



# **Summary of HHS Disaster Behavioral Health Assets and Capabilities**

**Excerpted from the  
*HHS Behavioral Health Survey:  
Disaster Preparedness and Response Assets, Capabilities, Gaps, and  
Recommendations***

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## I. INTRODUCTION

In 2005, the greatest emergency behavioral health challenge in the nation's history followed the landfall of Hurricanes Katrina, Wilma, and Rita. The behavioral health impact was felt across the nation as victims endured extraordinary trauma during and after the storm, and again during the rebuilding and resettlement process. This impact continues today as victims and responders alike struggle to find and nurture natural resilience, as well as receive efficacious mental health intervention. While individuals, communities, and all levels of government continue to recover, the Department of Health and Human Services (HHS) simultaneously must prepare for the next natural or manmade event.

The behavioral health impact of September 11<sup>th</sup> and Hurricanes Katrina, Wilma, and Rita continues to be felt across the nation.

HHS has a history of active involvement in disaster and emergency behavioral health that began more than 35 years ago. Since that time, many things have changed. Public awareness of the mental health consequences of disasters has grown, the demand for services has increased, media attention to the issue has emerged, the scientific community has devoted more attention to researching disaster mental health, and the Federal role has evolved significantly. As awareness of the issue has grown, behavioral health—encompassing mental health, substance abuse, and stress and resilience-related research and services—has assumed more importance for the Department and for individual planners.

The increased attention to emergency behavioral health emerges in many contexts. For example, since the completion of the survey described in this report, the White House released Homeland Security Presidential Directive (HSPD) 21, which, among other things, specifically mandates the establishment of a Federal disaster mental health advisory committee. HSPD 21 underscores the importance of this report and its relevance to larger public health emergency preparedness efforts. In another example, the General Accounting Office (GAO) released a report entitled *September 11: Problems Remain in Planning for and Providing Health Screening and Monitoring Services for Responders* in September 2007. This report examined the psychological consequences of the terrorist attacks and the provision of disaster mental health services to responders. Lessons learned from the report included the need to quickly identify and contact responders and others affected by a disaster and the need to ensure the availability of screening and monitoring services for non-Federal responders. The report also underscored the value of a centrally coordinated approach for assessing individuals' health and the importance of addressing both physical and mental health effects. GAO has also recently released the final report entitled, *CASTROPHIC DISASTERS: Federal Efforts Help States Prepare for and Respond to Psychological Consequences, but FEMA's Crisis Counseling Program Needs Improvements* in February 2008, emphasizing the continued interest in disaster mental health issues.

There is clearly greater recognition than ever that public health disaster planning must include attention to the behavioral health needs of victims, responders, evacuees, and witnesses during a disaster. In order to assess the Department's preparedness and ability to help partners at the Federal, State, Tribal, Territorial, and local levels, HHS undertook a survey of its own resources

related to capacity for behavioral health response to disasters and other emergencies. This report presents a summary of the findings of that survey.

## **A. HHS and ASPR**

Since its founding, HHS has maintained a stake in the psychosocial components of events that affect individuals and the larger communities in which they live. This was the basis of much of

In the early 1970s, the Stafford Act established the Crisis Counseling Assistance and Training Program (CCP) and legislatively mandated that it be administered in cooperation with HHS.

the community mental health movement that was brought to national prominence beginning in the early 1960s. Early Federal disaster legislation recognized the importance of behavioral health impacts from disasters. In the early 1970s, the Stafford Act established the Crisis Counseling Assistance and Training Program (CCP) and legislatively mandated that it be administered in

cooperation with HHS. Over time, the program was placed within the Substance Abuse and Mental Health Services Administration (SAMHSA). It has grown into one of the Federal Emergency Management Agency's (FEMA) more significant programs and continues today as a critical part of disaster response and recovery.

The HHS Office of the Assistant Secretary for Preparedness and Response (ASPR), established in 2006, serves as the Secretary's principal advisory staff on matters related to bioterrorism and other public health emergencies. ASPR was established following the enactment of the Pandemic and All-Hazards Preparedness Act (PAHPA), which designates ASPR as the lead HHS agency for all public health and medical preparedness and response activities. This leadership role is carried out in coordination with HHS Operating Divisions and Staff Divisions (OPDIVs/STAFFDIVs) and Emergency Support Function (ESF) 8 partners. ASPR also coordinates interagency activities between HHS; other Federal departments, agencies, and offices; and State, Tribal, Territorial, and local officials responsible for emergency preparedness and protecting civilians from acts of bioterrorism and other public health emergencies.

Despite its long history of involvement in disaster behavioral health, HHS faced unprecedented challenges in the wake of Hurricanes Katrina, Rita, and Wilma. While there is little disagreement that these were among HHS' finest hours, post-event reviews reveal many areas where changes, improvements, and new approaches are needed in the future. ASPR has undertaken this assessment of HHS behavioral health assets to identify and address future needs.

## **B. Behavioral Health is a Critical Component of Health Care**

### **Trauma and Psychological Stress**

The HHS mission encompasses all aspects of the nation's health. Although the science is still developing, research increasingly shows a link between exposure to trauma and other health care needs. While these findings include disaster and non-disaster related trauma, the correlation between trauma and medical needs is impossible to ignore. This is true not only immediately following an emergency event, but often for many years after. Studies are beginning to correlate trauma with later concerns including cardiovascular, musculoskeletal, and neurological illness,

as well as psychiatric diagnoses such as Post-Traumatic Stress Disorder (PTSD), anxiety, depression, and substance abuse disorders. With increased health care utilization, costs associated with the management and treatment of those problems also increase. Therefore, in addition to the obvious humanitarian benefits of providing psychological assistance and support to people impacted by disasters, there may be long-term benefits as well. A few studies make the point:

### **1. Immediate Impact**

- In the 1995 Sarin gas attack in the Tokyo subways, there were 12 deaths, 17 critical injuries, and 1,370 mild to moderate injuries. There were 5,510 visits to emergency medical facilities. Of those 5,510, 4,000 had *no medical effects at all*. In this case, the psychological casualties vastly outnumbered the medical casualties and placed a huge and rapid burden on emergency medical care organizations and providers (Kawana, Ishmatsu, and Kanda, 2001).
- In 1991 in Israel during the Gulf War, there was widespread fear that Iraqi missiles carrying poison gas would be launched toward Israel. There were 23 missile attack alerts, five false alarms, and in the end there were no attacks using poison gas. During this period, there were 1,059 emergency room visits representing 234 direct medical casualties and 835 psychological casualties (78% of all casualties). About half of those with psychological casualties were suffering from acute anxiety, 230 people had auto-injected atropine without exposure, and 40 were injured while running to sealed rooms. Of the 11 people who died, seven suffocated in their gas masks and four suffered fatal heart attacks. Psychological casualties far exceeded medical casualties. There were more fatalities from fear-driven behaviors than from missile impact, and there were more hospital visits resulting from psychological responses than from medical injury (Kron and Mendlovic, 2002).
- Following a fireworks disaster, those receiving treatment for psychological problems also presented more multiple unexplained physical symptoms (MUPS), gastrointestinal, and musculoskeletal problems in primary care settings, thereby increasing the caseload of primary care physicians and expenditures on health care (Den Ouden, Dirkwager, and Yzerman, 2005).

### **2. Long-Term Impact**

- A study in Mexico documented that people exposed to disasters had significantly more physical health symptoms than those not exposed (Norris, Slone, Baker, and Murphy, 2006).
- Six to 18 months following a terrorist attack in the Paris subways, PTSD significantly increased health care utilization (Jehel, Duchet, Paterniti, Consoli, and Guelfi, 2001).
- An evaluation of several studies demonstrated that stressful life events and psychological distress, when linked to depression and anxiety, are positively associated with MUPS, increased health care utilization, and increased costs in both primary care and medical specialties (Katon, Sullivan, and Walker, 2001).
- Among patients diagnosed with PTSD, there were significantly higher rates of medical consultations and service utilization (Tangay, Harpertz, Langkafel, and Senf, 2005).

- Women with a history of trauma in childhood (including abuse) reported significantly more cardiovascular, immune, musculoskeletal, neurological, and reproductive symptoms than those without such a history (Farley & Patsalides, 2001).
- The Centers for Disease Control and Prevention's (CDC) study of adverse childhood experiences has released more than 40 publications linking childhood traumatic stress to numerous mental health, behavioral health, and disease problems, ranging from smoking and obesity to psychiatric disorders (Anda, R.F., Brown, D.W., Felitti, V.J., Bremner, J.D., Dube, S.R., & Giles, W. H., 2007).
- Studies have documented the role of stress in the development of depression, cardiovascular disease, and HIV/AIDS. There are emerging findings regarding the role of stress in such conditions as respiratory tract infections, asthma, herpes virus infections, auto immune disease, and wound healing (Cohen, Janicki-Deverts, and Miller, 2007).

These studies illustrate the growing evidence for a connection between exposure to trauma and increased need for medical, mental health, and substance abuse services. Appropriate medical screening is always important, even for people without obvious injuries. Furthermore, the studies reveal the need for prevention and early intervention in order to avoid more serious trauma and costly services later on. Appropriate mental health and substance abuse services in the initial and early stages are a critical component of any strategy to mitigate the long-term impact of disasters. HHS has a clear stake in both the behavioral health and the larger public health and medical systems, and therefore has a responsibility to both recognize and respond to psychological consequences of disasters and other traumatic situations.

## II. THE HHS BEHAVIORAL HEALTH SURVEY

The natural disasters, terrorist attacks, and other emergencies of the last several years, in conjunction with the growing research on the long and short term impacts of these events, have highlighted the need for behavioral health capabilities. Furthermore, they have led to the development of relevant new programs, projects, and activities at HHS. ASPR recognized the need to catalogue these capabilities and assess their availability for future responses as part of its role in developing departmental emergency preparedness and response policy. The following sections describe the survey undertaken by ASPR to identify the full range of resources available to address behavioral health aspects of preparedness and response.

In fulfilling the ASPR mission of “A Nation Prepared,” the Office for At-Risk Individuals, Behavioral Health, and Human Services Coordination (ABC) within ASPR developed an extensive survey to assess the status of HHS behavioral health assets (Appendix A). Using a comprehensive approach, the survey aimed to identify relevant past activities, current assets, and capabilities. For the purpose of the survey, behavioral health was defined as the provision of mental health, substance abuse, stress management, and other related services. Assets were defined as human, financial, or other types of resources and were focused on resources relevant to addressing behavioral health needs before, during, and after various types of emergencies and disasters. Some respondents included issues related to resilience and applied behavioral health sciences in their response to the survey. Responses addressing these factors are also included in the report.

The survey was distributed to twenty-nine (29) HHS OPDIVs and STAFFDIVs in June of 2007. While all agencies responded to the survey, ten (10) OPDIVs and STAFFDIVs were found to have relevant behavioral health assets (Appendix B). Follow-up interviews were conducted in July and August of 2007 to clarify responses and to obtain more detailed information. The interviews were conducted by the ASPR ABC staff and a consultant.

The primary results from the survey and the findings of the responses from the interviews are included in this report. Information obtained from the survey and follow-up interviews was used to identify current assets and gather feedback needed to develop a comprehensive strategic plan for deployment of behavioral health assets. Because of the depth and variety of information, the information is grouped into five sections: Services; Research; Planning and Preparedness; Coordination, Integration, and Technical Assistance; and Training. The sections are described below, although it must be noted that there may be overlap between some categories.

**Services:** This section includes disaster behavioral health services provided to responders and victims. Issues regarding HHS response assets for force protection and force multiplication are discussed, along with other related service issues. For HHS, these services are provided by volunteers, civilians, and Commissioned Corps officers. Grants are also included in this section.

**Research:** This section contains information on activities and programs that advance the knowledge base on disaster mental health and substance abuse. Examples of research issues addressed in this section include the necessity of tailoring behavioral health services to the needs of particular groups, and departmental efforts to develop and promote clear evidence-based interventions for both responders and victims.

**Planning and Preparedness:** This section addresses promoting community readiness by assisting local, State, and regional entities in planning and preparedness for all-hazards disaster scenarios. It includes pre-event planning such as guidance for State mental health and substance abuse agencies. It also includes post-event planning such as the ability to conduct needs assessments and active surveillance for behavioral health impacts. These additional systems help to estimate the behavioral health burden by rapidly defining problems, identifying groups at risk for adverse outcomes, determining needs of special populations, informing resource allocation decisions (services, personnel, medication), and monitoring effectiveness of the relief response.

