Disaster Planning Handbook for Behavioral Health Treatment Programs

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Disaster Planning Handbook for Behavioral Health Treatment Programs

TAP

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

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Contents

Foreword . . . . . **xi**

Introduction . . . . . **xiii**

Audience for This TAP xiii

Organization of This TAP xiv

Behavioral Health Terms xiv

Disaster Terms xv

Chapter 1—Rationale and Process for Planning **1**

Essential Partners in National Preparedness 1

Providers of Essential Services 2

Partners in Community Preparedness 3

Mandates for Disaster Planning 3

All-Hazards Planning 4

The Planning Process 4

Continuity Planning 5

Overview of the Written Disaster Plan 6

Drafting a Usable Plan 8

Chapter 2—Beginning the Disaster Planning Process **9**

Select a Disaster Planning Team Leader and Team 9

Obtain Support From the Organization's Leadership 11

Review Requirements for Disaster Planning 11

Coordinate Planning With Others 12

Educate the Community About Behavioral Health Services 21

Prepare a Hazard Identification and Risk Assessment 23

Specify Planning Objectives and Assumptions 24

Chapter 3—Preparing for Disaster 27

Mitigate Risk 27

Negotiate Memoranda of Agreement 28

Designate Personnel To Assume Command for Incident Response 31

Prepare Clients for a Disaster. 32

Obtain Client Locator Information 34

Encourage Staff To Make Plans for Personal Preparedness 35

Prepare Staff for Supporting Clients in Disaster. 35

Prepare To Connect Clients to Disaster Case Management 40

Ensure Counselor Access to Shelters 40

Prepare for Financial Resiliency 41

Chapter 4—Continuity Planning 43

Identify Essential Functions 43

Identify Essential Staff 43

Provide for Continuity of Leadership 46

Arrange for Alternate Facilities 47

Ensure Interoperable Communications 48

Protect Vital Records and Databases 51

Develop Resources To Manage Human Capital 53

Chapter 5—Management of Prescription Medications. 57

Give Careful Oversight to Clients on Prescription Medications 57

Help Clients Access Prescription Medications 57

Provide for Continued Methadone Dosing 58

Prepare for Transfers of Patients 60

Treat the Guest Patient on Methadone Maintenance Treatment. 60

Handle an Influx of Patients With Opioid Dependence. 61

Address the Needs of Displaced Patients on Buprenorphine 61

Refer or Treat Pain Patients, as Appropriate 63
Manage Supplies of Controlled Substances 63
Chapter 6—Planning Issues for Pandemic Influenza 65
Potential Effects of Pandemic Influenza. 65
Procedures To Reduce Influenza Transmission 66
Vaccines 68
Antiviral Medications 68
Hygiene Policies 69
Staffing Policies 69
Staff Attitudes 70
Planning Assumptions for Pandemic Influenza 70
Drafting and Activating the Pandemic Plan 70
Chapter 7—Completing, Testing, Activating, and Deactivating the Plan 73
Assemble the Plan 73
Distribute the Plan 74
Train and Test 74
Activate the Plan in Disaster 77
Deactivate and Revise the Plan 78
Coordinate With the Community in Recovery 79
Support Staff Members, Clients, and Community After the Disaster 80
Continuously Revise and Update the Disaster Plan 81
Appendix A—Bibliography 83
Appendix B—Worksheets 89
Worksheet B1 Checklist for the Written Disaster Plan 90
Worksheet B2 Checklist for Disaster Planning 92
Worksheet B3 Checklist of State and Community Representatives and Groups 93
Worksheet B4 Checklist of Disaster Planning Discussion Topics. 94

Worksheet B5 Sheltering-in-Place Checklist 96

Worksheet B6 Record of Memoranda of Agreement and Qualified Service Organization Agreements 97

Worksheet B7 Incident Command System Positions. 98

Worksheet B8 Identify Essential Functions. 99

Worksheet B9 Identify Essential Staff Positions. 100

Worksheet B10 Essential Staff Roster 101

Worksheet B11 Checklist for Continuity Planning 102

Worksheet B12 Requirements for Alternate Facilities 106

Worksheet B13 Alternate Facility Arrangements by Disaster Scenario 107

Worksheet B14 Checklist for Relocation Planning 108

Worksheet B15 Checklist for Maintaining Communications With Essential Groups. 109

Worksheet B16 Checklist of Records and Databases To Ensure Interoperable Communications. 111

Worksheet B17 Checklist for Protecting Records and Databases. 112

Worksheet B18 Checklist for Managing Human Capital 113

Worksheet B19 Checklist for Management of Prescribed Medications 115

Worksheet B20 Disaster Plan Training and Testing Log 117

Appendix C—Abbreviations and Acronyms 119

Appendix D—Disaster Planning Web Resources 121

Appendix E—WATrac. 127

Appendix F—Sample Memorandum of Agreement Between Opioid Treatment Programs 129

Appendix G—Editorial Board and Field Reviewers 135

Appendix H—Acknowledgments 137

Exhibits

Exhibit 2-1. Importance of Comprehensive Training for All Staff 10

Exhibit 2-2. Mobilization of Behavioral Health Responders To Assist Hurricane Evacuees 12

Exhibit 2-3. Mobilization of Behavioral Health Responders To Assist Earthquake Emergency Responders 12

Exhibit 2-4. Discriminatory Attitudes That Affected Care for People With Mental Disorders 13

Exhibit 2-5. Discriminatory Attitudes That Affected Care for People With Substance Use Disorders 13

Exhibit 2-6. Networking To Improve Readiness for Disaster (Example 1) 14

Exhibit 2-7. Networking To Improve Readiness for Disaster (Example 2) 14

Exhibit 2-8. Program Use of SERG Grants 15

Exhibit 2-9. Distribution of Financial Aid in Louisiana After Hurricanes Katrina and Rita 15

Exhibit 2-10. Collaborative Planning by Healthcare Organizations 17

Exhibit 2-11. Sample of a Disaster-Specific Prevention Message 21

Exhibit 2-12. Example of Need To Coordinate With Voluntary Organizations 22

Exhibit 2-13. Examples of Program Vulnerabilities and Strengths in a Disaster 24

Exhibit 3-1. Welcome Bags and Personal Go Kits 28

Exhibit 3-2. Preparing for Power Failure 28

Exhibit 3-3. Examples of Disaster Mitigation Specific to a Behavioral Health Treatment Program 29

Exhibit 3-4. Negotiation for Assistance in Hurricane Season 29

Exhibit 3-5. Negotiation for Mutual Aid Following a Major Snowfall 29

Exhibit 3-6. Staff Issues To Consider in Mutual Aid Agreements 30

Exhibit 3-7. Incident Command System 31

Exhibit 3-8. Hypothetical Example of an ICS in Action 33

Exhibit 3-9. Psychological First Aid 36

Exhibit 3-10. Challenges in Disaster Preparedness for Clients With Limited English Proficiency. 38

Exhibit 4-1. Examples of Essential and Nonessential Functions 44

Exhibit 4-2. Essential Operations Continuity During a Winter Storm (Example 1). 45

Exhibit 4-3. Essential Operations Continuity During a Winter Storm (Example 2). 45

Exhibit 4-4. Examples of Order of Succession at a Behavioral Health Treatment Program 47

Exhibit 4-5. Communication Tree. 49

Exhibit 4-6. Priority Communications in an Emergency. 50

Exhibit 4-7. Benefits of Electronic Health Records (Example 1). 52

Exhibit 4-8. Benefits of Electronic Health Records (Example 2). 52

Exhibit 4-9. Office for Civil Rights HIPAA Guidance Following Hurricane Katrina 54

Exhibit 4-10. Building Staff Willingness To Respond in Disaster 55

Exhibit 5-1. Distant Dispersal of OTP Patients. 60

Exhibit 5-2. An OTP's Continuity Plan Executed Before Hurricane Hugo 61

Exhibit 5-3. Guidance for Treating OTP Patients From Areas Affected by Emergency Closure of Programs in the Event of a Disaster 62

Exhibit 5-4. Guidance on Working With Patients Who Are Dependent on Opioids and Not Currently in Treatment 63

Exhibit 5-5. Guidance on Working With Displaced Patients Treated by Pain Clinics 63

Exhibit 6-1. Pregnant Women at Special Risk From Influenza 66

Exhibit 6-2. Racial and Ethnic Minorities Disproportionately Affected by Influenza. 66

Exhibit 6-3. Potential Effects of Influenza Pandemic on Behavioral Health Treatment Programs 67

Exhibit 6-4. Pandemic Education Provided to Staff and Residential Patients 69

Exhibit 6-5. Examples of Pandemic Influenza Planning Assumptions. 71

Exhibit 7-1. Tabletop Exercise for Opioid Treatment Programs. 75

Exhibit 7-2. Beneficial Networking at a Tabletop Exercise. 76

Exhibit 7-3. Effect of Timing Decisions on Staff 78

Exhibit 7-4. Examples of Recovery Steps 79

Foreword

This Technical Assistance Publication (TAP), *Disaster Planning Handbook for Behavioral Health Treatment Programs*, provides guidance, and the underlying rationale, for management and staff as they work together to create a comprehensive, scalable, and flexible disaster plan. This resource can be used by management and the program's disaster planning team as they develop or update program processes, procedures, and written reference tools that support a rapid and effective response when a disaster occurs.

The TAP is intended to support the behavioral health treatment program at any stage of the disaster planning process. A program in the beginning stages can use the TAP as a step-by-step guide, whereas the program with a well-developed plan can consult the TAP for ideas on how to make improvements. In either case, disaster planning should be considered an evolving process, and the plan itself should be viewed as a living document that must regularly be reviewed, exercised, and updated.

Guidance in this TAP aligns with Federal guidelines and current best practices in disaster planning, including recommendations for protecting people's health, which includes their behavioral health, in the case of an emergency (U.S. Department of Health and Human Services [HHS], 2009b, 2011a); for integrating behavioral health into the Nation's overall disaster preparedness, response, and recovery efforts (U.S. Department of Homeland Security [DHS], 2011a); for planning across all threats and hazards (DHS, 2011b); and for the participation of businesses and nonprofit organizations in the Nation's preparedness (White House, 2011). A panel of field reviewers, including behavioral health services providers with experience in disaster preparedness and response, contributed and reviewed the content to ensure that this document realistically reflects how behavioral health services programs can respond to the challenge of disaster preparedness and response.

This TAP advances the Substance Abuse and Mental Health Services Administration's Strategic Initiatives, which provide a framework for addressing mental and substance use disorders, building supportive communities, and improving the health of all Americans. An overarching aim within these initiatives, "Achieving Excellence in Operations," is advanced when behavioral health treatment programs adopt best practices for disaster planning. A second aim, "Improving the Nation's Behavioral Health Care," is advanced when Americans are provided with essential behavioral health services during and following disaster.

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Introduction

This Technical Assistance Publication (TAP), *Disaster Planning Handbook for Behavioral Health Treatment Programs*, provides guidance for developing or improving the behavioral health treatment program's disaster plan. This document provides guidance for program staff members on reducing their facility's exposure to threats and hazards and retaining and restoring the program's capacity to function when a disaster does occur. A disaster plan is an essential reference for program staff in a disaster situation—the planning process is the path through which preparedness becomes possible.

A disaster plan describes procedures for ensuring safety in a disaster, reducing the potential for damage from a disaster, and maintaining or rapidly resuming essential services during and after a disaster. The plan details procedures for the quick and efficient linking of clients to other appropriate sources of care when the program itself cannot provide that care. It also describes processes for the reengagement of clients once the program can again offer regular services.

The TAP addresses planning issues for staff at programs that provide treatment for mental or substance use disorders, or both. This guidance addresses the planning needs specific to programs that offer prevention services, outpatient or residential treatment, medically managed detoxification, and medication-assisted treatment. The TAP also covers planning issues specific to at-risk populations (e.g., children, senior citizens, pregnant women, those with chronic medical disorders, those with pharmacological dependency). This guidance is to be considered supplemental to, and is not in conflict with, requirements by healthcare licensing or accreditation bodies (e.g., State licensing departments, CARF International, The Joint Commission) specific to disaster planning for programs affiliated with them. All programs are required to be in compliance with any regulatory requirements established by applicable Federal and State regulations or laws. It is beyond the scope of this TAP to cover specific regulatory requirements. Providers should obtain guidance directly from applicable regulatory entities.

Audience for This TAP

This TAP is intended for use by the disaster planning team of the behavioral health treatment program and others responsible for management and oversight of preparedness. This team may include program administrators responsible for developing and activating the organization's disaster plan, as well as senior staff members and clinicians who play leadership roles in developing and testing the plan, coordinating staff training of the plan, and activating the plan in an actual incident. The TAP also may be useful to executive directors and other members of management in helping them understand their specific roles in the disaster planning process and why their involvement and support are so important. State disaster behavioral health treatment coordinators may find the TAP helpful in supporting their efforts to promote standardized disaster planning, response, and recovery of mental health services and substance abuse treatment programs in coordination with State, Federal, and jurisdictional plans.

Organization of This TAP

Chapter 1 provides the rationale for the planning process. It also describes the development of a written disaster plan. Creation of the written document helps focus the disaster planning process, while the plan itself becomes a reference tool for use in any emerging disaster situation. Once completed, the plan must be regularly updated to ensure that it remains current and relevant.

Chapters 2, 3, and 4 provide guidance for creating a disaster planning team and describe steps to develop content for each part of the disaster plan. Chapter 5 provides guidance specifically for management of prescription medications. Chapter 6 addresses the content that would be included in a Pandemic Appendix to the disaster plan. Chapter 7 provides information on completing the basic plan; testing, activating, deactivating, and updating the plan; and coordinating with the community as it recovers from the disaster.

Worksheets (located in Appendix B) are tied to the chapter guidance. The disaster planning team can refer to these worksheets to identify steps and document actions and arrangements. Some worksheets are checklists to guide the planning process whereas others, when completed, can become part of the written plan. Appendix D includes useful disaster planning Web resources.

Behavioral Health Terms

A few key terms from the behavioral health field are defined here, for clarity.

behavioral health—*Behavioral health* is used in this TAP to refer to a

> state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. This includes a range of problems from unhealthy stress to diagnosable and treatable diseases like serious mental illnesses and substance use disorders, which are often chronic in nature but that people can and do recover from. The term is also used to describe the service systems encompassing the promotion of emotional health, the prevention of mental and substance use disorders, substance use, and related problems, treatments and services for mental and substance use disorders, and recovery support. (Substance Abuse and Mental Health Services Administration, 2011a, p. 1, footnote i)

client and **patient**—*Client* is used inclusively to refer to any recipient of behavioral health treatment services. *Patient* is used only when the reference is specifically to an individual in a medically directed residential treatment program, undergoing medical detoxification, or receiving medication-assisted treatment (e.g., methadone maintenance treatment).

co-occurring—The term refers to co-occurring mental disorder and substance use disorder. A client with co-occurring disorders may have one or more of both types of disorders.

program—*Program* is frequently used in this TAP in place of the full phrase *behavioral health treatment program*, meaning a program providing services for the treatment or prevention of mental or substance use disorders, or both. To avoid lengthy phrasing, the word *program* is also used to represent the people who work in the program and who develop and execute disaster planning activities (e.g., "The program has an obligation to prepare for potential disasters because . . . ."). The TAP provides guidance as if a program creates only one disaster plan. However, the program with multiple *facilities* (i.e., buildings or sites) will need to tailor its plan for each location.

Disaster Terms

Below are several disaster terms related to this TAP. Unless otherwise indicated, the definitions provided are verbatim from the cited source materials.

disaster—An occurrence of a natural catastrophe, technological accident, or human-caused event that has resulted in severe property damage, deaths, and/or multiple injuries. (Federal Emergency Management Agency [FEMA], 2010a, p. B-3)

emergency—Any incident, whether natural or human-caused, that requires responsive action to protect life or property. Under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, an emergency means any occasion or instance for which, in the determination of the President, Federal assistance is needed to supplement State and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the United States. (FEMA, ca. 2011)

Note: The words *disaster* and *emergency* are closely related and often used synonymously. However, in the healthcare field, *emergency* frequently refers to medical or psychiatric incidents involving an individual (e.g., a patient having seizures or hallucinations). To avoid confusion, in this TAP the word *disaster* is used when referring to any incident that has the potential to adversely affect a facility's ability to operate and provide services to clients, even if the incident is emerging or possibly small in scope. Similarly, in this TAP the term *disaster planning* is often used even though FEMA and many jurisdictions use terms such as *emergency planning* and *emergency operations planning*.

emergency management/response personnel—Includes Federal, State, territorial, tribal, substate, regional, and local governments, nongovernmental organizations (NGOs), private sector organizations; critical infrastructure owners and operators, and all other organizations and individuals who assume an emergency management role. Also known as emergency or first responder. (FEMA, ca. 2011)

hazard—Something that is potentially dangerous or harmful, often the root cause of an unwanted outcome. (FEMA, ca. 2011)

hazard identification and risk assessment (HIRA)—A process to identify hazards and associated risk to persons, property, and structures and to improve protection from natural and human-caused hazards. HIRA serves as a foundation for planning, resource management, capability development, public education, and training and exercises. (FEMA, 2008) Another term for this assessment is *threat and hazard identification and risk assessment* (THIRA).

incident—An occurrence, natural or human-caused, that requires a response to protect life or property. Incidents can, for example, include major disasters, emergencies, terrorist attacks, terrorist threats, civil unrest, wildland and urban fires, floods, hazardous materials spills, nuclear accidents, aircraft accidents, earthquakes, hurricanes, tornadoes, tropical storms, tsunamis, war-related disasters, public health and medical emergencies, and other occurrences requiring an emergency response. (FEMA, ca. 2011)

mitigation—Those capabilities necessary to reduce loss of life and property by lessening the impact of disasters. Mitigation capabilities include, but are not limited to, community-wide risk reduction projects; efforts to improve the resilience of critical infrastructure and key resource lifelines; risk reduction for specific vulnerabilities from natural hazards or acts of terrorism; and initiatives to reduce future risks after a disaster has occurred. (White House, 2011)

preparedness—A continuous cycle of planning, organizing, training, equipping, exercising, evaluating, and taking corrective action in an effort to ensure effective coordination during incident response. Within the National Incident Management System (NIMS), preparedness focuses on the following elements: planning, procedures and protocols, training and exercises, personnel qualification and certification, and equipment certification. Examples: Conducting drills, preparing homework packages to allow continuity of learning if school closures are necessary, etc. (FEMA, ca. 2011)

prevention—Actions to avoid an incident or to intervene to stop an incident from occurring. Prevention involves actions to protect lives and property. Examples include: Cyberbullying prevention, pandemic influenza sanitation measures, building access control procedures, security systems and cameras, etc. (FEMA, ca. 2011)

Note: When Institute of Medicine classifications for prevention are applied to behavioral health (e.g., prevention of mental or substance use disorders), the term *prevention* can carry the specific meaning of *universal* prevention (strategies targeted at the entire population); *selective* prevention (strategies targeted at subsets of the total population considered to be at-risk); and *indicated* prevention (strategies targeted at individuals who show signs and symptoms of the disorder) (paraphrased from National Institute on Drug Abuse, 1997). In this TAP, the intended meaning of *prevention* (disaster or behavioral health related) can be inferred from the context.

reconstitution—The resumption of non-emergency operations at a primary facility following emergency operations at an alternate facility. (FEMA, 2004)

recovery—Those capabilities necessary to assist communities affected by an incident to recover effectively, including, but not limited to, rebuilding infrastructure systems; providing adequate interim and long-term housing for survivors; restoring health, social, and community services; promoting economic development; and restoring natural and cultural resources. (White House, 2011)

Note: In the behavioral health treatment field, *recovery* means the remission of symptoms of mental or substance use disorders, or both. In this TAP, *recovery* is used as both a behavioral health term and as a disaster-related term. The meaning in each instance should be clear from the text.

response—Those capabilities necessary to save lives, protect property and the environment, and meet basic human needs after an incident has occurred. (White House, 2011)

Chapter 1—Rationale and Process for Planning

In This Chapter

- Essential Partners in National Preparedness
- Providers of Essential Services
- Partners in Community Preparedness
- Mandates for Disaster Planning
- All-Hazards Planning
- The Planning Process
- Continuity Planning
- Overview of the Written Disaster Plan
- Drafting a Usable Plan

Worksheet (see Appendix B)

- B1 Checklist for the Written Disaster Plan

Disaster planning can save lives, minimize injury and emotional trauma, protect property and operational capability, and prevent or reduce interruptions in treatment. For all of these reasons, the behavioral health treatment program should coordinate with its community long before disaster strikes, to plan and prepare for a rapid, effective response to disaster. Program staff also need to document those preparations in a format that is readily understood and easy to navigate so that personnel can refer to the plan under time-sensitive conditions. This chapter covers the reasons for disaster planning, explains the basis for the kind of planning proposed in this Technical Assistance Publication (TAP), and provides an overview of the written disaster plan.

Essential Partners in National Preparedness

> Our Nation faces a wide range of threats and hazards, including acts of terrorism, cyber attacks, pandemics, and catastrophic natural disasters. Communities can address the risks these threats and hazards pose by working together using a systematic approach that builds on proven preparedness activities. (U.S. Department of Homeland Security [DHS], 2011b, p. 1)

> National preparedness is the shared responsibility of our whole community. Every member contributes, including individuals, communities, the private and nonprofit sectors, faith-based organizations, and Federal, state, and local governments. (DHS, 2011c, p. 1)

As suggested by these quotations from national preparedness documents, disaster readiness is not accomplished ad hoc or in isolation. It is done systematically and in coordination with all stakeholders. To the extent that behavioral health treatment programs exist in the community *and* serve the community, they are essential partners in national preparedness.

Providers of Essential Services

The behavioral health treatment program has a special obligation to prepare for disasters because it provides essential services. Disaster services in support of behavioral health are named in Emergency Support Function (ESF) #8 (Public Health and Medical Services) of the *National Response Framework* (DHS, 2013) and in a Recovery Support Function (Health and Social Services) of the *National Disaster Recovery Framework* (DHS, 2011a).*

By their nature, disasters have an impact on behavioral health:

> Most people who experience a disaster, whether as a victim or responder, will have some type of psychological, physical, cognitive, and/or emotional response to the event. Most reactions are normal responses to severely abnormal circumstances. (American Medical Association, 2005, p. 2)

Thus, there can be significant demand for behavioral health services as a result of a disaster and significant consequences if a program suddenly closes or is forced to reduce services.

Disaster planning can prepare the program for continuing to provide behavioral health services to its existing clientele. Otherwise:

- Clients in recovery may relapse to substance abuse, or their psychiatric symptoms may recur, at the very time they must cope with the uncertainties, traumas, and losses caused by the disaster.
- Patients receiving medically managed detoxification for alcohol and drug abuse are at risk of serious medical and psychological complications if the process is interrupted.
- Patients in residential treatment programs that have closed may have no other safe place to go to complete their initial recovery goals.
- Patients on psychotropic medications (e.g., antipsychotic medications, anti-anxiety medications) who obtain their medications at the program, or who are assisted by staff in taking their medications regularly, are at risk of serious withdrawal symptoms (e.g., seizures, delirium tremens) if the medications are stopped abruptly. Similarly, patients receiving methadone treatment for opioid dependence may develop withdrawal symptoms (e.g., tremors, hallucinations) if their treatments are interrupted.
- At-risk populations (e.g., children, senior citizens, pregnant women, those with chronic medical disorders, those with pharmacological dependencies) may face unique hardships and challenges if suddenly deprived of their program's support.

Just as important, disaster planning can prepare the program for providing behavioral health services to new clients:

- In the weeks and months following a disaster, the program may experience a surge in demand for services from individuals for whom the disaster has created a need for assessment or treatment services and from clients previously treated at other programs who have been displaced from their local community.
- A program that has been spared by the disaster may be called on to provide aid to other programs (e.g., treating guest clients, sharing medications, lending staff members) or to other community organizations (e.g., sharing resources, reassigning staff).
- Staff members may be asked, based on their training, to provide emergency community-based behavioral health services (e.g., crisis counseling or intervention, psychological first aid, assessments and referrals).

*The Federal agencies that coordinate these Federal preparedness plans are the Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services (ESF #8), and National Disaster Recovery Planning Division, Federal Emergency Management Agency, DHS (*National Disaster Recovery Framework*). The behavioral health treatment program typically does not work directly with these Federal agencies but rather through local disaster planning leadership. See Coordinate Planning With Others, in Chapter 2.

Partners in Community Preparedness

The behavioral health treatment program's disaster planning contributes to the overall preparedness of the community. Proper planning helps prepare for potential rapid surges of vulnerable populations needing behavioral health services and for the rapid transition of services to other locations when the program and community are overwhelmed.

Such planning is critical; it has been estimated that, after a disaster, a community's healthcare facilities may experience a surge for behavioral health services that could range from 4 to 50 times higher than the surge for medical care (Meredith, Zazzali, Shields, Eisenman, & Alsabagh, 2010). A variety of factors or "triggers" are theorized to contribute to elevated demand for behavioral health services in a disaster situation. These include restricted movement (e.g., quarantine, shelter stays, evacuation); limited resources (including denial of, limitation of, or suspended access to care); exposure to trauma (both direct and indirect, such as through media exposure); limited information (including insufficient or inaccurate information or rumors); and perceived personal or family risk. Representatives of behavioral health treatment programs can work with community planners to put into place the structures and processes that support people's adaptive and appropriate responses to these triggers (Meredith, Eisenman et al., 2011).

Another significant contribution the treatment program can make as it participates in its community's disaster readiness is to advocate for the needs of people with behavioral health disorders, including people with chronic mental disorders, people with new-onset disorders triggered by the disaster, and people who are physiologically dependent on medications or illicit drugs (Rabins, Kass, Rutkow, Vernick, & Hodge Jr., 2011). Programs also can advocate for training of emergency responders so that they can recognize signs of severe psychological trauma, cognitive incapacity, or a substance use disorder and know how to route people displaying such signs to appropriate services. This would better ensure that responder interactions with affected individuals are managed appropriately, that the identified individuals receive the behavioral health services and protections they require, and that their due process rights are protected.

Mandates for Disaster Planning

Disaster planning is not just prudent and practical, it is required:

- Most States require a disaster plan for program licensure.
- The Joint Commission and CARF International each require a disaster plan for accreditation.
- To receive Medicaid reimbursement, programs offering mental or substance use disorder treatment services must be in full compliance with licensure regulations, including those pertaining to disaster planning.
- Disaster planning is a requirement for opioid treatment program certification.
- Behavioral health treatment programs that are part of healthcare coalitions receiving funds through the Hospital Preparedness Program are obligated to plan for response to common medical disasters (Office of the Assistant Secretary for Preparedness and Response, 2012).
- Federally qualified health center programs, rural health clinics, and other primary care safety net providers are obliged, as extensions of the Federal Government, to conduct disaster planning.

Ideally, the disaster planning process helps the program identify and obtain the resources and training it needs to forge an effective response to a range of potential calamities. As staff members work together across departments to create and test the plan, they build relationships that will be important when they must work together under the

intense conditions of a real disaster. The planning process also provides program staff with opportunities to meet and build relationships with other professionals from the community who will be key partners in the event of a disaster. As a result, the entire infrastructure of the program is strengthened and more adequately prepared for response to unusual incidents of any kind and scope.

All-Hazards Planning

This TAP describes an all-hazards approach to planning. *All-hazards planning* means that planners prepare for response to a full range of threats and dangers but with a focus on the specific incidents most likely to occur in their area (Federal Emergency Management Agency [FEMA], 2010a). This kind of planning begins with an extensive risk assessment based on probabilities of anticipated events occurring in the program's or facility's specific locality. Based on the risks identified, a program addresses the capabilities needed to respond. For example, the risk assessment may document that the program is situated in an area susceptible to flooding. The program begins with response plans for flooding (e.g., taking preventive actions to protect the facility from flooding, developing an evacuation plan, creating plans for clients and patients to be treated outside the flood area, ensuring that records are backed up in another location). These plans can be adapted when responding to other types of disasters.

The Planning Process

The planning process described in this TAP aligns with that recommended for entities such as State, territorial, Tribal, and local governments; planners in other disciplines, organizations, and the private sector (FEMA, 2010a); and courts (National Center for State Courts, 2007). This process is based on Federal policies for disaster planning, including the National Preparedness System, the *National Disaster Recovery Framework* (NDRF), and the National Incident Management System (NIMS).

The National Preparedness System presents a collaborative, whole-community approach for building a secure and resilient Nation that can confront any threat or hazard. Components include: identifying and assessing risk, estimating the level of capabilities needed to address those risks, building or sustaining the required levels of capability, developing and implementing plans to deliver those capabilities, validating and monitoring progress, and reviewing and updating efforts to promote continuous improvement (DHS, 2011b).

NDRF is a statement of the principles guiding effective recovery from large-scale or catastrophic disasters. Its objective is to guide a unified and collaborative response for restoring, redeveloping, and revitalizing communities (DHS, 2011a).

NIMS identifies the terms, protocols, procedures, and standards that should be used so that disaster response can be effectively coordinated at the local, regional, State, and Federal levels. NIMS provides all partners involved in a disaster response a common language and a standardized way to communicate about their responsibilities, activities, and functions. A NIMS-modeled disaster plan is flexible: it can be scaled up or down, depending on the size, scope, and complexity of the disaster, and it can be readily integrated into the plans of other responding organizations (DHS, 2008).

A basic premise underlying NIMS is that incidents typically are managed at the local level first. In the vast majority of incidents, local resources provide the first line of emergency management and incident response. If additional or specialized resources or capabilities are needed, State governors may request Federal assistance. However, local jurisdictions retain command, control, and authority over response activities in their areas.

Behavioral health treatment programs—whether public, private, or nonprofit—should develop disaster plans that comply with NIMS (FEMA, 2006). A NIMS-compliant

program agrees to manage disaster incidents using the Incident Command System (see Chapter 3) and to coordinate with other responders for decisionmaking and public communication. The program also agrees to train key staff members in NIMS preparedness, participate in internal and external training exercises, and incorporate NIMS concepts into its disaster plan.

The behavioral health treatment program should use the NIMS approach to disaster planning and training for the following reasons:

- NIMS was developed based on best practices and has been extensively tested throughout the country, proving its effectiveness in providing a framework for a coordinated disaster response.
- Almost all government and community training on disaster response is based on NIMS.
- Staff members who understand NIMS and prepare to respond using NIMS protocols will more readily fit into their community's response activities. The program, therefore, will be in a better position to get and to give help in a disaster.
- Adhering to NIMS enables the program to better use incoming resources, including deployed staff and volunteers.
- Program staff members who may be called on to serve as part of an external disaster response (e.g., as members of the State's behavioral health disaster response team) must be credentialed in and operate within the NIMS structure.

Appendix D, Disaster Planning Web Resources, provides links to various Federal planning guidelines.

Continuity Planning

Behavioral health programs need to plan not only for responding to a disaster as it hits (disaster planning), but also for continuing essential operations under a broad range of circumstances that could follow a disaster (continuity planning). Thus, a vital part of the program's overall disaster plan is its business continuity plan, commonly called its *continuity of operations plan*, or *COOP plan*. The latter term originally referred to planning by government entities, but it has been adopted by businesses and organizations.

Continuity planning requires a program's personnel to consider the threats that could adversely affect essential functions; determine the personnel, vital information (e.g., patient medical records including prescription records), and other resources required to continue those essential functions; develop plans for providing essential functions onsite or at alternate locations if needed; make advance arrangements for obtaining the resources necessary to support essential functions throughout the disaster and recovery phases; and plan for the safety of all personnel during these periods. The continuity plan can be scaled up or down as needed to accommodate the quantity and variety of clients who need services. Elements of the continuity plan may be activated either in conjunction with a disaster declaration by a government official or independent of such a level of response.

Examples of scenarios in which a program would implement a continuity plan include the following:

- When the program must cease provision of nonessential services due to a sudden reduction in resources, infrastructure, or available personnel (e.g., during a pandemic)
- When the program cannot provide essential services to clients at its original location (e.g., when the facility is damaged due to a fire or access is blocked due to a chemical spill or a blizzard)

- When evacuation to another geographic area is recommended or mandated (e.g., because of an advancing hurricane)
- When staff and resources are diverted to provide urgent care to community members in distress

Continuity planning helps the program prepare for meeting the needs of existing clientele and for a possible increase in demand that can occur after a disaster, either in the immediate aftermath or in the months that follow. Increases may occur both in the number of individuals needing services and in the severity of clients' addictions and psychiatric conditions. Characteristics (e.g., age, gender, culture, English-language proficiency, home location, behavioral health and medical conditions) of guest clients or new clients after a disaster may differ from those of the program's preexisting clientele. The program may have to adapt quickly to accommodate a variety of clients and their needs, such as:

- Current clients who are facing extra stressors arising from the disaster and need extra counseling, psychiatric monitoring, or other support to maintain and continue recovery from a behavioral health disorder.
- Guest clients from other treatment programs or under physician care who have been displaced by the disaster and who come to the program for short- or long-term assistance.
- Individuals who completed treatment or discontinued services prior to a disaster but whose recoveries are now threatened as a result of the event.
- Individuals with an ongoing, untreated mental or substance use disorder (or both) who need treatment to prevent further deterioration or to prevent an escalation of dangerous medical or psychological symptoms.
- Family members of clients who need assistance for their loved ones, or for themselves, to alleviate concerns. These individuals may benefit from an established or temporary telephone hotline answered by trained crisis intervention and referral staff (possibly nonclinicians or prevention staff).
- Patients who have been stabilized for long periods on antidepressants, antipsychotics, or medications for opioid addiction who are not able to obtain prescription refills and are in danger of sudden medication withdrawal or relapse to psychiatric or addiction symptoms. These patients may need evaluation and referral to resources.
- Patients on opioid medication for pain who cannot obtain services from their physician, are facing or experiencing withdrawal, and request help from the treatment program. These patients may need referral to pain specialists.

