Maine CDC
Disaster Behavioral Health
Response Plan

Annex to DHHS/Maine CDC
ESF #8 Emergency Operations Plan

Under Separate Cover

Record of Changes to Annex

Change Number	Date of change	Made by	Description of Change	Page Number
1.	02/01/2012	Pamela Holland	Update and format change for inclusion in CDC-PHEP EOP.	Full document
2.	06/29/2012	Pamela Holland	Addition of language to cite Family Assistance Center Plan	19, 21, 22; Appendix C added
3.	09/11/12	Pamela Holland	Change "Introduction" to "Concept of Operations"	pp. 4-5
4.	09/11/12	Pamela Holland	Family Assistance Center Appendix C and Attachments	Appendix C, Attachments 1-5
5.	9/3/2013	Kathleen Wescott	Program Director name changed to Kathleen Wescott	Full document
6.	9/11/2013	Kathleen Wescott	Update and change language in Agreements and Understandings	Appendix B, Agreements
7.	10/2/13	Kathleen Wescott	Add Background, Maine demographics for Population, MH, SA, ED	Pages 6-14
8.	12/18/13	Kathleen Wescott	Format change to follow HSEEP	Full document
9.	1/2/2014	Kathleen Wescott	Format changes and addition to Annex definitions	Full document
10.	1/15/2014	Kathleen Wescott	Revision of at-risk populations, and added Skills for Psychological Recovery	Full document
11.	1/24/14	Richard Higgins, MEMA	Review of complete document for format, policy and procedures	Full document
12.	2/3/14	Kathleen Wescott	Update Richard's changes	Full document
13.	2/19/14	Kathleen Wescott	Update Children section/descriptions	Children's responses
14.	4/7/14	Kathleen Wescott	Update DBH Committee changes	Full Document
15.	5/15/2014	Kathleen Wescott	Update with Richard Higgins changes	Full document
16.	6/9/2015	Kathleen Wescott	Confidentiality/HIPPA requirements for interns and volunteers	Page 36- Appendix B
17.	12/9/2015	Kathleen Wescott	Appendix A: Updated demographics data for at-risk populations	Appendix A At-Risk Populations
18.	1/7/2016	Kathleen Wescott	Appendix A: Tribal Nations as new category	Appendix A
19.	1/7/2016	Kathleen Wescott	Assessment of Risk; Added Triggers to community and workforce impacts	Page 12-14
20.	1/15/2016	Kathleen Wescott	Demobilization Forms for Responder Health and Safety capabilities	Page 39 - Appendix C
21.	1/25/2016	Kathleen Wescott	Maine CDC *PHEP* Healthcare Volunteer Health and Safety capabilities	Page 36
22.	8/31/2016	K Wescott	State Heroin and Drug 2015 statistics (SEOW) impacting response	Pages 72-73
23.	3/30/2017	Kathleen Wescott	Short Term Response: following active shooter drill based on Active Shooter exercise at Eastern Maine Medical Center (August 2016)	Page 32-34

Date of Change	Recommended Change	Change Number	Initials
May 2017	Updated Disaster Behavioral Health Fatality Management Annex pages 102-143 based on Bangor Airport Full Scale Exercise (May 2017) to include: • Federal assistance program for transportation accidents, e.g. NTSB, family assistance center floor plans, transportation carrier resources • Forms for psychological first aid services • Role of State Department, Customs and Immigration, and FBI Victims Assistance • Secondary traumatization symptoms- Responder Health and Safety capabilities	**24**	**KW**
5 July 2017	Updated Instructions for Telephonic Interpreter Services	**25**	**KW**
5 July 2017	Psychiatric advance directives (PADs)	**26**	**KW**
10 Aug 2017	**Appendix A: Treating Survivors of Trauma Center for PTSD**	**27**	**KW**
26 Jan 2018	DHHS Release of Confidential Information updated form	**Appendix B**	**KW**
26 Jan 2018	DBHRT training requirements to Crisis Counseling Core Content Training	**Appendix B**	**KW**

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This painting uses Faulkner's words reading from the bottom to top to portray that hope will prevail despite adversity. The artist relies on words as graphic images to communicate his message. The intensity of the colors strengthens the message and the expectation of overcoming a bioterrorist attack or disaster event. The message is clear: "*We Will Prevail."*

Introduction

A. Purpose

It is the purpose of the State of Maine Disaster Behavioral Health Response Plan Annex (Plan) to define the actions and roles necessary to provide a coordinated response within Maine Department of Health and Human Services, Maine Center for Disease Control and Prevention, Office of Public Health Emergency Preparedness, Disaster Behavioral Health program. This Plan provides guidance to those within the Disaster Behavioral Health Program with a general concept of potential emergency assignments. The Plan was developed by a Statewide Behavioral Health Committee with input from stakeholders representing government, non-government and private sector; and following community and healthcare trainings and exercise lessons-learned activities.