**Coordination/Integration/Technical Assistance:** The activities included in this section serve to reduce programmatic fragmentation and increase effectiveness when preparing for or responding to a disaster. Examples include coordinated meetings, training, and discussion among responders and ESF 8 partners, along with the provision of technical expertise.

**Training:** This section includes activities which promote readiness among responders. This includes team and field training and education in specific disaster behavioral health interventions. It also includes the identification and dissemination of materials and standards of care that would be utilized for both responders and victims, and includes websites and printed material.

### **III. PAST ACTIVITIES**

The breadth and depth of HHS' efforts related to emergency behavioral health highlight the Department's long-term commitment to these issues. Survey respondents cited the following examples of HHS agencies' provision of behavioral health services during disasters and other emergencies:

#### **Virginia Tech Tragedy (2007)**

In the aftermath of the shooting tragedy at Virginia Polytechnic Institute and State University, HHS engaged in many efforts. Secretary Leavitt led a multi-agency cabinet-level group in the development of the *Report to the President on Issues Raised by the Virginia Tech Tragedy*. CDC provided targeted communications and assessment tools via its Web site. SAMHSA provided personnel, technical assistance, and funding to the State in response to the incident. Many of SAMHSA's programs collaborated with the university to distribute materials and expertise to address the behavioral health consequences of the incident. Furthermore, SAMHSA collaborated with other Federal partners in assuring the needs of the affected communities were addressed.

#### **New Freedom Commission Interagency Work Groups (2007)**

The President's New Freedom Commission on Mental Health focused on traumatic events in two ways. The Commission defined "resilience" to include "qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stresses." The Commission also recommended that the knowledge base in trauma be further developed. HHS agencies participated in various New Freedom Commission Initiatives and are collaboratively in the process of implementing many of the recommendations from the Commission. For example, SAMHSA and the Health Resources and Services Administration (HRSA) are collaborating to develop a paradigm to integrate primary care and mental health models. This effort will address screening instruments and forms. It will also identify best practices so that HRSA can enhance its guidance for programs, community health centers, and grantees developing emergency preparedness plans.

#### **Suicides at Coleville Reservation (2006)**

In coordination with the Indian Health Service (IHS) Office of Emergency Services, the Office of Force Readiness and Deployment (OFRD) deployed 14 commissioned officers from Mental Health Teams in response to an increase in suicides among the Native American population at the Coleville Reservation. These teams were made up of psychiatrists, psychologists, and social workers. IHS provided logistics, management of resources, Tribal coordination, orientations, and cultural training for deployed OFRD officers.

#### **Hurricanes Katrina, Rita, and Wilma (2005)**

HHS agencies provided extensive support during the 2005 hurricane season. Some of the activities are described below.

- CDC designed measures for needs assessments, disaster surveillance, and etiologic studies that included behavioral/mental health issues. CDC also conducted field investigations of parishes within Louisiana after Hurricanes Katrina, Rita, and Wilma of 2005 to measure the mental health impact. Data were used by the State Department of Mental Health to

strengthen their emergency services grant applications. Findings were shared with State health departments for decisions regarding the grant allocations.

- The role of the Employee Assistance Program (EAP) was expanded to include case management, assistance with clothing, and food for HHS responders.
- HRSA deployed Commissioned Corps Officers with mental health expertise to provide crisis counseling services. In addition, HRSA provided supplemental grants to community health centers in affected areas to strengthen infrastructure.
- IHS deployed medical and mental health officers, as well as supplies, logistics, and communication assets.
- The National Institutes of Health (NIH) provided disaster-related information and material on drug/alcohol abuse, relapse, disruption of the drug treatment system, and associated medical care to local communities. They also provided funding to grantees to research recovery options.
- NIH operated a 24-hour call-in center. Clinical centers were created to provide technical assistance to professors, trainees, and communities. NIH's clinical center prepared a 220 bed hospital that had the potential to be used as a surge hospital. NIH partnered with Duke Medical Center to provide care to patients during the Katrina response.
- The NIH National Institute of Mental Health (NIMH) activated the Rapid Assessment Post Impact of Disaster (RAPID) research program to receive and fund new research grant applications for assessing needs, planning of services, and improving preparedness and response. NIMH also made available research supplements to previously funded clinical researchers focused on research related to stress and behavior, epidemiological and risk factors, and clinical trials to acquire new and needed knowledge.
- The National Institute of Drug Abuse (NIDA) and the National Institute of Alcohol Abuse and Alcoholism (NIAAA) provided administrative supplements to grantees that had been affected by disasters. These supplements were designed to be used by grantees to reestablish their laboratories. For example, during Fiscal Year (FY) 2006 three administrative supplements were issued to principal investigators impacted by Hurricanes Katrina, Rita, and Wilma at Tulane University, Louisiana State University, and the University of New Orleans.
- SAMHSA's consultation and technical assistance roles were used extensively during the response to Katrina: 1) FEMA mission assignments to SAMHSA totaled \$12.3 million for the Gulf Coast and were designed to address acute needs during both the response and recovery stages. 2) Between September 2005 and June 2006, SAMHSA coordinated over 1,200 two-week deployment assignments for teams consisting of behavioral health professionals, including both mental health and substance abuse responders. These teams conducted 91,000 counseling sessions, 13,700 referrals, and distributed over 47,000 psycho-educational materials. 3) SAMHSA provided suicide and early intervention grants; SAMHSA Emergency Response Grants (SERG) totaling \$900,000 to Alabama, Mississippi, Louisiana, and Texas; 20 CCP Immediate Services Program (ISP) grants and 20 Regular Services Program (RSP) grants. 4) SAMHSA expanded the capacity of the 1-800-273-TALK Crisis Hotline resulting in a 55% increase in call volume and produced public service announcements for the both the incident and the anniversary. 5) SAMHSA provided staff to

the Secretary's Response Teams and the Secretary's Operation Center. In addition, SAMHSA worked with the Occupational Safety and Health Administration (OSHA) to develop support strategies for Federal workers.

