Questions

Speakers

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National Children's Disaster Mental Health Concept of Operations

Merritt Schreiber, Ph.D.

TDC
Terrorism and Disaster Center
University of Oklahoma Health Sciences Center

NCTSN
The National Child Traumatic Stress Network

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The Terrorism and Disaster Center at the University of Oklahoma Health Sciences Center
The Terrorism and Disaster Center (TDC), in the Department of Psychiatry and Behavioral Sciences at the University of Oklahoma Health Sciences Center, is part of the National Child Traumatic Stress Network (NCTSN), a national network funded by the Substance Abuse Mental Health Services Administration to improve the standard of care for traumatized children and to increase their access to care. TDC focuses on achieving an effective, nationwide mental health response to the impact of terrorism and disasters on children, families, and communities. TDC works to achieve this goal through the development and evaluation of trainings and educational materials, interventions, and services aimed at addressing the mental health needs of those who experience terrorism and disaster-induced trauma. TDC is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). Visit http://tdc.oushc.edu for more information.

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National Children's Disaster Mental Health Concept of Operations

The National Children's Disaster Mental Health Concept of Operations (NCDMH CONOPS, CONOPS) is the first effort to comprehensively address the needs of children in disasters operationally. The NCDMH CONOPS outlines a triage-enhanced children's disaster mental health incident response strategy for "seamless" preparedness, response, and recovery operations. It contains essential elements needed for an interoperable, coordinated next generation incident command system (ICS) response for the mental health needs of children that can be immediately adopted by local communities, counties, regions, and states to protect its children affected by disasters and terrorism incidents.

Research reveals that children are at differential risk for disaster-engendered mental health consequences and require specialized plans heretofore not coherently developed and operationalized. Children's disaster reactions fall along a continuum ranging from new disorders with complex comorbidities at one extreme, to short-term distress and a trajectory toward resilience and possible posttraumatic growth for others. Recent longitudinal evidence from Hurricane Katrina reveals that approximately four years post event, 40% of parents in Louisiana and almost 50% of parents in Mississippi reported that their children still had mental health disorders as result of the hurricane. These findings suggest that critical windows of opportunity may be missed to intervene early with best-practice and evidence-based care for high risk children.

The NCDMH CONOPS leverages existing national best practices by matching the continuum of risk to a corresponding continuum of timely, evidence-based care through the use of a rapid disaster mental health triage system that includes key local children's disaster systems of care. The NCMDH CONOPS continuum of scalable, evidence-based disaster mental health interventions and practices should be integrated with public health, medical, human services, educational, and disaster preparedness/resilience-building efforts as a key aspect of homeland security preparedness activities in communities.

The NCDMH CONOPS includes the following action elements:

- Timely delivery of specific evidence-based practices to certain high risk children may improve clinical outcomes.
- Triage-driven rapid needs estimates, which identify locations, risk types, and numbers of children at risk, quickly determining needs and scaling response for services based on level of risk for a "graded range" of acute and long term evidence-based interventions for children.
- Flexible, engaged partnerships within communities and across the national response for integrated "unity of effort." The national response for children should be flexible with the partnerships it employs to achieve mutually-supportive disaster systems of care serving children (e.g., American Red Cross, child congregate settings including schools, Medical Examiner, Federal Medical Stations, volunteers, and federal disaster mental health sources).
- Rapid, consistent, and clear communication directly with disaster mental health response elements and families. The goal is to communicate using a common language of risk and requirements to achieve a "common operating picture" permitting parity to other emergency operations functions.

- Disaster mental health messaging that speaks to parents and those who serve children based on evidence-informed strategies (e.g., the *Listen, Protect and Connect* psychological first aid intervention for children delivered by parents and adapted for public messaging and social networking venues).
- Evidence-based and timely clinical disaster mental health services delivered to symptomatic and at-risk child victims and parents who require and desire them.
- A discrete child-specific disaster mental health tactical element in the planning and operations section of the next generation incident command system across sites (e.g. hospitals, schools, etc.) at local, county and state levels.

Highlighted Operational Features

Underlying the NCDMHCONOPS are a set of key operational features that define the practical features of this approach.