Overview of the Written Disaster Plan

The written disaster plan needs to be flexible in its application and comprehensive, but not overwhelming, in scope. Ideally, it is organized so that it can be quickly referenced in a disaster situation.

The components of a disaster plan are briefly described in the following section. More detail is provided in Chapters 2, 3, and 4, which outline the processes by which the disaster planning team gathers information, makes planning decisions, and compiles information into a written disaster plan. **Worksheet B1** (Appendix B) can be used as a checklist for assembling plan components into one document.

The Basic Plan

The introductory section of the *basic plan* includes a statement of purpose and objectives and other summary information, including the scope of the plan, the populations served by the program, and the program's essential functions. Also included in the basic plan are a situation overview

(e.g., the hazards the program is most likely to face, the program's response capabilities, the steps that have been taken to reduce risk) and a section on planning assumptions.

Following the introductory section, the basic plan contains a statement about the *concept of operations* (i.e., the organization's overall approach in responding to disaster). This statement should address procedures for activating and deactivating the plan and the general sequence of actions to be taken—by whom—before, during, and after an incident. The statement should also provide the following: a list of the personnel positions authorized to make requests for outside aid or assistance, the conditions under which to request aid, the procedures for managing requests to give aid, and a list of the resources that can be used in those efforts. Methods and schedules for updating the plan, communicating changes to staff, and training staff on the plan should also be included in the concept of operations.

Functional Annexes

A set of instructions for a specific hazard response procedure is referred to as a *functional annex.* Each annex is separately attached to the disaster plan to avoid cluttering the basic plan with too much detail. This structure also makes it easier to update and revise individual components of the disaster plan as needed.

A functional annex can be as short as a paragraph or as long as several pages. Examples of functional annex topics include procedures for the emergency phase, such as facility evacuation, sheltering-in-place, and handling the media. The continuity plan is a functional annex that is often the largest section of the overall disaster plan (development of this functional annex is addressed in Chapter 4). Decisions on whether to include procedural instructions in the basic plan or in a separate functional annex depend on the size and complexity of the program and the level of sophistication in planning that the program has attained.

A functional annex should not repeat information in the basic plan. It should add only those details that are necessary to perform the procedure.

Hazard-Specific Appendices

In its initial work, the disaster planning team conducts or gathers, from partner agencies in the community, a *hazard identification and risk assessment* (HIRA; see Chapter 2). The HIRA identifies the specific types of threats or risks most likely to occur and the potential impact of each type on the program. In response to each identified hazard, threat, or incident, the disaster planning team develops response procedures based on industry safety standards and regulations (e.g., those issued by the Occupational Safety and Health Administration). These procedures are attached as a hazard-specific appendix to the basic plan. For example, if the HIRA identifies hurricanes and hazardous materials spills as possible hazards to the program, the planning team would develop two appendices, one for each hazard.

A hazard-specific appendix should not repeat information that is in either the basic plan or any functional annex, both of which provide instruction applicable to all hazards. It should add only those details that are specific to the hazard being addressed. If the details are few, hazard-specific information can be presented in a few sentences at the end of each functional annex. For example, a functional annex of instructions for backing up and saving computer data may include separate procedures for tornado scenarios, in which there is little time to act, and for hurricane scenarios, for which more warning time is available.

Alternatively, an appendix can be added that contains all special instructions relative to a particular type of hazard, threat, or incident. Each specific appendix is inserted after the basic plan and the functional annexes. (See Chapter 6 for guidance on preparing a Pandemic Appendix.) The disaster planning team chooses the format for its hazard-

specific information that makes the most sense for the personnel who will be using the disaster plan when an incident occurs.

Implementing Instructions

Material that helps staff members perform essential tasks during a disaster—referred to as *implementing instructions*—are attached to the back of the basic plan, with copies distributed to pertinent personnel. Typically, the material includes the program's safety-related policies and procedures; these should be periodically reviewed and updated with a schedule in place to communicate to staff about changes and provide recurrent training.

Implementing instructions also can include job-related aids that staff can use to perform disaster response tasks (e.g., checklists, worksheets, laminated wallet cards or sheets, scripts that staff can use when providing disaster-related information to consumers and the public).

Other materials that can be attached to the plan include Memoranda of Agreement (see Chapter 3 and Appendix F), building floor plans, community maps, and one or more of the completed worksheets from Appendix B such as **Worksheet B7**, Incident Command System Positions. The types of implementing instructions that can be attached to the basic plan are discussed in subsequent chapters and are included in the checklist found in **Worksheet B1**, in Appendix B.

Drafting a Usable Plan

A key objective is to organize the material so that information can be referenced immediately when needed and actions can be taken quickly. The plan is a guide, not a script. It is a useful tool for training staff, evaluating exercises and drills, and sharing with other community partners who participate in disaster response. In a real disaster, the people who execute the plan will have to adjust their actions as the situation dictates and as facts replace planning assumptions.

Drafters of the plan are encouraged to aim for a simple and flexible plan and to avoid creating a document that attempts to cover all possible contingencies; that goal is impossible, and the result will be an unwieldy, difficult-to-navigate document. The plan should be written in easy-to-understand language that makes use of agreed-on and defined terms and that provides concrete, actionable guidance (FEMA, 2010a).

The plan can be maintained in electronic form, so long as it is accessible to all key personnel. Paper backup copies should also be kept in case of a situation in which electrical power or computer systems are down. Paper versions of the plan must be dated and old versions replaced and destroyed to eliminate confusion. Electronic version control is also important; it can be helpful to track changes on a separate grid sheet attached to the document, to replace the date as changes are made, and to archive old versions so that personnel access only the most current version. Communication to staff of any updates should be part of the program's standard safety practice.

Chapter 2—Beginning the Disaster Planning Process

In This Chapter

- Select a Disaster Planning Team Leader and Team
- Obtain Support From the Organization's Leadership
- Review Requirements for Disaster Planning
- Coordinate Planning With Others
- Educate the Community About Behavioral Health Services
- Prepare a Hazard Identification and Risk Assessment
- Specify Planning Objectives and Assumptions

Worksheets (see Appendix B)

- B2 Checklist for Disaster Planning
- B3 Checklist of State and Community Representatives and Groups
- B4 Checklist of Disaster Planning Discussion Topics

This chapter provides guidance on forming a disaster planning team, obtaining clarity on the scope and responsibilities for the team, and gathering initial data. A key step in this process is integrating with the other entities in the community whose efforts, when disaster occurs, will be orchestrated through an Incident Command System (Chapter 3 addresses the Incident Command System). Planning activities recommended in this chapter are listed in checklist form in **Worksheet B2** (in Appendix B).

Select a Disaster Planning Team Leader and Team

Disaster planning is a cycle that begins with planning and moves through various stages of training, testing, evaluating, revising, and further planning as circumstances evolve. This cyclical process helps a program create a suitable plan for its facility that can be effectively implemented by staff and kept current. Because of the continuous nature of this process, the program's disaster planning team needs to be a permanent part of the organization. Its ongoing responsibilities can include making revisions to the plan (based on insights gained through testing or actual disaster response, or because the program has changed), monitoring the plan as a whole to ensure that it remains coherent, and coordinating testing and training based on the plan.

The program with a small staff may include every employee on its disaster planning team, whereas a large program can assemble a team representing various departments or functions of the organization. The program with several locations will generate one disaster plan, but each separate facility (or its function) needs to be represented on the disaster planning team to ensure that its particular needs, vulnerabilities, and client population are reflected in the plan. Site-specific safety personnel or leadership would be logical members of the disaster planning team.

As another option, a program's existing standing committee (e.g., safety committee) can double as

the disaster planning team. Typically, this committee includes individuals or departments responsible for safety (e.g., fire drill coordination, building and parking lot safety, computer systems security).

Members of the planning team are described in the following sections.

Team Leader

The leader of the disaster planning team may hold any of several titles (e.g., emergency manager, emergency coordinator, business continuity manager, continuity of operations coordinator). If the program is small, the program's executive director or facility administrator may serve in this position. Alternatively, the executive director may delegate responsibility for managing the plan to someone else who has leadership and organizational skills, is familiar with all aspects of the organization, and has experience with disaster planning or has a willingness to learn.

Typically, the leader convenes and conducts team meetings, ensures that team members receive the training they need to contribute effectively to disaster planning, and works with team members to gather information. The leader is responsible for ensuring that the plan is developed, tested, and maintained and that the organization's leadership and departments are informed of the disaster plan and their roles in its implementation (Exhibit 2-1). The team leader also typically serves as the organization's representative at disaster planning meetings in the community and is the liaison for the program as it engages in local or regional disaster planning exercises.

The person who leads the disaster planning team is not necessarily the person who will be assigned to lead the organization during its response to a disaster. The latter role is called *Incident Commander*, and the position and its duties are described in Chapter 3.

Representatives From Across Departments

All departments of the facility or organization, especially those providing essential functions, should be represented on the disaster planning team. Members should include both clinical and nonclinical staff, especially those involved in residential or round-the-clock services, and administrative staff and management. Everyone has a role in disaster preparedness and response.

Staff members who do not serve on the planning team will become involved in later stages of planning, when sections of the draft plan are circulated for comment and when the plan is tested in exercises and drills. Feedback from these staff members can be used to improve the plan. This testing process is described in Chapter 7.

Exhibit 2-1. Importance of Comprehensive Training for All Staff

During a recent response to a highly unexpected earthquake at our program in Virginia, a "debrief" was scheduled with representatives from both administrative and clinical staff to discuss response to the event. During that debrief, what became clear was that the administrative staff had not been fully informed on the particulars of who would take charge of various disaster-related responsibilities or specific disaster roles. Prior to this event, the assumption was that only key staff needed full training on all aspects of the disaster plan. This proved to be a false assumption. Although role-specific training is important, there is a danger that it may become too targeted and not allow for a big-picture view of all parts and participant roles in a response. The debrief resulted in changes to training requirements and a new appreciation for providing all staff with more comprehensive training so that the disaster-related roles of everyone in the organization are clear.

Source: Elizabeth Ludeman-Hopkins, personal communication, January 22, 2012.

It is important to involve all staff members either on the disaster planning team or in support of the work of the team because:

- Broad staff involvement ensures that all critical operations are addressed in the plan.
- Ongoing input from all staff members can keep the disaster planning team aware of changes in equipment or procedures that may affect disaster operations.
- Staff members are more likely to follow a plan they have helped develop.
- Staff members already familiar with their roles are less likely to need last-minute training when the plan must be implemented.
- Staff members familiar with the disaster response plan may be less likely to experience panic, fear, and anxiety when an incident occurs.
- Staff members who are engaged in developing the plan may be more likely to recognize the importance of creating emergency plans for their homes. During a disaster, having home plans can reduce staff members' anxiety over their families' safety and enable those staff members to be physically and mentally present for their job functions.

Obtain Support From the Organization's Leadership

As with any kind of planning, disaster planning has costs associated with it. Management shows its support by considering the budget impact of the planning process, as well as disaster preparation, response, and recovery activities. To fully prepare the organization for continuity of operations, management may need to develop a multiyear budget plan.

An organization's leader contributes to the success of disaster planning by providing the planning team with specific expectations regarding the scope of its mission and encouraging everyone in the organization to cooperate with the team's work. Typically, the organization's leader serves in direct authority over the team and maintains a direct line of communication with the team leader to get regular updates related to planning and response activities. The leader lends credibility to the disaster planning by participating on the team as other duties permit.

Other ways that the program's leader promotes the importance of this project include appointing the members of the team (rather than delegating this task), ensuring that all relevant departments are included on the team, and allocating resources from the organization to the team (e.g., space to meet; compensated time for team members to obtain training, attend meetings, and work on assigned team tasks). Leadership (e.g., managers and supervisors) can consider specifying disaster planning responsibilities in the job descriptions for team members and taking into account those duties during each employee's annual review.

> Members of the disaster planning team can gain knowledge in all aspects of disaster planning and response through the Independent Study Program of the Emergency Management Institute (EMI), Federal Emergency Management Agency (FEMA). No-cost, online courses offered by EMI take approximately 3 hours to complete. They can be accessed at http://training.fema.gov/IS.

Review Requirements for Disaster Planning

The disaster planning team should review pertinent accreditation, licensing, or reimbursement requirements, as well as any State and Federal regulations or laws governing disaster planning. The team should identify its program's planning requirements as dictated by its State, The Joint Commission, CARF International, Medicaid, and any other bodies that govern its operations. Team members also should become familiar with Federal guidelines regarding disaster planning.

Mandates may require the program to conduct general disaster planning, as well as specific planning for pandemic influenza (see Chapter 6). Programs receiving State funding may be required to have staff members (who are credentialed and ready) participate in a *behavioral health disaster response team*. When a disaster occurs, such teams may be mobilized by the State behavioral health departments, or by specific lead organizations serving localities, to provide affected members of the public with psychological first aid, crisis intervention, assessments and referrals to ongoing services, public information, and other services as determined by the State authority (Exhibit 2-2). Teams also may be mobilized to support the behavioral health of emergency responders (Exhibit 2-3).

Coordinate Planning With Others

The program's disaster plan should be developed in coordination with the disaster planning of other behavioral health treatment programs, the State, the local jurisdiction, neighboring businesses and voluntary organizations, and Federal coordinating agencies. Advance coordination can make the program's efforts in a disaster situation more productive and the assistance it gives and receives more effective. Treatment programs are advised to participate in community coordination of predisaster recovery planning as outlined in the *National Disaster Recovery Framework* (U.S. Department of Homeland Security [DHS], 2011a).

Coordination with neighboring facilities and organizations is especially important because in any sizable disaster, the first assistance is likely to come from or go to neighbors (DHS, 2008). A behavioral health treatment program is less likely to receive help in community recovery efforts if neighbors do not know that the program exists, or if they do not understand that the program provides essential services. The program is also less

Exhibit 2-2. Mobilization of Behavioral Health Responders To Assist Hurricane Evacuees

Colorado opened an empty dorm unit on the campus of the closed Lowry Air Force base for people who were relocated there after Hurricanes Katrina and Rita. In a gesture of welcome, a bar across the street from the dorm offered free drinks to the evacuees, with unintended consequences. The dorm took on the atmosphere of a Wild West town, with heavy drinking, clearly identified gang members, and prostitutes. Recovery advocates who visited the dorm identified and referred individuals in need of medication-assisted treatment, mutual-help group meetings, and, in some cases, medical detoxification. The presence of these recovery advocates helped many evacuees withstand the stress and temptations of the situation to preserve their recovery and obtain needed services.

Source: Katie Wells, personal communication, May 11, 2010.

Exhibit 2-3. Mobilization of Behavioral Health Responders To Assist Earthquake Emergency Responders

Steps taken in Haiti included psychological readiness preparation for responders before they were deployed and assistance with stress management, addiction risks, and other emotional and behavioral health concerns during deployment. Mental health professionals were embedded in National Disaster Medical System teams in Haiti and a mental health officer served on the Incident Response Coordination Team. In addition, responders received systematic post deployment education that included advice on expected responses and danger signs indicative of emotional and behavioral health problems and on how to access appropriate follow up resources should they be needed. Overall, this effort to include mental and behavioral health concerns in the response broke new ground and can serve as a model for the future.

Excerpted from National Biodefense Science Board (2010, p. 15).

likely to be included in recovery efforts if neighbors are unaware of the contributions that the program and its staff can make in responding to disaster.

Furthermore, participating in the community's disaster planning can provide additional opportunities to ensure the well-being of the program's clientele during a disaster. For example, educating the community's disaster planning team on the importance of appropriate reception into general population shelters for individuals with behavioral health disorders (FEMA, 2010b) may help avoid the types of discrimination seen in previous disasters (Exhibits 2-4 and 2-5).

Exhibits 2-6 and 2-7 provide examples in which behavioral health treatment programs networked with other community agencies to improve their disaster preparedness. The various groups with which a program's disaster planning team can coordinate are described in the following sections and are presented in a checklist in **Worksheet B3** (in Appendix B).

State Disaster Behavioral Health Coordinator

An important source for disaster planning information, support, and coordination is the State disaster behavioral health coordinator;

Exhibit 2-4. Discriminatory Attitudes That Affected Care for People With Mental Disorders

During Hurricanes Katrina and Rita, individuals with psychiatric conditions faced multiple forms of discrimination. Problems included denial of access to housing and other services and inappropriate and involuntary placement in jails, emergency rooms, nursing homes, and mental institutions. Group home residents were removed to new locations without prearrangement or tracking systems in place and could not be found by family members or their original providers.

People with psychiatric disabilities "encountered enormous problems with general shelters" because such facilities were "crowded, noisy, chaotic, confusing, and sometimes violent, all inadequate circumstances for a person with psychosis, anxiety, or depression." Some special needs shelters were available, but these were designed for people with medical and physical disabilities and so were inadequately prepared to support the needs of individuals with psychiatric disabilities. In some instances, the existence of a special needs shelter was used as an excuse to discriminate against individuals seeking access to the general shelters, with the result that some people with psychiatric disabilities were unable to obtain shelter altogether.

Source: National Council on Disability (2006).

Exhibit 2-5. Discriminatory Attitudes That Affected Care for People With Substance Use Disorders

Interviews with employees of opioid treatment programs (OTPs) throughout the Gulf Coast region after Hurricanes Katrina and Rita suggest that discriminatory attitudes against people with substance use disorders—particularly those who were receiving dispensed methadone—complicated the ability of some individuals to receive needed services and compassionate care.

In one community, evacuees who were being transported from a public shelter to an OTP for daily methadone dosing were required to have an armed police escort on the short bus ride. If officers were busy attending to other duties, the patients (as well as the staff members who would dose them) had to wait until an officer became available. In another community, a provider reported that police refused to allow patients access to the methadone clinic located past a floodlighted area, despite their having a physician letter stating that they were clinic patients. Networking with social service providers, educating them about substance abuse treatment, and establishing relationships with them before a disaster occurs may mitigate discrimination-related problems for clients during or after any such incident.

Source: Podus, Maxwell, and Anglin (no date).

this official typically is located in the State agency focused on behavioral health (e.g., Division of Behavioral Health Services, Department of Mental Health). Some States have one person in this role, whereas others have two disaster coordinators—one for mental health services and one for substance abuse treatment—sometimes operating out of different agencies. For purposes of simplicity, the following description is of the combined position, the State disaster behavioral health coordinator. This coordinator oversees the State's behavioral health treatment response plans and may work closely with programs within the State to support coordination of efforts in response to disaster. He or she may also be in the position to offer disaster training for programs. Serving as a liaison to other Federal, State, and local disaster responding agencies (e.g., the National Guard), the coordinator can be a source of information for the individual treatment program's management and leaders of the disaster planning team.

Following a disaster that exceeds the local response ability, the State disaster behavioral health coordinator may become involved in the application for, and distribution of, disaster-related funds. These include any available State and Federal funds (e.g., those available through the Robert T. Stafford Disaster Relief and Emergency Assistance Act) and funds from two programs: (1) Crisis Counseling Assistance and Training Program (CCP) grants, which are funded by FEMA

Exhibit 2-6. Networking To Improve Readiness for Disaster (Example 1)

A behavioral health treatment program reported that it is among the first organizations in its community to get power back after outages because it is on the same priority electric grid as a nearby hospital. A drawback to this location is that during an emergency, authorities secure the area surrounding the hospital for emergency vehicles only. The OTP administrator worked with county government officials to have OTP staff members designated as emergency responders so that they could be provided with emergency responder IDs; these staff members now have ready access to the clinic when they encounter a roadblock. But challenges remain for patients trying to get to the program. After one hurricane, law enforcement officials set up a roadblock at a nearby intersection, where an officer demanded that patients show proof they were patients of the methadone program before permitting them inside the area. The administrator went to the roadblock with her patient list in hand and confirmed identities for police. "If I didn't know the [patients] . . . if they were not a name on the list," she reported, "they didn't get in." To avoid problems of this nature, programs are advised to ask law enforcement authorities about the circumstances under which access to their facility may be restricted and to negotiate in advance an access plan for staff and patients.

Source: Podus et al. (no date).

Exhibit 2-7. Networking To Improve Readiness for Disaster (Example 2)

A behavioral health treatment program faced problems with the emergency evacuation traffic measures that were developed for its community. In an evacuation, the highway becomes a one-way thoroughfare heading out of town; once a vehicle enters the highway, it cannot exit to local streets. This presents the risk that clients and staff who are delayed at the clinic to complete dispensing of take-home medications when the emergency traffic pattern is implemented will be unable to return home to prepare for the community's evacuation. To avoid problems of this nature, programs can ask local authorities for information about possible disaster traffic-control measures and road closures and ask community traffic planners for guidance on routes around potential roadblocks. However, program disaster planners should consider the possibility that, in an actual disaster, alternative routes may not be available and detours can greatly increase travel time, especially if power outages turn intersections with traffic lights into four-way stops.

Source: Podus et al. (no date).

and administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), and (2) SAMHSA Emergency Response Grants (SERGs).

CCP grants are made available after the President authorizes an individual assistance disaster declaration, under which Federal aid can be directed to the provision of professional counseling services, including

> financial assistance to State or local agencies or private mental health organizations to provide such services or training of disaster workers, to victims of major disaster in order to relieve mental health problems caused or aggravated by such major disaster or its aftermath (FEMA, 2007a, p. 47).

CCP-funded projects include crisis counseling, education, coping skills development, assessments, referrals, and linkages to services. The grants provide funds for either 60 days (Immediate Services Program grants) or 9 months (Regular Service Program grants) after the disaster declaration.

SERG grants, which constitute "funding of last resort" for behavioral health services, are disbursed when other State and local resources are unavailable; a Presidential declaration of disaster is not a requirement. SERG grants are provided out of SAMHSA discretionary funds dedicated to a variety of programs, which means that SERG funding may not be available when requested (Exhibit 2-8). For this reason, programs should work with their State disaster behavioral health coordinator in advance of any disaster to identify multiple options for funding after a disaster (Exhibit 2-9).

SAMHSA's Disaster Technical Assistance Center (DTAC) supports SAMHSA's efforts to prepare States, territories, Tribes, and local groups to deliver effective behavioral health response during disasters. DTAC specialists can help a program link with the disaster behavioral health coordinator for its State, and they can answer questions and provide guidance on CCP grants and SERG funds. The DTAC Web site links to a resources listing of more than 1,500 materials. It is located at http://www.samhsa.gov/dtac. For technical assistance, contact DTAC at 1-800-308-3515, or at DTAC@samhsa.hhs.gov.

Exhibit 2-8. Program Use of SERG Grants

In 2005, shortly after Hurricane Katrina was declared a disaster by President Bush, the State of Texas applied for and received $150,000 in SERG funds to provide methadone to patients of OTPs who had evacuated into the State from Louisiana. These funds went to direct care and not to administrative support of providers. Three years later, Hurricane Ike hit Texas directly, damaging or destroying many substance abuse treatment facilities and forcing patients to relocate. Texas again applied for a SERG grant, but as it was so late in the fiscal year, no SERG funds were available. Some small providers were forced to close. Other providers worked with the State behavioral health authority to find other funding options.

Source: Chance A. Freeman, personal communication, May 6, 2010.

Exhibit 2-9. Distribution of Financial Aid in Louisiana After Hurricanes Katrina and Rita

Following Hurricanes Katrina and Rita, the Robert Wood Johnson Foundation made funds available to help with replacement of equipment at substance abuse treatment facilities. These funds were available through a national nonprofit organization of treatment provider associations, the State Associations of Addiction Services (SAAS). At that time, Louisiana did not have its own State provider association, so SAAS passed funds to providers within the State via Louisiana's Single State Agency (SSA) for substance abuse services. This coordination was critical to the restoration of treatment services in the State.

Source: Michael Duffy, personal communication, April 21, 2010.

State disaster behavioral health coordinators can serve as liaisons with external emergency response teams from the U.S. Public Health Service Commissioned Corps or teams coordinated by National Voluntary Organizations Active in Disaster (see Voluntary Organizations, below). These teams, which can include behavioral health specialists, are sent into communities to respond to public health crises and national emergencies. In addition, some State disaster behavioral health coordinators are directly responsible for assembling behavioral health disaster response teams comprising staff members from programs operating in the State.

Finally, the State disaster behavioral health coordinator may help programs affected by disaster obtain precredentialed volunteer assistance through the Emergency System for the Advance Registration of Volunteer Health Professionals. This State-based registration system for volunteer professionals includes licensed behavioral health treatment counselors and other clinicians (U.S. Department of Health and Human Services [HHS], 2008).

Part 1 of **Worksheet B4** (in Appendix B) contains a checklist of topics that representatives of the disaster planning team can address with their State disaster behavioral health coordinator.

Behavioral Health Treatment Programs

As an initial collaborative step, the disaster planning team is advised to reach out to representatives from other behavioral health treatment programs located in the community and region. Programs need to collaborate so that they are prepared to assist each other's displaced populations in situations where one of them is unable to provide essential services or has clients who must relocate. Such programs can share information and resources on disaster planning and coordinate participation in the broader community's local emergency planning. The State disaster behavioral health coordinator can facilitate these connections.

Public Health Department

Public health departments are first responders to incidents that can affect public health. Responsibilities of the public health department vary by jurisdiction, but may include: coordination of the healthcare system throughout the jurisdiction to ensure continuity of essential functions and to avoid interruption of patient and client care; setup and operation of alternate medical care facilities or shelters for people who need medical care; support to healthcare partners in resource management and coordination; distribution of medications from the Strategic National Stockpile; mass vaccination; coordination of disaster advance training for healthcare personnel; and other duties.

National standards oblige public health departments to coordinate disaster planning with the community's behavioral health treatment systems (HHS, 2011b). For example, the Capability Standard for Community Preparedness notes that (HHS, 2011b, p. 10):

> By engaging and coordinating with emergency management, healthcare organizations (private and community-based), mental/behavioral health providers, community and faith-based partners, state, local, and territorial, public health's role in community preparedness is to do the following:
>
> - Support the development of public health, medical, and mental/behavioral health systems that support recovery.
> - Participate in awareness training with community and faith-based partners on how to prevent, respond to, and recover from public health incidents.
> - Promote awareness of and access to medical and mental/behavioral health resources that help protect the community's health and address the functional needs (i.e., communication, medical care, independence, supervision, transportation) of at-risk individuals.

- Engage public and private organizations in preparedness activities that represent the functional needs of at-risk individuals as well as the cultural and socio-economic, demographic components of the community.
- Identify those populations that may be at higher risk for adverse health outcomes.
- Receive and/or integrate the health needs of populations who have been displaced due to incidents that have occurred in their own or distant communities (e.g., improvised nuclear device or hurricane).

Standards in other capability areas (such as Community Recovery and Mass Care) also require coordination with providers of behavioral health treatment services.

The health department represents Emergency Support Function (ESF) #8 (Health and Medical) services at the Local Emergency Planning Committee, which exists in every jurisdiction to pursue federally directed objectives for emergency planning. The health department also may represent behavioral health and medical functions at the Emergency Operations Center that the community would establish during a disaster. Another role potentially played by the health department would be to relay requests for community assistance from behavioral health programs, as needed in a disaster situation. The public health departments coordinate their efforts with the requirements set forth by the State departments of health.

The public health department's emergency manager can provide planners from behavioral health programs with targeted planning assistance and can serve as a link between the programs and broader disaster planning and incident response efforts. Ideally, behavioral health treatment programs in a community collaborate on initial planning and then collectively approach the health department's emergency manager for integration into the community's planning activities. Some States organize public health departments by county, in which case the ideal is a countywide collaboration by programs, for purposes of working with their health department.

Exhibit 2-10 describes how a regional network of healthcare organizations collaborates extensively for disaster planning. Part 2 of **Worksheet B4** (in Appendix B) contains a checklist of topics that the team's representative can address with the public health department.

Strengthening Emergency Response Through a Healthcare Coalition: A Toolkit for Local Health Departments is a toolkit to support development of healthcare coalitions. Developed by the King County Healthcare Coalition, the toolkit can be accessed at http://www.apctoolkits.com/kingcountyhc.

Exhibit 2-10. Collaborative Planning by Healthcare Organizations

The King County Healthcare Coalition in the State of Washington is a network of healthcare organizations (i.e., behavioral health treatment programs, hospitals, nursing homes, adult family homes, surgical centers, dialysis providers, blood centers, and government agencies involved in public health). The coalition develops and maintains a comprehensive system that helps ensure coordination, effective communications, and optimal use of available health resources in response to emergencies and disasters for all hazards.

Since 2005, the coalition has focused on three major initiatives: building infrastructure to support a coordinated, regional emergency response across the healthcare system; strengthening each healthcare organization's continuity plan and emergency preparedness; and developing surge capacity and capability strategies that address public health service needs during disaster.

The coalition is making plans for alternate care facilities, a regional call center to manage demand for disaster-related health and medical information, and a health and medical volunteer management system to provide the staffing required supporting that demand.

Source: Michael Duffy, personal communication, April 21, 2010.

Emergency Response Organizations

A good practice is to provide a copy of the program's facility floor plan to local emergency responders (e.g., police and fire departments). The floor plan should indicate the locations of personnel who typically occupy the premises. Local emergency responders should be informed of whether controlled substances (e.g., barbiturates, methadone) that may require special protection during emergencies are stored onsite. If so, the responders should be informed where on the premises such substances are located. Additionally, local emergency responders should be notified as to whether people onsite need special assistance in exiting the facility. To find the right department for filing a floor plan, call the nonemergency phone number of the police or fire department.

In some evacuations, the choice of where to take people is made on an ad hoc basis by emergency responders (National Council on Disability, 2006). A representative of the disaster planning team can educate local emergency response organizations about:

- The characteristics of the program's residential patients (especially residents of group homes or other 24/7 residential treatment programs).
- The needs of these individuals during and after transport.
- The types of settings that would be most appropriate for them to be taken to when they are being relocated.
- The specific locations (such as another residential treatment program) that have been pre-arranged to accept patients in an evacuation, if such pre-arrangements have been made (see Negotiate Memoranda of Agreement, in Chapter 3).

The treatment program can work with emergency responders to ensure that in an evacuation its patients are not automatically routed to special needs shelters, institutions, nursing homes, or hotels rather than to a general population emergency shelter that is more likely to offer a fuller range of support services (e.g., assistance in transitioning back to permanent housing). Patients have a right to expect from general population emergency shelters support services that enable them to maintain their independence in that shelter (FEMA, 2010b). This includes, among other things, access to medications to maintain health, mental health, and function; refrigeration for medications; and assistance that may be required due to cognitive and intellectual disabilities.

Local Office of the Drug Enforcement Administration

The local Drug Enforcement Administration (DEA) agent monitors and reviews actions the program takes in a disaster regarding controlled substances (e.g., relocating a methadone supply to an alternate facility) (see Chapter 5). The treatment program's disaster planning team can inform the local DEA agent about the use of controlled substances that are prescribed or dispensed to patients and stored at the facility (e.g., anti-anxiety medications such as benzodiazepines, central nervous system stimulants such as methylphenidate [Ritalin] for treatment of attention deficit/hyperactivity disorder, methadone for opioid dependence). The team also can invite the DEA agent to participate in its disaster planning. These actions may expedite DEA decisions affecting the facility during a disaster. The State Opioid Treatment Authority can assist in making contact with the local DEA official.

Organizations of Pre-Credentialed Volunteers

The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) is a Federal program through which States and territories register health professionals who can provide volunteer service in disasters and public health and medical emergencies. The program verifies the identification and

licenses, credentials, accreditations, and hospital privileges of each health professional volunteer so that in a disaster incident the volunteers can be quickly deployed, across State lines if needed.

The Citizen Corps is a national service program that mobilizes volunteers for emergency preparedness and assistance in recovery after a disaster or terrorist attack. The program supports personal preparedness planning, provides training, and coordinates volunteer services. Each community has a Citizen Corps Council (CCC) to carry out the national program's objectives locally. Sponsored by the Office of the Surgeon General and a component of the Citizen Corps, the Medical Reserve Corps (MRC) is a grassroots, nationwide network of volunteer medical and public health professionals who contribute their skills and expertise throughout the year and in times of community need.

In a disaster, assistance from either the ESAR-VHP or a CCC to the behavioral health treatment program would be provided through the community's Emergency Operations Center or through a State coordinator. The behavioral health program's disaster planning team may choose to make proactive contact with these organizations to register its own staff. If no local MRC unit exists, the disaster planning team may want to work with community leaders to establish one.

> Appendix D, Disaster Planning Web Resources, provides links to organizations of pre-credentialed volunteers.

Voluntary Organizations

Local nonprofit or nongovernmental groups, especially those affiliated with the coalition National Voluntary Organizations Active in Disaster, can serve as facilitators and gatekeepers for emergency services. These groups include:

- The American Red Cross—A prominent provider of disaster shelter, supplies, and services, including tools for communicating with volunteers and partners in disaster conditions. The organization also provides disaster services training through certification courses (held online and at local chapters) for potential volunteers, including medical professionals who may be called upon to assist in Red Cross shelters.
- Faith-based organizations, service fraternities, sororities, and clubs—These often have resources, trained volunteers, and facilities to support the response efforts of disaster teams.
- Mutual-help and recovery groups or advocates (e.g., self-help groups for recovery from mental or substance use disorders, individuals credentialed by the National Alliance for Medication Assisted Recovery)—These programs and people can provide psychological support to individuals in recovery and affected by disaster.
- Consumer advocacy groups—These can be helpful in coordinating disaster support for particular client populations, such as people with cognitive or intellectual disabilities (see Prepare Clients for a Disaster, in Chapter 3).