### **Asian Tsunami (2005)**

- OFRD rostered and deployed a team of Commissioned Corps Officers, including primary health care professionals, psychologists, and social workers to help the people of Banda Aceh. The behavioral health mission was to help the local authorities and non-governmental organizations design short and long-term mental health programs for implementation and to attend to the needs of the deployed personnel aboard the USNS Mercy.
- CDC and SAMHSA collaborated at the operational level to better leverage scarce resources during the complex humanitarian relief effort.
- CDC developed a model practice for responder resilience during the Indian Ocean Tsunami response and shared iterative components and products with the Department of Labor's OSHA and SAMHSA during the Katrina/Rita/Wilma response. Key innovations include integrating organizational and worker resiliency into a more explicitly staffed health and safety function to advise leaders for strategic incident management.

### **Florida and Gulf Coast Storms (2004)**

- CDC funded research of health department personnel in response to the Gulf Coast storms of 2004 and 2005 to address mental health outcomes, work impairment, health risk behaviors, and organizational dynamics to assist emergency managers in policy formulation and personnel management for disaster response.
- SAMHSA received \$11 million from Congress to provide grants to the State of Florida for behavioral health services in impacted communities.
- NIH provided Federal, State, local and Tribal authorities and non-governmental organizations with science-based information about the anticipated psychological and behavioral responses among those with direct and indirect exposure, as well as evidence-based approaches to coping, assessing needs, triage for acute mental health services, and treatment.
- Over 300 Commissioned Corps Officers from various HHS agencies were deployed to Florida in support of disaster services in the wake of four hurricanes.

### **Katrina Lessons Learned and Other Recent Activities**

The 2006 *White House Katrina Lessons Learned Report* served as an impetus to improve organizational and operational response for future disasters. As a result:

- All HHS agencies have a fully developed and staffed emergency coordination office.
- CDC has funded and participated on expert panels and publications exploring triage and blended intervention strategies to mitigate the potential for hospitals to become overwhelmed by persons seeking medical reassurance during crises, thereby preserving tertiary care for critical cases and providing alternative strategies to address the needs of persons presenting symptoms of health anxiety (such as MUPS).

- The CDC Director's Emergency Operations Center now has three formal units that relate to this report: 1) responder mental health services (resiliency), 2) population/community mental health, and 3) worker safety and health.
- EAP has mental health and behavioral health experts that oversee and monitor contracts for quality control, e.g. credentialing, service provision, etc.
- Federal Occupational Health (FOH) has hosted seminars that address preparedness. FOH has an agreement with the National Disaster Medical System (NDMS) to provide physical readiness services to volunteers in response to a national disaster. FOH also has an agreement with FEMA to provide services to FEMA responders/field staff.
- HRSA supplemental grants are being used to help rebuild mental health infrastructure, e.g. centers and/or staffing. HRSA has also provided pre-deployment training on legal issues for Commissioned Corps Officers/responders.
- NDMS is updating, credentialing, and privileging members of its volunteer roster.
- As an after action item, NIH organized formal and informal meetings with State and local authorities to review NIMH activities and to facilitate long-term planning for assessing needs over time, training providers, and addressing challenges related to obtaining qualified mental health personnel.
- NIH has a list of pre-identified subject matter experts which includes a supervisor assessment of whether the individual is mission critical.
- NIDA and NIAAA have on staff a number of behavioral health professionals who can and have deployed during times of national emergencies or disasters.
- SAMHSA continues to support the Disaster Technical Assistance Center (DTAC) as well as crisis counseling grants (CCP and SERG).
- SAMHSA funded and arranged training for OFRD mental health teams in 2007 utilizing an evidence-informed Psychological First Aid modular approach to assistance.

## **IV. CURRENT ASSETS AND CAPABILITIES**

In addition to the wide range of past activities, the survey revealed that HHS has many ongoing assets and capabilities. Respondents shared information highlighting a number of innovative and important resources. The responses are grouped into five sections, described below.

### **A. Services**

#### **1. Human Resources: Volunteers**

There are currently two programs that utilize volunteers at the local, State, and national levels:

The Medical Reserve Corp (MRC) was founded by the Federal government shortly after September 11, 2001. This national system brings together citizen volunteers with health services skills to serve as response teams during times of emergency. The volunteer members of the MRC units are trained and prepared to respond to local emergencies. Local MRC volunteers include mental health providers such as psychiatrists, psychologists, and social workers. In addition, they provide education, outreach, and various health services in their own community throughout the year. MRC units supplement existing emergency and public health resources and agencies such as the American Red Cross (ARC) and local public health, fire, police, and ambulance services. Each MRC defines its role in the way that best suits the unique challenges for its area.

The Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) program is a State-based, standardized, volunteer registration system. The establishment of these standardized systems enhances each State's ability to quickly identify and better utilize health professional volunteers in emergencies and disasters. The mental health provider category includes volunteer professionals such as psychiatrists, psychologists, clinical social workers, and mental health counselors. In addition, these State systems enable the sharing of these pre-registered and credentialed health care professionals across State lines and even nationally. Each State's ESAR-VHP system maximizes the size of the volunteer pool.

#### **2. Human Resources: Civilian**

NDMS is a component of ASPR comprised of 6,000 intermittent Federal employees assigned to approximately 90 general disaster and specialty teams geographically dispersed across the United States. The overall purpose of NDMS is to establish a single integrated national medical response capability for assisting State and local authorities with the medical impacts of major peacetime disasters and to provide support to the military. Within NDMS, there are a variety of specialized teams such as the Disaster Medical Assistance Teams, National Pharmacy Response Team, and NDMS Mental Health Teams. NDMS currently has two mental health teams of approximately ten volunteer members each. The NDMS Mental Health Teams, which include social workers and psychologists, are responsible for providing force protection, i.e., services to responders. As of the date of this report, the teams are currently inactive and undergoing restructuring due to the move of NDMS to ASPR.

HHS's EAP is able to extend crisis and certain other mental health services, upon request, through existing vendor contracts when requested by a Federal agency in an area affected by a disaster. The total dollar amount of mental health services provided, however, cannot exceed the amount of the current contract.

FOH has an interagency agreement with FEMA that can be activated during a disaster to provide mental health services to Federal responders.

Most of the HHS OPDIVs/STAFFDIVs stated that they would prefer to delegate the responsibility of deploying civilians to HHS Headquarters. They are encouraging civilians to volunteer their services in their local community through other sources, i.e., MRC and ESAR-VHP. In addition, OPDIVs/STAFFDIVs are depending on civilians to back-fill and cover the office work of deployed Commissioned Corps Officers.