Principle 1	Adopt an "All Hazards" approach to address the unique effects of disaster-specific features on children, especially with respect to the impact of chemical, radiological, and nuclear incidents where children may be at enhanced risk.
Principle 2	Assess individual and population-level impact.
Principle 3	Implement a local rapid mental health triage-driven, next generation incident management system, characterized by a seamless triage-to-care service delivery system across diverse children's disaster systems of care.

The PsySTART Rapid Mental Health Triage and Incident Management System is an essential element of Principle 3. The PsySTART system collects evidence-based rapid individual triage data obtained across key disaster systems of care including hospitals, clinics, schools, decontamination sites, mass casualty collection points, and disaster relief settings such as American Red Cross shelters. PsySTART includes the aggregation of individual-level triage data to generate an estimate of the population-level impact of a disaster or terrorism incident across sentinel sites. This system permits aggregated triage risk data to be shared across "children's disaster systems of care" in near real time, permitting shared situational awareness of triage levels and specific risk indicators. This information can then be used to determine levels, types, and location of children's mental health needs. This forms the first known model for a children's mental health "incident action plan" from the planning and operations functions within local, state, or national incident command systems. When needs outstrip resources an ethical strategy to align limited resources or "crisis standards of care" is required. PsySTART includes a "floating triage algorithm to permit the rational allocation of limited resources to those most in need by using flexible prioritization." For example, based on available resources those with a greater number of risk factors are prioritized for next steps. This floating algorithm prioritizes relatively higher-risk children for services within the larger high risk category.

Accordingly, the National Children's Disaster Mental Health CONOPS has developed two new components within the traditional incident command system with the following:

1. A new Incident Command System (ICS) compliant "Children's Response Coordination Group/Operations Section" (CRCG) structure has been designed to augment the traditional ICS Operations section. In this new structure, the CRCG facilitates coordination to all jurisdictional operations in support of the emergency response by implementing the organizational level's Incident Action Plan (IAP). At the field-level, the CRCG within the traditional ICS Operations Section is responsible for the coordinated tactical response directly applicable to, or in support of, the response objectives in accordance with the IAP. The CRCG provides overall tactical management of disaster mental health operations and establishes "unity of effort" in a defined incident operational area within the children's disaster systems of care. Finally, the CRCG supports field disaster mental health efforts in accord with the "Children's Mental Health Incident Action Plan."

2. Within the Incident Command System planning/intelligence section, the NCDMH CONOPS has created a new "Children's Response Planning Group" (CRPG). The CRPG is responsible for collecting, evaluating, and disseminating operational information including aggregated triage information and resources related to an incident for the preparation of the IAP.

   More specifically, the CRPG functions include:

   - Situational awareness processes focused specifically on risk factor issues affecting children and their families.
   - Child-specific IAP for use during pre-event, response, and recovery.
   - Advance Planning Processes including, for example, preparation of a pre-scripted Crisis Counseling Program application and support for requesting enhanced or specialized crisis counseling services using aggregated triage data.

- Mutual aid linkage for additional mental health resources across sites and localities.

The CRPG is supported by local mental health professionals, "reachback" subject matter experts, and/or others on an incident-specific basis. The CPRG may flexibly include a virtual subject matter "reachback" advisory component in addition to "in person" subject matter expert inputs based on incident-specific features and needs.

The local CRPG will assume primary responsibility for the planning and intelligence functions within an existing mental health emergency plan and operational response structure. The CPRG also maintains information on the current and forecasted situations and on the status of resources assigned to the incident by the emergency operations center (EOC) specific to the mental health needs of children. In large events, Unit Coordinators are appointed as needed to:

- collect and analyze triage data
- prepare situation reports
- develop incident action plans
- set triage priorities
- compile and maintain documentation
- conduct advance planning
- manage technical specialists
- coordinate demobilization

National Children's Disaster Mental Health CONOPS:
Incident Action Plan
Merritt Schreiber, Ph.D.
Terrorism and Disaster Center
University of Oklahoma Health Sciences Center

Incident goals (desired response related mental health outcomes at the end of response)

Operational period objectives (major areas that must be addressed in the specified operational period to achieve the goals or control objectives)

Response strategies (priorities and the general approach to accomplish the objectives)

Response tactics (methods developed by Operations to achieve the objectives)

Organization list with ICS chart showing primary roles and relationships

Assignment list with specific tasks

Critical situation updates and assessments
Incident map (i.e., map of incident scene)

Additional component plans, as indicated by the incident

PsySTART Aggregated Triage System
-Geographic mapping
-Floating Triage Algorithm

Mental Health Resources:
-Numbers
-Types
-Locations

National Children's Disaster Mental Health Concept of Operations Phase-Specific Preparedness Elements for Community Resilience

The NCDMH CONOPS also includes actions to enhance community resilience with respect to the needs of children. By completing the actions listed below, communities have taken proactive steps to anticipate the needs of children and establish cooperative agreements among disaster systems of care.