Depending on the type of organization and the circumstances, a wide variety of help may be available to those affected by the disaster (e.g., meals; water; housing; clothing; toiletries; grant-writing help; replacement furniture and equipment; cleanup and reconstruction supplies, tools, and labor). Voluntary organizations may also be able to provide assistance with medication pickups, transportation to appointments, contacting family members, and other specific tasks. Some volunteer groups provide disaster case management services, which can be especially helpful for clients with disabilities including behavioral health disorders (Stough, Sharp, Decker, & Wilker, 2010). In a disaster situation, assistance from volunteer organizations would be requested through the

ESF #8 lead at the Emergency Operations Center; this is most likely the emergency manager at the local health department (see Public Health Department, above).

Federal guidelines for emergency shelters call for the inclusion in planning of people with mental health expertise as well as input from people with disabilities, access issues, or other functional needs (FEMA, 2010b). The guidelines also recommend that one or more licensed mental health professionals be present in a general population shelter or on call at all times.

The disaster planning team can meet with representatives from the voluntary organizations that operate shelters (and the mutual-aid groups that work in them) so that staff and clients of the behavioral health treatment program can learn how to access these shelters under disaster circumstances. In addition, such meetings present an opportunity to advocate for client needs and rights in a shelter setting. Issues that can be addressed include:

- Procedures for certifying and credentialing medical professionals and volunteers for access to, and providing services in, that organization's shelters. (Access to some shelters may be blocked by security or law enforcement personnel for anyone without such credentials.)
- Procedures to assist individuals in obtaining medications prescribed to them.
- Procedures for enabling clients in emergency shelters to meet with treatment counselors, recovery advocates, or mutual-help groups.
- Admitting procedures at shelters for people who have psychiatric medications or methadone take-home doses in their possession.
- Procedures for handling medications (e.g., documenting in writing any medications brought into the shelter that remain in the possession of the individual, are turned over to staff for dispensing, or are confiscated).
- First aid principles for identifying and assisting shelter residents who have psychotic symptoms, are in withdrawal, or have other symptoms of behavioral health disorders.

Vendors and Other Nearby Businesses

The disaster planning team can ensure that contingency plans are in place with suppliers of the goods and services that will be needed to respond to disaster (e.g., companies that provide fuel, water, medications, building supplies, dry ice for refrigeration in case of power outage, vans or buses for evacuation, snowplowing service, food services for residential programs, water damage repair).

Evacuation, sheltering-in-place, and mitigation are disaster-related activities that are best accomplished in coordination with neighboring organizations. Representatives of the disaster planning team can meet with nearby businesses to share contact information, identify resources in the neighborhood, and develop relationships for working together in a disaster. It is especially important to coordinate with any businesses located in the same building to facilitate the sharing of resources when sheltering-in-place.

Media

Local radio stations, which can be listened to even when local electrical power is disrupted (e.g., via car or solar radios), can be a powerful resource for coordination. The disaster planning team can request the program's inclusion in local radio and TV emergency listings. For example, local media can inform the public of the operating status of the program (e.g., open, closed, delayed opening, operating in an alternate location). In a disaster situation that affects more than the program alone, messages to the general public should be coordinated with the community via the Public Information Officer of the community's Incident Command System (see Chapter 3).

Educate the Community About Behavioral Health Services

An important objective that programs can accomplish in making the linkages described above is educating the community about the special importance of behavioral health services in disaster situations. Ideally in coordination with other local behavioral health programs, the disaster planning team can identify and arrange for opportunities to teach others (e.g., community leaders, private and public partner organizations, volunteer agencies, representatives from the faith-based community) about the program's mission, the treatment and recovery services the program provides, and the contributions the program can make to the community's behavioral health disaster preparedness. Exhibit 2-11 provides an example of mental

Exhibit 2-11. Sample of a Disaster-Specific Prevention Message

Coping With the Gulf Oil Spill—Mental Health Information

Practical advice on how to deal with the effects the Gulf oil spill can have on your mental health

Intense Feelings Are Expected

Over the years the residents of the Gulf coast have demonstrated remarkable resilience. Individuals, families, and communities impacted by the oil spill are taking steps to adjust and adapt to the situation. The reaction to financial and personal stress created by the spill is different for each person. Most may not need any help, or they may need only a little extra support to help them cope with the change in livelihood.

Talk About Feelings With Friends and Family

Talking about the way you feel and taking care of yourself by eating right, getting enough sleep, avoiding alcohol, and getting some exercise can help to manage and alleviate stress.

Take Care of Each Other

Check in with your friends and family members to find out how they feel. Feeling stressed, sad, or upset is a common reaction to life-changing events. Learn to recognize and pay attention to early warning signs of serious problems.

Know When To Seek Help

Depending on their situation, some people may develop depression, experience grief and anger, turn to drugs and alcohol, and even contemplate suicide. The signs of serious problems include:

- Excessive worry.
- Frequent crying.
- An increase in irritability, anger, and frequent arguing.
- Wanting to be alone most of the time.
- Feeling anxious or fearful, overwhelmed by sadness, confused.
- Having trouble thinking clearly and concentrating and difficulty making decisions.
- Increased alcohol and/or substance use.
- Physical aches, pains, complaints.

If these signs and symptoms persist and interfere with daily functioning, it is important to seek help for yourself or a loved one.

Excerpted from HHS (2010).

health information that a behavioral health treatment program can share with a community that is recovering from a disaster. (When called on, the program should make a good-faith effort to fulfill whatever it has promised to contribute; otherwise, the program may be less welcome in future collaborative planning.)

One way of educating the community about behavioral health services is to invite other community partners to disaster trainings for staff and provide the materials, free of cost. This would provide an opportunity to discuss the role, mission, and scope of services offered by the behavioral health treatment program, both in a disaster and in general. A secondary goal would be to increase the awareness of individual and community preparation.

The program can share general information concerning populations with which it has expertise (e.g., adolescents, older people, pregnant and postpartum women) and advocate for consideration of their special needs in disaster planning. The program also can emphasize to local leaders that, during a disaster, individuals needing behavioral health treatment (e.g., support and medication for mental or substance use disorders) should have the same priority as individuals needing care for other conditions (e.g., support and medication for epilepsy, diabetes, heart ailments, asthma). Information about the program's specific vulnerabilities should be conveyed to community leaders so that, in a time of disaster, its urgent needs are taken into consideration as community response efforts and resources are allocated.

A valuable contribution that a behavioral health treatment program can make to community disaster planning is to introduce planning partners to the NIDAMED Resources for Medical and Health Professionals. This initiative provides resources and information about how providers in primary care settings can provide: alcohol, tobacco, and drug screening (including an online interactive drug use screening tool); brief interventions; and treatment. It is located at http://www.drugabuse.gov/nidamed-medical-health-professionals.

Exhibit 2-12 describes the problems that occurred because, in advance of Hurricane Katrina, behavioral health treatment programs had not established clear procedures with the voluntary organizations that operated local emergency shelters.

Exhibit 2-12. Example of Need To Coordinate With Voluntary Organizations

Immediately following Hurricane Katrina, the American Red Cross established a shelter in Baton Rouge, LA, which housed more than 1,200 people. Officials from Louisiana's SSA for substance abuse services met with shelter staff to arrange an opportunity for individuals in the shelter to meet with substance abuse treatment counselors. SSA obtained permission to set up a booth inside the shelter and planned to use impaired eye goggles (simulating the effects of substance use) as a novelty item to attract people to the booth. The staff would conduct screening, brief intervention, and referral to treatment (SBIRT) as indicated. At 6 a.m.—before counselors arrived at the booth—SSA was contacted by officials from the Governor's Office and the State and local police. The officials said that they understood the SSA planned to conduct urine drug testing on all individuals being housed at the shelter and ordered them not to do so. This miscommunication occurred because information about the purpose of the booth was passed along informally among shifts and distorted into a false rumor. The misinformation was corrected, and staff members were deployed to the shelter. This incident demonstrates that advance coordination may help avert the miscommunications that can occur when attempting to coordinate activities in the midst of a disaster.

Source: Michael Duffy, personal communication, April 21, 2010.

Strong relationships with others in the community also can lay the groundwork for the sustained support that may be needed—over weeks, months, or even years—to help the program and its clients recover from a disaster's effects.

Prepare a Hazard Identification and Risk Assessment

Once the disaster planning team is formed and educated regarding its mission and scope and has identified the planning partners in the community, its first priority is to obtain and review an assessment of its community's particular vulnerabilities. Typically, a community already has prepared such a document, called the *hazard identification and risk assessment* (HIRA) or the *threat and hazard identification and risk assessment* (THIRA). A copy can be requested from the planning team's contact at the public health department or from the community's emergency manager, if different. The HIRA identifies the types and scopes of hazards most likely to occur in the jurisdiction.

By using the community's preexisting assessment as a foundation, the disaster planning team can make informed decisions about its own priorities for disaster planning, assess the capacity of the organization to respond to such hazards, and plan to meet any gaps in the ability to respond. Furthermore, it can plan disaster response measures that align with other local response plans. The HIRA serves as the basis of planning disaster responses that are particular to the region that a program serves. It can be included in the planning assumptions section of the basic plan and should be used to determine which hazard-specific appendices are prepared and documented in the plan.

Hazard risks differ depending on their type and scope. Types of hazards include *natural* (events related to weather, geography, or pandemic infectious disease), *technological* (potential disasters involving human-made materials and stemming from technological or industrial accidents or negligence), and *human caused* (potential disasters caused by human accident, civil unrest, or deliberate action). The scope of a hazard can be *internal* (only one location of the program is affected), *local* (the program in one locality, its community, and the local infrastructure are affected, including nearby hospitals, businesses, and schools), or *regional* or *national* (the hazard affects a broad geographical area).

All hazards present risks of injury, psychological trauma (including panic), or death for clients and staff members, as well as health risks to clients who experience sudden interruptions in care and potential public safety issues if individuals with addiction resort to illegal acts to procure drugs. Examples of other hazard-posed risks to behavioral health treatment programs include the following:

- Destruction of property, medications, and clients' treatment and billing records
- Damage to facilities or properties that make access difficult or unsafe
- Damage to community infrastructure including landline telephone service, utilities (e.g., water, sewage, electricity), and transportation facilities
- Disruption in the delivery of supplies (e.g., medications, linens, food)
- Clients unable or reluctant to travel to the facility for services
- Staff shortages

Program-specific factors can affect the program's vulnerability to hazards, as well as its strengths in responding to a disaster (Exhibit 2-13). Depending on the characteristics of the disaster, a program may be able to continue operations by relying on its resources, or it may need assistance from the community or local, State, and Federal governments.

Exhibit 2-13. Examples of Program Vulnerabilities and Strengths in a Disaster

Factor	Potential Vulnerabilities	Potential Strengths
General Location	The program is situated, for example, in a flood plain or in a building that does not meet safety codes.	The program is situated, for example, on high ground above floodwaters or in an earthquake-proof building.
Rural Location	The program is far from emergency rescue stations, hospitals, and other resources that will be helpful in a disaster.	The program is more prepared for self-reliance because of its relative isolation in normal times.
Urban Location	The program faces an overwhelming demand for services from its populous community.	The program can refer its overflow to nearby programs.
Community	The program is isolated from or misunderstood by its community. Cultural barriers separate the community from the program. The community does not know what the program would need or can offer in a disaster.	The program is well integrated into the community and is connected by cultural ties. The community is aware of what the program will need and can offer in a disaster.
Recovery Support	The program is not networked into the local recovery communities. Recovery advocates are not prepared to respond to the needs of the program and its clients after a disaster.	The program has close ties to the recovery community. Recovery advocates have been prepared and pre-credentialed to offer practical assistance to the program and its clients in a disaster.
Capacity	The program is small in terms of staff and resources, which puts it at risk of being overwhelmed by a disaster and increasing the chance that it will have to close. The program does not have the resources (e.g., reserve fund, inventory, insurance, budgeted line items for disaster response) to endure the disaster period, absorb losses, and avert closure.	The program has sufficient staff and resources so that in a disaster it can scale down yet still provide essential services to clients. The program has enough resources to survive the disaster and its aftermath.

Specify Planning Objectives and Assumptions

The disaster planning team can best focus its efforts and avoid working at cross-purposes if it establishes planning objectives and if it bases planning on accurate assumptions. Objectives and assumptions are documented in the basic plan.

Planning objectives are the outcomes that the team seeks to attain by developing a disaster plan, such as the following:

- Minimize hazards and risk of disaster.
- Ensure the safety of all employees, clients, and visitors.
- Promote personal and family disaster planning by staff members.
- Prepare the organization for continuous provision of essential services to clients and staff (and affected family members, whenever possible) during and after a disaster.
- Plan reengagement strategies, to be initiated after a disaster is over, for clients who have not finished treatment or who were involved in nonessential services.

Each annex to the plan also may include additional objectives. For example, the annex that includes the continuity plan can include objectives, such as the following (FEMA, 2004):

- Identify essential operation functions, staff positions responsible for maintaining those functions, and position descriptions.

- Put in place succession planning to maintain operations if primary positions become vacant.
- Ensure that operations related to the continuity of the business are sustainable for a given number of days.
- Ensure that operations that have been shut down because of the disaster can resume within a given time period.

Planning assumptions are best guesses about the physical and operating environments that will be in place at the time a disaster occurs. Examples include:

- The amount of time it takes emergency responders (e.g., police, firefighters, emergency medical technicians) to reach the facility under normal conditions.
- A typical number of staff, clients, family members, and visitors on the premises or in residence at any one time.
- The times of day when staff and clients are on the premises and services are provided.
- The quantity and types of medications stored at the facility, especially controlled substances (e.g., benzodiazepines, methadone) (see Chapter 5).
- The frequency with which client records are updated and either printed for a paper filing system or migrated electronically to a remote computer server.
- Recognition that a disaster can occur at any time and during any shift and can reduce the size of the workforce available to perform essential functions.
- Recognition that disaster response relies primarily on the staff preparation, equipment, and Memoranda of Agreement that the program has in place before the disaster occurs.

Chapter 3—Preparing for Disaster

In This Chapter

- Mitigate Risk
- Negotiate Memoranda of Agreement
- Designate Personnel To Assume Command for Incident Response
- Prepare Clients for a Disaster
- Obtain Client Locator Information
- Encourage Staff To Make Plans for Personal Preparedness
- Prepare Staff for Supporting Clients in Disaster
- Prepare To Connect Clients to Disaster Case Management
- Ensure Counselor Access to Shelters
- Prepare for Financial Resiliency

Worksheets (see Appendix B)

- B5 Sheltering-in-Place Checklist
- B6 Record of Memoranda of Agreement and Qualified Service Organization Agreements
- B7 Incident Command System Positions

Once the behavioral health treatment program's disaster planning team has been organized, oriented itself to its tasks, forged connections with community planning partners, and reviewed risk assessments (Chapter 2), it can progress to the next important preparedness activities. This chapter provides guidance on risk mitigation, readiness support to clients and staff, and other advance planning issues.

Mitigate Risk

The disaster planning team can help its program avoid discontinuation of essential services by working with management to prepare the program and its facilities in ways that will lessen the impact of a disaster when it does occur. Such actions are referred to as *mitigation*. These actions are guided by the program's hazard identification and risk assessment (see Chapter 2). Mitigation examples include the following:

- Making changes to the building and grounds to improve the facility's capacity to withstand a disaster. Examples: Secure shelves and appliances to wall studs to prevent them from falling if earthquake is a likely hazard. Clear the facility's outdoor property of flammable material and debris if wildfire is a risk.
- Preparing to shelter-in-place for disasters in which it would be either impossible or unsafe for staff and clients to evacuate. Examples: Identify and prepare a safe room in the basement or interior of the building for sheltering from tornado. Ensure that the space is sufficient to house the average number of people (clients, staff members, and visitors) on the premises at any one time. (See **Worksheet B5** in Appendix B.)
- Planning for building evacuation. Examples: Stock evacuation chairs or slings and other equipment to enable swift removal of people who need assistance. Train staff in the use of this equipment.
- Stocking supplies. Example: Store cots, linens, and nonperishable food items for emergencies during which staff members must stay overnight.

- Preparing staff and clients onsite for personal disaster response. Example: Stock portable bags (*personal go kits*), one per person at the facility, that include emergency evacuation supplies (e.g., water bottle, flashlight with batteries) (Exhibit 3-1).

To limit as much as possible the extent to which staff members are affected by any disaster that occurs, the treatment program's disaster planning team can identify ways to support staff in home disaster planning. Staff can be directed to Federal guidance for the disaster readiness of individuals and families (e.g., preparing a family emergency supply kit, developing a family emergency plan for evacuation and for staying in contact, and becoming familiar with appropriate actions to take during an emergency).

Exhibit 3-2 demonstrates the importance of preventive action to lessen the impact of a disaster, and Exhibit 3-3 contains examples of mitigation specific to behavioral health treatment programs.

Negotiate Memoranda of Agreement

In the context of disaster preparedness, a *Memorandum of Agreement* (MOA; also called a *Memorandum of Understanding,* or MOU), is a document that defines how one party will assist another on request. When the agreement is bilateral or multilateral, the document may be referred to as a *mutual aid agreement*. MOA can be arranged among all programs within a county or State, and they can be arranged State-to-State, to plan for disasters with wide geographic impact. The optimal situation is to have written agreements prepared in advance and reviewed by all parties, either annually or when relevant circumstances change (Exhibit 3-4). If needed, they can be arranged after the fact (Exhibit 3-5).

Examples of issues that might be covered in an MOA include the following:

- Arrangements for use of alternate facilities

Exhibit 3-1. Welcome Bags and Personal Go Kits

Our team has created welcome bags for our residential intake clientele that contain toiletries as well as comfort items such as a blanket, a journal, a deck of cards, a novel or book of meditation, a portable media player, scented candles, and so forth. We also put clothing (sweat suits and t-shirts—sized at admission) into the welcome bags of patients who are emergency intakes and have not had time to prepare for admission. We prepare 20–30 welcome bags at a time so that we always have an adequate inventory and try to have 10 for each gender on hand at all times. The welcome bags are backpacks with designated ID tags and space for storage of medication should the need arise for evacuation. We also store about 40 smaller emergency go kits in the same location. These contain potable water, high-energy food bars, and other foods with long shelf life, such as dehydrated fruits. The go kits are stored near the welcome bags to be placed in the backpacks or provided to staff as needed.

Source: Michael Lynde, personal communication, April 26, 2010.

Exhibit 3-2. Preparing for Power Failure

An inpatient behavioral health treatment program in the State of Washington had court-ordered individuals among its patients. To allow someone to exit through the facility's doors, a code had to be entered into an electronic keypad. When the power failed, the doors automatically unlocked—to the surprise of the program's administrators—and some of the court-ordered patients nearly escaped. Although the facility had a generator, the electronic keypads were not connected to it. After this incident, the facility's staff connected the electronic door system to the generator and instituted a policy of regular testing.

Source: Michelle McDaniel, personal communication, August 14, 2009.

- Agreements to provide essential services on a temporary basis to another program's clients when needed
- Agreements to support computer system needs in a move to an alternate location

Exhibit 3-3. Examples of Disaster Mitigation Specific to a Behavioral Health Treatment Program

- Store medications in a safe, locked area that can be protected from the most probable hazards. For example, programs in flood-prone areas can store medications above ground level, whereas programs that are in earthquake-prone areas can store medications in cabinets that are secured to an interior wall.
- Maintain a 3-day supply of water, food, linens, garbage bags, sanitation products, and other provisions to sustain the maximum number of people who may be on the premises at any one time. This includes clients, staff members, volunteers, and visitors. The supply should include provisions particular to people who may be on the premises and who are defined as at-risk (U.S. Department of Health and Human Services, 2012) (e.g., children, senior citizens, pregnant women, those with chronic medical disorders, those with pharmacological dependency) as well as provisions for any pets or service animals on the premises. Keep an inventory of these supplies, and check the expiration dates as necessary to ensure their safety and effectiveness.
- Keep coolers onsite for use when transferring refrigerated medications in an evacuation.
- Ensure that electricity-dependent systems, such as security alarms or water pumps, have battery backups or are connected to generators that automatically launch if power is lost.
- Ensure and test all means of exit from buildings, such as elevators and stairwells, that may be affected by power outages.

Exhibit 3-4. Negotiation for Assistance in Hurricane Season

During hurricane season in South Florida, small behavioral health treatment programs in vulnerable areas, such as the Keys, have evacuation and transfer agreements with larger programs located in metropolitan areas. Programs evaluate the necessity of evacuating and transferring clients based on advisory information from local and State officials and from the National Hurricane Center, which provides information on a continuous basis about the patterns and severity of an approaching hurricane. Evacuation and transfer agreements are ongoing and include plans for client continuity of care. Most of the programs' agreements also include plans for the relocation and transfer of the staff members who will provide needed services to clients. The objective is to conduct evacuation and transfer at least 24 hours before the predicted landfall of an approaching hurricane.

Source: John Lowe, personal communication, January 8, 2009.

Exhibit 3-5. Negotiation for Mutual Aid Following a Major Snowfall

In winter 2009, the State of Washington experienced an unexpected heavy snowfall—more than 5 feet of snow fell within a month in some areas. As temperatures rose and snow melted, flood risk increased. An opioid treatment program (OTP) administrator became concerned that her facility might have to close temporarily. She contacted an OTP in neighboring King County to arrange for guest dosing of her program's methadone patients. This neighboring OTP was a party to a mutual aid agreement (arranged under the auspices of the King County Healthcare Coalition) that described the terms under which King County OTPs would provide guest dosing services to one another. The King County OTP used this mutual aid agreement as a template for a new agreement between itself and the OTP located outside King County that was at risk of flooding. Fortunately, the patient transfer was not needed, and the two OTPs now have an agreement in place for future use.

Source: Michelle McDaniel, personal communication, August 5, 2009.

- Provision of evacuation transportation assistance
- Lending or borrowing personnel to temporarily fill key staffing gaps (Exhibit 3-6)
- Payment arrangements for any of the above

Other details that typically are covered in a mutual aid agreement include the roles and the scope of responsibilities of each party; procedures for requesting, providing, and ending aid; procedures for reimbursement and allocating costs between the parties to the agreement; and communications compatibility issues (e.g., for running client record software on another program's hardware systems; see Ensure Interoperable Communications, in Chapter 4). Other topics a mutual aid agreement might cover include mechanisms for invoking and revoking the agreement and liability and immunity issues (National Fire Protection Association, 2007).

The mutual aid agreement between behavioral health treatment programs may also cover procedures to be used to ensure client privacy and confidentiality (e.g., as mandated by 42 Code of Federal Regulations [CFR] Part 2 [Confidentiality of Alcohol and Drug Abuse Patient Records]; the Health Insurance Portability and Accountability Act, which establishes privacy rules for the protection of health and mental health information; the Health Information Technology for Economic and Clinical Health Act; any applicable State privacy regulations).

Organizations with which information about clients in substance abuse treatment may be exchanged in a disaster, but that are *not* providers of substance abuse treatment services, should be asked to sign a qualified service organization agreement (QSOA), as required under 42 CFR Part 2. Such organizations may include voluntary organizations, local emergency responder organizations, and alternate service providers (e.g., drug testing providers).

Appendix F includes a sample MOA used by OTPs in King County, WA. Other programs can use it as a template or can adapt it, as needed. **Worksheet B6** (in Appendix B) can be used to create a record of all completed agreements. The disaster planning team can consult with its State disaster behavioral health coordinator for advice on drawing up an MOA, including mutual aid agreements and QSOAs. Because of the legal implications, programs are advised to consult an attorney when negotiating such agreements.

Exhibit 3-6. Staff Issues To Consider in Mutual Aid Agreements

Agreements to provide mutual aid for staffing assistance may be helpful, but the ramifications of such efforts are best explored in detail long before any disaster occurs. An administrator at a program that experienced an influx of displaced clients after Hurricane Katrina felt that having more staff members would not have helped. He explained, "We have a limit of space, and we knew what would have to be done . . . . If you weren't already working here and [didn't know] what needed to be done, you'd have to be trained and we didn't have time to train."

An administrator at another program affected by the hurricane was part of a network of clinics and requested staff assistance from an affiliate. The greatest challenge, he reported, was finding housing for the guest workers. Three people stayed with the administrator and his family at their small home, and others stayed with another staff member. "We put them in our own houses and fed them and brought them to work with us. It was a very difficult time." Similar challenges occurred at other programs. One provider, for more than a month, housed several medical volunteers in a motorhome parked outside his house.

Source: Podus et al. (no date).

The Emergency Management Assistance Compact (EMAC) is a national disaster relief compact that facilitates the transfer (within or across States) of personnel, equipment, commodities, and services to affected localities. All 50 States, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands are EMAC members. Liability, cost responsibilities, credentialing, licensing, and certification issues are resolved in advance through the EMAC compact. In a disaster, the behavioral health treatment program would route or receive resource requests through the State emergency management agency. Information on EMAC is available at http://www.emacweb.org.

Designate Personnel To Assume Command for Incident Response

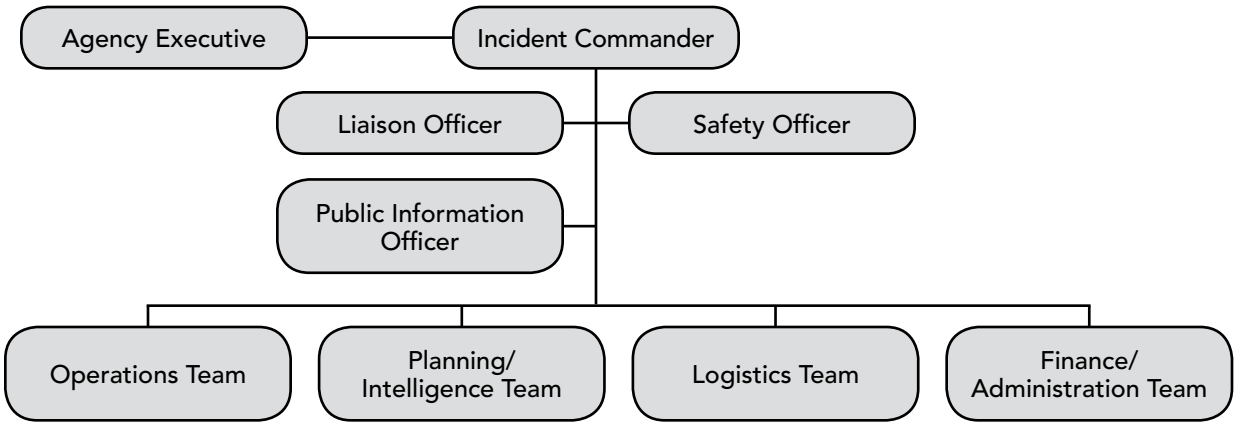
Federal guidelines for disaster planning suggest that organizations follow a management approach called the Incident Command System (ICS; Federal Emergency Management Agency [FEMA], 2007b), which allows for flexible, appropriate response to any kind and size of incident and which provides common terminology for use by all responders so that they clearly communicate with each other. As part of the ICS, each organization names its leaders for disaster response who, in a large-scale incident, can readily integrate into the hierarchy of the whole community's disaster response leadership.

In the ICS hierarchy, the leader of an organization is referred to as the *Agency Executive*. When a disaster occurs and the behavioral health treatment program's Agency Executive activates its disaster plan, he or she appoints an *Incident Commander*. Typically, the Agency Executive delegates the Incident Commander role; however, in some circumstances the Agency Executive may double as Incident Commander, for example, if the program has a small staff or if the effects of the disaster are relatively limited.

During the disaster and in its aftermath, the Agency Executive focuses on the organization's essential functions, while the Incident Commander takes charge of disaster response. The latter independently manages response activities (e.g., evacuating the premises, coordinating with rescue workers, assessing damage, arranging for temporary quarters and coordinating transportation to that site, contracting for supplies or repairs) and periodically communicates incident status to the Agency Executive.

Disaster planning teams are encouraged to assign other incident response positions in accordance with ICS (FEMA, 2007b). The ICS structure is illustrated in Exhibit 3-7.

Exhibit 3-7. Incident Command System



Source: FEMA (2007b).

The position of Incident Commander is the only one that must be filled when the disaster plan is activated (FEMA, 2007b). If the incident is small in scope or short lived, the Incident Commander may choose to retain all responsibility for disaster response. If the incident is larger or expanding, the Incident Commander may assign duties to other command officers, if they have been appointed (e.g., Liaison, Public Information, Safety).

The disaster planning team should designate one or more backups for each ICS position in case the primary designee is unavailable when a disaster occurs or needs to be relieved during the disaster response. Large programs operating in a disaster with significant impact may also organize teams for response, as recommended for an ICS (Operations, Planning/Intelligence, Logistics, and Finance/Administration).

For the behavioral health treatment program, an advantage of organizing personnel into an ICS is that the unambiguous hierarchy provides for effective management and accountability. The size of the responding group can be changed, depending on immediate needs and the scope and duration of the incident. Another advantage is that personnel can be readily integrated into the teams of other organizations involved in disaster response.

External response groups (e.g., those headed by a county emergency manager or fire department) will be organized using the ICS structure. For example, the Operations Team of an external response group might be responsible for conducting search and rescue or fire suppression. The behavioral health treatment program's key personnel should be familiar with the names and functions of ICS positions, in case they are called on to interact with external response groups that are organized in this manner.

To clarify how ICS works, a hypothetical example is presented in Exhibit 3-8. **Worksheet B7** (in Appendix B) can be used to assign staff members to ICS positions.

> Online courses on ICS, offered through the Independent Study Program of the Emergency Management Institute, FEMA, can be accessed at http://training.fema.gov/IS.

Prepare Clients for a Disaster

Psychological distress, severe depression, somatic symptoms, posttraumatic stress disorder (PTSD), and changes in the amount and type of substance use—these are some of the reactions individuals may have during or following disaster. Program clients will vary in their resilience, depending on many interacting factors, including an individual's social supports, previous experience with trauma, preexisting medical and behavioral health status, gender, ethnicity, and socioeconomic status (Cepeda, Saint Onge, Kaplan, & Valdez, 2010; Cepeda, Valdez, Kaplan, & Hill, 2010; Cerdá, Tracy, & Galea, 2011; Laditka, Murray, & Laditka, 2010; Picou & Hudson, 2010; Rhodes et al., 2010; Zwiebach, Rhodes, & Roemer, 2010). People with health issues may respond more slowly in disaster situations and may be unable to respond adequately, placing them at greater risk. They also may be more susceptible to disaster effects (e.g., extreme weather conditions or limited food and water supplies) (Bethel, Foreman, & Burke, 2011). Young people are at particular risk for negative mental health effects subsequent to disaster (Mace et al., 2010b; Murray, 2010).

Specific disaster-related factors (e.g., the impact in terms of injury, loss, or displacement; the passage of time since the disaster) will influence the behavioral health issue that predominates among a program's clientele. For example, the predominant behavioral health issue for 182 survivors of the Oklahoma City bombing 6 months after the incident was symptoms of PTSD; for 421 evacuees 2 weeks after Hurricane Katrina, the issues were preexisting, chronic mental and substance use disorders (North, 2010).

Even though resilience and need after a disaster will vary and cannot be fully predicted,

all clients can benefit from preparation. People are more intentional about preparing for disaster when they consider the basic service interruptions that could occur (Martel & Mueller, 2011). For this reason, programs should be explicit in describing how a disaster can affect the community at large (e.g., electrical outages, interruptions in water service) and the behavioral health treatment program specifically (e.g., closures, reductions in services, services provided at an alternate facility). Programs can educate clients about what to do to take care of their own needs to the extent possible in a disaster (see Emergency Planning for Staff and Clients, in Appendix D).

Disaster preparedness resources for individuals and families are available from the National Child Traumatic Stress Network. These include family preparedness tips and family preparedness wallet cards (for recording emergency contact information) in English and several other languages. They can be accessed at http://www.nctsn.org/resources/public-awareness/national-preparedness-month#q3.

Exhibit 3-8. Hypothetical Example of an ICS in Action

An earthquake occurs at 1 a.m., damaging a two-story residential treatment center located on a major urban thoroughfare. The senior person on staff is the night shift clinical nurse supervisor. Both the executive director and security officer are at home when the earthquake occurs, and, because of highway damage, getting to the facility is difficult. Phone and Internet systems are out of service where the treatment program is located.

The clinical nurse supervisor is aware that although he is third in line to fill the Incident Commander role (behind the executive director and security officer), he must assume the role because the other two persons are not onsite. As Incident Commander, he assigns the two custodians on duty to assess the condition of the building and report back. They report structural damage, so the Incident Commander orders an evacuation of the building to a safe location—a city park two blocks away.

The Incident Commander assigns the role of Safety Officer to a nurse on duty. Using staff and patient rosters, the Safety Officer makes sure that everyone leaves the building safely. As the patient roster indicates, two patients on the upper floor have physical disabilities and cannot use the stairs. It is inadvisable to use an elevator after an earthquake, so the Incident Commander organizes staff members to evacuate those patients using evacuation slings. Before permitting this evacuation to proceed, the Safety Officer ensures that the evacuation slings are in good condition; that staff members are trained, licensed, and physically able to use the slings; and that the evacuation route is safe.