The Plan sets out the overall framework to be used by governmental, non-governmental and private sector agencies and organizations to ensure coordination of disaster behavioral health efforts prior to, during and after a disaster, public health emergency, and a potentially traumatic event. Public health emergencies and disasters are often defined by their impact on human health. The physical effects of large-scale

emergencies are a consistent focus on emergency preparedness; however, hidden behavioral health threats linger among impacted populations for years, exacerbated by the extreme loss of life, environmental destruction, and diminished socioeconomic status. Disasters are "one-time or ongoing mass traumatic events of human or natural cause that lead groups of people to experience stressors, including the threat of death and injuries, bereavement, disrupted social support systems and insecurity of basic human needs, such as food, water, housing and access to close family members". *Source:* "*Providing Psychosocial Support to Children and Families in the aftermath of Disasters and Crisis"*. American Pediatrics Association, *October 2015, Volume 136.*

The Plan recognizes mental/behavioral health as a component of public health and emergency services; and that emotional preparedness can help reduce the psychological or potentially traumatic impacts of disasters. Trauma is defined as an experience in which a person's internal resources are not adequate to cope with external stressors. Trauma theory suggests that many of the behavioral, emotional and cognitive symptoms that we see in individuals are a direct result of coping with adverse experiences.

B. Scope

Disaster Behavioral Health is an integral part of the overall public health and healthcare system. It includes the many interconnected psychological, emotional, cognitive, developmental and social influences on behavior, mental health, and substance abuse, and the effect of these influences on preparedness, response and recovery from disasters, public health emergencies or potentially traumatic events. One of the program goals is to increase measurable levels of hope, safety, trust, emotional recognition and management; and build problem solving skills in both staff (paid and volunteer) and impacted communities.

Many people who do not meet the diagnostic criteria for mental health intervention may, nonetheless, exhibit behavioral problems during and following a disaster—putting them at risk for health problems, interpersonal complications with family and friends and difficulties at school or work. Research suggests that 30 percent to 75 percent of individuals who go through a distressing event will experience symptoms such as grief, anxiety about safety, feelings of hopelessness and physical symptoms. It is even common for experienced healthcare workers and first responders to be overwhelmed emotionally by an unusual or particularly upsetting event; or to develop a foreshortened sense of future or feelings of powerlessness to create one's future impacting 5-20 percent rescue workers during the first year following an event. *Source: National Institute of Health, "The Epidemiology of Post-Traumatic Stress Disorder after Disasters" (2004)*

Some groups are more at risk of psychological disruption after emergencies. Children and elderly adults are known to be more vulnerable to extreme stress reactions after a disaster. Persons with pre-existing psychiatric comorbidity and persons who have chronic exposure to traumatic events or substantial stressors are at greater risk for new

or renewed problems. Most disaster survivors will recover psychologically on their own over time by connecting to their normal coping mechanisms and social supports. Some, however, may find their psychological conditions worsen or add additional concerns, such as substance misuse, so specialized strategies may help these individuals regain stability. *Source: "Including Mental Health Resilience in your Disaster Plan". Department of Health and Human Services' Office of the Assistant Secretary for Preparedness and Response (ASPR)*

Disaster Behavioral Health is distinguished from other forms of mental/behavioral health in that it is specifically focused on the psychological impact of disasters. Disaster Behavioral Health Teams can direct psychological intervention efforts on helping people to set disaster priorities and develop plans on how best to manage the many tasks involved in their own recovery. *Source: U.S. HHS CONOPS, February 2014*

a) *Relationship to other Plans*

The Plan is the supporting Annex document to the DHHS/Maine Center for Disease Control and Prevention's Emergency Operations Plan.

The Maine Emergency Management Agency (MEMA), following the Federal Emergency Management Agency (FEMA) guidelines, created the State's Emergency Operations Intra-Agency Plan in September 2015 that describes the (14) Emergency Support Functions (ESF); and designates specific state agencies with responsibility for these functions. This Disaster Behavioral Health Response Annex falls under two functions: ESF #6 and ESF#8. Mass Care ESF#6 describes the coordination of Emergency Managers, American Red Cross, and local efforts to deliver mass care services of shelter, feeding and emergency first aid to disaster victims; establish a system to provide bulk distribution of emergency relief supplies; and establish systems to report victim status and assist in family reunification.

The Maine Department of Health and Human Services is responsible for meeting ESF#8 Public Health and Medical Services capabilities. The primary objectives of ESF#8 are to restore and improve the health and social services networks to promote the resilience, health, independence and well-being of the whole community in response to public health and medical care needs during a major disaster or traumatic event, or during a potentially adverse public health situation.

C. Situation Overview

a) Characteristics of Department

The Disaster Behavioral Health Program has one full-time employee, paid under a contract between AdCare Educational Institute of Maine, and Maine Center for Disease Control and Prevention Public Health Emergency Operations. This position is the Director, Disaster Behavioral Health, that directs the state disaster behavioral health response during specific emergencies to include behavioral health preparedness activities, training and coordinated responses with state and community-based behavioral health providers, healthcare coalition partners and emergency managers;

recruitment, training and supervision of the DBH Response Team volunteers who represent all regions within the state; responsible for CCP program administration during a federally declared disaster and serves on MEMA's Emergency Response Team.

Ad Care Educational Institute provides payroll, benefits administration and clerical support to this full time employee. Supervision of the Disaster Behavioral Health Director is shared by AdCare Educational Institute and Maine CDC Public Health Operations; with additional guidance from the MEMA Individual Assistance Coordinator during a federal level disaster event. Overall, guidance for the Disaster Behavioral Health (DBH) Response Plan and support of DBH activities and programs comes from a statewide Advisory Committee of interested behavioral health partners and emergency services administrators.