Pre-event/preparedness Phase

1. Conduct a Children's Disaster Mental Health GAP analysis[1].

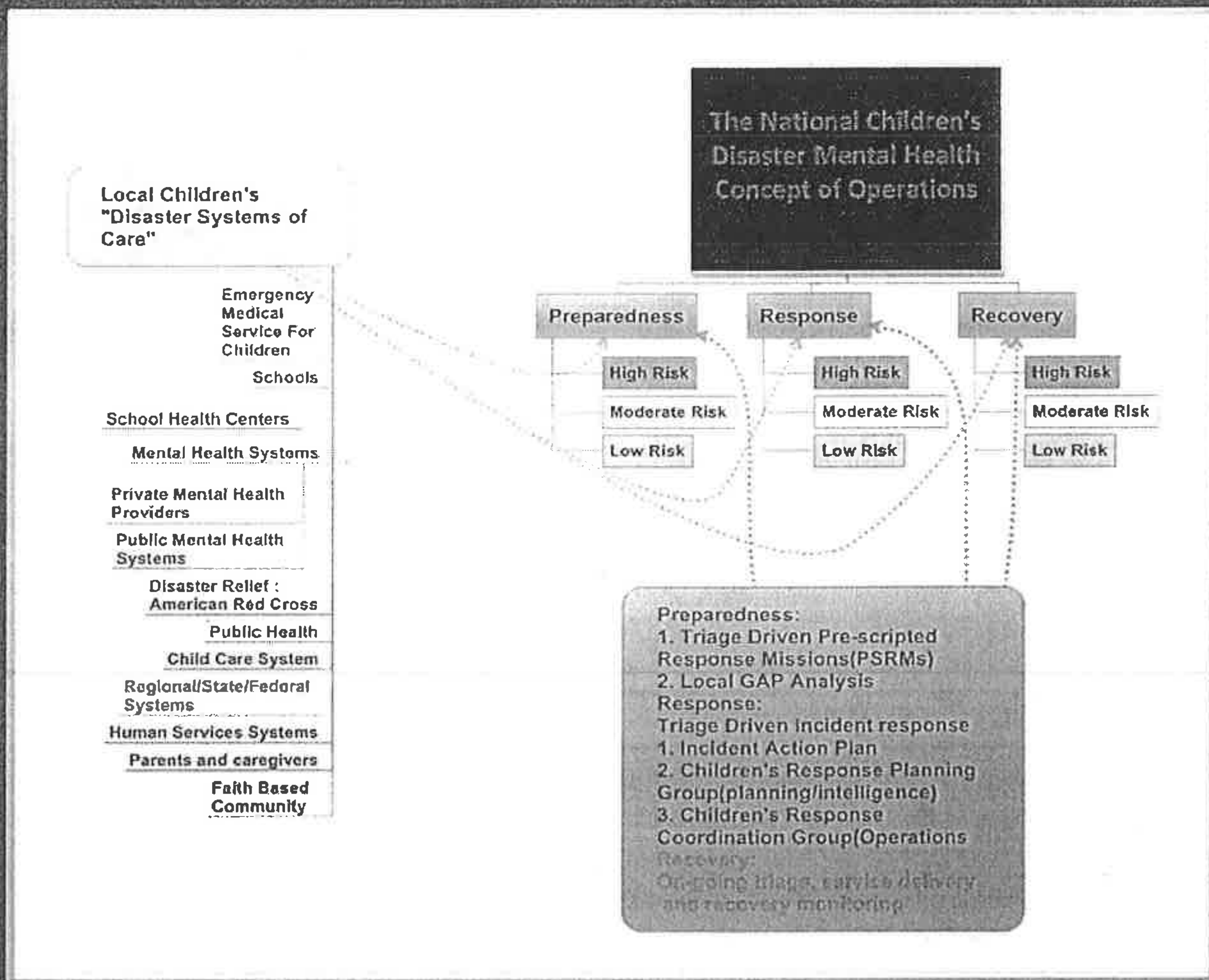
- Identify local disaster scenarios for GAP analysis (based on local hazard identification and risk assessment).
- Estimate response capability requirements for children's needs across response and sustained recovery phases based on incident-specific scenarios including local hazards and national planning scenarios.
- Assess current (baseline) capabilities and capacities for the disaster mental health needs of children following a continuum of evidence-based interventions.
- Estimate population level children's disaster mental health needs using PsySTART triage system risk factors which are then aggregated based on scenario specific indicators and population demographics.
- Using estimated aggregated triage estimate of needs, estimate specific capability and capacities gaps for high risk children (beyond psychological first aid or crisis intervention).