Shortly thereafter, a fire breaks out on the block, and several fire trucks and ambulances arrive. The head of the fire squad assumes the role of Incident Commander for the fire incident. The treatment program's clinical nurse supervisor maintains the role of Incident Commander for the residential treatment center and takes on the role of Liaison Officer to coordinate with the emergency responders. He provides the fire squad's Liaison Officer with information about the patients under his care, including confirmation that the building was evacuated and that the residents have been congregated in a safe location outside the fire zone.

The treatment program's security officer arrives an hour later, and, after being briefed, she assumes the Incident Commander role from the clinical nurse supervisor. She directs the clinical nurse supervisor to retain the role of Liaison Officer, because communication between the treatment center and the fire department continues to be important.

Based on plans established earlier, the Incident Commander manages the treatment program's disaster response. She immediately arranges for patients to be moved to a residential center unaffected by the earthquake and coordinates the reassignment of staff to the temporary location and the notification of families with updated information and the status of their family members. The next day, conferring with the executive director (the Agency Executive, in ICS parlance), she sets in motion the inspections and repairs needed to restore onsite clinical services.

All clients need to know how they will be informed if the program is closed or has changed its hours of operation and what they should do if the program closes or is providing services in another location. They also need to know what they should do if they cannot access prevention, treatment, or recovery services for several days or if they begin to experience a physical or behavioral health crisis. The program can consider issuing clients maps that contain directions to the facility using different routes and modes of transportation. The map also can indicate routes to the alternate care facility clients are advised to use if the program is closed (based on a previously developed MOA). Maps should be in an accessible format for the client population (e.g., in large type, in Braille, in languages other than English that are prevalent in the community), and they should contain street address, phone, email, and Web site information.

Clients can be informed of the items they should bring to an alternate site. These may include the name of their home behavioral health treatment program and treating physician, an ID card issued by the program or other form of personal photo ID (e.g., a driver's license), and medications and dosage information (see Chapter 5).

Ideally, the program discusses with clients the need for disaster preparedness at intake and at regular intervals during their treatment involvement (e.g., by reviewing procedures at the start of each hurricane season). Counselors can provide clients with instructions for self-care related to their behavioral health disorder treatment (on a laminated wallet-sized card, for example). They also can direct clients to disaster preparedness planning information for individuals and families. The program can prepare in advance a recorded phone message, to be used in a disaster situation, providing instructions to clients on what to do if the program is closed. These emergency instructions also can be readied for posting on the facility's front door and to social media Web pages.

Members of a client's support network (e.g., family, partner) also need to be provided with emergency instructions and should be informed as soon as possible of unexpected discharge, evacuation, or relocation. To the extent possible, any evacuations or relocations should be coordinated with the client's support network so that the client can be accompanied. Individuals to be contacted in an emergency should be listed in the client's records, and appropriate authorizations/releases should be in place.

Programs can help clients prepare an emergency health information card, which lists the client's special needs and provides guidance to emergency responders on appropriate methods for assisting the person, communicating with the person, and interpreting the person's behavior. The card allows for fast communication of pertinent information to rescuers and personnel working evacuation and shelter sites.

> The Independent Living Resource Center of San Francisco's Web site contains a series of tip sheets on emergency preparedness for people with disabilities. These tip sheets can be accessed through their publications page at http://www.ilrcsf.org/access-resources/publications/.

Obtain Client Locator Information

After a disaster, clients may be dispersed from their regular residences and surroundings. The program's efforts to locate clients after a disaster, and to reengage them in services, can be facilitated by collecting sufficient contact information at intake. The disaster planning team can work with staff responsible for the program's intake form to ensure that sufficient emergency contact information is collected and regularly updated.

Ideally, the intake form requests the following: client contact information (e.g., address, landline, cell phone, email, social

networking Web sites); emergency contact information for one or more relatives, friends, or professionals with whom the client interacts (e.g., employer, probation officer, mutual-help group sponsor); and an out-of-area point of contact. Locations that the client frequents can be noted on the form, if this information is available. A physical description or photo of the client also can be helpful. The form should have a place for the client's signature indicating that release of the information is permitted for purposes of tracking the client for reengagement. Counselors should explain the intent behind the form. This discussion can be used as an opportunity for introducing the topic of disaster preparedness.

Client locator forms are used by researchers to find subjects from a study for follow-up interviews. Such forms can be used as models by the behavioral health treatment program wanting to supplement its intake form with enough information to find clients who may be displaced in a disaster situation. An example of a client locator form is provided in *Staying in Touch: A Fieldwork Manual of Tracking Procedures for Locating Substance Abusers in Follow-up Studies*, published by the University of California, Los Angeles Integrated Substance Abuse Programs. The manual can be found at http://www.uclaisap.org/trackingmanual/manual/Tracking-Manual.pdf.

Encourage Staff To Make Plans for Personal Preparedness

Staff members should be strongly encouraged to develop emergency plans for their own households. Having personal plans in place has personal benefits for staff members and their families and increases the likelihood that they will be available to respond to their professional duties.

Information on personal preparedness is available at a FEMA-sponsored Web site, http://www.ready.gov.

The American Red Cross has developed a series of mobile apps that provide users with real-time information on what to do before, during, and after emergencies. They are available at http://www.redcross.org//prepare/mobile-apps.

Prepare Staff for Supporting Clients in Disaster

The disaster planning team can arrange for staff trainings that address disaster-related behavioral health topics (e.g., recognizing symptoms of psychological trauma in clients, referring such clients to psychological first aid services provided in the community, supporting clients' coping skills, conducting trauma-informed therapy). Training may be valuable not only for direct service staff members, but also for administrative staff members, particularly those who answer phones or greet clients at the entrance. An ideal approach is to provide live, in-person disaster training, in which the trainers can focus on the roles of the participants and how disaster may affect their jobs. Live training also allows for discussion of topics that are of particular concern to staff. Live training can be supplemented by further online training as appropriate (such as for yearly refresher training).

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Disaster Behavioral Health Information Series provides themed resource collections and toolkits pertinent to the disaster behavioral health field on topics such as psychological first aid, resilience, and stress management. They are available at http://www.samhsa.gov/dtac/dbhis/.

Exhibit 3-9 provides psychological first aid recommendations for first responders (emergency and disaster response workers). These recommendations may be shared with behavioral health treatment program staff members so that they are sensitive in their initial contacts with clients after a disaster.

Programs may wish to provide training to clients to support peers in disaster preparedness and in coping after disaster. Some programs already use peer professionals as part of their staff. Having these individuals trained as members of the disaster response team, or available to assist other staff in working with clients under disaster conditions, provides an additional resource for the program.

Exhibit 3-9. Psychological First Aid

Promote Safety:

- Help people obtain emergency medical attention.
- Help people meet basic needs for food and shelter.
- Provide repeated, simple, and accurate information on how to meet these basic needs.

Promote Calm:

- Listen to people who wish to share their stories and emotions; remember that there is no right or wrong way to feel.
- Be friendly and compassionate even if people are being difficult.
- Offer accurate information about the disaster or trauma, and the relief efforts underway, to help victims understand the situation.

Promote Connectedness:

- Help people contact friends and loved ones.
- Keep families together. Keep children with parents or other close relatives whenever possible.

Promote Self-Efficacy:

- Give practical suggestions that steer people toward helping themselves.
- Engage people in meeting their own needs.

Promote Help:

- Find out the types and locations of government and nongovernment services and direct people to those services that are available.
- When they express fear or worry, remind people (if you know) that more help and services are on the way.

Do Not:

- Force people to share their stories with you, especially very personal details.
- Give simple reassurances like "everything will be okay" or "at least you survived."
- Tell people what you think they should be feeling or thinking or how they should have acted earlier.
- Tell people why you think they have suffered by alluding to victims' personal behaviors or beliefs.
- Make promises that may not be kept.
- Criticize existing services or relief activities in front of people in need of these services.

Excerpted and adapted from SAMHSA (2005).

Information on training individuals with behavioral health disorders to provide peer support in and after a disaster is available from After the Crisis, a collaborative initiative between the National GAINS Center and the National Center for Trauma Informed Care and supported in part by SAMHSA. Information is available at http://gainscenter.samhsa.gov/atc.

Staff may need to be prepared to give extra support to certain groups of clients. These groups, and the support that can be provided to them, are detailed in the following paragraphs.

Clients With Cognitive or Intellectual Disabilities

Disaster preparedness education may need to be simplified, provided through multiple means, and repeated frequently. Clients may need individual support when being unexpectedly discharged, evacuated, or transferred. Counselors also may need to work with surrogate decisionmakers (e.g., a client's parent, other family member, guardian) to plan and prepare clients for disasters. The program can recommend clients with cognitive or intellectual disabilities for priority disaster case management by organizations that provide that service (see Prepare To Connect Clients to Disaster Case Management, below).

Clients With Mobility Issues

Clients may need special help and assistive devices during building evacuation and relocation, especially if the program is located on upper floors of a building. Such clients should be informed in advance of the evacuation methods that will be used to help them exit the premises (e.g., the use of wheelchairs, gurneys, evacuation slings, two-person hand carrying). Regular safety-related drills (e.g., for response to fire, bomb threat, chemical hazard; loading people in wheelchairs onto buses) provide opportunities for clients and staff to become familiar with any special evacuation plans and methods. Such drills are required by all licensing and credentialing bodies. Though staff (and clients) may find them inconvenient, they are important practice for evacuation in an emergency, and especially for safe and efficient evacuation of clients with mobility issues.

Clients With Limited Literacy, Limited English-Language Proficiency, or Cultural Differences

Disaster-related messages (e.g., evacuation instructions, phone and Web site messages about facility closures, instructions to clients on accessing treatment during a disaster) should be tested with clients who have limited reading ability. Messages should be provided in the client's primary language, if possible, and in a manner appropriate to the client's culture. Program staff should be instructed not to assume that clients are literate and can follow written directions. Key messages should be presented orally and frequently. The disaster planning team may wish to consult with community members who have expertise in the cultural attitudes and languages of clients to ensure that disaster planning concepts and instructions are effectively communicated. Interpreters can be included in disaster planning and exercises. Disaster-related communications with clients may be enhanced when staff members have received training in cultural competency. Exhibit 3-10 illustrates the challenges in disaster preparation for clients with limited English proficiency.

Developing Cultural Competence in Disaster Mental Health Programs is a SAMHSA-published guide that can help States and communities plan, design, and implement culturally competent disaster mental health services for survivors of natural and human-caused disasters of all scales. The guide is one component of the SAMHSA Disaster Kit, which includes a range of materials for disaster recovery workers. Other items in the kit include brochures for distribution to the general public and guidance on dealing with the stress of disaster response. The kit can be ordered or downloaded from SAMHSA at http://store.samhsa.gov/product/SMA11-DISASTER.

Exhibit 3-10. Challenges in Disaster Preparedness for Clients With Limited English Proficiency

Shiu-Thornton, Balabis, Senturia, Tamayo, and Oberle (2007) studied disaster preparedness for clients with limited English proficiency by interviewing 38 medical interpreters representing 30 languages. The researchers found that few interpreters had training in disaster preparedness or direct experience with interpreting in disaster situations. Furthermore, many cultural groups do not discuss the potential for disasters or engage in discussions concerning disaster preparedness, and some cultural groups have beliefs that are dissonant with the concept of preparedness. Disaster may be a taboo topic, group members may believe that events are predestined or in the hands of fate, or they may believe that the United States is a safe haven where disasters do not occur.

Clients Who Are at Risk of Acute Episodes of Psychiatric Illness

A *psychiatric advance directive* (PAD) may provide some measure of protection for clients who could become destabilized in a disaster. A PAD is a legal document, accepted in most States, through which an individual can indicate preferences and instructions for treatment of behavioral health disorders at times when he or she is not competent to express his or her own wishes. Through a PAD, individuals can assign power of attorney to the person of their choice to make decisions about care when they themselves are incapacitated. PADs can include instructions on refusal or consent regarding hospital admission, particular medications, and treatments. PADs also can contain other important information, such as guidance about the type of care that could help the individual avoid hospitalization (or, if hospitalization is needed, accommodate to it). A PAD is used to guide healthcare decisions only when an authority (one or more physicians or a judge, depending on the State) determines that the individual lacks capacity to make decisions. Treatment program counselors can assist clients in understanding PADs and drafting PADs that are accepted in their respective State. They also can assist clients in distributing copies of their PADs to their treatment program, medical doctor, local hospital (for filing in their medical records or inclusion in their electronic health record), and reliable friends or family members. Clients also can be advised to keep a copy on their person when relocating in disaster.

The National Resource Center on Psychiatric Advance Directives provides information about PADs. How-to instructions, State requirements, and other forms can be downloaded from http://www.nrc-pad.org.

Children and Youth

Young people's positive coping can be promoted by sharing age-appropriate information about disasters, before they occur (Murray, 2010). The information can include what to expect before, during, and after a disaster incident. The opportunity to ask questions is also important. Families of young clients can be encouraged to develop a family response plan, to include younger family members in making preparations (e.g., in assembling the family's go kit), and to periodically review and discuss their response plan with family members. Parents and caregivers of children and youth can be directed to resources that will help them develop a family response plan and prepare their young family members (see Emergency Planning for Staff and Clients, in Appendix D).

As previously stated, any evacuations or relocations should be coordinated with the client's support network so that families and significant others become aware of these plans and have a way to contact the client once they are relocated. To the

extent possible, family members should be kept continuously informed of changing circumstances. Young people in residential treatment, along with their families, may need extra help with any transitions of care to alternate providers or locations, to reunite as needed, and to handle the psychological effects of the disaster. Efforts should be made to provide youth-oriented treatment services and supports at any new location (e.g., separate group meetings for youth and connecting relocated young clients with clinicians who have training and experience working with that age population). Youth may need assistance transitioning to a new school if the disaster has forced a transfer, and they may need activities to keep them safely occupied if schools are closed. Despite changed conditions, effort should be made to promote an atmosphere of normalcy (Mace et al., 2010a).

Pregnant Clients or Clients With Dependents

Pregnant clients will need to be closely monitored to ensure that they can maintain a healthy pregnancy despite disaster conditions; they may need extra counseling on disaster-related medical treatment that best protects them and their fetuses (see also Exhibit 6-1, Pregnant Women at Special Risk From Influenza, in Chapter 6). Patients who have children with them in residential treatment and who are relocated will need to be transferred to like facilities that enable the children to stay with them. The facilities will need to be ones that can provide a safe and secure environment for those children, with access to child care or schools as appropriate. Some clients may be unwilling to disclose their behavioral health disorder treatment needs to care providers at a new location for fear of losing custody. These clients need to be educated in advance about how to advocate for their needs without risking custody.

Clients Who Are Experiencing Homelessness

People who do not have a residence are less able to prepare for emergency (e.g., stockpile supplies, identify a safe part of a house in which to shelter). In addition, people without a home may have limited access to electronic means of communication (e.g., TV, radio, Internet) and thus may be slower to learn about emergency warnings and calls for evacuation. Furthermore, for a variety of reasons, people who do not have a home may have difficulty or concerns about entering shelters, and they also may have more difficulty transitioning out of shelters, especially if the locations where they formerly took refuge (such as an encampment) are no longer habitable (Edgington, 2009). Behavioral health treatment programs can support clients known to be experiencing homelessness by making sure they receive disaster planning education and aids (e.g., emergency kits, emergency health information cards). In addition, the program can request that its outreach workers be included in the local community's emergency notification systems so that they can be mobilized in a timely manner to communicate emergency situations to clients who are experiencing homelessness. The program also can recommend clients who are experiencing homelessness for priority disaster case management by organizations that provide that service (see Prepare To Connect Clients to Disaster Case Management, below).

Older Clients

Factors that can cause some older clients to be particularly vulnerable in disaster include physical frailty, chronic illness, cognitive impairment (including impaired capacity to make decisions and execute tasks), mobility and sensory issues, reliance on devices such as hearing aids and glasses, limited transportation options, and susceptibility to exploitation and abuse (Cloyd & Dyer, 2010). Other age-related factors that may interfere with clients obtaining necessary aid include a preference for self-reliance,

difficulties navigating bureaucratic recovery systems (especially those that require online applications and other computer-related tasks), and concerns about loss of entitlements. Among older adults, disaster response may manifest itself in physical rather than psychological distress (Sakauye et al., 2009). Staff training on the particular needs of older clients, as well as coordination with community services for older adults, can facilitate support to this client population in disaster.

Clients on Medications

Assisting clients who are on prescription medications is covered in Chapter 5.

Prepare To Connect Clients to Disaster Case Management

People affected by disaster often face a "challenging service labyrinth" as they seek to recover housing and other resources (Stough et al., 2010). The process can be especially complex and difficult for people with psychiatric disabilities who, in past disasters, have faced discrimination with regard to evacuation, emergency shelters, and relief services (National Council on Disability, 2006).

Some jurisdictions have plans in place for providing citizens with disaster case management (i.e., personal assistance in navigating recovery services). In an event that is declared a major disaster by the President of the United States and that meets other criteria, the Federal Disaster Case Management (DCM) Program may rapidly allocate funding for disaster case management assistance to disaster survivors. Funds are administered by the Administration for Children and Families, U.S. Department of Health and Human Services, and the case management services are offered via existing State, local, and voluntary programs (Lavin & Menifee, 2009). "Mental health issues" and "medication management" are specifically cited by the DCM Program's guidelines as among the needs that can be addressed by disaster case management services.

A representative of the behavioral health treatment program's disaster planning team can contact the local office of emergency management to determine whether the community has a disaster case management program equipped to provide services to clients with behavioral health issues and, if so, how to refer clients to it. In addition, the program can seek to work with Voluntary Organizations Active in Disaster (VOADs) whose case managers have expertise with the issues of its clientele (e.g., issues related to disabilities or mental or substance use disorders).

The disaster planning team may want to work with its program's management to train counselors in providing disaster-specific case management and to develop a list of community resources to which counselors can refer clients for disaster recovery support. Alternatively, the team can work with program management to develop policies for identifying and prioritizing clients for referral to disaster case management, if such services will be available from other community providers.

Ensure Counselor Access to Shelters

During Hurricane Katrina, situations occurred in which professional counselors and members of mutual-help groups (e.g., Narcotics Anonymous, Alcoholics Anonymous) were prohibited from entering shelters to assist evacuees in need of behavioral health treatment services (SAMHSA, 2009). As a result, Federal guidelines for emergency shelters now call for the inclusion in planning of people with mental health expertise as well as input from people with disabilities, access issues, or other functional needs (FEMA, 2010b).

The disaster planning team leader can work to arrange for the program's counselors and recovery advocates to participate in local shelter planning and to become credentialed for shelter staffing. The disaster planning team also can encourage program staff members and community recovery advocates to take the advanced training and obtain the credentialing that would allow them inside shelters and at evacuation departure and receiving sites. A working relationship with the American Red Cross and other VOADs, through the community's emergency planning committee, can facilitate these arrangements (see Chapter 2).

Prepare for Financial Resiliency

A study of 15 substance abuse treatment programs affected by the September 11, 2001, attacks in New York City found that several programs experienced financial losses following the disaster (Dewart, Frank, Schmeidler, Robertson, & Demirjian, 2003). Outpatient programs were particularly affected because of declines in client attendance and retention. Of the 15 programs surveyed, the 3 that closed on the day of the attacks and in the days afterward were outpatient treatment programs (not OTPs). Fewer financial problems were experienced by programs with substantial numbers of clients on Medicaid or clients able to access emergency Medicaid. Programs that provided outpatient counseling by telephone as a substitute for in-person sessions had mixed results in obtaining insurance reimbursement.

This experience suggests that behavioral health treatment programs should consider how they can support client retention through active outreach following a disaster. Program staff members should become informed about procedures for enrolling clients in Medicaid under emergency conditions, and they should educate payers about modified counseling services (e.g., telephone or Web-based counseling) that may be instituted in disaster situations; this may help facilitate reimbursement. Management can establish a contingency or reserve fund or a line of credit for unexpected cash flow issues (e.g., maintaining payroll for staff when billing is disrupted).

Programs also can make plans for persevering through a period of low revenue following a disaster (e.g., planning ahead for emergency grant proposal writing, temporary modification of fees, intensive marketing and outreach, expansion into community disaster-specific behavioral health response and support activities, careful tracking and documentation of services provided during the disaster so that reimbursements are facilitated).

Chapter 4—Continuity Planning

In This Chapter

- Identify Essential Functions
- Identify Essential Staff
- Provide for Continuity of Leadership
- Arrange for Alternate Facilities
- Ensure Interoperable Communications
- Protect Vital Records and Databases
- Develop Resources To Manage Human Capital

Worksheets (see Appendix B)

- B8 Identify Essential Functions
- B9 Identify Essential Staff Positions
- B10 Essential Staff Roster
- B11 Checklist for Continuity Planning
- B12 Requirements for Alternate Facilities
- B13 Alternate Facility Arrangements by Disaster Scenario
- B14 Checklist for Relocation Planning
- B15 Checklist for Maintaining Communications With Essential Groups
- B16 Checklist of Records and Databases To Ensure Interoperable Communications
- B17 Checklist for Protecting Records and Databases
- B18 Checklist for Managing Human Capital

This chapter addresses the tasks required to ensure business continuity, commonly referred to as *continuity of operations planning* or *COOP planning*. A continuity plan can be included as a functional annex to the basic plan. Chapter 5 provides additional guidance on continuity planning for programs that manage prescription medications for treatment of behavioral health disorders.

Identify Essential Functions

To identify the program's essential functions, the disaster planning team first works with management to inventory all functions performed at the facility. From this comprehensive list, the team and management work together to identify those functions that are essential because they provide vital services to clients; are required by regulation or law; are required to maintain onsite safety for clients, family members, and staff members; or are necessary for the performance of other essential functions (Federal Emergency Management Agency [FEMA], 2004).

These essential functions should be prioritized by potential consequences if the function is not performed or is delayed. Exhibit 4-1 provides examples of what a program might decide are its essential and nonessential functions. (Note: Each program makes its own determinations of what is essential.) **Worksheet B8** (in Appendix B) can be used to help identify essential functions.

Exhibits 4-2 and 4-3 provide examples of programs that worked to continue essential operations during winter storms.

Identify Essential Staff

Once essential functions have been identified, the disaster planning team continues to work with program management to identify the staff positions required to perform those essential functions. The team and management also work together to identify the specific individuals who can serve in

Exhibit 4-1. Examples of Essential and Nonessential Functions

Program Type	Essential Functions	Nonessential Functions
All Programs	• Provide for the physical safety of all clients and visitors at the facility. • Provide behavioral health emergency services. • Conduct basic screening, intake, and discharge procedures. • Track clients affected by dispersal and evacuation to ensure they continue to receive needed behavioral health services. • Provide crisis and relapse prevention counseling; ensure that some support is available to clients. • Assist clients in accessing needed medications. • Conduct drug testing for mandated clients. • Adhere to applicable State licensing standards. • Maintain treatment and billing records in accordance with payer and regulatory requirements. • Document transfer of clients and their records to another provider. • Protect client rights and privacy, including the integrity of protected health information records. • As resources are available and based on mandates, provide disaster mental health services to the community as requested by the Emergency Operations Center or Emergency Support Function #8 Coordinator. • Provide prevention guidance specific to the present disaster to reduce the likelihood of traumatic stress in the program's clientele and other members of the local community.*	• Perform extended intake and discharge procedures. • Conduct nonmandated drug testing. • Offer routine counseling and education. • Provide general mental and substance use disorder prevention services.
Outpatient Treatment Programs	• Assist with case management activities such as linking to resources, including helping clients obtain replacements or refills, as appropriate, for needed medications. • Provide crisis stabilization, crisis intervention, or other emergency services to outpatients.	• Provide regular outpatient services. • Host onsite mutual-help group meetings. • Donate meeting space for community groups.
Residential Treatment Programs	• Provide residential care for patients who do not meet discharge criteria. • Stabilize patients undergoing nonmedical (social) detoxification (see section below for essential functions of a program providing medically managed detoxification). • Continue medications and supportive counseling to patients to prevent decompensation or escalation of symptoms of behavioral health disorders. • Coordinate or address transportation needs for accessing medical services. • Provide case management services, as appropriate, to move patients toward discharge readiness.	• Provide residential care for patients who can be discharged.

* Public messages in disaster should be coordinated with the Public Information Officer of the community's Incident Command System (see Chapter 3).

Exhibit 4-1. Examples of Essential and Nonessential Functions (continued)

Program Type	Essential Functions	Nonessential Functions
Medically Managed Detoxification Programs	• Follow established medically managed detoxification protocols. • Medically stabilize patients; closely monitor patients' withdrawal symptoms. • Transfer patients who require a higher level of medical care than the program can provide to an appropriate facility; provide residential care for patients who remain at the facility.	• Medically detoxify patients who can be safely transferred to and detoxified in another setting.
Opioid Treatment Programs (OTPs)	• Confirm identities and dose information for patients receiving medication. • Provide or facilitate access to prescribed or dispensed medications (e.g., methadone, buprenorphine). • Provide case management to assist with medically appropriate transfer or discharge.	• Provide other case management services beyond those determined essential.

Exhibit 4-2. Essential Operations Continuity During a Winter Storm (Example 1)

A major winter storm stranded residential program staff members in their homes and resulted in on-duty staff extending their shifts to nearly 72 hours. Travel was not advised, and access to the interstate highway was closed. Food was not an issue because the program had stored a 2-week supply of provisions. The program had recently purchased and implemented a Web-based client management system that clinical supervisory staff could access from home to create and modify treatment plans that could be implemented by clinical staff. This system allowed staff to document client progress and medical updates with no interruption to client services.

During the storm, assigned therapy sessions had to be rescheduled or canceled because some therapists could not get to work. The onsite team had to be creative, and the program assumed a comfortable "retreat" atmosphere as the staff took this opportunity to work with clients more deeply on specific group topics. It was decided afterward to plan a series of mini retreat activities as "off-the-shelf" options, for use in future incidents when the program is short staffed because of emergency.

Source: Michael Lynde, personal communication, May 3, 2010.

Exhibit 4-3. Essential Operations Continuity During a Winter Storm (Example 2)

An outpatient treatment facility was hit hard by an unexpected snow and ice storm. The emergency preparedness plan was initiated. A few staff members who had computer access at home worked throughout the day providing phone counseling and documenting those client services in the client record electronically. Phone services included triaging counseling emergencies, rescheduling appointments, and providing supportive recovery counseling to clients and family members, as well as counseling to relieve any mild anxiety caused by the storm. Client care continued throughout the storm.

Source: Kathyleen M. Tomlin, personal communication, May 1, 2010.

those positions. Such people must have the knowledge, skills, and abilities for the designated roles, as well as the required certifications and licenses. Some personnel may be able to assume the essential duties of multiple staff positions. The credentials and State licenses of essential staff should be scanned and saved electronically, in case this documentation is needed at an alternate location or receiving facility (see Protect Vital Records and Databases, later in this chapter). Essential function status should be included in job descriptions and expectations communicated to employees.

In a disaster situation, only essential staff members would report for work onsite or in the new location (if the facility has moved); other available staff members would be directed either to stay at home or to be available to work on a rotating schedule. The goal is to assemble a roster of the minimum number of people who together can perform all essential functions. Multiple backups for all positions should be assigned in case the designees are unavailable or have been called away to serve in behavioral health response efforts. **Worksheets B9 and B10** (in Appendix B) can be used to complete this task.

To facilitate the development of an essential staff roster, the team can ask the program's management to prepare staff members for the possibility that, in a disaster situation, they will have to perform additional duties or work under changed schedules. Staff members need to be briefed regarding the scope of their responsibilities as outlined in the disaster plan, and they need to be willing to carry out those duties (e.g., a mental health services provider may be asked to pass out blankets and water bottles when speaking to people who have been evacuated into a shelter). Expectations related to reporting to work during a disaster can be clearly stated in policy, included in job staff descriptions, and covered in annual reviews. Staff members also can be assisted in creating plans, in advance, for dependent care so that they can report as needed for duty.

Management can work with staff members who usually perform an essential function to develop a written plan for maintaining that function in a disaster situation. The planning team can assemble these plans together into the continuity plan functional annex. **Worksheet B11** (in Appendix B) lists some questions to be addressed as the team drafts the continuity plan.

Provide for Continuity of Leadership

Leadership is essential in a disaster, so alternate leaders need to be identified in advance for situations in which personnel who normally exercise authority are incapacitated or unavailable. For each such position, management must approve the order of succession and the delegation of authority.

Order of Succession

An order of succession officially passes authority from one person to another. Depending on the size of the facility and staff, several successors may be named for each position; multiple successors are especially important for the pandemic influenza scenario (see Chapter 6). If possible, the order of succession should include successors who work at different facilities in the event all leaders at one facility are incapacitated. Examples of order of succession for leadership positions at a behavioral health treatment program are provided in Exhibit 4-4.

Delegation of Authority

A delegation of authority describes the permissible range of actions for each leadership successor. The scope of authority can be determined in advance for each named successor, based on his or her qualifications. For example, if the executive director is not on duty when a disaster occurs that calls for immediate evacuation, a successor may

Exhibit 4-4. Examples of Order of Succession at a Behavioral Health Treatment Program

Leadership Position	Example Order of Succession
Executive Director/ Administrator	1. Assistant director 2. Clinical director 3. Clinical nurse supervisor
Clinical Director	1. Clinical nurse supervisor 2. Clinical nurse 3. Senior licensed counselor or program manager
Medical Director or Chief Psychiatrist	1. Staff physician 2. Advanced registered nurse practitioner (or other staff member with independent prescriptive authority) 3. Certified physician assistant (or other staff member with independent prescriptive authority)

assume authority to make decisions about the move and, through prior arrangement, have the authority to expend funds for transport. Authority can be limited so that the successor cannot make decisions about long-range matters. Once the executive director resumes leadership, the successor's delegated authority is terminated.

Arrange for Alternate Facilities

The program's disaster planning team can research several options for continuing essential operations elsewhere. These options would be considered by leadership, and the program director could authorize them through Memoranda of Agreement with alternate facilities. When a disaster occurs, a displaced program can move to the most practical prearranged alternate facility, given the circumstance (e.g., another space within the building, another location of the organization, space that is borrowed from or shared with another organization in the community, a site that is miles away or out of State).

The team should evaluate alternate facilities and suggest to leadership multiple options. For each option, the team should consider whether the prospective alternate facility is located at a safe distance from the area—such that it would not be compromised by the hazard that forces relocation; can be made operational in 12 hours or less; and has sufficient space, equipment, supplies, and support services so that staff can perform essential functions (FEMA, 2007c). Other considerations include whether the proposed facility has the necessary compatible communications and computer systems infrastructures to maintain essential services and is capable of meeting food, lodging, health, sanitation, and security needs of essential staff and clients either onsite or nearby. Some programs may already have offsite hosting of software supporting various functions, including electronic records. This may provide an advantage in the case where relocation of these functions is necessary.

Each disaster planning team makes its own determination of criteria for alternate facilities. For example, in addition to meeting the criteria identified above, the team may look for an alternate facility that is licensed by the State authority, as required (e.g., for an alternate residential, opioid dependence, or child and adolescent treatment program). Another feature the team may seek is space that can be configured for providing essential services (e.g., a client waiting room, private rooms for counseling, large space for group therapy) and that has necessary furnishings (e.g., beds for residential services, tables for serving meals, chairs for group rooms, secured storage area such as lockable file cabinets). Other features to consider are whether the alternate facility is physically accessible under Americans with Disabilities Act of 1990 requirements, is affordable (in

terms of reserving in advance and using the space), and meets security needs (e.g., provides secure space for storing medication, records, and drug testing specimens). A final consideration is whether the alternate facility is appropriate for the population being served (e.g., youth, women with young children).

Worksheet B12 (in Appendix B) can be used to collect data necessary to evaluate prospective alternate facilities. **Worksheet B13** (in Appendix B) can be used for recording information about the facilities that are most appropriate for internal, local, regional, or national disasters.

The program has several options when arranging for alternate facilities. It can negotiate with another behavioral health treatment program to provide space for each other as necessary. This approach can be practical because such programs often have similar infrastructures. These sorts of mutually beneficial arrangements are best arranged in advance and in writing (see Negotiate Memoranda of Agreement, in Chapter 3). Alternatively, the program can arrange to use space at another type of healthcare facility (e.g., nursing home, hospital), or it can negotiate for space at a non-healthcare-related facility (e.g., college dormitory, sports complex, motel, community-based facility).

Essential services may need to be divided among more than one alternate site, if no single site meets all requirements. A situation may arise in which no alternate location is available or staff members are unavailable to work at or reach the alternate location. To prepare for this contingency, the disaster plan should include a section on temporarily transferring clients to another program where they can be treated as guest clients. Advance arrangements are needed, especially if the plan will require that clients be dispersed among multiple programs (see Prepare for Transfers of Patients, in Chapter 5).

The disaster plan needs to account for situations when relocation will occur on short notice, such as when the facility has been compromised or the entire community has been ordered to evacuate. **Worksheet B14** (in Appendix B) includes a checklist for relocation planning.

Another task of the team is to explore, and have approved by the program director or designee, standby contracts for critical equipment and quantities of supplies that would be needed at an alternate location (e.g., generators, tents, cleaning supplies or services). For residential programs, standby contracts may be needed for camp beds, bedding supplies, and food supplies or services. These contracts become effective only if necessary following a disaster and, typically, they establish prices at the level in effect on the day before the incident occurs. Related to this, the disaster planning team can research local laws or regulations that protect against price increases in periods of disaster.