The Maine Disaster Behavioral Health Volunteer Response Teams were developed and are coordinated through the Maine Department of Health and Human Services, Center for Disease Control and Prevention. These teams are meant to augment local resources by providing behavioral health support in the event of an emergency public health incident, terrorist attack or disaster. Volunteers are required to have qualifications and training to meet the disaster behavioral health program needs.

b) *Hazard Profile*

The State of Maine is subjected to the effects of many disasters, varying widely in type and magnitude from local communities to statewide in scope.

Disaster conditions could be a result of a number of natural phenomena such as floods, severe thunderstorms, tornados, hurricanes, high water, drought, severe winter weather, ice storms, fires (including urban, grass and forest fires), severe heat, high winds, earthquakes or pandemics/epidemics. Apart from natural disasters, Maine is subject to a myriad of other possible disaster contingencies, such as train derailments, aircraft accidents, transportation accidents involving chemicals and other hazardous materials, plant explosions, chemical oil and other hazardous material spills, leaks or pollution problems, dumping of hazardous wastes, building or bridge collapses, utility service interruptions, information systems failure, energy shortages, food contamination, water supply contamination, civil disturbances, terrorism, cyber-attack, or a combination of any of these which might result in mass casualties and/or mass fatalities.

The Annex Plan applies to all hazards and is scalable to any size disaster. The disaster behavioral health program aims are to provide services and activities to promote resilience in individuals and communities by providing communications, education, and promoting access to state and community-based behavioral health programs and treatments.

Disasters can be experienced within a continuum of mental health impacts from transitory distress toward resilience and eventual posttraumatic growth for some, while others may develop new incidence disorders. Traumatic events can be defined as those exceeding the person's or communities' coping resources or breaking down protective defenses. The severity of traumatic events is related to them being intense, inescapable, uncontrollable, and unexpected. Psychological distress, severe depression, somatic symptoms and posttraumatic stress, and changes in the amount and type of substance use –these are some potential reactions individuals may have during or following a disaster. Resilience can be defined as the capability of individuals and systems to cope and maintain positive functioning in the face of significant adversity or risk. Resiliency can be enhanced by building in protective factors that enable people to help identify coping strategies for themselves and others following exposure to a potentially traumatic experience.

In addition, behavioral health impacts of catastrophic incidents can be demonstrated in public health emergencies. Mass illness that could occur in pandemic flu or other infectious disease outbreaks brings enormous challenges to both the healthcare system surge and to the psychosocial reactions of the community. Some emergencies require isolation measures such as sheltering in place or keeping a physical distance from other people during a disease outbreak (social distancing). Isolation from their support networks may make community members more vulnerable during an event or disaster.

The magnitude of death and destruction in disasters, and often, the difficult nature of the medical response can be difficult due to disturbances to critical infrastructure, such access to airports, roads, and communications. Disasters often produce mass physical trauma, and the injuries seen may be more severe, or delayed. The surge of ill persons may overwhelm local hospitals, health clinics, and EMS. An article, "*A Framework for Addressing the Emotional, Behavioral, and Cognitive Effects of Patient Surge in Large Scale Disasters*" (source: University of Florida) identified five triggers associated with psychological reactions among disaster survivors. These triggers are restricted movement, limited resources, potential exposure to trauma, limited information, and perceived personal or family risk due to exposure or isolation. Some examples of adverse behavioral health risks during Public Health Emergencies: *Source: State of CA Disaster Mental –Behavioral Health Disaster Response Framework-2013*

- Loss of credibility for public health, in government authorities, and social structures. Reactions include lack of adherence with mandatory quarantine measures; and supply depletion due to panic buying of critical supplies, such as N-95 respirators, pharmaceuticals, bottled water, hand sanitizer and disposable gloves.

- Serious overload on healthcare systems by *concerned citizens* with "medically unexplained physical symptoms" or "disaster somatic reactions" can result in ratios above normal patient census

- Fear, agitation and acute anxiety may be expected after a traumatic incident, particularly from a bioterrorism or chemical attack, or exposure to highly infectious diseases
- Psychological casualties may be **four to ten times** greater than physical casualties

- Patients receiving medically managed detoxification for alcohol and drug use are at risk of serious medical and psychological complications when 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. anti-psychotic medications, anti-anxiety medications, methadone who obtain their medications at a behavioral health treatment program or who are assisted by staff in taking their medications regularly, are at risk of serious withdrawal symptoms if the medications are stopped abruptly

c) Vulnerability Assessment

Maine is a large, rural state, with a land mass of over 30,800 square miles, making it almost as large as the other 5 New England States combined. Maine has a population of 1.33 million residents, and a limited sub-state public health infrastructure. Maine is also home to nearly 16,000,000 overnight visitors annually and nearly 19,000,000 day visitors annually.