### **3. Human Resources: Commissioned Corps**

All HHS agencies have a liaison to the Public Health Service (PHS) to facilitate the coordination of deployment of Commissioned Corps officers. All agencies state that they will defer to OFRD to deploy Commissioned Corps Officers, unless otherwise assigned to agency disaster activities.

As a result of the *Katrina Lessons Learned Report*, the strategy employed by OFRD is that officers have been placed into pre-configured tiers and teams. All officers are now placed on a roster for each tier and most have met readiness, licensure, and competency requirements, and have also obtained supervisory approval. Each month approximately 800 officers are on call and ready to be deployed.

Currently, there are four types of teams: the Incident Response Coordination Team, the Rapid Deployment Force Teams, the Applied Public Health Teams, and the ORFD Mental Health Teams. Each of the five ORFD Mental Health Teams has a minimum of 28 officers. This team is made up of social workers, psychologists, psychiatrists, and leadership and administrative support staff. The current number of ORFD Mental Health Team members available for deployment is approximately 150.

The mission of the ORFD Mental Health Teams is to treat individuals affected by major disaster/incidents, help the local systems that are also involved in the response, as well as care for the behavioral health needs of the deployed force itself. The ORFD Mental Health Teams are part of a much larger Commissioned Corps that has a pool of medical resources and information that can be accessed to assist with the response.

### **4. Grants**

Through an interagency agreement with FEMA, the SAMHSA Center for Mental Health Services (CMHS) provides technical assistance and monitoring to both FEMA and the States through immediate, short-term crisis counseling and ongoing support for the emotional recovery of victims of trauma and disasters. The Emergency Mental Health and Traumatic Stress Services Branch of CMHS makes funding available to State mental health authorities

through two types of grants: Immediate Services Program (ISP) grants and Regular Services Program (RSP) grants. ISP grants provide funds for up to 60 days of services immediately following declaration of a disaster including FEMA Individual Assistance. RSP grants provide funds for up to nine additional months following the declaration of a disaster including FEMA Individual Assistance. The CCP is important as a public health approach in that it seeks to reach large numbers of people; assess their level of distress and needs; and provide brief emotional support, assistance with coping strategies, and connection to needed services, including mental health and substance abuse services as well as concrete services and tangible needs.

Funding for the SAMHSA SERG is designed to meet local emergency substance abuse and mental health needs for primary victims and their families as a direct consequence of a precipitating event. The SERG program enables public entities to address disaster mental health and substance abuse services when existing resources are overwhelmed and other resources are unavailable. SERG monies are considered “funds of last resort” and cannot supplant or replace other existing funds.

CDC provides oversight to State and local grantees for preparedness grants, which have grant performance areas pertaining to mental and behavioral health planning and steering, especially for workforce support.

## **B. Research**

CDC has funded research to develop and pilot test a community participatory assessment tool to build community resilience and to develop guidance about building such resiliency. They have also funded research of health department personnel in response to the Gulf Coast storms of 2004 and 2005 to address mental health outcomes, work impairment, health risk behaviors, and organizational dynamics to assist emergency managers in policy formulation and personnel management for disaster response.

Within NIH, NIMH has a substantial research portfolio on the consequences of stress and trauma that spans and integrates basic science, clinical practice, and health care system factors. Within the NIMH extramural program, there are several active research announcements to foster research aimed at understanding and addressing the mental health effects of trauma. This research will clearly inform efforts to improve risk assessment, diagnosis, interventions, and recovery activities. They include:

- The RAPID program (disaster research grants).
- Grants to study mental health consequences of violence and trauma.
- Grants on emergency medical services for children.
- Small business technology transfer and innovation research to mitigate and understand mental health effects of disasters.

NIH also has a number of research initiatives that address behavioral health issues. This includes domestic research focused on disaster victims/survivors (e.g., Ecological Approaches to Understanding Post-Disaster Distress in the Gulf Coast; Long-Term Impact of World Trade Center [WTC] Attacks in Primary Care; Hurricane Katrina Community Advisory Group;

Psychological Functioning of Children in the Aftermath of Hurricane Katrina; Effectiveness of Therapy in New Orleans Schools; Combination Treatment for PTSD After the WTC Attack). NIH also sponsors international research addressing trauma and terrorism (e.g., Treating Terror-Related PTSD in Adolescents; Coping with the Threat of Terror; Terrorism and Traumatic Responding: Developing Culturally Competent Trauma Therapy.) Furthermore, early intervention and prevention research in disaster and emergency contexts is conducted (e.g., Prevention of PTSD by Early Treatment; Early Combined Intervention After Traumatic Injury; Prophylaxis of PTSD with Post-Trauma Propranolol; Prevention of PTSD with Early Cortisol Treatment; Telehealth Trauma Interventions; Primary Care For Trauma-related Mental Health Problems).

NIH leads disaster research education and mentoring projects that educate and train researchers and public health officials (e.g., The Disaster Research Education and Mentoring Center and the Child & Family Disaster Research Training & Education Program). In addition, research into military/war/combat experiences and efforts to understand and promote resilience in part of the NIH portfolio (e.g., Outreach Intervention for Operation Iraqi Freedom Veterans to Promote Use of Mental Health Services; Randomized Trial of an Online Early Intervention for Combat PTSD in Primary Care; Randomized Trial of a Self-Management Early Intervention for Combat-Related PTSD; Meaning-Directed Writing to Reduce PTSD and Develop Resilience for Future Trauma; Prospective Study of Emergent and Chronic PTSD Following War-Zone Duty).

### **C. Planning and Preparedness**

SAMHSA has significant expertise in the area of disaster mental health services and substance abuse. Documents that have been developed by SAMHSA to facilitate planning at the State and community levels include *Mental Health All-Hazards Disaster Planning Guidance* (2003) and *Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations* (2003).

CDC has expertise with behavioral and communication sciences with a fully functioning communication response function that assists message development for strategic and tactical operations. In addition, CDC has documented strengths and mission focus in the conduct of post-disaster surveillance (facility-based, population-based, and/or clinical encounter-based mental health monitoring) and needs assessments to estimate health burden and inform resource allocation decisions (e.g., services, personnel, medication). CDC has significant deployable assets for applied public health (assessment, measurement, programmatic support, and applied epidemiologic research) including senior level health officials embedded within each State health department to assist information exchange and improve tactical resource coordination.