[1] A gap analysis in the NCDMHCONOPS refers to a FEMA process for comparing the estimated impact of a specific incident with current resources. The difference between needs and resources identifies the gap.

- Estimate the number of children with the following conditions for local GAP analysis:
    - Functional or special health care needs, including severely emotionally disturbed
    - Juvenile justice system involvement
    - Homeless

This approach was developed by the author for the US Geological Survey "Shakeout Scenario" and further modified for the Southern California Catastrophic Earthquake Planning Group.

When communities address incident specific gaps for children's mental health needs, the way forward to address specific gaps with metrics is achieved, the floating algorithm can be shaped, and ultimately community resilience is enhanced.



2. Develop Pre-scripted Children's Disaster Mental Health Response Missions.

The pre-scripted children's disaster mental health response missions (PSRM) approach proposed in this CONOPS pre-identifies or "pre-scripts" probable children's mental health response/recovery actions at the county level. The PSRMs include deploying mental health providers, initiating rapid triage, conducting just time mental health risk surveillance and providing parents and caregivers coping messaging tools (such as the "Listen, protect and connect" Psychological First Aid for Children for mental health risk messaging) that specifically address children's unique needs.. Examples include providing PsySTART rapid triage at key disaster systems of care touch points and providing disaster crisis intervention/secondary assessment for those at higher risk based on the floating triage algorithm.

3. Targeted preparedness actions.

- Family level: Parents/caregivers develop a customized "personal resilience plan" based on their own local community "hazard vulnerability analysis" and other pre-incident risk factors.
    - Parents/caregivers use the "Anticipate, Plan and Deter" family resilience approach which is comprised of three basic modules:

      Stress inoculation for anticipated stressors and needs ("anticipate")

      Customized planning for identified child and family needs ("plan")

      Activation of the personal coping strategy during a disaster ("deter") that includes self-triage of risk exposure for all family members

- Community level: Based on GAP analysis, local disaster systems of care engage to eliminate or mitigate identified GAPs yielding enhanced community resilience via:
    - Establish common rapid disaster mental health triage for incident operations, estimating system capacity across all community disaster systems of care.
    - Create interoperability, a common operating picture for near real time situational awareness based on Integrated PsySTART triage into incident operations interoperability and establishing this CONOPS model locally.

    - Delineate core competencies and training in evidence-based capabilities.
    - Train all responders in rapid mental health triage as a "core competency."
    - Pre-identify incident-specific "reachback" subject matter experts in child disaster mental health (local or otherwise) to advise the Children's Response Planning Group within the local ICS.

Figure 2

Children's Disaster Mental Health Gap Planning
Aggregated Triage Estimation Tool

National Disaster Mental Health
CONOPS for Children
Merritt Schreiber, Ph.D.

Specify:
1. Incident type:________
2. Location____________
3. Child Population size/demographics:_____
-Special population estimates(SED,etc)______

PsySTART Disaster Mental Health Triage System

Original – Patient Chart

For designated incident, calculate each estimated item totals for each triage factor: yields estimated total # of children projected for each factor to yield aggregated estimate for each triage level

Immediate Danger:
ESTIMATED TOTAL #

High (Immediate) Risk:

ESTIMATED TOTAL #
List each item:

Moderate (Delayed) Risk:

ESTIMATED TOTAL #
List each item:

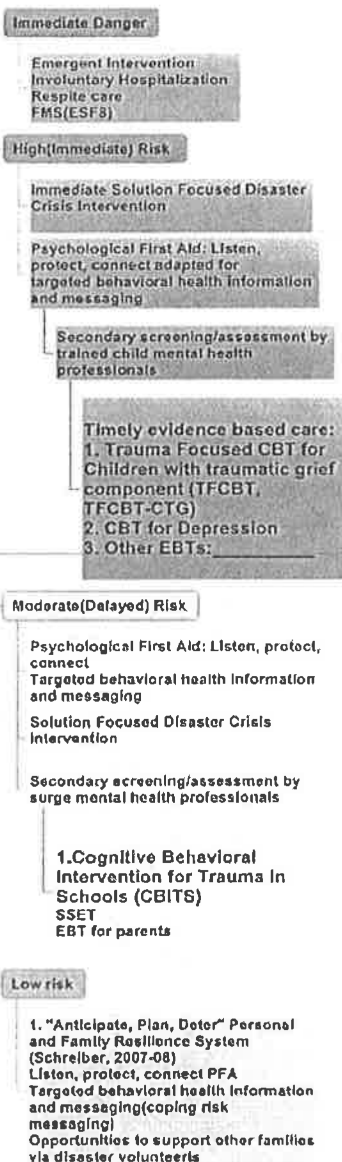
Low Risk
ESTIMATED TOTAL #

Response and Recovery Phase

In response and recovery phases, the CONOPS provides for a seamless continuum of triage to care incident operation. For operational purposes, individual triage data are aggregated from local disaster systems of care to enable near real time, geographic mapping of aggregated, population level risk levels and Graphical Information Systems (GIS) based near real time situational awareness of population-level risk. This information permits the rational allocation of limited acute phase resources to maximize the ability to reach as much of the high risk population as feasible. This information also informs mutual aid requests and provides the basis to justify federal funding for crisis counseling after presidentially declared disasters.

In the recovery phase of complex, evolving disasters, this CONOPS specifies on-going sustained assessment of emerging on-going and persistent life event stressors using the (PsySTART) triage platform for timely linkage to appropriate interventions as new risk accrues.

Figure 3
Seamless Continuum of Triage to Care:
Response Phase



Acute phase Tactical Response Actions

Activation

Upon learning of an incident or possible incident with significant surge or mass casualty consequences, the CRPG will posture to develop situational awareness and a common operating picture (COP)[2] focused on particular children's disaster systems of care inputs.

The CRPG will develop a Children's Incident Action Plan (IAP) and direct assets according to the IAP. An operations IAP will describe:

- Current situational awareness of numbers of high risk children including locations, types of risk factors using the rapid triage platform
- Determination of floating triage algorithm to prioritize available resources for those at greater levels of risk
- Specification of staffing needs
- A communications plan for deployed assets and resources
- Information technology requirements

[2] A **common operational picture** (COP) is a single identical display of relevant (operational) information, in the case of the NCDMH CONOPS, it refers to shared aggregated PsySTART triage data across disaster systems of care.

Summary

The National Children's Disaster Mental Health Concept of Operations (NCDMH CONOPS) is the first known effort to create an evidence-based national strategy for use by local communities, schools, states, and others to improve the response to our nation's most vulnerable population. The NCDMH CONOPS is fueled by an evidence based rapid triage system (PsySTART) that creates near real time situational awareness and a common operating picture across diverse systems. The individual triage data are used to link higher risk children to needed services when indicated, and when individual triage data are aggregated at the community level, a projection of need for children in the entire community is achieved.

The NCDMH CONOPS uses the aggregated triage data to create a common data metric to guide operations. In addition, the NCDMH CONOPS has created two new Incident Command System (ICS) functional components within next generation ICS. The CPRG is the planning intelligence ICS function adapted for mental health response and uses the triage data to drive response, identify gaps, and support requests for mutual aid using geo-coded resource allocation. The CRCG creates an operational linkage between diverse disaster systems of care providing services to children and facilitates coordination among the lead agency for children's mental health response, parents and caregivers, local disaster systems of care and outside resources that may be requested.

In the pre-event/preparedness phase, the needs of children are estimated by using the disaster scenario to estimate total numbers of triage risk factors and estimated immediate and long term recovery needs. Current resources, capabilities, and capacities are compared to projected needs for the first known children's disaster mental health GAP analysis. When communities work to address identified GAPs, create common triage among varied disaster systems of care and create child focused Incident Action Plans (IAP), community resilience is facilitated.

For further information:

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