Maine has four metropolitan areas throughout the state, numerous small towns and communities, and vast rural areas that are virtually unpopulated. While the average number of people per square mile was 43.1 in 2010, this greatly varies by county. The most populated counties were Cumberland with 337.2 persons per square mile and Androscoggin with 220.8 per square mile; while the least densely populated counties were Piscataquis with 4.4 and Aroostook with 10.8 persons per square mile. *Source: U.S. Census data*

Maine is primarily a rural state, and rural communities face challenges in the delivery of health care and emergency services that are often very different from those faced by urban communities. Geographic isolation is a significant barrier to providing a coordinated emergency response. Rural areas are more affected by variations in weather conditions and by seasonal variations in populations. These areas have fewer human and technical resources e.g. health care professionals, medical equipment, transportation, and communication systems. *Source: Rural Communities and Emergency Preparedness,'' (published by the Health Resources and Services Administration's (HRSA) Office of Rural Health Policy, April 2002)*

At-Risk Individuals

The U.S. Department of Health and Human Services (HHS) has developed the following definition of at-risk individuals: at risk is defined as the susceptibility of individuals to conditions created by an emergency or disaster which may jeopardize their usual standards of care and coping, rather than being indicative of their state of health.

Before, during, and after an incident, members of at-risk populations may have difficulty in managing their functional needs. Individuals who may need additional response supports include those who have disabilities, live in institutionalized settings, are from diverse cultures, have limited English proficiency, are economically disadvantaged, have chronic medical and mental health disorders, and have pharmacological dependency. (See Appendix A "Snap shot on At-Risk Populations in Maine")

D. Planning Assumptions

Plan capabilities:

- Disaster behavioral health includes mental health, stress management and substance misuse considerations for survivors and responders; and addresses the behavioral health infrastructure, individual and community resilience.
- Local communities maintain primary responsibility to coordinate emergency response in the impacted area. The state carries out response activities in support of and in coordination with local response activities.
- State agencies will maintain situational awareness to identify and provide technical assistance, and leverage federal resources for state health and human services.
- Strong coordination is needed between behavioral health and social services stakeholders.
- Behavioral Health programs in the weeks and months following a disaster 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.
- Need to incorporate planning for disaster mental/behavioral health for the transition from response to recovery into preparedness and operational plans in close collaboration with ESF#6 and ESF#8.

At-Risk Populations:

- Many individuals will recover from a disaster with little or no help from professional interventions depending on the nature of the event.
- All emergencies potentially have behavioral health impacts broader than the population physically impacted by the disaster due to their family, social and media influences.
- Some individuals or populations may be at higher risk for more severe reactions. At-risk populations, e.g. children, seniors, pregnant women, those with chronic medical disorders, those with pharmacological dependencies may face unique hardships and challenges if suddenly deprived of healthcare services.
- Disasters result in secondary effects. Primary effects are damage caused directly by the disaster event, where secondary effects are problems that occur from the primary damage. These secondary effects may include living

in temporary housing, having to permanently relocate, job loss, and economic hardship due to the lack of appropriate insurance.
- In public health incidents, emergency departments may experience a significant medical surge of patients with psychologically-based complaints, as well as more severe mental/behavioral health presentations.

Interventions:

- Disaster behavioral health teams both paid and volunteer will be trained to triage, assess, and provide early psychological first aid, crisis counseling and make referrals consistent with their level of training and scope of practice
- The provision of mental/behavioral health services will be based on current evidence informed/best practices and widely accepted national guidelines
- Existing systems that provide mental/behavioral health services may be damaged, disrupted or overwhelmed during an emergency. This could be due to a lack of utilities, an inability for staff to safely report to work, damage to their communication or transportation systems, and disruptions to the delivery of pharmaceutical supplies
- A behavioral health 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
- Messages, information, and education materials that specifically address behavioral health issues are part of the overall public health message strategy. Some behavioral health issues include anxiety, stress, fear, grief and loss.
- Messages should be adapted to the cultural practices of each target audience as they relate to seeking help, coping and healing.

II. CONCEPT OF OPERATIONS

A. General

Disaster behavioral health response is focused on short- and long-term interventions with individuals and groups experiencing the psychological impact of disasters. These interventions involve the counseling goals of assisting disaster survivors and responders in understanding their current situation and psychological reactions; reviewing their options; providing emotional and spiritual support; and to encourage linkages with other individuals and agencies that can help them recover to their pre-disaster level of functioning.

B. Hazard Control and Assessment

a) Perceive the threat

In effect, the goal of a behavioral health disaster response is to assist individuals in coping with the immediate psychological aftermath of the disaster, mitigate additional stress and psychological harm, and to promote the development of resilience techniques and coping strategies.

b) Assessment of Community Behavioral Health Threats and Needs
(Source: IOM Crisis Standards of Care 2012)