Ensure Interoperable Communications

To continue providing essential services after a disaster, essential staff members need systems and equipment that allow them to communicate with one another, whether onsite, at home, or traveling, and to retrieve and record data in client records and other files. They also need systems and equipment that enable them to communicate with key partners (e.g., frontline emergency responders; staff at alternate facilities; nonessential staff; clients in residential settings, at their homes, or at alternate facilities; clients' families and other care providers; insurers and other payers; vendors; the public).

Examples of communications systems include:

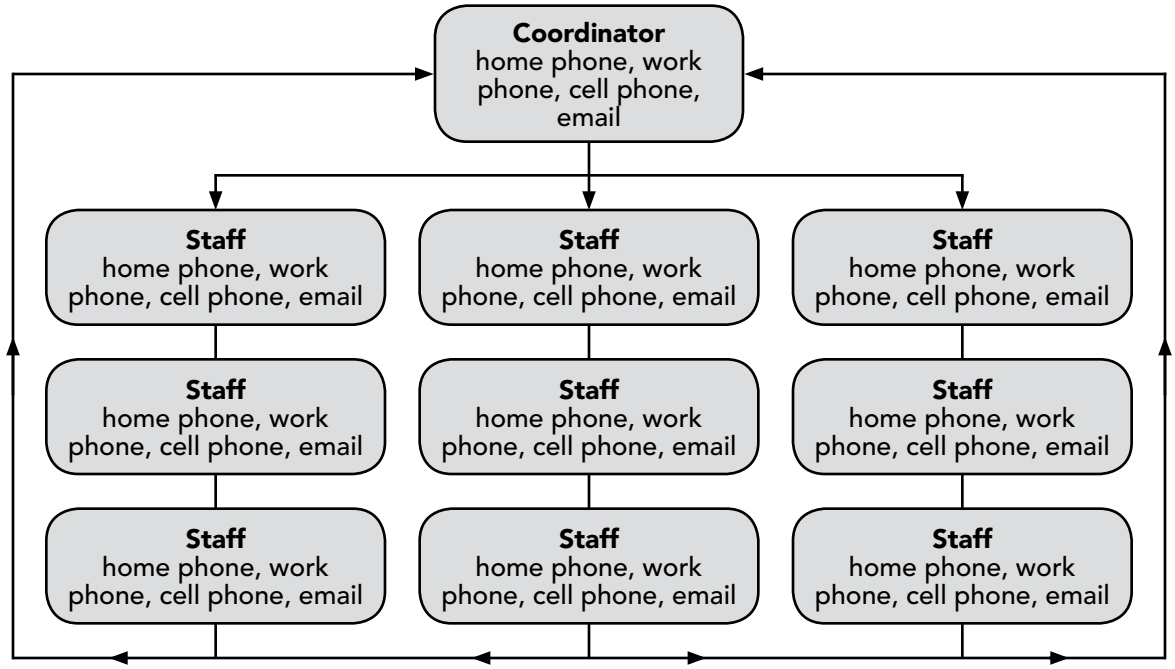
- At least one dedicated telephone line and corded telephone on the premises for use in case of power failure. Most cordless telephones do not work without electricity, and cell phone systems can jam from overuse; also, individual cell or cordless phones will need recharging. (Note: Corded phones may run out of power after several hours if they are linked by fiber-optic [as opposed to

copper] wires to the telephone company's central office.)

- Cell phones with text messaging capabilities, personal digital assistants, or Internet-based telephone accounts.
- Two-way radios (e.g., inexpensive walkie-talkies), satellite phones (rented or purchased), and other devices for person-to-person communications when cell and landline phones are inoperable. Some of these communications devices may not be secure, so providers must be careful when relaying client information over them.
- An Intranet *hot site*, which is a private, password-protected area that can be accessed only by authorized users and which can be used to receive status information from, and provide information to, employees in a disaster situation.
- An offsite telephone number that employees can call to report status and obtain information. Programs can partner with programs in other localities to provide one another with emergency calling numbers.
- Battery operated laptops with software and memory capacity enabling access to clinical data stored at an offsite server if the primary facility network is inoperable.
- Computers at guest locations that are loaded with software capable of running the program's necessary files and databases or that have the ability to access the program's hosted software site containing this information.
- Emergency contact information in multiple formats (e.g., stored in a computer database; entered on paper copies stored at the office, at home, and in vehicles; programmed into office phones for speed-

Exhibit 4-5. Communication Tree

The coordinator initiates distribution of a message by contacting the people on the branches directly below him or her. Those people then contact those below them on the branch. The final people to receive the message contact the coordinator, completing the chain and confirming that everyone has been informed. If callers cannot reach an assigned contact, they move to the next person down the branch, passing along the name or names of those who could not be reached. This information is passed along until it reaches the coordinator.



dialing; stored in cell phones). This would include the contact information collected in **Worksheet B3** (in Appendix B).

- Memoranda of Understanding with amateur radio (ham) operators for assistance in emergency communications.
- An agreement with local TV and radio stations to communicate the program's status to the public in emergencies.
- Routine reminders to staff members to print or back up to a second location their computer-based personal calendars, address books, and other critical databases, such as by synchronizing them to a handheld device that can be password protected.
- Multiple means of broadcasting alerts to staff and clients (e.g., intercom for within-facility communications; out-of-town phone number that dispersed staff members can call for information about program status; group messaging via cell phone, email, or Internet; closure listings via TV and radio; instant messaging via social networks, such as Twitter).
- A *communication tree*, which is an arrangement that distributes responsibility among staff to contact all personnel in case of emergency (Exhibit 4-5).

Exhibit 4-6 provides information on three priority services that can help behavioral health treatment programs communicate in emergencies: Government Emergency Telecommunications Service (GETS), Wireless Priority Service (WPS), and Priority Listing for Electric Service. The disaster planning team can research whether its program is eligible for these services.

The behavioral health treatment program must apply to be accepted into the GETS and WPS systems. The program may be asked to obtain a government sponsor and may have to submit a letter explaining the nature of the relationship between the sponsor and the program, the role that the program plays in community disaster response efforts, and the staff roles that will need priority service and why.

The disaster planning team can inventory its current communications systems to ensure that redundant, compatible systems have

Exhibit 4-6. Priority Communications in an Emergency

Service	Description
Government Emergency Telecommunications Service (GETS)	Provides priority access to the switches that route telephone calls. This service is most useful during an event when telephone systems are not damaged but the circuits are overloaded. In this situation, the caller usually hears a very fast or very slow busy signal after the number is dialed, indicating that too many people are making calls at the same time. By using a GETS calling card, subscribers have priority access to the circuit, which allows the call to go through. GETS cards are free, but there is a small fee-per-minute charge when they are used. Further information can be found at http://www.dhs.gov/government-emergency-telecommunications-service-gets.
Wireless Priority Service (WPS)	Provides priority access to the cellular towers that route cell phone calls. This service is most useful in situations when the cellular infrastructure is intact but the circuits are overloaded by a large number of callers. In this situation, the caller usually receives a message indicating that the call cannot be completed or receives a fast busy signal. WPS subscribers receive priority access through the cellular phone system. WPS is attached to a specific cell phone number, and the monthly fee is added to the phone bill. Further information can be found at https://www.dhs.gov/wireless-priority-service-wps.
Priority Listing for Electric Service	Ensures first priority for electric service restoration, following service disruption or shortage, to organizations that provide vital services or that would be most adversely affected by lack of service. In some areas, priority services may not be available to nonhospital healthcare providers. The disaster planning team should contact the local power company to learn about eligibility.

been created for person-to-person and data communications and that the personnel authorized to use those systems in a disaster situation have access to authentication procedures and passwords. The team can also seek advice and assistance from its local disaster planning body and the State disaster behavioral health coordinator on obtaining the equipment, "gateway" devices or patches that enable interoperability, and permissions for communicating with emergency responders in disaster. The team can use **Worksheets B15** and **B16** (in Appendix B) to ensure that it has considered a range of options for ensuring interoperable communications.

Protect Vital Records and Databases

Treatment programs may consider housing their IT equipment offsite at specialized data centers, which offer customers a safe, secured environment with redundant systems ensuring uninterrupted processes. Programs also are encouraged to convert from paper medical records to electronic health records (EHR; also known as *electronic medical records*, or EMR). These steps can circumvent many of the records-related problems that can occur in a disaster (Exhibits 4-7 and 4-8). For example, EHR stored at a secure offsite server, such as one hosted by a medical records software company, can be accessed even if paper records are destroyed at the original facility, and they can be readily accessed by the program if it has relocated to an alternate site. In addition, EHR can be transferred, efficiently and securely, to another provider as needed.

Information on EHR can be obtained from the Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services, at http://healthit.gov.

Psychiatric programs that accept Medicare and Medicaid are eligible for incentives for adopting certified EHR technology. Programs that do not successfully demonstrate meaningful use of EHR technology by 2015 will have a payment adjustment in their Medicare reimbursement. Information is available from the Centers for Medicare and Medicaid Services at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html.

To ensure all appropriate records remain accessible or are transferred as needed in a disaster situation, the disaster planning team can work with management to ensure there is a current inventory of records and databases (e.g., temporary and permanent records, those stored in all formats and media). The inventory also can include a list of current software versions necessary to support functions and files and contact information for the software and hardware companies.

From this comprehensive inventory, personnel assigned to this task can identify the records, databases, and software necessary to perform essential functions and to restore normal operations after a disaster. Some fields in a database may not be essential and can be sorted out if needed to save space on paper or on a hard drive. **Worksheet B17** (in Appendix B) can be used to ensure that plans are in place for protecting all vital records and databases.

The disaster planning team can check to confirm whether computer systems staff has in place a schedule for regularly updating each vital record or database and backing up each update on a remote server. The team also should ensure that copies on paper, CD-ROM, or encrypted external memory drives can be kept at an alternate location or in a portable, waterproof, and fireproof case that can be carried to an alternate facility as needed; this case is typically referred to as a *facility go kit* (distinct from the personal go kit addressed in Chapter 3).

Exhibit 4-7. Benefits of Electronic Health Records (Example 1)

St. John's Regional Medical Center in Joplin, MO, converted from paper to EHR just weeks before a tornado devastated the town in May 2011, and this may have "saved lives," according to Health and Human Services Secretary Kathleen Sebelius. Patient medical information was relayed within hours to outlying hospitals treating tornado victims, and St. John's was able to operate effectively for weeks in a mobile medical unit. "Think of a typical hospital waiting room, and the infamous clipboard where somebody is being asked to put together their medical history and prescription regime by memory, and add a huge traumatic incident on top of that," Secretary Sebelius said in an Associated Press interview. "There's no question that . . . the availability of an electronic record may have actually saved lives. They were able to immediately go into the treatment phase and not spend a lot of energy trying to reconstruct (records)."

Source: Zagier (2011).

Exhibit 4-8. Benefits of Electronic Health Records (Example 2)

Access Family Care (AFC) is another Missouri provider that averted a communications breakdown following the May 2011 tornado. The smaller of its two locations in Joplin, which provided primary care and behavioral health services, was completely destroyed. The organization had converted to EHR more than 2 years previously. Clinicians could access records from desktop computers or mobile devices, and they could reenter the system at the point where they left off without needing a repeat login. The system had many other useful features, such as e-prescribing and interconnection with a third-party lab.

The core systems and applications were hosted and maintained by an IT company in an offsite building. The tornado destroyed that building—except for the data center itself, which was in a reinforced section that survived. The IT company relocated to temporary quarters and resumed operations within half a day. "This proved critical for the health center. When they reopened in the days immediately following the storm, AFC became the focal service delivery point for their own patients, as well as an emergency access point for others in the community, providing emergency medical triage and medication refills for community residents in need, while continuing to manage direct care and assist their own staff and staff families who were affected by the storm. . . . The experience of Access Family Care in Joplin, as well as of other community health centers at the epicenter of recent disasters, underscores the importance of investment in HIT [health information technology] at both the health center and community level. The operating costs incurred by the center are a manageable share of the overall budget and allow for operational and programmatic efficiencies while supporting the delivery of care. In the wake of the recent tornado, these dollars are clearly money well spent."

Source: Shin and Jacobs (2012, pp. 4–5).

Any electronic forms that are essential for continuity of operations and emergency response (e.g., forms for reporting and recording disaster response measures such as daily situation reports; records of expenditures and obligations; client assessment, intake, treatment planning, and discharge forms) should be available in paper copies as backup when the power is down or systems are inoperable; these can be kept in the facility go kit. The facility go kit also might contain forms required for medications ordering, administration, and management, as well as client progress note forms and other client forms (e.g., drug testing forms).

Computer applications and data should be prioritized by management staff responsible for this function so that those most critical to operations are recovered and brought back online first following a disaster. A plan should be developed for disassembling, transporting,

and reassembling any necessary equipment in an evacuation.

The behavioral health treatment program must ensure that client confidentiality is maintained as the program shares information with other sites for client transfers and as it creates duplicate records, such as for the facility go kit (per requirements of 42 Code of Federal Regulations [CFR] Part 2, Health Insurance Portability and Accountability Act [HIPAA], and Health Information Technology for Economic and Clinical Health Act).

Guidance provided by the Office for Civil Rights, U.S. Department of Health and Human Services, following Hurricane Katrina is excerpted in Exhibit 4-9. (Updated guidance may be issued in future disasters.) If staff members find themselves in a situation in which confidentiality must be broken, they should attempt to contact the State agency that oversees treatment of behavioral health disorders to explain the situation. If that is impossible, they should document the circumstances and report the breach as soon as possible.

Develop Resources To Manage Human Capital

As discussed in the Mitigate Risk section of Chapter 3, the disaster planning team can take steps in advance to limit the extent to which staff members are affected by any disaster that occurs. The team also can create, in advance of any event, a list of providers of social services that will be available to support staff members with personal emergency needs (e.g., medical assistance, crisis counseling, temporary housing).

An effective disaster plan provides a mechanism for informing staff members when the plan has been activated and how each person should respond (i.e., as an essential staff member who should report immediately for duty or as a nonessential staff member who should wait for further instruction). To ensure effective deployment of personnel, the disaster planning team needs to have in place—and communicate through training and other means—a clear delineation of the staffing chain of command and leaders' authority in a time of disaster, if it is different from the chain of authority during regular operations. There also needs to be a contact list of all staff members, including emergency contact information and after-hours locations. (Personal contact information, such as home and cell phone numbers, should be shared on a need-to-know basis through the chain of command, and the information should be used only for appropriate purposes.)

Multiple means of communicating among staff need to be in place (see Ensure Interoperable Communications, earlier in this chapter). Information on staff credentials and levels of expertise will be useful, to ensure that no one is moved into an assignment he or she is not trained or prepared to perform.

An individual's willingness to work in a disaster situation will be affected by concerns about family, personal safety, and pet care (Meredith, Eisenman et al., 2011). The disaster planning team can recommend policies that support staff members as they serve during the disaster. These may include policies that:

- Provide staff members with advance training in disaster self-care.
- Ensure access to phones or Internet to check on family members while working through a disaster situation.
- Allow for adjustments to shift schedules, as needed to perform essential functions while also managing personal responsibilities (maintaining 8-hour or shorter work shifts if possible).
- Provide for compensation to employees who work additional hours in the disaster situation.

Exhibit 4-9. Office for Civil Rights HIPAA Guidance Following Hurricane Katrina

September 2, 2005

U.S. Department of Health and Human Services Office for Civil Rights

Hurricane Katrina Bulletin: HIPAA Privacy and Disclosures in Emergency Situations

Persons who are displaced and in need of health care as a result of a severe disaster—such as Hurricane Katrina—need ready access to health care and the means of contacting family and caregivers. We provide this bulletin to emphasize how the HIPAA Privacy Rule allows patient information to be shared to assist in disaster relief efforts and to assist patients in receiving the care they need.

Providers and health plans covered by the HIPAA Privacy Rule can share patient information in the following ways:

Treatment. Healthcare providers can share patient information as necessary to provide treatment. Treatment includes:

- Sharing information with other providers (including hospitals and clinics).
- Referring patients for treatment (including linking patients with available providers in areas where the patients have relocated).
- Coordinating patient care with others (such as emergency relief workers or others who can help in finding patients appropriate health services).

Providers can also share patient information to the extent necessary to seek payment for these healthcare services.

Notification. Healthcare providers can share patient information as necessary to identify, locate, and notify family members, guardians, or anyone else responsible for the individual's care of the individual's location, general condition, or death. The healthcare provider should get at least oral permission from individuals, when possible; but, if the individual is incapacitated or not available, providers may share information for these purposes if, in their professional judgment, doing so is in the patient's best interest.

Thus, when necessary, the hospital may notify the police, the press, or the public at large to the extent necessary to help locate, identify, or otherwise notify family members and others as to the location and general condition of their loved ones.

In addition, when a healthcare provider is sharing information with disaster relief organizations that, like the American Red Cross, are authorized by law or by their charters to assist in disaster relief efforts, it is unnecessary to obtain a patient's permission to share the information if taking the time to get permission would interfere with the organization's ability to respond to the emergency.

Imminent danger. Providers can share patient information with anyone as necessary to prevent or lessen a serious or imminent threat to the health and safety of a person or the public—consistent with applicable law and the provider's standards of ethical conduct.

Facility directory. Healthcare facilities maintaining a directory of patients can tell people who call or ask about individuals whether the individual is at the facility, their location in the facility, and general condition.

Of course, the HIPAA Privacy Rule does not apply to disclosures if they are not made by entities covered by the Privacy Rule. Thus, for instance, the HIPAA Privacy Rule does not restrict the American Red Cross from sharing patient information.

Excerpted from Office for Civil Rights (2005).

The team, working with human resource personnel, should review personnel policies to ensure they support continuity of operations in a disaster. A central issue is educating and preparing staff members so that they are willing to report for and stay on duty during an actual event (Exhibit 4-10). **Worksheet B18** (in Appendix B) can be used as a tool for considering personnel policies pertaining to a disaster.

Exhibit 4-10. Building Staff Willingness To Respond in Disaster

One OTP reported that during a hurricane, staff members abandoned their posts over concerns that they would be unable to get home to protect themselves and their families. To avoid a recurrence of that situation, the program developed a detailed disaster plan that, among other things, clearly advised staff members of their roles in a disaster and enunciated policies for compensating staff if the program closed because of a disaster. As a result of these measures, the OTP was better staffed in subsequent hurricanes.

Source: Podus et al. (no date).

Chapter 5—Management of Prescription Medications

In This Chapter

- Give Careful Oversight to Clients on Prescription Medications
- Help Clients Access Prescription Medications
- Provide for Continued Methadone Dosing
- Prepare for Transfers of Patients
- Treat the Guest Patient on Methadone Maintenance Treatment
- Handle an Influx of Patients With Opioid Dependence
- Address the Needs of Displaced Patients on Buprenorphine
- Refer or Treat Pain Patients, as Appropriate
- Manage Supplies of Controlled Substances

Worksheet (see Appendix B)

- B19 Checklist for Management of Prescribed Medications

This chapter covers disaster planning to support clients who take prescribed medications for the treatment of behavioral health disorders or for other medical conditions. The chapter also covers issues regarding management of onsite controlled substances during a disaster.

Give Careful Oversight to Clients on Prescription Medications

Clients on prescription medications will need to be monitored to determine if the unusual circumstances have interrupted or altered their medication regimen. Depending on the patient and situation, the effects of medication changes can include withdrawal and symptom return. Innumerable kinds of adverse drug reactions also can occur. The majority of them are related to drug interactions, occurring when the amount or action of a drug in the body is changed—usually increased or decreased—by the presence of another drug or multiple drugs. For example, adverse reactions can occur from the unanticipated interactions of prescribed medications, methadone, illicit drugs, over-the-counter products, and other substances. In cases of patients on elaborate drug regimens—such as multidrug therapies for HIV/AIDS, hepatitis C, or severe mental illness—consultation with specialists will be necessary to manage any transitions resulting from the disaster situation.

Programs can facilitate care in disaster conditions for their own patients on prescribed medications by proactively converting from paper medical records to electronic health records. Electronic recordkeeping avoids problems caused by destruction of paper records in disaster and facilitates the transfer of those records to an alternate facility or guest provider (see Protect Vital Records and Databases, in Chapter 4).

Help Clients Access Prescription Medications

Clients may be on prescribed medications for treatment of mental disorders (e.g., antipsychotic medications,

benzodiazepines, selective serotonin reuptake inhibitors, barbiturates). Clients also may be on one or more prescribed medications for treatment of substance use disorders (e.g., buprenorphine, naltrexone, disulfiram, acamprosate). In addition, clients may take prescribed medications for medical conditions (e.g., hepatitis C, HIV/AIDS, diabetes, high blood pressure, pain).

In a disaster, clients may need to have their prescriptions refilled due to losing access to or running out of their medications. Clients who are unable to take their regular doses can experience one or more of the following symptoms, depending on their diagnoses and medications: sudden return of psychotic symptoms (e.g., hallucinations, delusions), recurrence of other psychiatric symptoms (e.g., depression, anxiety), withdrawal symptoms, relapse to substance use, or deterioration of physical condition. Some of these effects can be directly or indirectly life threatening. In addition, people who become emotionally or mentally unstable or experience a relapse to substance use because of lack of access to their medications may be at risk for unnecessary or lengthy hospitalization or institutionalization, especially if the cause and the treatment of their condition are unknown by providers of emergency care.

To lessen the likelihood of clients experiencing medication-related problems, the disaster planning team can recommend that the program adopt policies to educate clients on how to handle emergency situations. For example, clients can be assisted in reviewing their options for obtaining prescription replacements and refills under various scenarios, such as if the clinic or their primary pharmacy is not open or if they are relocated without advance notice because of an unforeseen event. Clients also can be educated to include a 7-day supply of medication in their household preparedness supplies (American Red Cross, 2009). Clients can be advised to carry all of their medications with them if they are relocated, even temporarily, and to bring with them the following items so that they can more easily obtain medication refills, as needed, from a new medication-dispensing facility:

- A photo ID
- Medication containers of currently prescribed medications (even if empty)
- Written prescriptions
- Packaging labels that contain dose, physician, and refill information
- Any payment receipts that contain medication information

The program's executive director or other designated representative can talk to the local and State public health departments to find out whether psychotropic or substance abuse treatment medications are included in the public stockpile and to obtain clarification on the disaster conditions under which such medications would be made available to the program's clients.

A 2006 review of the response to Hurricanes Katrina and Rita found that locations receiving evacuees were not prepared to support the prescription replacement/refill needs of arriving individuals. The report noted, "For some people with psychiatric disabilities, this remains one of their chief concerns for the next hurricane season" (National Council on Disability, 2006, Section III, B2). Therefore, the topic of medication maintenance for clients should be addressed with local disaster planning committees, especially with the operators of shelters and evacuation receiving sites. Continued client access to prescription medications can be a topic included in tabletop or functional exercises that test the disaster plans of the program, community, and State (see Chapter 7).

Provide for Continued Methadone Dosing

Methadone is a Schedule II substance under the Controlled Substances Act, which means that prescribing, dispensing, and

transporting methadone is tightly regulated by the Drug Enforcement Administration (DEA), under 42 Code of Federal Regulations (CFR) 8.12. Many patients on methadone maintenance treatment (MMT) for opioid dependence receive their daily dose at their opioid treatment program (OTP). For such patients, a disaster that cuts them off from the OTP and their daily dose of methadone can precipitate withdrawal symptoms and increase risk of relapse.

To ensure continued dosing in all circumstances, an OTP will need access to patients' dosing information or will need to be able to provide that information to another program that will provide guest dosing. This will be difficult if computer-based records are inaccessible or lost in a disaster. As a mitigation step, the OTP should store and regularly update patient medical records (including dose levels and take-home privileges) at a secure location (e.g., an offsite server located in a reinforced building). The program also should be ready to quickly and securely transfer patient records and the supporting software to an alternate location (see Protect Vital Records and Databases, in Chapter 4).

Some OTPs provide patients with *smart* ID cards. Each card contains the patient's photograph and encrypted medical information. A program that uses such cards should ensure that other OTPs to which patients may be transferred have the equipment (and the electric or battery power) to read the cards. The program also should provide a backup method for transferring medical records and verifying patient status and identity, because patients affected by disaster may lose all possessions, including their ID cards. Many patients on MMT who were affected by Hurricanes Katrina and Rita experienced this loss (Maxwell, Podus, & Walsh, 2009).

Some State Opioid Treatment Authorities (SOTAs) maintain a central database with identifying information on patients on MMT, including dosage levels, admission dates, and take-home privileges. The disaster planning team should check with its State agency that oversees behavioral health services to learn the procedures for accessing patient records in emergencies. Issues to cover include:

- The process for accessing the OTP's own patient information when records at the program are destroyed or inaccessible.
- The process by which a receiving OTP will be able to access the records of guest patients.
- Whether an OTP can rely on guest patients for dosage information when the home OTPs are not able or available to verify the information.
- Whether the OTP will have to obtain patient releases for that information.

Some States have developed statewide healthcare communications systems through which dosing information can be securely transferred. Details on one such system, the Washington System for Tracking Resources, Alerts, and Communication, are included in Appendix E. An example of the challenges in patient dosing after a disaster is illustrated in Exhibit 5-1.

> Information on the State of Washington's statewide healthcare communications system, through which dosing information can be securely transferred, is available at http://www.doh.wa.gov/PublicHealthandHealthcareProviders/EmergencyPreparedness/WATrac.aspx.

In some emergency situations (e.g., an impending snowstorm or hurricane that is expected to make street travel difficult for a few days), the optimal choice may be to provide patients with extra take-home doses. OTPs can prepare in advance to submit emergency programwide exception requests to the Substance Abuse and Mental Health Services Administration (SAMHSA) and to the SOTA, where applicable, to extend take-home privileges, or to dispense extra take-home doses for a reasonable period of time.

Exhibit 5-1. Distant Dispersal of OTP Patients

An OTP administrator reported that his clinic prepared for disaster situations by backing up its data to an offsite location. This database could be directly accessed by other clinics owned by the same company. In addition, the administrator retained hard copies of patient names and dosing histories. This preparation proved insufficient, however, to deal with the impact of a major hurricane. In its aftermath, the administrator had to spend hours on the phone with staff members at alternate facilities throughout the United States and not owned by the same company, verifying data and dosing information for patients who had been relocated. "Planning is great and having channels and [cooperative agreements] with other programs is great," he said, "but you have to understand that people are going to end up almost anywhere." The administrator was particularly frustrated by the reluctance of some alternate facilities to accept his verification. Instead, they requested a signed faxed document authorizing the patient transfer. Power outages made complying with this request extremely difficult.

Source: Podus et al. (no date).

Exception requests may be submitted to SAMHSA online, by fax, or by mail. According to SAMHSA, OTPs that submit requests online will typically have a decision, also viewable online, within 1 hour of the submission.

Information on making requests for exceptions to the Federal opioid treatment standards is available at http://www.dpt.samhsa.gov/regulations/exrequests.aspx.

A SOTA directory is available at http://dpt2.samhsa.gov/regulations/smalist.aspx.

Prepare for Transfers of Patients

In an impending disaster, a behavioral health treatment program may have little time in which to activate its plan for continuity of operations (see Chapter 4). This factor is particularly crucial for a residential program that provides medical detoxification or for an OTP, both of which must rapidly accomplish several extra steps in its continuity plan.

A program that provides onsite medical detoxification must prepare for evacuation, which will involve the transfer and tracking of patients and their medical information to an alternate location—or to another program with which it has a Memorandum of Agreement (MOA). Similarly, an OTP must prepare for transfer and tracking of patients receiving methadone to an alternate location or to another clinic that will be able to provide guest dosing. Steps to accomplish these transfers should be included in the program's continuity plan.

Exhibit 5-2 provides an example of an OTP's continuity plan that was executed before landfall of Hurricane Hugo.

Treat the Guest Patient on Methadone Maintenance Treatment

Every OTP should have procedures for how to handle people who arrive with or without advance arrangement and who request courtesy methadone dosing after a disaster. The disaster planning team needs to consider how many such patients its facility can handle. A small program that does not have the resources to treat guest patients should consider developing plans and procedures for referring prospective guests elsewhere. This can be formally accomplished through an MOA with a larger provider (see Negotiate Memoranda of Agreement, in Chapter 3).

Programs that have the capacity to treat guest patients should follow guidance provided by SAMHSA to State Methadone Authorities (SMAs) in States directly affected by Hurricane Katrina and included in the

Exhibit 5-2. An OTP's Continuity Plan Executed Before Hurricane Hugo

In 1989, Hurricane Hugo hit South Carolina. The Opioid Treatment Center of Charleston was located in a flood zone and near a major river. The staff thought the building would flood and that the streets leading to the program would be impassable for days. Staff members had 5 hours to notify 400-plus patients that the program might be unable to operate for a few days, to contact State and Federal officials to obtain permission to dispense extra take-home doses, to dispense the medication, and to get home themselves to secure their homes or relocate.

The program had agreements with OTPs in other parts of the State, in neighboring States, and with hospitals and mental health centers (for patients with co-occurring disorders). The six counselors, two nurses, an administrative assistant, and a program director did the following:

1. Contacted the medical director to report back to the facility to sign take-home orders and to sign emergency take-home requests to be sent to State and Federal authorities.
2. Called each patient to inform him or her of the situation, using agreed-on emergency contacts where necessary, and to tell the patient to come to the clinic to pick up the extra doses.
3. Communicated with OTPs in neighboring counties that might serve patients should the program be unable to reopen within 3 days.
4. Contacted a local mental health service provider to determine whether all patients served by them had enough prescriptions to ride out the storm and aftereffects.
5. Informed nearby emergency departments (EDs) of the OTP's closing, in case patients went to an ED for methadone because they did not receive extra take-home doses.
6. Called the local public communications systems to ask that they broadcast the program's closure.

All these procedures had been established with scripts that each staff member had access to and used during the disaster.

There was only one incident: a pregnant mother could not get in to pick up her extra doses. She was assisted by local ED staff members, who communicated with the medical director for guidance and assistance. Agreements remain in place with medical and mental health centers, OTPs, and other community support agencies.

Source: Shirley Beckett Mikell, Clinical Supervisor, The Opioid Treatment Center of Charleston, SC, personal communication, January 11, 2010.

Federal Guidelines for Opioid Treatment (SAMHSA, 2013). See Exhibit 5-3.

Handle an Influx of Patients With Opioid Dependence

A disaster may disrupt distribution of street drugs, causing individuals dependent on illicit opioids and not in treatment to turn to an OTP for help. A disaster also can be a life-changing experience that impels people to enter treatment. OTPs should anticipate a potential rush of new patients. Guidance provided by the Division of Pharmacologic Therapies (DPT) on handling displaced patients who are opioid dependent and not currently in treatment is presented in Exhibit 5-4.

Address the Needs of Displaced Patients on Buprenorphine

There are hundreds of thousands of patients receiving buprenorphine products for the maintenance or detoxification treatment of opioid dependence. Most of these patients are being treated by office-based, Drug Addiction Treatment Act-waived physicians, in settings other than OTPs. Buprenorphine patients displaced by disasters may be treated in OTP settings.

Additional buprenorphine treatment resources may be found at the Buprenorphine Physician & Treatment Program Locator at http://buprenorphine.samhsa.gov/bwns_locator.

Exhibit 5-3. Guidance for Treating OTP Patients From Areas Affected by Emergency Closure of Programs in the Event of a Disaster

Programs receiving displaced patients should make every effort to contact the home treatment program of people who have had to evacuate the area in which they live after an emergency or disaster. Information about the program may be obtained from the OTP Directory on the DPT Web site (http://dpt.samhsa.gov) or at the SAMHSA Behavioral Health Treatment Services Locator at http://findtreatment.samhsa.gov. In an emergency, program personnel may disclose information to the program medical director; program physician or mid-level practitioner, as appropriate; registered nurse; or dosing nurse without a patient's signed consent. If unable to contact the patient's home program, the OTP receiving a displaced patient should follow the procedures listed below along with existing emergency plans:

- The emergency guest patient should show a valid form of picture identification that includes an address in close proximity to the area affected.
- The patient should show some type of proof that indicates the patient was receiving services from a clinic located in one of the affected areas. Examples of proof may include a medication bottle, program identification card, or a receipt for payment of fees, etc. In cases in which the patient does not have any items of proof, including picture identification, the physician or mid-level practitioner, as appropriate, should use his or her best medical judgment combined with a stat drug test for the presence of methadone (lab test with quick turnaround, dipstick, or similar procedure).
- OTP staff may administer the amount of medication that the patient reports as his or her current dose; however, each patient is reminded that the dose that is reported will be verified with the home program as soon as possible. It may be prudent to closely observe an unknown patient for several hours post-administration to ensure that the dosage decision was correct, or take appropriate medical action in the event the dose was too high. In cases in which the reported dose appears questionable, it is best to use good medical judgment when determining the dose level. In certain cases in which the patient can demonstrate no prior enrollment in treatment or medication dosage amount, it may be advisable to treat the patient as a new admission and follow initial dosing procedures for a routine admission. (See 42 CFR § 8.12 (h) (3) (ii).)
- Emergency guest patients should be medicated daily with take-home doses provided only for days that the program is closed (Sundays and holidays). The clinic should have a plan to administer methadone appropriately and safely on days or at times when the program is closed. If the patient's current take-home status is verified, take-home doses may be provided in accordance with State and Federal regulations (42 CFR Part 8). In the case of a patient who is unable to receive daily treatment at the program location due to medical hardship, travel restrictions, or other hardship, take-home medication for unsupervised use may be considered using the SMA-168 "Request-for-Exception" process.
- Documentation of services provided to displaced patients should be a priority for OTPs. The OTP should assign a clinic identification number and maintain a temporary medical record for each guest patient. Reasonable efforts should be made to contact the patient's home program periodically to verify patient information prior to dispensing medication. The results should be recorded in the temporary chart. OTP staff should record the day, date, amount of medication administered to each patient along with any observations made by the staff. As time passes and affected OTPs reopen, some patients may elect to remain in treatment at the receiving facility and change from guest to permanent status. At the conclusion of emergency treatment, the receiving program may be asked to report to the SMA and/or SAMHSA the number of patients treated and the types of services provided.