CDC has also been instrumentally involved in all-hazards planning with HHS to address mental/behavioral health (workforce, vulnerable, and general populations) with SARS, anthrax, extreme weather or geologic events, humanitarian relief operations, pandemic influenza planning, and radiological dispersal devices. Inputs have been aligned with best practices used in international settings by groups such as the Sphere Project, Antares Foundation, International Red Cross and Red Crescent Societies, USAID, and the United Nations International Guidelines for Psychosocial Relief. Partnerships have been operationalized with the Department of Defense Uniformed Services University of the Health Sciences Medical School, the Veteran's

Administration's National Center for Post Traumatic Stress Disorder (NCPTSD), the National Institute of Environmental Health Sciences, and academic centers of public health excellence to assist implementation of plans during critical events.

#### **D. Coordination, Integration, and Technical Assistance**

CDC collects and analyzes (or facilitates State/local data collection of) population-based, facility, or clinical encounter mental/behavioral health-related data from the field (e.g., assessment, screening, and surveillance) that measure the magnitude and severity of health burdens and needs to inform resource allocation decisions in a timely and effective manner. CDC has senior level health officials embedded within each State health department to assist information exchange and improve tactical resource coordination. CDC also develops and reviews technical materials and disseminates information and health-related mental/behavioral communications to support pre-event community resilience, event messaging, and post-event recovery as a public service to local authorities, health service providers, and other Federal agencies. National worker safety and health is the mission of the National Institute for Occupational Safety and Health. Internal technical assistance and leveraging of committed partners has helped CDC develop a living laboratory to test best practices for responder resiliency programs, dissemination pathways to share best practices, and research expertise to evaluate efficacy and implementation.

SAMHSA provides technical assistance to States and local communities in disasters. In collaboration with FEMA, it provides crisis counseling grants to those communities in which FEMA Individual Assistance has been included in a presidential disaster. SAMHSA funds and directs DTAC which is designed to provide telephone consultation, logistical support, technical assistance, and information dissemination. In FY 2006, DTAC responded to approximately 1,000 requests, 40% of which were for preparedness material, training, and interventions and 60% were in support of active disasters. In FY 2007, DTAC responded to 1,329 requests, 47% of which were for preparedness material, training, and interventions and 53% were in support of active disasters. In addition, SAMHSA develops and DTAC distributes training material and maintains a SAMHSA-approved list of consultants/trainers. Another SAMHSA resource, the National Mental Health Information Center, is a web-based site that also provides a wide array of training materials and publications on emergency mental health and traumatic stress. Materials can be obtained in small or large quantities. After Katrina, SAMHSA developed several sets of material for first responders: pre-deployment, intra-deployment, and post-deployment. Materials for supervisors for each stage of deployment were also developed. These materials were developed as part of a project with OSHA to provide support to workers responding to the 2005 Gulf Coast hurricanes.

The HHS Office on Disability (OD), created in October 2002 in response to President Bush's New Freedom Initiative, oversees the implementation and coordination of disability programs, policies, and special initiatives for persons with disabilities in the United States. To this end, OD reviews HHS policy and advises the HHS Secretary on mental health and disabilities concerns and issues related to emergency preparedness. In particular, OD works with the Interagency Coordinating Council on Emergency Preparedness and Individuals with Disabilities. This group, known as the ICC, has a public health committee, chaired by OD, which addresses many relevant issues, including the needs of people with serious mental illness, as part of its purview.

## **E. Training**

### **1. Civilian**

The Bioterrorism Training and Curriculum Development Program (BTCDDP) has provided funds via cooperative agreements to 19 educational institutions and non-profit organizations, and also administers two accreditation contracts to develop emergency preparedness training curricula for health care professionals and other first responders. The Resource Center for the BTCDDP serves as a functional repository that is available to the public for educational materials on disaster preparedness. It aims to substantiate work by the BTCDDP grant awardees, who first received grant funding in 2003. Each training curriculum contains a behavioral health component.

Psychological First Aid (PFA) was created by the Terrorism Disaster Branch of the National Child Traumatic Stress Network and NCPTSD, with support from SAMHSA as well as others involved in disaster response. PFA is an evidence-informed modular approach for assisting people in the immediate aftermath of disasters and terrorism: to reduce initial distress and to foster short and long-term adaptive functioning. It is for use by mental health specialists including first responders, incident command systems, primary and emergency health care providers, school crisis response teams, faith-based organizations, disaster relief organizations, Community Emergency Response Teams, Medical Reserve Corps, and the Citizen Corps in diverse settings.

CDC's Coordinating Office for Terrorism Preparedness and Emergency Response has created a Web-based course on *Psychosocial Consequences of Disasters* which is offered to all HHS employees and contractors via the HHS Learning Portal. The CDC University's School of Preparedness and Emergency Response also offers mental health modules related to emergency response embedded within the CDC's *Public Health Preparedness and Emergency Response Certificate Program* and the *Emergency Response Field Team Leader Certificate Program*. CDC's Centers for Public Health Preparedness (CPHP) have developed numerous courses and training materials, which are located online via the CPHP Resource Center (<http://www.asph.org/cphp/ResourceCenter.cfm>) to assist local/regional practice partners (e.g., first responders, emergency management, and health department personnel). There has been an ongoing CPHP Mental Health Exemplar Group that evaluated all the products produced and formulated minimal competencies for disaster mental health service provision. This and other CPHP Resource Guides are available via the Associated Schools of Public Health website (<http://www.asph.org/cphp/ResourceReports.cfm>). The Public Health Information Network also hosts numerous satellite and online educational programs on behavioral health and preparedness, stress management for first responders, enhancing pod flow for the strategic national stockpile, and other programs from universities to enhance mental health core competencies.

## **2. Commissioned Corps**

In 2004 and 2005, a one-week disaster mental health training course was provided to Commissioned Corps Officers. The training was a coordinated effort of SAMHSA, ARC, CDC, and OFRD and covered basic disaster mental health issues. Separate trainings have focused on having various types of teams within a tier deploy together and train as a team. For example, in 2007 each ORFD Mental Health Team trained together with its Rapid Deployment Force and Applied Public Health Team at Camp Bullis, Texas.