Community Indicators	Response	Crisis and Medical Surge	Recovery
	Indicators: ○ Medical surge of patients, and searching family members ○ Anxiety and agitation increases presentations for treatment to and beyond normal limits ○ Police, social services, schools and others report increasing incidents of disruptive, anxious behaviors, e.g. DV, DUI, civil unrest ○ Increased psychiatric admissions to ED's ○ Increased calls to crisis 24/7 hotlines ○ Increased waiting lists for BH providers ○ Hospitals begin to prematurely discharge BH patients ○ Family members are separated at time of disaster and out of contact with children and senior members ○ As a result of building damage or limited access, BH agencies and faith based organizations are closed and the population cannot gather for social support ○ Reports on short supplies of BH medications ○ General services are compromised and goods in short supply which increases anxiety and agitation.	**Indicators:** ○ Data indicates increasing demand for BH services ○ Hospital services become increasingly compromised by searching family members ○ BH agencies are at capacity and refuse to take new cases ○ Increased public presentation of BH casualties, e.g. ill from detox, withdrawal, crimes ○ Widespread acute anxiety, agitation and demand for care threatens treatment systems ○ 10% of workplaces and schools are closed ○ Alternative care/diversion programs are at capacity and no more admissions ○ Jails at capacity **Crisis Triggers:** ○ Healthcare systems can no longer admit patients exhibiting acute anxiety and agitation ○ Roads become impassable as a result of residents	**Indicators:** ○ Decline in demand for services ○ Reduction of waiting lists to present levels ○ Number and severity of "new" cases declines ○ Reduced reports from police, social services, schools and others regarding BH issues ○ **Triggers:** ○ 20% decline in demands for services ○ Reduction of waiting lists ○ 20% decline in number and severity of new cases ○ 10% reduction in reports from law enforcement, social services, schools and others regarding BH ○ Pre-event BH capacity and admissions re-established

	○ Work and school logistics become increasingly complex as schedules need to be adaptive to employee availability **Triggers:** ○ 20% increase in law enforcement/social service reports ○ Jail and alternative diversion programs at capacity ○ 20% increased psychiatric presentations in ED ○ 20% increased calls to Crisis Hotlines ○ 10% increased waiting list for BH appointments ○ 20 % BH providers report seeing only emergency cases.	evacuating or searching for family members ○ BH providers report they can no longer provide prescription medications due to supply line disruption ○ ED's threaten closure due to inability to manage BH cases, no beds, no referral options ○ Hospital triage results in reduction of BH patients admitted ○ Increased number of BH patients being maintained in ED or general medical treatment areas ○ Specialty psychiatric units exceed capacity or experience damage to infrastructure ○ BH problems increase in systems as patient families, searching family members, and bereaved family members share space and services ○ Increasing BH problems resulting from social distancing, e.g. suicide, depression, substance abuse, anxiety	

Resources:
SAMHSA Tap 34: Disaster Planning Handbook for Behavioral Health Treatment Programs

Technical assistance and guidance is provided to a Behavioral Health Treatment Programs to develop or improve their facilities exposure to threats and all-hazards; and to retain and restore their program's capacity to function when a disaster does occur. http://store.samhsa.gov/shin/content//SMA13-4779/SMA13-4779.pdf

Med Map (ASPR)
MedMap is a program for identifying at-risk individuals that may need assistance during disasters and emergencies. Med Map is an interactive geographic information system (GIS)-based mapping system, which can query data to assist in response and recovery, such as potential medical care sites and assembly centers, evacuation routes, hazards, and what regional and national resources are available.

State and Federal Surveillance
Agencies query existing surveillance systems for information about behavioral health and resilience. Maine CDC and SAMHSA, if indicated, tailor existing surveillance systems, such as the Behavioral Risk Factor Surveillance System (BRFSS), and CASPER to ascertain disaster-related behavioral health trends.

B.) Legal Authority

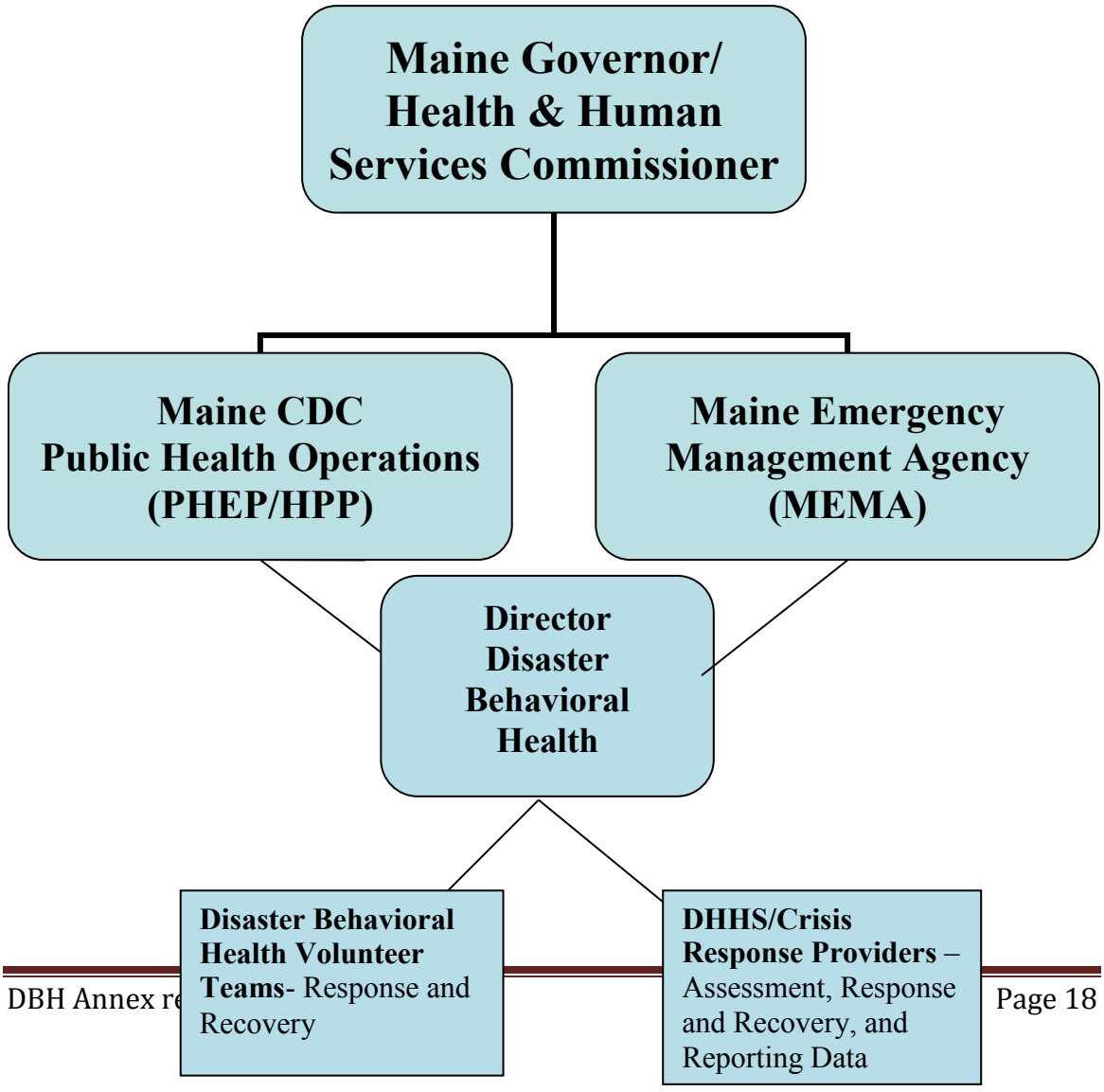
At the State level, authority and responsibility for community emergency management resides with the Maine Emergency Management Agency (MEMA). The Maine CDC, working under the Department of Health and Human Services, serves as the executive board for enforcing laws that protect the health of the people of Maine. As the State's Public Health Agency, Maine CDC addresses health concerns on a broad population basis and works in partnership with agencies and organizations at all levels to achieve public health goals.