Excerpted and adapted from SAMHSA (2013, pp. 60–61).

Refer or Treat Pain Patients, as Appropriate

During a disaster, some people on opioid medication for pain may lose access to medication and experience withdrawal. Some may seek help from an OTP. SAMHSA (2013) recommends that such people be referred to a local physician, preferably a pain management specialist. See Exhibit 5-5.

Manage Supplies of Controlled Substances

OTPs should take steps to ensure an adequate supply of approved opioid treatment medications, such as methadone and buprenorphine, are on hand for emergency dosing and other purposes (see Chapter 6 on pandemic flu preparations). Some emergencies may necessitate that a behavioral health treatment program remove controlled substances such as methadone

Exhibit 5-4. Guidance on Working With Patients Who Are Dependent on Opioids and Not Currently in Treatment

Individuals dependent on opioids—including heroin or prescription drugs—may arrive at the guest treatment program seeking help as a result of the disruption in the supply of street drugs. OTPs may admit, treat, and dose these patients under existing guidelines and regulations. Initiation on buprenorphine products may be appropriate for patients new to medication-assisted treatment.

Excerpted from SAMHSA (2013, p. 61).

Exhibit 5-5. Guidance on Working With Displaced Patients Treated by Pain Clinics

Patients who are being treated for pain with methadone by a physician may contact an OTP when they run out of medication and have no access to the former treatment setting. The first response should be to refer the patient to a local physician, particularly a pain management specialist. Additionally, the SAMHSA guidelines provide the following guidance:

- Patients, in general, are not admitted to OTPs to receive opioids only for pain, but there are exceptions to this principle. The Narcotic Addiction Treatment Act and the Drug Addiction Treatment Act (DATA) were established to allow for maintenance and detoxification treatment, using certain opioid controlled substances like methadone and buprenorphine. These requirements and limitations in no way affect the ability of a practitioner to utilize opioids for the treatment of pain when acting in the usual course of medical practice. Consequently, when it is necessary to discontinue a patient's opioid therapy for the treatment of pain by tapering or weaning doses, there are no restrictions, under Federal opioid treatment regulations, with respect to the drugs that may be used. Because this is not considered "detoxification" as it is applied to addiction treatment, no separate DEA registration as an OTP or DATA waiver requirements apply.
- Patients with a chronic pain disorder *and* physical dependence are managed by multidisciplinary teams that include pain and addiction medicine specialists. The site of such treatment may be in a medical clinic or in an OTP, depending on each patient's need and the best utilization of available resources. Similarly, addiction patients maintained on methadone or buprenorphine are not prohibited from receiving needed pain treatment including, when appropriate, adequate doses of opioid analgesics.
- Patients who are diagnosed with physical dependence and a pain disorder are not prohibited from receiving methadone or buprenorphine therapy in an OTP for either maintenance or withdrawal, if such a setting provides expertise or is the only source of treatment.

Excerpted from SAMHSA (2013, pp. 61–62).

from the premises during evacuation or relocation. The program needs to know, in advance, legal procedures for moving the controlled substances and the procedures for requesting moves. DEA or the SOTA can provide the most current advice on this matter.

> Emergency authorization for requests to move controlled substances in response to a disaster may be submitted to DEA via http://www.deadiversion.usdoj.gov/disaster_relief.htm.

To facilitate the request process, the disaster planning team can educate the DEA agent for its jurisdiction, in advance, about the controlled substances that it stocks and about the potential need for expedited permissions in emergencies. The relationship between the behavioral health treatment program and the DEA agent can be fostered through joint participation in the community's disaster preparedness planning and related practices or drills.

Programs should inform the local law enforcement agency, in advance of any emergency, that controlled substances are on the property. The disaster planning team may request that the facility be considered for high-priority protection if looting is a concern or for police escort when transporting program supplies to a new location. Again, the program can facilitate these requests by establishing relationships with the law enforcement agency before any disaster and ensuring that the appropriate law enforcement contact information is available in the disaster plan.

A program's supply of controlled substances may become inaccessible (e.g., if the methadone safe is buried in rubble or under water). A representative of the program should consult with the local DEA agent, the SOTA, and the program's medication suppliers to develop contingency plans for resupply. The local health department may be able to facilitate resupplies from local strategic stockpiles, hospital supplies, or other sources. The treatment program can coordinate, in advance, with these other parties to create signed agreements that detail procedures and protocols for emergency transfers of controlled substances. At a minimum, these agreements should be reviewed and updated annually.

Worksheet B19 (in Appendix B) is a checklist of planning issues to support patients who take prescribed medications and to manage controlled substances in a disaster.

Chapter 6—Planning Issues for Pandemic Influenza

In This Chapter

- Potential Effects of Pandemic Influenza
- Procedures To Reduce Influenza Transmission
- Vaccines
- Antiviral Medications
- Hygiene Policies
- Staffing Policies
- Staff Attitudes
- Planning Assumptions for Pandemic Influenza
- Drafting and Activating the Pandemic Plan

Medical Offices and Clinics Pandemic Influenza Planning Checklist, from the U.S. Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC) can be used in conjunction with this chapter. It is available at http://www.flu.gov/planning-preparedness/hospital/medofficesclinics.pdf.

A regional or global disease outbreak, known as a *pandemic*, presents a unique kind of hazard. Unlike tornadoes, earthquakes, and other events typically associated with the word *disaster*, the primary effects of a pandemic would not be destruction of property and traumatic injury, but rather sickness and death.

Influenza is the infectious disease most likely to become a pandemic. Influenza can spread throughout the world in a matter of weeks and before sufficient quantities of antiviral medications and vaccines can be produced and distributed. The Occupational Safety and Health Administration (2009) estimates that workplace absences could reach 40 percent during peak weeks of a community outbreak.

An influenza pandemic will likely recur in waves that may last for months. A community that has been affected by a pandemic may only partially recover before experiencing another wave of illness. Because a pandemic affects an entire region simultaneously, the response and recovery help that might otherwise be available could be very limited.

A pandemic presents such a unique disaster scenario that behavioral health treatment programs are advised to develop a specific plan for pandemic response. The disaster planning team can develop this plan, or it can delegate the task to a pandemic planning committee. The pandemic plan can be attached to the basic plan as a Pandemic Appendix. This chapter presents the information that should be considered as this appendix is prepared.

Potential Effects of Pandemic Influenza

When influenza reaches pandemic proportions, the operations of a behavioral health treatment program can be adversely affected in multiple ways. Significant numbers of staff members, clients, and residential patients may become ill or die. Staff shortages may occur because workers have been quarantined, want to avoid exposure, or must care for ill family members. There may be increased mental stress on staff and clients.

Specific client populations may be at special risk of illness or complications. Typically, this includes women who are pregnant (Exhibit 6-1) and people from racial and ethnic minority groups (Exhibit 6-2). Other groups that may be at special risk include people who are 65 years or older; have asthma or other chronic pulmonary, cardiovascular, hepatic, hematological, neurologic, neuromuscular, or metabolic disorders such as diabetes; are immunosuppressed; or are residents of a nursing home or other chronic-care facility. Children younger than 5 and children and youth on long-term aspirin therapy also are at special risk (HHS, 2009a).* Exhibit 6-3 lists potential effects of an influenza pandemic on the specific types of treatment programs.

Procedures To Reduce Influenza Transmission

CDC continuously updates its advice regarding procedures to reduce influenza transmission. These include annual vaccination for employees (and vaccination against specific strains of pandemic influenza as they are made available) and minimizing potential exposure by promoting good respiratory hygiene and cough etiquette, separating symptomatic clients from other persons, and a range of other actions.

Seasonal influenza guidance for the general public and health professionals from CDC is available at http://www.cdc.gov/flu and from HHS at http://flu.gov.

Exhibit 6-1. Pregnant Women at Special Risk From Influenza

Pregnant women who contract influenza are at increased risk for severe illness or death, and babies born to them have increased risk of adverse outcomes (Rasmussen, Jamieson, & Breese, 2008). The disaster planning team should consider actions the program can take to mitigate risk for pregnant clients during a pandemic outbreak, such as the following:

- Provide services to pregnant women in ways that minimize their exposure to others (e.g., in individual rather than group settings, in separate areas of the facility).
- Educate women to protect themselves against infection while performing their roles as family caregivers and members of the workforce.
- Help women develop a plan to maintain prenatal care while minimizing exposure.
- Provide counseling to women on the benefits and risks—for themselves and for their fetuses—of influenza vaccine, antiviral medication, antifever medication, and antibiotics, such as for secondary bacterial pneumonia.
- Support pregnant women in their compliance with physician recommendations for use of antiviral and other prescribed medications.

Exhibit 6-2. Racial and Ethnic Minorities Disproportionately Affected by Influenza

Historically, people from racial and ethnic minority groups have been disproportionately affected by severe influenza due to higher rates of underlying health conditions as well as cultural, educational, and linguistic barriers that interfere with adoption of intervention strategies (Hutchins, Fiscella, Levine, Ompad, & McDonald, 2009). To minimize disparities, programs can involve members of racial and ethnic minorities in its pandemic preparedness and response planning and facilitate their participation in community pandemic planning. Programs also can advocate for equitable allocation of resources including antiviral medications and vaccines. When providing pandemic planning education and services, programs can offer culturally and linguistically sensitive educational materials and interpreters for non-English-speaking clients.

*An influenza virus may affect people atypically. For example, in the 1918 pandemic, healthy young adults comprised the predominant risk group. It is theorized that the virus triggered an overload of response from the immune system and that people with stronger immune systems were more susceptible to an overreaction to the virus.

Exhibit 6-3. Potential Effects of Influenza Pandemic on Behavioral Health Treatment Programs

Program Type	Potential Pandemic Effects
Outpatient Treatment Programs	Client drop-in and attendance at individual appointments and group events may decline. Alternatively, client drop-in and attendance may surge because of concern, panic, or lack of other psychological or medical support. Clients may not heed instructions to stay home if experiencing influenza-like symptoms, and consequently transmit the illness to other clients and staff. Mental health emergencies may increase as the result of a disruption in client support and access to ongoing treatment. Services may have to be provided using procedures to reduce influenza transmission (addressed in the section below). Staffing shortages may occur as clinicians become ill or stay at home to care for ill family members. The entire program or specific services may close during local outbreaks of disease. Revenues may decline dramatically, with effects on the viability of the program.
Residential Treatment Programs	Patients may become ill and need to be isolated. Staff may need to take care of patients who become ill. The facility may be quarantined. Visitation may need to be suspended or highly restricted. Electronic communications may replace actual onsite visitation.
Medically Managed Detoxification Programs	Beds may be redirected for use by patients with influenza. Medical and nursing staff may be redirected to care for patients with influenza. Necessary antiviral drugs may be slow in arriving or not be available at the necessary levels. Influenza symptoms (e.g., fever, nausea, diarrhea) may be difficult to differentiate from withdrawal symptoms. A surge in patients may occur that includes people who are infected with influenza, people who misinterpret influenza symptoms as withdrawal symptoms, and people who seek psychological or medical support.
Opioid Treatment Programs (OTPs)	An OTP may need to provide patients with take-home methadone doses for longer periods than usual (following guidelines from the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment [CSAT], Division of Pharmacologic Therapies [DPT]). The program may need to provide patients with take-home doses earlier in their recovery than usual (again, following CSAT's guidelines). Increased numbers of patients may need to have doses brought to them because they have contracted a communicable disease. Hospital emergency departments may be operating at capacity and unavailable for methadone maintenance treatment of patients whose home OTP has closed. Patients in fear of not receiving scheduled doses may overwhelm the program as they seek additional take-home supplies or support. Programs may be at increased risk of theft or diversion of medications.
Prevention Programs	The program may be discontinued until the local pandemic crisis is over.

Some modified procedures require advance planning and investment. For example, increased staff telecommuting may require improvements to the program's communications infrastructure and the development of policies. Telephone or Web-based counseling may require setup of equipment and testing that ideally are conducted in advance of a pandemic. Prior approval from funding sources, such as insurance providers and Medicaid, for substitute forms of counseling may be needed to facilitate reimbursements. Any plans to provide counseling through remote means (e.g., telephone or Internet) need to specify how clients who do not have telephones or computers will access the service. In addition, the program should review any program modifications (e.g., telephone or Internet counseling) for their potential impact on patient confidentiality. Programs can seek guidance on planning for modifications to procedures during an influenza pandemic from the State disaster behavioral health coordinator. The program is also advised to work with its attorney to ensure that procedures comply with privacy requirements and to develop documents for new procedures (e.g., client release forms for phone, texting, or Internet counseling.

Procedures should be tested and practiced to identify weaknesses in the plan and to prepare staff. Chapter 7 provides information on testing the plan and training staff to use it.

Vaccines

The disaster planning team can ensure that the program has policies in place to facilitate vaccination of staff and clients for seasonal flu, if medically indicated. The program's executive director or other appointed representative can contact local and State public health departments to learn about the community's policies on distribution for a particular pandemic influenza vaccine, when it becomes available, and to ask for the inclusion of the program's essential staff, as healthcare professionals, on the priority list.

A decision on whether to provide residential patients with the pandemic vaccine, if available, should be made by senior management in consultation with the local health department. If vaccines are offered, the program will need to implement policies and consent forms to support this practice. If possible, a patient's pertinent medical information (e.g., previous vaccinations and responses, allergies, risks, contraindications) should be reviewed before vaccinating. The program may prefer to refer nonresidential clients and staff to their primary care providers or local clinics for vaccinations.

Antiviral Medications

The use of prescription antiviral medications is an important strategy for suppressing the spread of pandemic influenza (Homeland Security Council, 2005). Recommendations for antiviral drug use in an influenza pandemic and plans for distribution of public stockpiles of antiviral medications continuously evolve. Priority distribution of antivirals will be to workers at critical infrastructure organizations—those providing goods or services essential to community health, safety, or well-being.

The program's executive director or appointed representative is advised to talk to contacts at the public health department to clarify whether antivirals from the public stockpile will be made available to the program or whether the program should purchase its own supply. The team also should become informed of the medical, legal, and ethical issues involved in the use and rationing of antivirals.

Purchase of an antiviral stockpile should be considered by all programs, especially if the program has a residential component, serves clients who have compromised immune systems, or serves women and girls (as indicated in Exhibit 6-1, pregnancy has been found to increase risk for severe illness or death from some influenza strains). Antiviral stockpiling could be costly, but financial assistance may be available from

manufacturers. All plans to stockpile should be coordinated with local and State emergency pandemic preparedness efforts and in conjunction with other measures to protect workers and maintain continuity of operations.

A behavioral health treatment program with medical staff may become an authorized point of distribution (POD) for antiviral medications and vaccines. The local or State health department coordinating these efforts can provide guidance on the requirements for becoming a POD. If the program does not choose to become a POD, it should establish plans to transport residential patients to a location where vaccinations are offered or to contract with the health department for personnel to come onsite to provide vaccinations.

Hygiene Policies

In consultation with program management, the disaster planning team can review and revise hygiene policies, including policies to:

- Encourage hand hygiene among staff and clients.
- Reduce spread of virus through respiratory means (e.g., coughing etiquette).
- Stock sanitation supplies (e.g., disinfectants, hand sanitizers, facial tissues, face masks).
- Provide preventive education for staff and clients (e.g., on the importance of maintaining overall good health, avoiding unnecessary exposure to people who are ill, and keeping all suggested immunizations up to date to protect against illness that weakens the ability to fend off influenza).
- Educate staff and clientele on influenza symptoms, social distancing procedures (the public health practice of encouraging people to keep their physical distance from each other to avoid infection), and other influenza-related topics.
- Make alterations to sick leave policies during pandemics to encourage those who are infected or recently exposed to the virus to remain away from the facility for the duration of their contagious period.
- Make temporary modifications during pandemic conditions to the program's appointment policy to ensure that clients who are contagious are not penalized for canceling appointments at short notice.

Exhibit 6-4 describes how a residential facility educated residents about flu prevention hygiene and pandemic scenarios.

Staffing Policies

The order of succession in the disaster plan may need to be extended several people deep to ensure that leadership and other essential

Exhibit 6-4. Pandemic Education Provided to Staff and Residential Patients

In our facility, monthly meetings are held for staff and residents that cover a range of topics focused on the importance of staying well. Some of these topics include correct hand washing techniques; proper use and disposal of tissues; and the importance of keeping warm, drinking enough fluids, and dressing appropriately. We also talk about how we would manage an outbreak, including containment of [residential] houses, and staff management of infectious diseases (e.g., staff stress, communications, shifts). Staff and residents need to know whom they can contact for further information.

"Talking about it" includes more than just specific education sessions. In our cases, it means building and maintaining an environment in which individuals feel they are able to tell someone if they are not feeling well and in which monitoring signs of illness is viewed as a positive response rather than an intrusion. Effective communication will also enable us to identify the early signs of stress and anxiety among our residents for early intervention.

Excerpted from Hughes (2010, pp. 39–40).

positions are filled. In addition, multiple layers of staff trained in sanitation duties (e.g., disinfecting surfaces, changing linens, removal of trash) may need to be identified because sanitation will be essential during a pandemic.

The program's pandemic plan can provide direction for rapid identification of staff members who become symptomatic and for staff substitutions so those identified workers can be sent home. If staff levels become critically low, the program may need to hire qualified staff members from a staffing agency, or it may need to refer or transfer clients. However, if there is concern about contagion, other programs may not be willing to treat guest clients even if a mutual aid agreement had been negotiated. Local hospitals also may be overwhelmed with ill patients and find it difficult to dispense methadone to referred OTP patients or to treat patients needing medical detoxification. The disaster planning team is advised to consider these scenarios. The executive director or appointed representative should clarify assumptions with the behavioral health treatment programs with which the program has mutual aid agreements, with staffing agencies, and with hospital representatives.

The disaster planning team should identify alternative ways to serve clients if the program reduces its operations or closes, and if other programs are not immediately available to serve its clients. For example, an OTP may provide patients who qualify with take-home doses for an extended duration, following CSAT's DPT guidance for pandemic situations.

Staff Attitudes

A survey of 1,835 public health workers indicates that the most important factor influencing workers' willingness to respond for duty during a pandemic is their confidence that they can perform the emergency duties expected of them *and* that their response makes a difference. A second factor influencing workers' willingness to respond is their perception of whether the pandemic threat is significant. Workers who felt they could be effective and that the threat was high had a declared rate of willingness to respond that was 31.7 times higher than the rate for workers who perceived that both their ability to respond and the disaster threat were low (Barnett et al., 2009).

The implication for behavioral health treatment program disaster planners is that staff competencies and attitudes need to be assessed to ensure that all employees are prepared, and feel prepared, for the duties they will be expected to perform under pandemic conditions. Workers who are not confident of their abilities may need more training in their designated disaster roles and education about how their contributions make a difference. Barnett et al. (2009) also suggest that in an actual pandemic situation, program management should not minimize the threat. In addition, staff members should be encouraged to develop pandemic-specific emergency plans for their own households.

Planning Assumptions for Pandemic Influenza

When drafting the Pandemic Appendix, the first step is to identify planning assumptions for pandemic influenza. These assumptions, based on available data and information from public health authorities, form the basis for planning decisions. Exhibit 6-5 provides examples of planning assumptions.

Drafting and Activating the Pandemic Plan

The Pandemic Appendix should state who determines when the plan is activated because of pandemic conditions, what information will be used to make the decision to activate the plan, and the modified policies and procedures that will be implemented. The appendix also should describe actions that will be taken if essential services cannot be provided because of staff shortages, quarantine, facility closures, or

Exhibit 6-5. Examples of Pandemic Influenza Planning Assumptions

Issue	Assumptions
Time Factors	The time interval between an alert issued for pandemic influenza and its arrival in the community may be short or long (ranging from days to months). The pandemic may last as long as 18 months and occur in several waves, with mortality and morbidity increasing and decreasing sporadically. Waves of severe disease may last 1–4 months.
Prevention and Treatment of the Influenza	A vaccine may not be available for many months after an influenza pandemic begins, and supplies of it may be limited. Antivirals may not treat or protect against the pandemic influenza virus strain. Even if effective, antiviral medications may be in limited supply, and their distribution may occur in phases. Infection control strategies and social distancing strategies (e.g., postponing public gatherings such as support group meetings, substituting Internet and phone counseling for in-person sessions) can be used to slow the spread of disease. Isolation of ill people will be required. Quarantine of healthy people exposed to ill people may be implemented.
Clients and Staff Members	Clients with weakened immune systems or who are pregnant are at higher risk for severe illness and death. Twenty to fifty percent absenteeism for staff, clients, vendors, and services within the community may occur. Absenteeism will be the result of staff members and clients becoming ill, staying home to care for children or family members, or refusing to go to the facility for fear of contracting the virus. Every person who becomes ill is likely to miss from a few days to many weeks of work. In a severe pandemic, 0.1 percent–2.5 percent of people who become ill may die. Staff members and clients (including residential patients) may develop symptoms while on program premises. Staff members may be asked to perform tasks that are not part of their normal job descriptions, to provide coverage for essential services; alternatively, they may be transferred to other duties or facilities where coverage is needed, or they may be assigned to work extended or additional shifts. In a severe pandemic, essential staff members may be drafted into the care of the sick, and residential facilities may be commandeered to create pandemic wards separate from the main hospitals. In a severe pandemic, fear and anxiety levels will increase.
Services	Services will be stressed but will remain functional. Telecommuting practices may be implemented for support services (e.g., administrative functions). Critical functions carried out by contractors, consultants, and vendors may be erratic. The program may be unable to rely on mutual aid resources to support its response efforts. Staff may accrue an unbudgeted amount of overtime or use higher-than-normal amounts of leave and sick time.

Excerpted and adapted from San Francisco Department of Public Health (2006, p. 6).

other pandemic-related events, and it should describe the conditions under which the plan will be deactivated and staff will return to normal duties.

The local public health department is a primary source of information about local pandemic conditions, and CDC provides continuously updated information on conditions nationwide.

The decision to activate the pandemic plan must be made carefully. The hardships imposed by reducing or modifying services to clients must be weighed against the risks of infection. If pandemic procedures are activated too soon, the hardships will outweigh the benefits and adherence (such as to social distancing procedures) may wane. However, if procedures are activated too late, the infection prevention benefits may be limited.

The program's Pandemic Appendix should detail how staff members, clients, and the public will be notified of changes in service provision and procedures including closings and alternative options for seeking assistance. This notification plan will likely not differ significantly from those for other types of emergencies. Model text for notification messages can be composed in advance and included in the Pandemic Appendix. Examples of message objectives include:

- Informing staff and clients of pandemic conditions.
- Counteracting rumors and misinformation.
- Providing basic situational anxiety management information and suggested techniques (e.g., deep breathing, relaxation techniques, keeping hydrated).
- Providing staff members with a resource for their confidential use (e.g., an employee assistance program) that can help them with pandemic-related challenges.
- Providing information on the general health conditions of colleagues and clients (including notifications of death).
- Providing referral to bereavement counseling and other social supports.

Chapter 7—Completing, Testing, Activating, and Deactivating the Plan

In This Chapter

- Assemble the Plan
- Distribute the Plan
- Train and Test
- Activate the Plan in Disaster
- Deactivate and Revise the Plan
- Coordinate With the Community in Recovery
- Support Staff Members, Clients, and Community After the Disaster
- Continuously Revise and Update the Disaster Plan

Worksheets (see Appendix B)

- B1 Checklist for the Written Disaster Plan
- B20 Disaster Plan Training and Testing Log

As explained in Chapter 1, the behavioral health treatment program's disaster planning team drafts the sections of the written disaster plan as it gathers information based on a risk assessment document; the team recommends to management implementation options (following the processes outlined in Chapters 2 through 6). This chapter explains the steps involved in completing and working with the plan. These steps include assembling and distributing the plan, training staff on using it, testing the plan, activating the plan when a disaster incident occurs, deactivating the plan when the state of emergency ends, revising the plan based on lessons learned from the disaster response, and providing support to staff and clients after the disaster.

Assemble the Plan

When all sections of the disaster plan are completed, they can be assembled into one document. **Worksheet B1** (in Appendix B) provides a checklist of all items that should be included in the plan. The following elements are inserted at the front, or Preface, of the document:

- **Cover page.** Include the title, date, and facility covered by the plan.
- **Signature page.** This page includes signatures of the program's executive director and other senior managers (e.g., the chair of the program's board of directors) that affirm that the program's leadership approves and endorses the plan. Management can sign off on sections as they are completed or at one time on the entire document.
- **Title page.** This page includes placeholders to record the date of changes and revisions to show that the plan is being kept current and to indicate that the document is the current version.
- **Record of changes.** This record indicates changes that were made to the plan and the dates they were made.

- **Record of distribution.** This page indicates who has received a copy and where other copies are stored (e.g., in the facility go kit).
- **Table of contents.** A list of the sections in the plan (as well as a tabbed page at the start of each section) helps users find information quickly.

Distribute the Plan

Once management approves the plan, the disaster planning team should distribute it to all relevant parties. Staff members assigned responsibilities under the plan can receive the full document or the sections relevant to their duties, and they can be given two copies—one for the office and one for home. The disaster planning team can develop a management-approved summary to provide to other staff members. The team also can provide copies of the summary or the full plan, as appropriate, to the State agency that oversees behavioral health disorder treatment and to other organizations with which the program has developed relationships for disaster response (e.g., the local departments of health and social services, the local jurisdictional emergency managers, the local chapter of the American Red Cross).

Train and Test

In an actual disaster, no one has time to *read* a disaster plan. Training and testing staff members familiarize them with procedures so that they can respond efficiently when and if a disaster does occur, using the written plan as a reference.

Disaster exercises can help staff members build the skills and teamwork they will need when executing a disaster plan. These activities also identify problems or gaps in the plan that should be addressed, as well as actions that can mitigate risk. These drills and exercises may involve staff from, and take place within, a single facility. Alternatively, they may encompass the multiple facilities of one organization or unaffiliated programs that are geographically close. Behavioral health treatment programs may consider providing staff with compensated time for training conducted outside regular working hours and other incentives to enhance disaster readiness skills. Disaster-related courses are offered by the Emergency Management Institute of the Federal Emergency Management Agency (FEMA) and by local chapters of the American Red Cross. **Worksheet B20** (in Appendix B) can be used to log training and testing activities.

Each training exercise should build on the previous one (FEMA, 2009). Types of exercises are summarized in the following sections.

Discussion-Based Seminars

Training can begin as the disaster plan is being developed. With the support of senior management, the disaster planning team can schedule briefings to familiarize staff with basic disaster concepts and staff roles and to build support for the disaster readiness concept.

Discussion-Based Workshops

Through facilitated discussions, staff can provide input on the disaster plan and the policies that would support the plan, draft specific sections of the written plan, and develop supporting products, such as job-related aids.

Tabletop Exercise

A tabletop exercise provides initial training to key staff members who are responsible for executing the disaster plan. In a classroom setting, a scenario is presented by a facilitator, and participants talk through possible responses (FEMA, 2009). New developments in the scenario are presented during the exercise so that participants reconsider previous decisions and plan their next actions. Participants share ideas and discuss options for responding to the hypothetical situation, without the pressures that occur in a real or simulated event. The tabletop exercise familiarizes participants with their roles and

responsibilities and reveals issues that require revision or additional planning. Tabletop exercises also enable local organizations to network and share ideas on improving disaster readiness. Exhibit 7-1 summarizes a tabletop exercise involving opioid treatment programs (OTPs) in King County, WA. Exhibit 7-2 provides an example of the useful networking that can occur at a tabletop exercise.

Functional Exercise

In a functional exercise, participants act out responses according to their assigned roles in a simulated disaster scenario rather than simply discuss potential responses. This role-play places participants under time pressure. The simulation evolves over time; for example, the scenario might start as a wildfire that is followed by a rainstorm and landslide.

As its name implies, the functional exercise typically tests a function rather than the entire breadth of activities that would be engaged in a real disaster. For example, an exercise might focus on one of the following:

- Coordination of staff members from two behavioral health treatment programs for the transfer of clients from one facility to another
- Communicating during a severe pandemic with clients who have limited English proficiency

Exhibit 7-1. Tabletop Exercise for Opioid Treatment Programs (1.5 hours)

Element	Description
Participating Organizations	City of Seattle Office of Emergency Management Drug Enforcement Administration (DEA) Evergreen Treatment Services King County Healthcare Coalition Public Health—Seattle and King County Therapeutic Health Services University of California, Los Angeles Veterans Administration (Washington State Department of Veterans Affairs) Washington State Board of Pharmacy Washington State Division of Alcohol and Substance Abuse
Exercise Objectives	Determine ability to support timely decisions about operations of OTPs in an emergency Demonstrate ability to coordinate communication and resources among key stakeholders Evaluate process for activating mutual aid agreements among OTPs Discuss protocols and rules of regulatory agencies
Scenario Timeline and Major Events	Friday, May 29, 7:59 a.m.: A very large earthquake occurred, rumbling through the entire Puget Sound region for 2 minutes. Damage is visible in the entire county. All landline and cell phones are jammed. Electricity is out in the neighborhoods of SODO, Capitol Hill, and First Hill. Friday, May 29, 8:45 a.m.: Media report a shallow 6.8 magnitude earthquake occurred in the Black Diamond area and extensive damage in Kent, Auburn, and Renton. The 520 bridge has collapsed. The Alaskan Way viaduct is closed. Saturday, May 30: Landline and cell phones work sporadically. Text messages are getting through. Limited power returns to SODO region. Evergreen Treatment Services has power but no water. Monday, June 1: President signs a disaster declaration for the area. Monday, July 6: Several moderate aftershocks (2–5 in magnitude) have occurred since May 29.

Continued on next page

Exhibit 7-1. Tabletop Exercise for Opioid Treatment Programs (continued)

Element	Description
Lessons Learned	OTPs that have generators will assess what equipment, including alarms and medication storage areas, are powered by their agencies' backup generator. OTPs will advise staff members that they should plan alternate routes to work. OTPs will work on strategies for communicating with staff members, patients, and the general public, including the media, in a disaster. This includes developing communication strategies for contacting patients if power is down and landline and cell phones are jammed and encouraging staff members to have an out-of-area phone contact. OTPs will work on developing strategies for communicating with one another about their ongoing activities in a disaster. OTPs that anticipate a need for enhanced services in a disaster (e.g., heightened security, priority in restoring power, transportation considerations) should immediately contact their local Emergency Operations Center for guidance on addressing problems identified during the exercise. The contact at the Emergency Operations Center should be at least at the level of captain. Local OTPs may need to coordinate with OTPs outside King County. Although nothing is currently in place to enable that process, the use of the existing mutual aid agreement as a template for working with OTPs in other counties is encouraged. A State-level entity would be most appropriate to take the lead in facilitating emergency preparedness activities among OTPs across the State. To balance the needs of patient access to medication, patients' and staff members' physical safety, security of medication, and provider's liability exposure, OTPs will need support from regulatory authorities. DEA wants OTPs to keep it apprised of their activities in a disaster but does not want to impede program activities. DEA will provide OTPs with an emergency contact telephone number. The King County jail needs a disaster plan for dosing methadone patients if a licensed OTP is unable to do so. Verification is needed as to whether general population shelter operators will allow patients to bring take-home doses of methadone into the shelter, even when prescriptions can be verified. A medically based disaster plan is needed to address citizens who are chronically intoxicated and/or who abuse opioids and are suddenly cut off from their substance of choice because of the disaster.

Excerpted and adapted from King County Healthcare Coalition (2009).

Exhibit 7-2. Beneficial Networking at a Tabletop Exercise

Various community agencies and organizations participating in a tabletop exercise can exchange useful information that might otherwise not be shared. During the tabletop exercise described in Exhibit 7-1, discussion turned to the use of generators for emergency power. The manager of an emergency responder agency indicated that OTPs might be able to obtain priority fuel assistance for their generators during an outage. This advice was useful to the OTP administrators, because lines at gas stations can be long during an emergency. One administrator who had experienced a communitywide extended power outage after a storm reported that he had had to divert staff members from their treatment functions to the task of finding gas: "I'd load them up with gas cans and send them out to fill them all up, so we'd have fuel for a couple of days."

Source: Podus et al. (no date).

- Notifying families and referral agencies during an emergency evacuation at an adolescent residential treatment program
- Executing a plan for sheltering-in-place that provides for the unique needs of populations defined as at-risk (U.S. Department of Health and Human Services [HHS], 2012)

Typically, it will be more feasible, cost-effective, and productive for a behavioral health treatment program to participate in a community-sponsored functional exercise than to conduct one on its own. The disaster planning team that has an established working relationship with local emergency planners, as described in Chapter 2, can stay apprised of when such exercises are scheduled and find out how to arrange for program staff members to participate.