The ORFD Mental Health Teams have also worked to develop job descriptions for each of the team members. The ORFD Mental Health Teams are in the process of developing behavioral health protocols and a Concept of Operations (CONOPS) for various disaster scenarios. Without outside funding, the ORFD Mental Health Teams have used their own time and initiative to develop material.

The teams are trained using the Mercy Model of disaster response services. The Mercy Model refers to the deliberate creation of virtual support network of worldwide experts using advanced digital communication and data-sharing technologies, which has allowed a global network of multidisciplinary experts to inform, provide critical resources, review drafts, and revise products for timely intervention. The Mercy Model provides general leadership precepts on system-level intervention with a focus on population-based services. A small group of officers provides ongoing support and consultation to a large system infrastructure that has been damaged or destroyed due to a disaster.

## **F. Conclusion**

HHS's more than 35 year history of active involvement in disaster behavioral health has yielded significant assets to call upon in time of emergency. As recognition of the importance of disaster and emergency behavioral health has grown, so have HHS's capabilities in this area. The comprehensive nature of the Behavioral Health Survey—encompassing all 29 HHS OPDIVs and STAFFDIVs—has provided a clear view of recent and current assets and programming. It will serve as a valuable tool to improve existing disaster behavioral health response protocols. In addition the information collected by the survey can contribute to the enhancement of plans that target emerging threats. This will ensure that behavioral health becomes fully integrated into public health preparedness and response systems. The seamless integration of behavioral health into these systems is critical to achieving the HHS ASPR vision of “a nation prepared to prevent, respond to, and reduce the adverse health effects of public health emergencies and disasters.”

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## Appendix: HHS Agency Behavioral Health Survey

### HHS AGENCY DISASTER/EMERGENCY BEHAVIORAL HEALTH COORDINATION

#### **AUTHORITY/PURPOSE:**

ASPR is tasked with the responsibility of coordinating public health, medical and human services during an emergency or disaster. The purpose of the questionnaire is to identify the behavioral health assets and resources within HHS. For the purpose of this survey:

**Behavioral health** is defined as the provision of mental health, substance abuse, staff stress management and general stress related services.

**Assets** are defined as human, financial, or other types of resources that can be provided to address behavioral health needs before, during, and following various types of emergencies and disasters.

Information obtained from this two phase assessment (survey and follow-up interview) will be used to develop a comprehensive strategic plan for deployment of assistance during a natural or manmade disaster.

Please note that, for the purposes of this data collection we are interested primarily in resources available at the Agency/OPDIV level and/or resources that you can control in emergency situations. For example, if a grantee organization has psychologists who would provide disaster behavioral health services only in the context of their regular program role and location, they should not be included in this survey. However, if agreements/arrangements have been made for them to be a deployable resource to work in other parts of the country, they should be included.

#### **INSTRUCTIONS FOR COMPLETING:**

##### **Phase I: Survey**

For some HHS divisions many topics apply; for others, few or none will apply. Completion of the document will reduce the time and amount of information needed during the interview phase. For any questions that arise when completing the questionnaire, please contact CDR Davis at (202)206-6053 or email [gail.davis@hhs.gov](mailto:gail.davis@hhs.gov).

##### **Phase II: Follow up Interview**

The purpose of the follow up interview is to clarify and/or obtain more detailed information to responses provided on the survey instrument. The follow-up interview meeting will be conducted by RADM Flynn with the assistance of CDR Davis. The interviews will be held the week of June 11-June 15 and will last about an hour. CDR Davis will contact your office to arrange a date and time that is convenient.

**HHS Agency Disaster/Emergency Behavioral Health Coordination Survey**

**PHASE I: SURVEY**

**AGENCY CONTACT INFORMATION**

Agency Name: \_\_\_\_\_

Agency Address: \_\_\_\_\_  
\_\_\_\_\_

Agency representative completing questionnaire: \_\_\_\_\_  
Name

\_\_\_\_\_                      \_\_\_\_\_                      \_\_\_\_\_  
Title                                      Phone #                                      Email Address

Are you the primary point of contact (POC) during an emergency?

If not, please identify the current POC:



**HHS Agency Disaster/Emergency Behavioral Health Coordination Survey**

8. Are your efforts directed toward any special populations? (Check all that apply)

- Children     Older Adults     Frail Elderly     With mobility limitations  
 With cognitive limitations     With sensory limitations     With serious mental illness (SMI/SED)  
 Other \_\_\_\_\_

9. Does your agency have any other program(s) or special expertise that relate to behavioral health in emergency/disaster situations?

- TA center     Subject Matter Experts (SMEs)     Databases (facility location, providers, etc)  
 Other \_\_\_\_\_

**B. SCOPE/VARIETY OF PREPAREDNESS FOR NATIONAL EMERGENCY/DISASTER SCENARIOS:**

*PURPOSE: TABLE I is designed to ascertain your agency’s behavioral health preparedness for various national emergency/disaster scenarios. The table below contains the 15 national planning scenarios. For each scenario, put an “X” in the box that describes your agency’s behavioral health readiness/preparedness for each scenario.*

TABLE I					
TABLE A KEY					
1 = No preparation		2 = Minimal preparation		3 = Fully prepared	4 = N/A
NRP Scenario #	1	2	3	4	
1. Nuclear detonation					
2. Biological Attack-Aerosol Anthrax					
3. Biological Attack -Pandemic Flu*					
4. Biological Attack -Plague					
5. Chemical Attack – Blister Agent					
6. Chemical Attack – Toxic Industrial Chemicals					
7. Chemical Attack – Nerve Agent					
8. Chemical Attack – Chlorine Tank Explosion					
9. Natural Disaster – Major Earthquake					
10. Natural Disaster – Major Hurricane					
11. Radiological Attack – Radiological Dispersal Devices					
12. Explosives Attack –Bombing Using Improvised Explosive Devices					
13. Biological Attack – Food Contamination					
14. Biological Attack – Foreign Animal Disease					
15. Cyber Attack					

\* Preparation for the potential of pandemic influenza and other types of widespread infectious disease is an area of high priority and concern for DHHS. Do you have any additional comments about your agency’s behavioral health role(s) with respect to this topic?