Disaster Behavioral Health's program activation and volunteer deployment policies and authority have been guided by statute 37-B MRSA §784-A. *Maine Emergency Management Assistance Agency right to call for and employ assistance; 37-B M.R.S.A. §1784-A*: *The Maine Emergency Management Agency and local organizations for emergency management may employ any person considered necessary to assist with emergency management activities. All persons called and employed for assistance shall proceed as directed by the Maine Emergency Management Agency. Any person called and employed for assistance is deemed to be an employee of the State for purposes of immunity from liability pursuant to section 822 and for purposes of workers' compensation insurance pursuant to section 823, except for persons excluded from the definition of employee pursuant to Title 39-A, section 102, subsection 11. A health care worker licensed in this State, either designated by the Maine Emergency Management Agency to perform emergency management or health activities in this State in a declared disaster or civil emergency pursuant to section 742 or designated by the Maine Emergency Management Agency to render aid in another state under chapter 16, is deemed to be an employee of the State for purposes of immunity from liability pursuant to this section and section 926 and for purposes of workers' compensation insurance*

pursuant to sections 823 and 928, except for persons excluded from the definition of employee pursuant to Title 39-A, section 102, subsection 11. [2005, c. 630, §2 (amd).]

The Maine Department of Health and Human Services has adopted rules, which establish public health control measures to address public health threats, and public health emergencies. The interventions available to the Department include counseling, treatment and confinement. The statutory procedures for the processing of public health measures are established in *Title 22 M.R.S.A. Chapter 250, Subchapter 11*.

Furthermore the Governor may declare a state of emergency and thereby activate a host of extraordinary powers, including the authority to suspend regulatory legislation, direct the evacuation of affected geographical areas, enlist the aid of emergency personnel and undertake all measures to mitigate or respond to the disaster emergency. In order for the Department to exercise the extraordinary public health powers vested in it pursuant to *Title 22, chapter 250, subchapter 11-A*, the Governor must have declared an extreme public health emergency under *Title 37-B, chapter 13, subchapter 11*



C. Preparedness – Control Strategy

Preparedness involves activities undertaken in advance of an emergency to develop and enhance operational capacity to respond to and recover from an emergency. 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.

The FEMA/SAMHSA Crisis Counseling Program uses a graph to illustrate the collective reactions of communities within specific disaster phases to assist with monitoring individuals in community response and resilience. Each phase has specific behavioral health interventions including communications, treatment, public outreach and education, and resource management.

Disaster Preparedness Interventions

Pre-disaster preparedness activities are designed to lay the foundation for the actual response. The activities in this phase include training, solidifying community linkages and crisis network development. This phase may blend with the post-disaster phase in terms of evaluating a previous response and refining policies and procedures based on known experiences.

Strategies to identify hazards during the Preparedness Phase:

- Engage mental/behavioral health, and substance treatment agencies to review their organization's continuity of operation plans to ensure that their operation and client services will be available during and following an emergency event.
- Meet with behavioral health agencies to provide mental/behavioral health planning documents, review after action reports, and relevant publications to identify common mental/behavioral health issues in emergencies.
- Establish preparedness priorities and engage volunteers in emergency management training exercises and DBH training throughout each county, region and the state.
- Work with DHHS and state mental/behavioral health partners for provision of culturally sensitive behavioral health supportive services.
- Meet with healthcare coalition partners to develop processes to request behavioral health support during medical surge incidents.
- Develop guidelines for use of evidence-based rapid mental/behavioral health triage; including PsySTART, Psychological First Aid and SPR Screening Forms.
- Conduct community baseline mental/behavioral health surveillance to be used to identify the adverse public health and psychological effects of a disaster.