Field Exercise

A field exercise is a full-scale enactment of a disaster, with people acting out their roles in real time, using actual equipment, and testing multiple emergency functions. A field exercise takes a great deal of planning, is disruptive to normal business operations, and is expensive. Thus, a behavioral health treatment program is unlikely to conduct this kind of exercise on its own. However, its staff can benefit from participating in a field exercise organized by local or regional emergency management leaders.

Although community field exercises can be beneficial, behavioral health treatment programs do not have a strong record of participating in such efforts. A survey of 90 OTPs found that, whereas all responding OTPs had disaster plans and participated in tabletop and functional exercises of their plans, less than 17 percent had partnered with another agency for a field exercise (Podus, 2009). Less than 30 percent reported that they knew "a good deal" about how local government and community agencies (e.g., mental health services providers, law enforcement, emergency management, the American Red Cross) would handle circumstances related to a disaster in their areas. Leaders of behavioral health treatment programs should actively network with local emergency managers so that the leaders are aware of joint exercises, can testify to the importance of being included in the planning and execution of these exercises, and are invited to be involved.

> Evaluation is an integral part of any training exercise, whether a tabletop or a full functional exercise. Decisions on exercise goals and how to evaluate these goals should be decided upon at the beginning of the process. Effective exercise planning begins with setting these measurable goals. The exercise itself ends with a measurement of success in achieving those goals, which leads to decisions that may include how to improve the current disaster plan, policies, and trainings. The resulting document is referred to as an *After-Action Plan* and includes improvement goals, objectives, responsible parties, and timelines for making these improvements. FEMA's Homeland Security Exercise and Evaluation Program is a tool for developing training exercises and establishing and evaluating the exercise goals. This tool can be scaled up or down for exercises of all sizes and types, and it can modified based on the needs of the program. It is located at https://www.llis.dhs.gov/hseep.

Activate the Plan in Disaster

When a disaster occurs, swift mobilization can lessen the impact. Through the process of testing and training, staff can become familiar with the four key steps to take in disaster response. These are:

1. Activate the program's Incident Command System (a key person is designated Incident Commander to manage response; see Designate Personnel To Assume Command for Incident Response, Chapter 3).

2. Decide on objectives and priorities to minimize risk to persons and property, based on the nature of the incident (e.g., if a wildfire is approaching a program, the first priority will be immediate evacuation of the facility and a second priority will

be protection of property). The disaster plan's hazard-specific appendices provide guidance on objectives for response to a specific threat, such as a wildfire.

3. Create an Incident Action Plan to accomplish the objectives in a specified timeframe. The plan will indicate assignments and the resources that can be used to complete those assignments. An informal draft can suffice unless the incident response is expected to be large and complex.

4. Follow through on the plan, except where it is necessary to make modifications to the plan to address changing circumstances.

Familiarity with disaster procedures helps leaders activate a disaster response at the right time—not too soon, too late, or unnecessarily. Exhibit 7-3 illustrates timing ramifications. Two key variables affect the decisionmaking process: (1) whether the program has received advance notice of the disaster, and (2) when the incident occurs (during or after business hours). A hurricane or severe blizzard usually allow for advance notice, whereas an earthquake or hazardous materials spill typically will not. Disaster incidents that occur when key staff members are off duty or are out of town may require subordinate staff members to make decisions on when and how to contact their supervisors and on the actions to take. Recurrent disaster training for all staff members and clarity about succession planning are the best protections against a sudden disaster that occurs when senior management staff members are not present. Training for management and staff can be offered in short sessions over time and build from basic to more advanced skills, based on roles. This kind of graduated training schedule avoids disruption of treatment services.

Deactivate and Revise the Plan

Deactivation is the process by which an organization ends its state of emergency and resumes normal operations. Examples of deactivation activities for a behavioral health treatment program include:

- Returning from an alternate facility to the home location after the disaster incident has passed, such as when a mandatory evacuation has ended. (Among disaster response planners, this return is called *reconstitution* [FEMA, 2004].)
- Contacting outpatient clients to inform them that counseling services have

Exhibit 7-3. Effect of Timing Decisions on Staff

Nurses are key personnel in OTPs. In an impending disaster such as a blizzard or hurricane, they are often among the last to leave the premises because they are the ones who provide patients with emergency take-home medications.

In a disaster, the treatment program must request, and receive approval for, any needed dispensing exceptions from the Center for Substance Abuse Treatment's Division of Pharmacologic Therapies. Carrying out a decision to provide emergency doses can take up to 72 hours after approval has been obtained, according to providers who have been through weather-related emergencies. That much time may be necessary for notifying patients, for patients to reach the clinic during business hours, and for the providers to dispense the medication.

"Sometimes I wish they would just let us know a little bit sooner," reported a nurse who has worked during several weather-related emergencies. She recalled one situation in which she stayed to dispense medication so long that "on our drive home, the wind force was really bad. . . . I could feel my car going like this [gestures]. I'm really having to hold my car in the road. I would like to see them maybe make a decision a little bit sooner. . . . I mean, you know, [it] would be a little bit more safe for us, too, as the employees."

Source: Podus et al. (no date).

resumed a regular schedule and to reschedule appointments, as needed.

- Encouraging clients to reengage in services by having their assigned counselors contact them by phone about additional services or referrals, as needed.
- Arranging for the return of patients on methadone maintenance who have received guest dosing at another facility (and the retrieval of records related to this treatment).
- Completing reconstruction of all or part of a facility that had been destroyed.

After deactivation, designated disaster planning team members should debrief staff to obtain a complete picture of the program's response throughout the incident. Based on this information, the team may be able to identify steps it can take to improve future preparedness and response. With the approval of senior management, the team can update or revise the plan and retest it to ensure that the corrective actions are workable and appropriate.

When a disaster occurs or when a training exercise is completed, the disaster response leadership prepares an After-Action Report. This report summarizes the event, lists the strengths and weaknesses of the response, and presents lessons learned. Based on this report, an After-Action Plan is prepared. The plan is often presented in table format and identifies goals and objectives, due dates for completion of tasks, and the responsible parties for completing each objective. Depending on the kind of incident that has occurred, the recovery phase guided by an After-Action Plan can last weeks, months, or longer.

Adequate planning and training for disaster can expedite the recovery time. Staff should be encouraged to follow the disaster plan's recovery procedures (e.g., for contacting insurance representatives, collecting necessary documentation, filing claims, applying for recovery grants and aid, recording recovery expenses). A system should also be in place to allow staff members to record their extended hours of duty during and after the disaster so that they can be duly compensated and recognized. Exhibit 7-4 provides examples of recovery steps.

Coordinate With the Community in Recovery

The behavioral health treatment program's involvement with its community's recovery may be governed by the extent to which it engaged in predisaster recovery planning

Exhibit 7-4. Examples of Recovery Steps

- Keep staff members and clients away from debris, floodwaters, and damaged property; do not allow reentry to the building until permitted by the program's security officer or other officials.
- Prioritize and address needed repairs to damaged buildings and grounds, and take necessary steps to prevent new hazardous incidents (e.g., address erosion caused by a storm so that basement flooding does not occur).
- Inform staff of procedures for documenting recovery steps and expenses to facilitate reimbursements.
- Arrange for inspections by certified safety specialists as required by circumstances.
- Clean, disinfect, or discard wet items to avoid mold.
- Ventilate and clean shelter areas.
- Restock emergency supplies.
- Reimburse and thank providers of aid and emergency supplies.
- Evaluate the disaster response and recovery, and use this evaluation to update the disaster plan.
- Provide avenues to inform staff of any updates to the disaster plan.

and other recovery preparedness, mitigation, and community resilience-building work (see Chapter 2). Community recovery is managed by local governments, in conjunction with nongovernmental partners and stakeholders and with State and Federal agencies. Behavioral health treatment programs are most likely to become involved via the Health and Social Services Recovery Support Function, as defined by the *National Disaster Recovery Framework* (U.S. Department of Homeland Security, 2011a).*

Appendix B of the *National Disaster Recovery Framework* includes predisaster and postdisaster checklists and planning activities by sector, including private and nonprofit sectors. They can be accessed at: http://www.fema.gov/pdf/recoveryframework/ndrf.pdf.

Support Staff Members, Clients, and Community After the Disaster

The emotional well-being of staff is an important consideration throughout the disaster recovery phase. Stress management mechanisms (e.g., regular rather than overtime shifts as much as possible, compensatory time for personal recovery needs) can be built into the recovery action plan to reduce the psychological burdens for staff. Staff members should always be referred *outside* the program for assessment or treatment of personal stress reactions related to the disaster (this does not refer to incident briefings or debriefings that are part of the program's efforts to share information during disaster response and recovery). One option for providing staff support is to contract with a local employee assistance program for these services. Traumatized mental health professionals should be able to resume their normal duties when they are no longer symptomatic, but such decisions need to be made on an individual basis by the administrator, the clinical supervisor, and the person involved. Professionals who claimed disability benefits also will need permission to return to duty from their physicians or therapists.

The Disaster Distress Helpline is the Nation's first hotline dedicated to providing disaster crisis counseling. The Helpline operates 24 hours a day, 7 days a week. This free, confidential, and multilingual crisis support service is available via telephone (1-800-985-5990) and SMS (text TalkWithUs to 66746) to U.S. residents in psychological distress due to natural or human-caused disasters. Callers are connected to trained crisis counseling professionals. The Helpline staff provides confidential counseling, referrals, and other needed support services. Information on the Helpline is available at http://disasterdistress.samhsa.gov.

Clients can benefit from extra support (e.g., educational sessions, pertinent handouts, additional counseling sessions, access to a crisis hotline) to help them maintain recovery following a major calamity. The program can provide clients with a list of recovery resources that has been updated after the disaster to reflect changes in organizations, locations, meeting dates, and times. The program also may take on other activities to support the mental and substance use disorder recovery communities (e.g., arranging for translation services at meetings of mutual-help groups, organizing transportation to those meetings, providing space for a meeting at the facility, ensuring that mutual-help groups are available for specific populations such as those with co-occurring disorders or those with pharmacological dependency).

Finally, through its participation in the community's coordinated disaster recovery, the behavioral health treatment program should stay alert to the needs of the local community after the disaster. The program may be able to offer targeted assistance;

*This Recovery Support Function is coordinated by the Office of the Assistant Secretary for Preparedness and Response, HHS.

for example, it may be able to partner with other agencies to offer SBIRT services—screening, brief intervention, and referral to treatment of mental, substance use, or co-occurring disorders (Substance Abuse and Mental Health Services Administration, 2011b). SBIRT assessments can be offered on quarterly or yearly anniversaries of the disaster or as requested. Programs may want to be especially proactive about offering SBIRT services to community members who were directly affected by the disaster or who were involved in response efforts (e.g., police, firefighters, search-and-rescue volunteers, shelter staff, members of the media who reported on the disaster).

Continuously Revise and Update the Disaster Plan

The development, planning, and testing cycles of any good disaster plan are ongoing. After every test and every activation—and in tandem with any significant change to the program's services or facilities—the plan must be reviewed, evaluated, and updated. This cycle is continuous and ever challenging, requiring resources and commitments from leadership and the whole staff. Yet the benefits of disaster preparedness and planning for behavioral health programs, clients, and staff cannot be underestimated. The effort that goes into continuous disaster planning can save lives and mitigate the long-term impact of disaster on those whom the program serves.

Appendix A—Bibliography

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Appendix B—Worksheets

Worksheet B1 Checklist for the Written Disaster Plan

Worksheet B2 Checklist for Disaster Planning

Worksheet B3 Checklist of State and Community Representatives and Groups

Worksheet B4 Checklist of Disaster Planning Discussion Topics

Worksheet B5 Sheltering-in-Place Checklist

Worksheet B6 Record of Memoranda of Agreement and Qualified Service Organization Agreements

Worksheet B7 Incident Command System Positions

Worksheet B8 Identify Essential Functions

Worksheet B9 Identify Essential Staff Positions

Worksheet B10 Essential Staff Roster

Worksheet B11 Checklist for Continuity Planning

Worksheet B12 Requirements for Alternate Facilities

Worksheet B13 Alternate Facility Arrangements by Disaster Scenario

Worksheet B14 Checklist for Relocation Planning

Worksheet B15 Checklist for Maintaining Communications With Essential Groups

Worksheet B16 Checklist of Records and Databases To Ensure Interoperable Communications

Worksheet B17 Checklist for Protecting Records and Databases

Worksheet B18 Checklist for Managing Human Capital

Worksheet B19 Checklist for Management of Prescribed Medications

Worksheet B20 Disaster Plan Training and Testing Log

Worksheet B1 Checklist for the Written Disaster Plan

Name _____ Date _____

Instructions: Use with **Chapter 1, Rationale and Process for Planning**, and **Chapter 7, Completing, Testing, Activating, and Deactivating the Plan**. List the dates that each component of the disaster plan was drafted and compiled into one resource or updated.

Component Completed (date)	**Component Updated (date)**	**Preface**
		Cover page (title, date, and facility covered by the plan)
		Signature page (with placeholders to record management and, if applicable, board of directors' approval of the plan and confirmation of its official status)
		Title page (with placeholders to record the dates that reviews/revisions are scheduled/have been made)
		Record of changes (indicating when changes have been made and to which components of the plan)
		Record of distribution (including internal and external recipients identified by organization and title)
		Table of contents
Component Completed (date)	**Component Updated (date)**	**Basic Plan**
		Statement of purpose and objectives
		Summary information
		Planning assumptions
		Conditions under which the plan will be activated
		Expense support of plan and impact on budget
		Procedures for activating the plan
		Sequence of actions to be taken
		Procedures and resources for managing requests
		Methods and schedules for updating the plan, communicating changes to staff, and training staff on the plan
Component Completed (date)	**Component Updated (date)**	**Functional Annex: The Continuity of Operations (COOP) Plan**
		Essential functions and essential staff positions
		Continuity of leadership and orders of succession
		Leadership for incident response
		Alternate facilities (including the address of and directions/mileage to each)

Continued on next page

Worksheet B1 (page 2)

Component Completed (date)	Component Updated (date)	Functional Annex: The COOP Plan (continued)
		Memoranda of Agreement (MOA) and qualified service organization agreements (QSOAs)
		Interoperable communications
		Vital records and databases (backups and form of information)
		Management of human capital
		Staff training plan
		Testing and revisions of plan
Component Completed (date)	**Component Updated (date)**	**Other Functional Annexes** **List the annex for each essential activity that requires procedural instructions.**
Component Completed (date)	**Component Updated (date)**	**Hazard-Specific Appendices** **List the appendix for each hazard identified by the hazard identification and risk assessment (HIRA) as most likely to occur and for which specific response guidance is necessary.**
Component Completed (date)	**Component Updated (date)**	**Implementing Instructions** **List the materials necessary to perform essential tasks in emergency.**
		Safety policies and procedures
		Job aids (checklists, worksheets, laminated wallet cards or sheets, scripts that staff can use when providing disaster-related information to clients and the public)
		Communication tree listing (home, work, and cell phone numbers; email addresses)
		Contact information for essential groups (see Worksheet B3)
		MOA and QSOAs
		Building addresses, phone numbers, floor plans, and building evacuation routes
		Community maps
		Other:

Worksheet B2 Checklist for Disaster Planning

Name _____ Date _____

Instructions: Use with **Chapter 2, Beginning the Disaster Planning Process**. Indicate by date when each planning step has been addressed.

Date Addressed	Planning Step
	Disaster planning team leader has been selected.
	Disaster planning team members provide representation for all departments, including: • Safety/security • Clinical management/services • Medication management/services • Counseling and case management services • Public relations (handling communications with client families, the media, the recovery community, and the broader community) • Staff training and orientation • Compliance (privacy and regulatory knowledge) • Operations management • Engineering maintenance • Housekeeping services • Food services • Pharmacy services • Transportation services • Purchasing agent and contracts management • Medical records • Computer hardware and software system • Human resources • Billing • Corporate compliance (e.g., human rights, privacy, regulatory compliance) • Grant writing • Other members as appropriate (e.g., department heads; resident and family representatives; representatives of relevant cultures, languages, special interest groups; those with special emergency expertise, such as paramedic training)
	The organization's leadership provides support to the team.
	The team has reviewed requirements for disaster planning.
	The team has coordinated with others in the State and community (see Worksheets B3 and B4).
	A hazard identification and risk assessment (HIRA) has been prepared.
	Planning objectives and assumptions have been specified; objectives are measurable and have been approved by leadership.
	Other:

Worksheet B3 Checklist of State and Community Representatives and Groups

Name _____ Date _____

Instructions: Use with **Chapter 2, Beginning the Disaster Planning Process**. Indicate by date when networking for disaster response has been established with each listed representative or group. Provide names, titles, and contact information. If multiple parties are involved in the networking, attach a sheet listing all of them.

Date Addressed	State/Community Representative/Group	Names, Titles, and Contact Information (phone number[s], email)
	State disaster behavioral health coordinator	
	Other behavioral health treatment programs in the community	
	Public health department	
	Emergency response organizations	
	Local office of the Drug Enforcement Administration (DEA)	
	State Opioid Treatment Authority (SOTA)	
	Organizations of Pre-Credentialed Volunteers such as Citizen Corps Council (CCC) or Medical Reserve Corps (MRC)	
	Voluntary organizations	
	Vendors and other nearby businesses	
	Media contact and Public Information Officer of Incident Command System (ICS)	
	Other:	

Worksheet B4 Checklist of Disaster Planning Discussion Topics

Name _____ Date _____

Instructions: Use with **Chapter 2, Beginning the Disaster Planning Process**. Indicate by date when each action item has been addressed with the State disaster behavioral health coordinator (Part 1) and with public health department/local emergency planners (Part 2).

Part 1: Action items to address with the State disaster behavioral health coordinator

Date Addressed	Action Item
	Obtain information on pertinent accreditation, licensing, or reimbursement requirements as well as regulations and laws governing disaster planning as it relates to behavioral health treatment programs.
	Become informed regarding State and local disaster planning contacts and the established network of organizations involved in disaster planning at the local level.
	Obtain access to, and provide input on, the State disaster plan for behavioral health treatment programs.
	Learn about procedures for obtaining State, Federal, and private-sector assistance (including financial assistance) for disaster preparedness, disaster recovery, and expansion of services to respond after a disaster.
	Learn about assistance that can be obtained via the State from the U.S. Public Health Service Commissioned Corps, the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), and volunteer groups.
	Learn about education, training, and support opportunities, including opportunities for staff members to learn about personal emergency preparedness.
	Develop ways to coordinate disaster planning with that of other behavioral health treatment programs in the State.
	Obtain information about alternate sites that can provide behavioral health services in a disaster and the procedures for arranging reciprocal Memoranda of Agreement (MOA) or qualified service organization agreements (QSOAs) with these entities.
	Become informed of opportunities for trained staff to participate in the State and local disaster response drills and tabletops, within the scope of providing appropriate services (e.g., psychological first aid and crisis intervention).
	Discuss the unique opportunities and capabilities of the program to assist its community in a time of disaster, the support it may need from the State in a disaster, and the special services it can provide after a disaster.
	Other:

Continued on next page

Worksheet B4 (page 2)

Part 2: Action items to address with the public health department/local emergency planners

Date Addressed	Action Item
	Obtain access to the community's emergency operations plan.
	Learn whether behavioral health treatment programs' capabilities are included in the community's emergency operations planning and, if not, request their inclusion as an annex under Emergency Support Function (ESF) #8.
	Educate local emergency leadership about the program's services, its importance to the community, the assistance the program and the local recovery community can provide in a disaster, and special needs the program and its clients may have in a disaster.
	Coordinate with emergency responders on notification procedures in a disaster incident.
	Learn about education and training opportunities for the disaster planning team and/or for program staff (e.g., through Citizen Corps Councils).
	Learn about potential hazards that are particular to the community served by the program (i.e., obtain a hazard identification and risk assessment [HIRA] from the Local Emergency Planning Committee).
	Learn about the Emergency Management Assistance Compact (EMAC) and how this might affect behavioral health treatment programs.
	Consider and plan how all this information will be shared with leadership, the disaster planning team, and other staff members as appropriate.
	Other:

Worksheet B5 Sheltering-in-Place Checklist

Name _____ Date _____

Instructions: Use with **Chapter 3, Preparing for Disaster**. In column 1, indicate when the preparation listed in column 2 has been addressed or updated.

Date(s) Addressed/ Updated	Preparation for Sheltering-in-Place
	Shelter space has been identified that offers maximum protection for the particular hazards deemed most likely, according to the hazard identification and risk assessment (HIRA). Multiple spaces may be required for facilities located on more than one floor of a building or occupied by a large number of persons. Sheltering space may be different for different forms of disaster.
	Emergency supplies have been stockpiled in the shelter areas within the site, preferably in movable containers, such as wheeled plastic storage bins. The quantity of supplies is based on the maximum number of people onsite at any one time. A plan is in place to rotate or discard and restock any perishables or supplies that expire, such as batteries and bottled water. An accurate inventory of these supplies is kept current.
	The shelter space provides for communications (such as having a landline phone), sanitation, the needs of those who are mobility impaired or have special requirements, and pets, if any are routinely on premises.
	The shelter plan is coordinated with other tenants of the building.
	A chain of authority is established for communicating the need to shelter-in-place and indicating the all-clear.
	Orders to shelter-in-place will be issued through several channels so that everyone onsite is reached, including those who are visually or hearing impaired or who do not speak English as their primary language. Members of the local disability community and special language groups have been consulted to determine the most effective strategies for notification.
	For each shelter space, one or more staff persons should be assigned presheltering tasks, such as (if time permits): • Shutting down critical operations including the ventilation system if advised given the emergency. • Transporting the facility go kit and an emergency supply of medications. • Locking doors. • Sealing the room as needed for the specific hazards (e.g., a biohazard incident) that warrant sealed rooms. • Taking a head count (using a prepared roster) of those sheltering. • Assisting sheltering persons in contacting family or others to inform about their location. • Arranging for personal comfort during confinement (e.g., coordinating sleeping arrangements). • Maintaining contact with emergency authorities. • Monitoring communications for official instructions.
	Multiple means are in place for alerting local authorities when sheltering-in-place so that they can assist if the situation further deteriorates or there is a medical emergency.
	Staff and clients have been apprised of and drilled in sheltering plans to enhance willingness and cooperation when a call to shelter-in-place is issued. People cannot be forced to shelter-in-place except by government emergency authorities.

Worksheet B6 Record of Memoranda of Agreement and Qualified Service Organization Agreements

Name _____ Date _____

Instructions: Use with **Chapter 3, Preparing for Disaster**. In the left column, list the agreements that have been negotiated. For each agreement, indicate the organization involved (if a multiparty agreement has been made, attach a sheet listing all parties), where the written agreement is stored, its expiration date, and special notes (e.g., costs, limitations).

Agreement	Organization Name, Address, and Contact Information	Location of Agreement	Expiration Date	Notes

Worksheet B7 Incident Command System Positions

Name _____ Date _____

Instructions: Use with **Chapter 3, Preparing for Disaster**. Complete at least the top table. For each position, list the primary staff member and one or more backups. Worksheet B10 can be used to create a roster for the Incident Command System (ICS) positions.

Position	**Primary**	**Backup**	**Backup**	**Backup**
Incident Commander				
Liaison Officer				
Safety Officer				
Public Information Officer				
Agency Executive				

Position	**Primary**	**Backup**	**Backup**	**Backup**
Operations Team Leader				
Planning/Intelligence Team Leader				
Logistics Team Leader				
Finance/Administration Team Leader				

Worksheet B8 Identify Essential Functions

Name _____ Date _____

Instructions: Use with **Chapter 4, Continuity Planning**. Complete a copy of this worksheet for each department. List all functions that the department performs.

Department:

Function	**Provides vital services to clients: Check (√) if yes**	**Is required by regulation or law: Check (√) if yes**	**Is required to maintain safety for clients and staff: Check (√) if yes**	**Is a support function for other essential functions: Check (√) if yes**	**Is essential for other reasons:** **If yes, explain below**	**Essential:** **Yes or No**

Worksheet B9 Identify Essential Staff Positions

Name _____ Date _____

Instructions: Use with **Chapter 4, Continuity Planning**. Complete a copy of this worksheet for each department. In the left column, list the department's essential functions (those determined to be essential on Worksheet B8) in priority order. In the right column, identify the staff position(s) necessary to perform the function.

Department:

Essential Function	Essential Staff Position (Note: There may be more than one.)

Worksheet B10 Essential Staff Roster

Name _____ Date _____

Instructions: Use with **Chapter 4, Continuity Planning**. Complete a copy of this worksheet for each essential staff position identified in Worksheet B9. Record contact information for the primary staff member and backups who can perform the essential staff position's duties.

Essential Staff Position:

Information	**Primary Staff Member**	**Backup**	**Backup**	**Backup**
Name				
Office phone				
Office email				
Alternate email				
Cell phone				
Home phone				
Phone contact outside city*				
Notes†				

*Each staff member should provide emergency contact information, using a phone number (e.g., a friend's or relative's number) that is in a location distant from the facility (for use in situations in which local communications systems are not working).

†Add any information pertaining to the staff member's availability and scheduling preferences in emergency.

Worksheet B11 Checklist for Continuity Planning

Name _____ Date _____

Instructions: Use with **Chapter 4, Continuity Planning**. Indicate by date when each planning question has been addressed or updated.

All Program Types

Date(s) Addressed/ Updated	Planning Question
	What is the approximate number of active clients participating onsite in services at various times of day?
	Do client medical/service records have current contact information?
	Have clients been requested to designate an emergency contact and signed a release of information allowing the release of specific information in case of an emergency?
	How can intake procedures be expedited in a time of disaster? Have procedures been written to support these actions? Has staff been informed of these modified procedures?
	At what times of the day are family members onsite, and how many are onsite at any one time? What locations in the facility do family members visit or congregate in?
	What type of documents will be accepted to establish client identity, especially for guest clients (e.g., driver's license, State ID, military ID, other picture ID)?
	How will essential staff members be notified of the situation and their need to report for duty?
	How will treatment records be maintained and accessed during a disaster? If primary avenues for record access are inaccessible, what is the backup plan?
	How will client direct fees be determined and collected? How will billing be conducted (e.g., Medicaid, insurances)?
	How can crisis/relapse prevention counseling be provided? Are crisis phone lines available in the program, or can the program request assistance from/referral to an existing hotline?
	How will crisis/relapse prevention counseling be provided? How will the availability of this resource be communicated to clients?
	How will patients be assisted in accessing refills or replacements of prescribed or dispensed medications?
	Which mutual-help groups will be available during or after a disaster? How can the program facilitate client use of these groups as needed in disaster?
	Is participation by staff in behavioral health response (e.g., crisis counseling teams) mandated? If yes, how many staff members may be called offsite, what credentials and training are required for those staff members, and how will the essential functions of staff members called offsite be covered?
	How will care be provided to clients as they are relocated or transferred?
	How will a system be implemented to reintegrate clients once the program resumes normal operations after disaster?
	Other:

Continued on next page

Worksheet B11 (page 2)

Outpatient Treatment Programs

Date(s) Addressed/ Updated	Planning Question
	In a disaster situation, how will client needs be prioritized (those who are at substantial risk of substance use relapse or psychiatric illness if treatment is discontinued, those who can tolerate interruption of treatment)?
	Which clients are mandated for drug testing? How will drug testing for those clients be conducted under disaster-related conditions? Are there existing Memoranda of Agreement (MOA) that will provide alternate and secured drug testing for clients who cannot travel to the facility for this service? If yes, how will this information be communicated to clients?
	Are the program's doctors prescribing medications to any patients? How will patients who need refills obtain them? What backup options/agreements have been established for medication refills if the program's doctors are not available?
	Can some clients be supported by telephone- or Web-based counseling? Have specific releases of information been developed and put in place to support getting client authorization for Web-based counseling? Have these options, along with their risks and benefits, been discussed with clients? What needs to be done to provide offsite support to clients?
	What arrangements need to be made to ensure that clients have access to counselors in shelters or other locations?
	What contracts or MOAs are in place to bring in additional medical assistance through professional staff-placing agencies in a personnel shortage?
	Have staff members discussed with clients what changes might occur during an emergency situation and how this may alter how they would access services? Have clients been encouraged and directed to information that would help them prepare for disaster?
	Other:

Residential Treatment Programs

Date(s) Addressed/ Updated	Planning Question
	In a disaster situation, which staff members will be responsible for determining status of patients (those who require continued residential treatment, those who can be transferred or referred for treatment elsewhere, and those who can be discharged)?
	How will parents/guardians of patients who are younger than 18 be notified of discharge or transfer plans? For patients older than 18, how will family members or others involved with the patient's care be notified?
	How will emergency condition discharges be handled in terms of providing patients with take-home medications, instructions for continuing care, and referral to outpatient treatment or mutual-help groups after the disaster has passed? Have specific written or transfer instructions related to this type of discharge and follow-up been provided to the patients?
	Has a list been developed of emergency housing and shelters that will be available in the community for patients who can be safely discharged in a disaster if they have someplace safe to go? Does this list include contact information for these resources? How will this list be updated?
	Other:

Continued on next page

Worksheet B11 (page 3)

Medical Detoxification

Date(s) Addressed/ Updated	Planning Question
	In a disaster situation, how will patient status be determined (those who require continuing medical care, those who can be transferred or referred for treatment elsewhere, and those who can be discharged)?
	How can a specific treatment protocol of patients being detoxified be addressed and continued under emergency/disaster-related conditions?
	How can the specific needs of persons with physical or medical conditions that affect mobility or stability be addressed and managed under emergency/disaster-related conditions?
	How will parents/guardians of patients younger than 18 be notified of discharge or transfer plans? For patients older than 18, how will family members or others involved with the patient's care be notified?
	How will emergency condition discharges be handled in terms of providing patients with take-home medications, instructions for continuing care, and referral to outpatient treatment or mutual-help groups after the disaster has passed?
	What facilities can take patients needing continuing medical care? How will those patients be transported? How will the patients' medical information be transferred?
	How can assessment and intake be streamlined for intake during emergency conditions?
	Other:

Opioid Treatment Programs (Note: See also Chapter 5, Management of Prescription Medications.)

Date(s) Addressed/ Updated	Planning Question
	How many of the program's current patients will likely need methadone dosing within 24 hours of a disaster incident?
	How many patients will need refills of their take-home methadone doses and within what timeframe?
	How much methadone will be needed onsite at any one time to provide take-home doses for all eligible patients in an emergency?
	How will dose information be accessed and maintained under emergency/disaster conditions?
	How will methadone be transported to patients at other locations (e.g., jails)? Who will be responsible for this?
	How will patients who are disabled or affected by communicable disease, such as influenza, be provided methadone?
	In emergencies for which there is advance warning, can take-home doses of methadone be provided above the usual quantities? If so, in what amounts? Can take-home privileges be extended to additional patients? If so, what will be the criteria? How will lockboxes be provided, as required, to patients provided with new take-home privileges? Has the authority to make these changes been documented fully?
	How will exception requests (per Section 8.12 of 42 Code of Federal Regulations [CFR]) be submitted under various emergency scenarios to the Substance Abuse and Mental Health Services Administration (SAMHSA) and the State Opioid Treatment Authority (SOTA)?
	Other:

Continued on next page

Worksheet B11 (page 4)

Primary Prevention Services (Note: Primary prevention will not be an essential service in a disaster.)

Date(s) Addressed/ Updated	Planning Question
	How will participants of nonessential services be notified of the cancellation of these services?
	How will participants/clients be notified when regular services will be resumed?

Worksheet B12 Requirements for Alternate Facilities

Name _____ Date _____

Instructions: Use with **Chapter 4, Continuity Planning**. In the left column, list the behavioral health treatment program's essential functions (from Worksheet B8). In the middle columns, estimate the number of people involved in each essential function at any one time, and list facility requirements to accommodate that number of people. Then, make a copy of this partly completed worksheet for every alternate facility being evaluated. On each copy, write the prospective alternate facility's name and contact information and indicate whether it meets the requirements. Use the data collected to compare prospective alternate facilities and to consider how to meet requirements that an alternate facility cannot provide.

Alternate Facility Name, Address, and Contact Information:

Essential Function	**Number of Staff Members To Perform Function**	**Maximum Number of Clients Served at any One Time**	**Requirements: Estimate of needed floor space, furniture, beds (for male and female adults, adolescents, children), power, privacy, communications, security, storage, restrooms, meal preparation or serving areas, accessibility**	**Meets Requirements: Yes or No**

Worksheet B13 Alternate Facility Arrangements by Disaster Scenario

Name _____ Date _____

Instructions: Use with **Chapter 4, Continuity Planning**. For each disaster scenario, list the alternate facilities that have been arranged. Add any notes (e.g., whether prearrangements have been confirmed, costs for use, distance from facility, whether some staff members will work from home). If the program has multiple sites, a separate sheet should be completed for each noting the specific alternate arrangements. Memoranda of Agreement (MOA) and/or prearrangements are recommended for external sites not owned by the program.

Disaster Scenario	**Primary Alternate Facility: Name, Address, Contact Information, and Notes**	**Secondary Alternate Facility: Name, Address, Contact Information, and Notes**
Internal (only the behavioral health treatment program site is affected)		
Local (the program site and its community are affected)		
Regional or national (the emergency affects a broad geographical area)		

Worksheet B14 Checklist for Relocation Planning

Name _____ Date _____

Instructions: Use with **Chapter 4, Continuity Planning**. Indicate by date when each planning step has been addressed or updated.