**B. SCOPE/VARIETY OF BEHAVIORAL HEALTH ROLES AND FUNDING:**

**PURPOSE:** Table B attempts to capture an overview of the full range of your agency’s behavioral health roles, current capability and the human resources necessary to carry out the roles. It also attempts to identify the various types of resources (human and funding) that your agency **currently has** to perform the roles identified above. The follow up agency/program interviews will capture more detailed information.

<b>TABLE II</b>						
<b>TABLE II KEY</b>						
<b>Columns A-C:</b> Y = Yes N = If no, leave blank <b>Column D:</b> 1 = Internal Staff R = Reassigned Staff C = Consultant/contractor V = Volunteer O = Other <b>Column E:</b> S = Stafford Act A = Supplemental Appropriation C = Current/existing funds R = Reallocation of existing funds O = Other <b>Column F:</b> 1 = Prior to the disaster 1 = 1 to 14 days after 2 = 15 to 30 days after 3 = 31 to 90 days after 4 = Longer than 90 days O = Other						
	A. Planning	B. Pre Event/ During/ Immediate Aftermath	C. Long Term Aftermath	D. Human Resources	E. Funding Source	F. Duration
<b>1. PLANNING/PREPAREDNESS for behavioral health in emergencies</b>						
<b>a. Internal</b>						
Within your agency						
With other federal agencies						
<b>b. External</b>						
States						
Regional						
Local						
Tribal						
NGO's						
<b>2. COORDINATION AND INTEGRATION of behavioral health services and related activities</b>						
<b>a. Internal</b>						
Within your agency						
With other federal agencies						
<b>b. External</b>						
States						
Regional						
Local						
Tribal						
NGO's						
<b>a. Internal</b>						
Within your agency						
With other federal agencies						
States						
Regional						
Local						
Tribal						
NGO's						
<b>c. Informational Material</b>						
Internal (distribution to workers, supervisors, etc.)						
External (develop/disseminate for general public)						
<b>4. CONSULTATION/TECHNICAL ASSISTANCE (For behavioral health services and activities)</b>						
a. Needs assessment						
b. Monitoring						
c. Behavioral health surveillance						
d. Databases (facilities, providers, etc)						
e. Other						

**HHS Agency Disaster/Emergency Behavioral Health Coordination Survey**

**TABLE II (CON'T)**

**TABLE II KEY**

**Columns A-C:** Y = Yes N = If no, leave blank

**Column D:** 1 = Internal Staff R = Reassigned Staff C = Consultant/contractor V = Volunteer O = Other

**Column E:** S = Stafford Act A = Supplemental Appropriation C = Current/existing funds R = Reallocation of existing funds O = Other

**Column F:** 1 = Prior to the disaster 1 = 1 to 14 days after 2 = 15 to 30 days after 3 = 31 to 90 days after 4 = Longer than 90 days O = Other

	A. Planning	B. Pre Event/ During/ Immediate Aftermath	C. Long Term Aftermath	D. Human Resources	E. Funding Source	F. Duration
<b>5. SERVICES (behavioral health/event stress/workplace stress)</b>						
<b>a. Direct Services</b>						
Primary victims/survivors at the community level						
Workers in the field (from your agency)						
Workers in the field (not from your agency)						
<b>b. Indirect Services</b>						
General primary victims						
Special primary victim groups (children, seniors, etc.)						
Workplace						
Workers/families						
Other						
<b>6. MONITORING</b>						
<b>a. Funds</b>						
<b>b. Programs</b>						
<b>c. Personnel in the field</b>						
<b>d. Other</b>						
<b>7. OTHER ROLES</b>						

**C. PROGRAM INFORMATION CONTACT:**

*PURPOSE:* During the completion of Table II above and previous portions of this survey, you may have referenced specific programs within your agency with assets, resources or expertise in behavioral health that might be helpful in an emergency response. Please identify the POC for each program office in your agency.

Program Office	Name of Contact	Title of Contact	Phone #	Email Address

## HHS Agency Disaster/Emergency Behavioral Health Coordination Survey

### **D. Challenges:**

1. Please identify any difficulties/challenges of any type that your agency has experienced in establishing and/or implementing a behavioral health role.

### **E. Future Plans/Desires:**

1. Are there roles your agency would like to fulfill that you currently do not? Please describe in as much detail as you can.
2. Please identify what would be needed to allow you to fulfill these roles (e.g., legislation, staffing, funding, etc).
3. Are there Federal or other partners that would be helpful/essential in establishing or implementing those roles?

### **F. Additional comments:**

Please feel free to make any other comments relevant to this topic.

*Thank you for your assistance and contribution.  
You will be contacted shortly to set up  
a time and date  
for the follow up interview.*

**PHASE II: FOLLOW-UP INTERVIEW**

***PURPOSE:** The follow-up interviews will offer an opportunity for you to provide more detail about your behavioral health activities. As part of that interview, the questions below will be asked regarding those programs/ contacts identified in previous pages. You may complete and submit this information prior to the interview.*

**A. Initiation of Behavioral Health Disaster/Emergency Activities:**

**1. Human Resources:**

- a. Have you pre-identified existing human resources?
- b. In the event of a disaster/emergency, do new human resources become available to you? If so please describe the nature of these resources, processes involved, and any limitations (e.g., duration, magnitude) placed on these resources.
- c. Under what conditions do you reallocate human resources?
- d. Are your behavioral health activities dependent on obtaining additional human resources?
- e. When/if this happens, what is the source of the staffing?
- f. Is there a different process when initiating human resources (i.e., civilian, contractors, and Commission Corps)?
- g. When you send staff into the field in a disaster/emergency to assist in behavioral health issues, what is (are) their chain-of-command and/or other reporting relationship(s)?
- h. Are there other human resources issues you would like to describe?

**2. Funding:**

1. Have you pre-identified existing funding resources?
2. How are your disaster behavioral health activities supported from a funding resources perspective?
3. In the event of a disaster, do new funding resources (e.g., funding, human resources) become available to you? If so please describe the nature of these resources, processes involved, and any limitations (e.g., duration, magnitude) placed on these resources.
4. Under what conditions do you reallocate funding?
5. Are your activities dependent on obtaining additional funding?
6. When/if this happens, what is the source of the funds?
7. Are there other funding issues you would like to describe?