D. Proactive Action Selection

a. Analyze the hazard

In most disaster circumstances, response to emergencies is initiated at the local level with local resources the first to be committed. Use and coordination of resources and the management of the situation is a local public safety responsibility.

b. Determine Proactive Action

The disaster response phase initially requires a timely and accurate account of what has happened and what is needed, that is a "rapid needs assessment." **Rapid Needs Assessment** refers to the start of the incident usually 0 – 72 hours from the onset of an incident. During the acute phase, services will be focused on crisis stabilization and meeting basic needs for shelter and safety. When possible, existing structures such as the *Crisis Response Teams* will be the core element of the immediate response, due to their ability to rapidly deploy and knowledge of respective geographic area needs.

Response Phase refers to the middle of the incident usually 3-14 days into the incident. Two major goals of the response phase are to assess the impact of the event upon the community and to facilitate referral of those in need to behavioral health treatments, and to other services and resources. Another way that public health can affect mental and behavioral health outcomes is by providing the public with timely and credible emergency risk communications. Disasters that involve injury or loss of life or that threaten or kill are high-risk situations for children and families. At times, it may be necessary to seek specialized funding, such as the FEMA *Crisis Counseling* grant.

Services available during the Response Phase may include the following:

- **Needs Assessment:** The Disaster Behavioral Health Director will pay special attention to the psychological impacts on at-risk populations and to provide data to analyze the mitigation efforts required.

- **Crisis Intervention**: Crisis intervention and brief supportive counseling will be provided to survivors and impacted family members.

- **Disaster Case Management and Advocacy**: Regional Crisis Response Teams, DHHS Division Staff and Maine VOAD will link survivors and their family members to appropriate community services including emergency financial assistance, housing and shelter.

- **Community Outreach and Public Education**: Regional Crisis Response Teams and Healthcare Coalition Partners will provide outreach and public education to impacted groups in the community.

- **Emergency Client Movement**: Safety permitting, Regional Crisis Response Teams and DHHS may be involved in the emergency relocation of people being evaluated or treated for psychiatric or substance use disorders or functional needs.

- **Training**: if needed, DHHS Office of Child and Family Services, Substance Abuse and Mental Health Services and the Disaster Behavioral Health programs will provide specialized training on trauma-informed care and psychological first aid.

- **Development of Specialized Disaster Resources**: Resources may be developed through special funds to provide intermediate ongoing relief. Examples; include FEMA *Crisis Counseling* programs to support local crisis responses with additional staff, and programs such as *Psychological First Aid for Schools*.

- **Care Coordination with other Disaster Resources**: In order to minimize duplication of efforts, DHHS Divisions will coordinate with other disaster responders, such as MEMA, Maine American Red Cross and Voluntary Organizations Active in Disasters (MEVOAD).

Demobilization and Recovery Response (15 days +) occurs when the acute phase is stabilized and the community begins to focus on restoration to a new normal. A simple imperative during the recovery phase is to reestablish a sense of normalcy in the community with an understanding that this will constitute an adaptation of disaster impacts and transitions to "new normal". Interventions during this phase may include:

- **Brief Supportive Counseling:** Brief supportive counseling will be provided using evidence-based practices for dealing with traumatic events. *Skills for Psychological Recovery* will be offered to survivors and other impacted community members.

- **Disaster Case Management and Advocacy:** VOAD partners and MEMA Long Term Un-Met Need Case Managers will link eligible survivors and their family members to continued financial assistance, shelter needs and rebuilding, unemployment benefits, long term counseling, and other disaster-related services.

- **Community Outreach and Public Education:** Community crisis response teams, Public Health District Coordinating Councils, Healthcare Coalitions, MEMA and Maine Department of Education will provide outreach and public education to promote recovery and resilience.

- **Information Dissemination:** Information will be provided on the expected behavioral health responses and coping strategies.

Disaster Declarations and Trigger Points for DBH:
Emergencies generally fall into three disaster declaration categories.

1-Local Disasters
A local disaster is any event, real or perceived that threatens the well-being of citizens in one municipality. It is confined geographically to a small area and primarily impacts only persons living in that area. A local disaster is manageable by local officials without a need for outside resources. Local government such as police, fire, health and municipal officials handle the response. Costs associated with a response to this type of disaster are not reimbursable by federally funded sources.

Trigger Point for DBH:
The decision to involve DBH is made on a case-by-case basis in concert with local officials. A disaster behavioral health response will be based on casualties, injuries or other losses that impact at-risk populations and responders. There is no set time for response to a local disaster.

Maine Emergency Management Agency (MEMA) may activate representatives who comprise the State's Emergency Response Team (ERT). The Director currently is a member of MEMA's ERT; and has been assigned an ESF #8 coordinating position at the State Emergency Operations Center.