Date(s) Addressed/ Updated	Planning Step
	Options for relocation of operations have been identified and confirmed through Memoranda of Agreement (MOA).
	Written agreements have been made with transport companies that will be used, such as bus and van services to relocate clients and staff.
	A plan for triaging patients has been detailed (to identify those who are able to be discharged and relocate independently vs. those who need further treatment or sheltering).
	Multiple routes to each predetermined alternate site have been mapped. Routes have been marked on maps, which are kept with the emergency supplies or in facility vehicles.
	Disaster preparedness education and assistance, tailored to clients, have been provided.
	Vehicles that will be used in emergency evacuation are kept in ready condition and fully fueled. Drivers have the appropriate driver's license for the vehicle and will have access to a credit card or cash in a disaster situation to pay for fuel as needed.
	Primary and backup transportation options have been identified. Modes of transportation will accommodate clients being moved who need special assistance (e.g., vans equipped for wheelchairs). The transportation plan considers the need to move supplies including medications, computers, and so forth.
	A chain of authority is established for ordering full-site relocation and indicating the all-clear (in coordination with local emergency authorities) to return to the facility.
	One or more staff members have been assigned closing and relocation tasks, such as (if time permits): • Shutting down critical operations, including shutoff of utilities (e.g., gas or propane at main switches or valves, disconnection of electric appliances, extinguishing woodstove fires). • Transporting the emergency supplies. • Transporting the facility go kit and emergency supply of medications. • Transporting other critical equipment such as hard drives or servers. • Locking doors and securing the building. • Supervising logistics of transporting people and supplies. • Taking a head count (using a prepared roster) of those relocating, and informing emergency authorities of those not relocating or any missing persons and their likeliest locations. • Coordinating with those in authority at the alternate site. • Informing emergency authorities of the facility's evacuation plan. (Confidentiality regulations may restrict the program from providing authorities with the names of clients who were relocated.) • Locking cabinets and safes that contain controlled substances and medical equipment, or arranging for their legal and secure transfer.
	Procedures are in place to inform the public of the facility's evacuation and the location of the alternate facility (e.g., posted signs on door, message on telephone answering machine, information posted to Web site and social media outlets).

Worksheet B15 Checklist for Maintaining Communications With Essential Groups

Name _____ Date _____

Instructions: Use with **Chapter 4, Continuity Planning**. For each essential group listed in the left column, place an X to indicate the means by which communications will be maintained during an emergency.

Group	Landline Phone	Cell Phone/ Smart-phone	Web Site or Intranet	2-Way Radio or Walkie-Talkie	Satellite Phone	Hotline (outside facility)	GETS, WPS, or Priority Listing for Electric Service*	Amateur Radio	Recorded Message	Sign on Door	In-Person	Announcement via Media (social network such as Twitter, TV, radio)	Other
Emergency responders													
Essential staff													
Nonessential staff													
Clients													
Client families													
Substance Abuse and Mental Health Services Administration (SAMHSA)													
Drug Enforcement Administration (DEA)													
Vendors/ insurers													
Providers of mutual aid													

*GETS = Government Emergency Telecommunications Service; WPS = Wireless Priority Service

Continued on next page

Worksheet B15 (page 2)

Group	Landline Phone	Cell Phone/ Smart-phone	Web Site or Intranet	2-Way Radio or Walkie-Talkie	Satellite Phone	Hotline (outside facility)	GETS, WPS, or Priority Listing for Electric Service*	Amateur Radio	Recorded Message	Sign on Door	In-Person	Announcement via Media (social network such as Twitter, TV, radio)	Other
Referral agencies (e.g., service agencies that can assist with other emergency needs)													
Recovery advocates and groups													
State disaster behavioral health coordinator													
State Opioid Treatment Authority (SOTA)													
Licensing Entity													
Funders or billing entities (e.g., Medicaid)													
Media													
Others:													

*GETS = Government Emergency Telecommunications Service; WPS = Wireless Priority Service

Worksheet B16 Checklist of Records and Databases To Ensure Interoperable Communications

Name _____ Date _____

Instructions: Use with **Chapter 4, Continuity Planning**. For each category of record or database listed in the left column, place an X to indicate the options for retrieving or entering data. Also indicate the staff members who have authority to retrieve or enter data and whether they will have access to the passwords or authentication procedures for accessing the record.

Category of Record or Database	Onsite Computer	Offsite Server	Laptop (battery operated)	Portable Memory Device (e.g., encrypted flash drive, encrypted DVD)	Paper	Copies in Facility Go Kit	Other	Staff Members With Authority To Retrieve or Enter Information and Who Have Access to Passwords or Authentication Procedures for Accessing the Record or Database
Current client medication information								
Other client medical information								
Client psychosocial history								
Client billing information								
Drug testing data								
Personnel information								
Payroll								
Computer systems information (network diagram, passwords)								
Vendor records								
Other:								

Worksheet B17 Checklist for Protecting Records and Databases

Name _____ Date _____

Instructions: Use with **Chapter 4, Continuity Planning**. For each category of record or database listed in the left column, provide the information requested in the other columns. Use this information to determine the steps to ensure protection of vital records and databases.

Category of Record or Database	Form of Records/ Databases and Location	Supporting Hardware/ Software Needed	Frequency of Maintenance and Backup	Backup Protections	Means of Securing Records/Databases	Other
Client clinical information						
Client billing information						
Legal and financial records (e.g., personnel, Social Security)						
Drug testing data						
Personnel contact information						
Essential staff credentials and State licenses						
Payroll						
Computer systems requirements (e.g., network diagram, passwords, and keys; equipment manufacturer, model, and serial numbers; installation procedures and licenses)						
Software and hardware operation manuals						
Order of succession, delegation of authority, and Incident Command System (ICS) structure						
Other:						

Worksheet B18 Checklist for Managing Human Capital

Name _____ Date _____

Instructions: Use with **Chapter 4, Continuity Planning**. Indicate by date when each staff policy has been addressed or updated.

Date(s) Addressed/ Updated	**Maintaining Contact With Staff**
	A system has been developed for staff members to contact supervisors following a disaster to inform the program of their status, location, and current contact information.
	A system has been developed for the program to inform staff members of their work status (essential or nonessential) and whether they are to report for work or to stay home.
Date(s) Addressed/ Updated	**Work Schedules**
	Staff members have been preassessed for their capacity during an emergency (e.g., availability to work overtime, to stay onsite as needed, to assume other or additional duties, to deploy to an alternate facility).
	Staff functions that can be performed from home have been determined.
	Methods of tracking and supporting staff members reassigned to work at an alternate facility have been developed.
	Staff members have been assisted in preplanning alternate means and routes of transportation to and from work.
Date(s) Addressed/ Updated	**Compensation and Leave**
	Pay rates for disaster situations have been determined (e.g., when staff members take on additional duties, duties above their current level, duties at alternate facilities, work overtime, or stay overnight at the facility).
	A continuation plan has been determined for wages and salaries of employees who are unable to return to work immediately following a disaster.
	A plan for payment of salaries in disaster situations has been determined (e.g., a backup system is in place if the electronic/ direct deposit is not available for payroll).
	Policies have been determined regarding whether staff members can take paid or administrative leave to stay home or volunteer in the community recovery after a disaster.

Continued on next page

Worksheet B18 (page 2)

Date(s) Addressed/ Updated	Staffing
	Accommodations (e.g., day care) are available for essential staff members who have dependents and might be required to work after business hours or when schools/day care facilities are closed.
	Substitutes to fill essential positions have been identified from within the staff.
	Outside substitutes have been arranged with another behavioral health treatment program under the terms of a mutual aid agreement.
	An alternate plan is in place to fill essential positions, such as by using a placement firm or by developing a list of on-call temporary workers or volunteers (e.g., recent retirees).
	A procedure is in place for checking the credentials and conducting background criminal checks if necessary of substitute providers or volunteers brought on board immediately after a disaster.
Date(s) Addressed/ Updated	**Training**
	Staff members have been assigned for training or credentialing in disaster response (e.g., National Incident Management System [NIMS], Incident Command System [ICS]).
	Staff members have been assigned for training in trauma-informed therapy (e.g., CPR, first aid, psychological first aid, grief and bereavement counseling).
	Staff members have been provided training to be culturally responsive to new populations that may seek services following a disaster (e.g., people migrating from adjacent States or who have substance use disorders different from those typically treated by the program).
	Staff members who may be assigned to alternate facilities through a mutual aid agreement have been credentialed and approved for that work.
	Staff members have been selected and trained for participation on a behavioral health response team that may deploy into the community.
	Staff members who may be offered for mutual aid have been trained and credentialed for that work.
	Staff members have been encouraged to develop home disaster plans.
Date(s) Addressed/ Updated	**Staff Behavioral Health Needs**
	Staff members are trained to recognize the support needs of their colleagues and themselves during emergency response and recovery phases.
	Employment policies address leave for staff to access services for dealing with disaster-related behavioral health issues.
	A list has been compiled of referral resources for staff members needing social services after a disaster (e.g., critical incident stress debriefing; disaster recovery assistance with housing, insurance claims, workers' compensation).
	Policies are in place to support confidential self-referral or supervisor referral of staff members who are experiencing the need for services to address stress and other reactions to disaster.

Worksheet B19 Checklist for Management of Prescribed Medications

Name _____ Date _____

Instructions: Use with **Chapter 5, Management of Prescription Medications**. Indicate by date when each planning step has been addressed or updated.

Date(s) Addressed/ Updated	Planning Steps—All Programs
	Clients have been advised on how to obtain prescription replacements and refills under various disaster scenarios.
	Clients have been educated on what to carry with them when evacuating or seeking services at an alternate facility so that they can obtain prescription replacement, refills, or methadone dosing.
	The program has communicated with the public health department for information on the public stockpile of medications.
	The topic of medication maintenance for clients has been addressed with local disaster planning committees.
	Plans are in place for transfer and tracking of patients receiving medications to an alternate location or to another clinic that will be able to provide guest dosing or other prescription medications.
	Other:

Date(s) Addressed/ Updated	Planning Steps—Opioid Treatment Programs
	Patient medical records (including dose levels and take-home privileges) are stored and regularly updated at a secure location (e.g., an offsite server).
	The opioid treatment program (OTP) is ready to quickly and securely transfer patient records and the supporting software to an alternate facility.
	The OTP is ready to submit exception requests to the Substance Abuse and Mental Health Services Administration (SAMHSA) and the State Opioid Treatment Authority (SOTA) (as authorized).
	The option of providing patients with smart ID cards has been considered. If smart ID cards are used, other OTPs have been identified that have the equipment to read the cards and that can accept guest patients in emergency. A backup method for transferring medical data has been established, in case patients lose their smart ID cards.
	The program has discussed with its SOTA the capabilities of its central database and has determined the procedures for accessing patient records in emergencies. Issues covered include: • How patient information will be accessed when records at the program are destroyed or inaccessible. • How information on guest patients from other OTPs will be accessed. • How the OTP's patient records will be accessed by other OTPs providing guest dosing. • Whether patient releases and other permissions will be required to access patient records. • Whether dosage information from guest patients will be relied on before verification of that information from the guest patients' home OTPs.
	The program is aware of the current status of State-run healthcare communications systems through which dosing information can be securely transferred.
	Procedures are in place for handling patients who request courtesy dosing after a disaster and/or for referring prospective guest patients elsewhere when the facility does not have the resources to handle those guest patients itself.

Continued on next page

Worksheet B19 (page 2)

Date(s) Addressed/ Updated	Planning Steps—Opioid Treatment Programs (continued)
	Procedures are in place for handling an influx of new patients after a disaster.
	Procedures are in place for referring prospective pain patients to providers who can assist with pain management.
	Program staff is aware of lawful procedures for moving controlled substances and the procedures for requesting moves.
	The Drug Enforcement Administration (DEA) agent for the program's jurisdiction has been informed about methadone maintenance treatment and use of other controlled substances for behavioral health treatment and about the potential need for expedited permissions in emergencies.
	The local law enforcement agency has been advised that controlled substances are located on the property and has been requested to provide the facility with high-priority protection if looting occurs following a disaster or with a police escort when transporting program supplies to an alternate facility.
	Contingency plans have been developed for resupply of methadone if the original supply becomes destroyed or inaccessible.
	Counselors have discussed with physicians and pharmacies the options patients have to obtain prescription replacements and refills under various scenarios (e.g., if patients cannot contact their prescribing physician, if their primary pharmacy closes, or if they are relocated).
	Counselors and/or OTP physicians provide education to patients on what to do to maintain supplies of their prescriptions.
	Other:

Worksheet B20 Disaster Plan Training and Testing Log

Name _____ Date _____

Instructions: Use with **Chapter 7, Completing, Testing, Activating, and Deactivating the Plan**. List each training and testing activity in the left column and details about that activity in the other columns.

Training/Testing Activity	Date Conducted	Objective	Sponsor/Provider (note credentials)	Department/Groups Participating	Number of Participants

Appendix C—Abbreviations and Acronyms

AFC	Access Family Care
CCC	Citizen Corps Council
CCP	Crisis Counseling Assistance and Training Program
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
COOP	continuity of operations
CSAT	Center for Substance Abuse Treatment
DATA	Drug Addiction Treatment Act
DCM	Disaster Case Management (Federal program)
DEA	U.S. Drug Enforcement Administration
DHS	U.S. Department of Homeland Security
DPT	Division of Pharmacologic Therapies
DTAC	Disaster Technical Assistance Center
ED	emergency department
EHR	electronic health record(s)
EMAC	Emergency Management Assistance Compact
EMI	Emergency Management Institute
EMR	electronic medical record(s)
ESAR-VHP	Emergency System for Advance Registration of Volunteer Health Professionals
ESF	Emergency Support Function
FEMA	Federal Emergency Management Agency
GETS	Government Emergency Telecommunications Service
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HIRA	hazard identification and risk assessment

HIT	health information technology
ICS	Incident Command System
KAP	Knowledge Application Program
MMT	methadone maintenance treatment
MOA	Memorandum of Agreement (singular); Memoranda of Agreement (plural)
MOU	Memorandum of Understanding (singular); Memoranda of Understanding (plural)
MRC	Medical Reserve Corps
NDRF	*National Disaster Recovery Framework*
NGO	nongovernmental organization
NIMS	National Incident Management System
OTP	opioid treatment program
PAD	psychiatric advance directive
POD	point of distribution
PTSD	posttraumatic stress disorder
QSOA	qualified service organization agreement
SAAS	State Associations of Addiction Services
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	screening, brief intervention, and referral to treatment
SERG	SAMHSA Emergency Response Grant
SMA	State Methadone Authority
SOTA	State Opioid Treatment Authority
SSA	Single State Agency
TAP	Technical Assistance Publication
THIRA	threat and hazard identification and risk assessment
VOAD	Voluntary Organization Active in Disaster
WATrac	Washington System for Tracking Resources, Alerts, and Communication
WPS	Wireless Priority Service

Appendix D—Disaster Planning Web Resources

Resources From the Substance Abuse and Mental Health Services Administration (SAMHSA)

After the Crisis Initiative: Healing from Trauma after Disasters (provides information on training people for peer support in and after disaster):
http://gainscenter.samhsa.gov/atc

Behavioral Health Treatment Services Locator:
http://findtreatment.samhsa.gov

Disaster Technical Assistance Center (provides access to technical assistance, resources on preparedness and response, and a contact database of State and territory disaster behavioral health coordinators):
http://www.samhsa.gov/dtac

Exception Requests (for the administration and management of opioid treatment):
http://www.dpt.samhsa.gov/regulations/exrequests.aspx

Federal Opioid Guidelines, April 2013:
http://www.dpt.samhsa.gov/pdf/FederalGuidelinesforOpioidTreatment5-6-2013revisiondraft_508.pdf

Medication-Assisted Treatment:
http://dpt.samhsa.gov

Opioid Treatment Program Directory:
http://dpt2.samhsa.gov/treatment/directory.aspx

SAMHSA's Disaster Behavioral Health Information Series Resource Collections (contains themed installments of resources and toolkits in disaster behavioral health. Each installment focuses on a specific population, disaster type, or other topic pertinent to disaster behavioral health preparedness, response, and recovery):
http://www.samhsa.gov/dtac/dbhis

State Opioid Treatment Authorities:
http://dpt2.samhsa.gov/regulations/smalist.aspx

At-Risk Populations and Disaster

Health Information Translations: Quality Health Education Resources for Diverse Populations (provides translations into multiple languages of disaster preparedness and response information for clients), Ohio State University Medical Center, Mount Carmel Health System, Ohio Health, and Nationwide Children's Hospital:
https://www.healthinfotranslations.org/disaster-preparedness.php

National Council on Disability:
http://www.ncd.gov

National Resource Center on Psychiatric Advance Directives:
http://www.nrc-pad.org

Psychosocial Issues for Older Adults in Disasters, SAMHSA and the National Council on Aging:
http://store.samhsa.gov/shin/content//SMA11-DISASTER/SMA11-DISASTER-03.pdf

Special Populations: Emergency and Disaster Preparedness, National Library of Medicine, National Institutes of Health:
http://sis.nlm.nih.gov/outreach/specialpopulationsanddisasters.html

Staying in Touch: A Fieldwork Manual of Tracking Procedures for Locating Substance Abusers in Follow-up Studies (2nd ed.), University of California, Los Angeles, Integrated Substance Abuse Programs (a model client locator form is located in Appendix A):
http://www.uclaisap.org/trackingmanual/manual/Tracking-Manual.pdf

Tips for People With Disabilities and Medical Concerns, Independent Living Resource Center of San Francisco:
http://www.ilrcsf.org/wp-content/uploads/2012/09/Emergency-preparedness-for-people-with-disabilities.pdf

Communications

Government Emergency Telecommunications Service, U.S. Department of Homeland Security (DHS):
http://www.dhs.gov/government-emergency-telecommunications-service-gets

Wireless Priority Service, DHS:
https://www.dhs.gov/wireless-priority-service-wps

Electronic Health Records

Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs, Center for Medicare & Medicaid Services (CMS):
https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html

Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services (HHS):
http://www.healthit.gov

Emergency Planning for Staff and Clients

Basic Disaster Supplies Kit, Federal Emergency Management Agency (FEMA):
http://www.ready.gov/basic-disaster-supplies-kit

National Preparedness Month, National Child Traumatic Stress Network (resources for families):
http://www.nctsn.org/resources/public-awareness/national-preparedness-month

Plan & Prepare, American Red Cross:
http://www.redcross.org/prepare

Ready.gov (consumer readiness Web site), FEMA:
http://www.ready.gov

Red Cross Mobile Apps:
http://www.redcross.org//prepare/mobile-apps

Federal Guidance and Support

Business (readiness Web page), FEMA:
http://www.ready.gov/business

Continuity of Operations, FEMA:
http://www.fema.gov/continuity-operations

Emergency Authorization for Disaster Relief—Domestic and International, Office of Diversion Control, Drug Enforcement Administration:
http://www.deadiversion.usdoj.gov/disaster_relief.htm

Guidance on Planning for Integration of Functional Needs Support Services in General Population Shelters, FEMA:
http://www.fema.gov/pdf/about/odic/fnss_guidance.pdf

Homeland Security Exercise and Evaluation Program, DHS:
https://www.llis.dhs.gov/hseep

Independent Study Program, FEMA (provides courses on topics including emergency management, continuity of operations, and Federal guidance):
http://training.fema.gov/IS

National Disaster Recovery Framework, FEMA:
http://www.fema.gov/media-library-data/20130726-1820-25045-5325/508_ndrf.pdf

National Incident Management System, FEMA:
http://www.fema.gov/national-incident-management-system

National Preparedness Goal (1st ed.), FEMA:
http://www.fema.gov/pdf/prepared/npg.pdf

National Preparedness System, FEMA:
http://www.fema.gov/pdf/prepared/nps_description.pdf

National Response Framework, FEMA:
http://www.fema.gov/national-response-framework

Planning & Templates, FEMA:
http://www.fema.gov/planning-templates

Survey & Certification—Emergency Preparedness, CMS (provides guidance for State Survey Agencies and healthcare providers):
https://www.cms.gov/SurveyCertEmergPrep

Financial Aid for Programs

Crisis Counseling Assistance and Training Program (CCP), SAMHSA and FEMA:
http://store.samhsa.gov/shin/content//SMA11-DISASTER/SMA11-DISASTER-17.pdf

Disaster Loans, Small Business Administration:
http://www.sba.gov/category/navigation-structure/loans-grants/small-business-loans/disaster-loans

Robert T. Stafford Disaster Relief and Emergency Assistance Act, as Amended, and Related Authorities, FEMA:
http://www.fema.gov/pdf/about/stafford_act.pdf

Information for Medical and Health Professionals

Emergency Management Assistance Compact:
http://www.emacweb.org

NIDAMED (tools and resources that assist healthcare providers in identifying drug use early and in referring patients to treatment):
http://www.drugabuse.gov/nidamed-medical-health-professionals

Public Health Mutual Aid Agreements—A Menu of Suggested Provisions, Centers for Disease Control and Prevention (CDC):
http://www.cdc.gov/phlp/docs/Mutual_Aid_Provisions.pdf

Sample Qualified Service Organization Agreement:
http://www.lac.org/doc_library/lac/publications/QSO-BA%20Agreement%20Form.pdf

Screening, Brief Intervention, and Referral to Treatment (SBIRT), SAMHSA:
http://www.samhsa.gov/prevention/sbirt/

Pandemic Planning

Flu.gov—Know What To Do About the Flu, HHS:
http://www.flu.gov

IS-520: Introduction to Continuity of Operations Planning for Pandemic Influenzas (interactive online course), FEMA:
http://training.fema.gov/EMIWeb/IS/IS520.asp

Seasonal Influenza (Flu), CDC:
http://www.cdc.gov/flu

Planning

Emergency Preparedness, Small Business Administration:
http://www.sba.gov/prepare

Public Health Practices: Enhancing Emergency Preparedness and Response, Center for Infectious Disease Research & Policy, University of Minnesota:
http://www.cidrap.umn.edu/public-health-practices

Strengthening Emergency Response Through a Healthcare Coalition: A Toolkit for Local Health Departments, Public Health—Seattle & King County:
http://www.apctoolkits.com/kingcountyhc/

Pre-Credentialed Volunteer Organizations

Citizen Corps:
http://www.ready.gov/citizen-corps

Emergency System for Advance Registration of Volunteer Health Professionals:
http://www.phe.gov/esarvhp/Pages/home.aspx

Medical Reserve Corps:
http://www.medicalreservecorps.gov

Voluntary Organizations

American Red Cross:
http://www.redcross.org

National Voluntary Organizations Active in Disaster:
http://www.nvoad.org

Appendix E—WATrac*

WATrac (Washington System for Tracking Resources, Alerts, and Communication) is a web-based application serving the Washington healthcare system by providing two distinct functions: 1) daily tracking of agency status and bed availability and, 2) incident management and situational awareness during a disaster response.

The system provides a means for notifying healthcare partners of emergency incidents and for supplying situational updates throughout the event. During an incident the daily facility status and bed tracking feature not only provides emergency medical services (EMS) and hospitals with patient transport information, but also automates the process for obtaining bed counts for statewide updates. *Command Center*, for on-line chat and conferencing, provides an easily accessible tool for real-time communication within agencies and between healthcare partners.

WATrac is web-based and will run on any computer with an internet connection, standard web plug-ins, and Adobe Flash 10.0 or newer. The system meets HIPAA [Health Insurance Portability and Accountability Act] security requirements by providing 128-bit encryption for all transmitted data. Access to data is controlled by user permission groups, and strong passwords can be required. The HIPAA requirement for recording who views, updates, or edits records is met only by the *Patient Tracking* module. All other modules and features in WATrac are not HIPAA compliant.

The WATrac application and data resides on servers in Minneapolis with back-up servers containing duplicate data in Chicago. This service includes dynamic redirection in the event of a server failure.

The Washington State Department of Health and participating regions, support statewide implementation using federal funds. WATrac is administered and maintained as a partnership between the Washington State Department of Health and Public Health—Seattle & King County. A statewide Advisory Group made up of representatives from healthcare, EMS, and public health provides direction and input for future use and implementation of the WATrac system.

Full system access is currently available to hospitals, EMS, trial health, community health centers, public health, nursing homes, and in-home service providers throughout Washington State. Additional access is being guided by the WATrac Advisory Group and by resources and staff availability.

For More Information
Email: support@watrac.org

*Excerpted from Washington State Department of Health and Public Health—Seattle & King County (2012).

Appendix F—Sample Memorandum of Agreement Between Opioid Treatment Programs*

Note: This Memorandum of Agreement (MOA) is provided for example purposes only. Programs should seek legal counsel before using or signing any legal document.

Continuity of care for patients of licensed opioid treatment program (OTP) providers in times of emergencies

Between the following providers:

_____ (Licensed OTP Provider)

_____ (Licensed OTP Provider)

_____ (Licensed OTP Provider)

_____ (Licensed OTP Provider)

[add more lines as needed]

1. Purpose

Each signing party of this MOA desires to voluntarily aid and assist one another by the interchange of resources and services if an emergency or disaster should occur in which a signing party cannot provide opioid replacement medication to all or a portion of its patients. The signing parties agree that this MOA, however, will not create a legal duty to provide assistance.

This memorandum defines the responsibilities of the parties and establishes a mechanism whereby a licensed OTP provider (*receiving provider*) dispenses methadone or other prescribed opioid replacement medication during an emergency on behalf of the OTP provider in which the patient is enrolled (*primary provider*).

2. Description

Licensed OTP providers enter into this MOA to provide prescribed opioid replacement medication to enrolled patients in an emergency in which either provider cannot serve its patients. Emergency circumstances include loss of power, structural damage to facility, fire, flooding, or staff shortage.

*Adapted from an unpublished document provided courtesy of King County (WA) Healthcare Coalition.

The following are the minimum tasks that will be performed by the receiving provider when the MOA is activated:

a. Provide short-term (30 or fewer consecutive days) methadone dosing of primary provider's patients.

b. For receiving providers who are licensed to dispense opioid replacement medication in addition to methadone (e.g., buprenorphine), provide short-term (30 or fewer consecutive days) dosing of prescribed opioid replacement medication to primary provider's patients.

c. Document dispensing and treatment in accordance with county, State, and Federal requirements.

d. Make best effort to verify patient's dosage.

e. Make best effort to verify patient's identity.

f. Within 90 days, communicate to primary provider information that is required (e.g., activity information, discharge data) for the State registry of OTP patients (if such registry exists) and for State billing purposes.

g. Communicate to primary provider clinically significant information (e.g., recent history of missed dosage, impairment, pregnancy, medication changes).

h. Dispense up to 30 mg of methadone to patient if verification of dosage is not reasonably possible after best efforts to do so have been made.

i. Keep records of dispensing, including doses delivered and by whom, and submit them to primary provider within 15 calendar days after services are rendered.

j. If operational, use [name of system being used to securely exchange information] to assist with sharing patient data (e.g., identity and dosage verification) and clinically significant information.

The following are the minimum tasks that will be performed by the primary provider when the MOA is activated:

a. Make best effort to give receiving provider patient names, name of opioid replacement medication prescribed, amount and date of last dosage, any other clinically significant information, and additional information that will assist in verifying patient identity (e.g., race/ethnicity, date of birth, last four digits of Social Security number).

b. Input required data into State registry of OTP patients if such registry exists.

c. Bill State of [name of State] or other funding source for services rendered to primary provider's patients by receiving provider while this MOA is activated.

d. Communicate to patients where to present for dosage and which documents and items to bring (e.g., picture ID, pill bottle, prescription).

e. Deploy clinical or administrative staff from the primary agency to the receiving agency when requested by the receiving provider for activities such as dispensing, counseling, and other medical care.

f. Make best efforts to transport opioid replacement medication and a completed Drug Enforcement Administration Form 222 from primary provider's supply to receiving agency.

g. If operational, use [name of software being used to securely exchange information] to assist with sharing patient data (e.g., identity and dosage verification) and clinically significant information.

3. Activation and Deactivation

This MOA shall become effective immediately on its execution by the signatory providers' respective executive directors or designees. This MOA is activated by written or oral notification by the primary provider's executive director or his/her designee to the receiving provider's executive director or his/her designee and by written or oral communication by the receiving provider of activation of the MOA. Activation of this MOA may occur at any time, day or night, including weekends and holidays.

Mutual aid shall continue to be available until participation in activation is terminated in writing by the withdrawing parties. The receiving provider agrees to give reasonable notice to the primary provider before withdrawing assistance.

4. Terms and Termination of MOA

a. This MOA shall be in full force and effect from date of execution [date] through ending date [date] but will be renewed automatically unless terminated pursuant to the terms hereof.

b. Signing parties may terminate this MOA with written notification to the other signing parties no less than 30 calendar days in advance of the termination date.

c. The receiving provider's clinical personnel who care for primary provider's patients must be in good standing with the receiving provider and be current on all requisite licensing and permitting.

d. The receiving provider and its participating personnel must abide by all Federal, State, and local laws.

e. The primary and receiving providers must ensure that detailed records of expenditures and time spent by deployed staff are complete and accurate and have adequate supporting documentation.

5. Employees

If the receiving provider requests clinical or administrative staff members from the primary provider, employees of a primary provider shall at all times while providing assistance continue to be employees of the primary provider. Wages, hours, and other terms and conditions of employment of the primary provider shall remain applicable to all of its employees who provide assistance under this MOA. The primary provider shall be solely

responsible for payment of its employees' wages, required payroll taxes, and benefits or other compensation. The receiving provider shall not be responsible for paying wages, benefits, taxes, or other compensation to the primary provider's employees.

Each party shall pay workers' compensation benefits to its own injured personnel, if such personnel sustain injuries or are killed while rendering aid under this MOA, in the same manner and on the same terms as if the injury or death were sustained serving its own patients. Nothing in this MOA shall abrogate or waive any party's right to reimbursement or other payment available from any local, State, or Federal government or abrogate or waive the effect of any waiver, indemnity, or immunity available to a party under local, State, or Federal law or other governmental action. To the extent that such reimbursement, payment, waiver, indemnity, or immunity does not apply, then each party shall remain fully responsible as employer for all taxes, assessments, fees, premiums, wages, withholdings, workers' compensation, and other direct and indirect compensation, benefits, and related obligations with respect to its own employees. Each party shall provide workers' compensation in compliance with the statutory requirements of the State of [name of State].

6. Cost and Method for Reimbursement

a. The receiving provider must submit to the primary provider complete and accurate documentation of services rendered to patients of the primary provider, which include dispensing records and an invoice, within 15 calendar days after rendering services.

b. On receiving complete and accurate documentation from the receiving provider and agreement of invoice, the primary provider will submit documentation for reimbursement at the Medicaid rate at time of service to the State of [name of State] or other funding source as applicable.

c. The primary provider will reimburse the receiving provider within 15 calendar days of receiving payment from the State of [name of State] or other funding source.

d. If the primary provider has not reimbursed the receiving provider within 15 calendar days, the receiving provider can allow a 45-day grace period to the primary provider. At the end of the grace period, the receiving provider may take appropriate action to pursue reimbursement.

7. Contract Claims

This MOA shall be governed by and construed in accordance with the laws of the State of [name of State] as interpreted by the State of [name of State] courts. However, the parties may attempt to resolve any dispute arising under this MOA by any appropriate means of dispute resolution.

8. Acceptance of Agreement

Providers offering to enter into this MOA shall fully complete this MOA with the information requested herein and sign two originals of a fully completed MOA. Each provider will keep one of the original MOA.

In addition, a copy of the MOA, signed and fully completed by the providers, shall be faxed or sent to:

To: [Insert the name, address, and contact information including fax number for outside party location, such as the Single State Agency for Substance Abuse.]

As noted by the providers' signatures (below), the providers agree to the terms and conditions as set forth in this MOA and agree to abide by the requirements for reimbursement. All amendments to this MOA must be in writing and agreed to by both providers.

OTP provider [Insert the following information for each party to the MOA]:

Company Name _____

Business Address _____

Phone No. _____

Fax No. _____

Email Address _____

After-hours emergency contact information:

Contact Name _____

Phone No. _____

Fax No. _____

Cell No. _____

Email Address _____

Signature of Chief Executive _____

Printed Name _____

Title _____

Date _____

Appendix G—Editorial Board and Field Reviewers

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Appendix H—Acknowledgments

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Technical Assistance Publications (TAPs) include:

TAPs 1–18, 20, 23–27 are no longer available.

TAP 19 *Counselor's Manual for Relapse Prevention With Chemically Dependent Criminal Offenders*

TAP 21 *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice*

TAP 21-A *Competencies for Substance Abuse Treatment Clinical Supervisors*

TAP 22 *Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers*

TAP 28 *The National Rural Alcohol and Drug Abuse Network Awards for Excellence 2004, Submitted and Award-Winning Papers*

TAP 29 *Integrating State Administrative Records To Manage Substance Abuse Treatment System Performance*

TAP 30 *Buprenorphine: A Guide for Nurses*

TAP 31 *Implementing Change in Substance Abuse Treatment Programs*

TAP 32 *Clinical Drug Testing in Primary Care*

TAP 33 *Systems-Level Implementation of Screening, Brief Intervention, and Referral to Treatment*

TAP 34 *Disaster Planning Handbook for Behavioral Health Treatment Programs*

TAPs may be ordered or downloaded from SAMHSA's Publications Ordering Web page at http://store.samhsa.gov. Or, please call SAMHSA at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).

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