2- State Emergency Management
A state disaster is any event real and/or perceived, that threatens the well- being of citizens in multiple towns, cities, or regions or overwhelms a local jurisdiction's ability to respond, or affects state owned property or interests. Only the Governor or their designee can declare a state emergency. A response by DBH may be required depending on a moderate disaster with escalating magnitude, nature and duration of the emergency and has a potential for crisis and trauma.

Trigger Point for DBH:
The Maine Emergency Management Agency (MEMA) may supplement local resources with state resources and may call upon DBH response team members to provide a number of supportive services. The Maine CDC Public Health Operations may also request DBHRT assistance for a public health threat that is challenging to manage and has the potential for transmission to other areas or raising public fear and anxiety.

The Governor may declare that a state of emergency exists within certain or all parts of the State and make State assets available to save lives, protect property, and aid in disaster response and recovery.

3-Presidential Disaster Declaration
A Presidential Disaster Declaration is any event, real or perceived that threatens the well- being of citizens in multiple locales throughout the state and overwhelms the local

and state ability to respond and recover, or the event affects federally owned property or interests. The Governor proclaims a State of Emergency first and then requests federal assistance through MEMA to FEMA; and Maine CDC requests guidance and assistance through ASPR or U.S DHHS. Only the President of the United States can declare a presidential disaster. The declaration needs to include the Individual Assistance category for Crisis Counseling and Disaster Case Management.

Trigger Point for DBH:
The Disaster Behavioral Health Response Plan would be activated including alerts and notification to behavioral health organizations within the state. Activation of the Disaster Behavioral Health function at the local, region and state levels would occur. Participation with multi-agencies, DBH will coordinate disaster behavioral health activities and begin to prioritize the incident demands for critical or competing behavioral health resources, working with the Statewide DBH Committee, American Red Cross, VOAD, and DHHS Commissioner's office. The DBH Director, working with the MEMA Individual Assistance Officer, may be directed to process and complete a FEMA Crisis Counseling grant application to meet the disaster-caused response and recovery needs that have overwhelmed state resources.

E. Determine Public Warning

A disaster may occur with little or no warning and may escalate rapidly, depleting the resources of any single local response organization or jurisdiction to handle. Risk communications become essential to direct citizens to appropriate care and self-care within their own homes. During an emergency, the coordinated and verified information is disseminated through the EM Resource, MEMA Joint Information Center (JIC) and/or Department of Health and Human Services Public Information Officer about the emergency to keep the public informed about what has happened and personal protective measures that should be taken.

What the Public Will Ask First in Public Health Emergencies?

1. Are my family and I safe?
2. What have you found that may affect me?
3. What can I do to protect myself and my family?
4. Who caused this?
5. Can you fix it?

a. Determine Message Content

Messages should be available in diverse languages and accessible with cultural and age-appropriate formats. Messages should be delivered promptly and frequently by a credible and trusted source. **(Refer to the Maine DBH Communications Plan, October 2014)**

Some examples of information to be shared with Joint Information Centers from the disaster behavioral health function include:

- Public health advisories pertaining to disaster behavioral health
- Disaster behavioral health programs and services available in impacted communities

- Status of behavioral health infrastructure, i.e. facilities, providers/personnel, medication supplies, counseling services available
- On-line resources to promote behavioral health self-assessment, coping strategies, and recovery

DHHS Telephonic Interpreter Services
When a telephonic interpreter is needed to help a member of the public to access programs and services, call only to vendors listed:

CTS Language Link
Call 9-1-888-338-7394; enter Account 18843#, select 9 for a customer service representative. Enter 4 digit billing code: 2543#.

Linguistica International
Call 9-1-866-908-5744; enter Account 10605#, provide 4 digit billing code: 2543#. Request the language; provide the first name and provide a call back number.

Public Warning Resources:
SAMHSA Disaster Response Template Toolkit
The Disaster Response Template Toolkit features public education materials that DBH programs can use to create resources for reaching persons affected by a disaster. The templates include print, website, audio, video and multimedia materials that behavioral health programs can use to provide outreach, psycho-education, and recovery news for survivors and communities. The templates can be adapted for future preparedness events: http://www.samhsa.gov/dtac/dbhis_templates_intro.asp

National Child Traumatic Stress Network
Website: http://www.samhsa.gov/traumaJustice
This behavioral health resource can be accessed by visiting the SAMHSA website and then selecting the related link.

b. Select appropriate warning system

Maine Health Alert Network (HAN or Maine HAN) is a secure, web-based alerting and notification tool capable of sending messages via e-mail, fax, SMS, and voice. The Disaster Behavioral Health Director will contact the Response Team members and select Behavioral Health Treatment Providers to alert them that a Disaster Behavioral Health Response Team (DBHRT) and *Maine Responds* volunteers may be mobilized, utilizing the *Maine Responds* and HAN notification process.

EMResource is another two-way communication tool that would be vital during a disaster event. EMResource™ is a proven communications and resource management solution that streamlines communications between medical response teams and healthcare providers by monitoring healthcare assets, emergency department capacity, and dialysis bed status; and facilitates NDMS and HAvBED reporting and broadcasting.

Additional incident-specific resources are easily tracked, such as decontamination capability, ventilators, pharmaceuticals, and specialty services.

Web EOC is a web-based communications system used in emergency operations centers, including Maine Emergency Management Agency, County Emergency Managers and the Maine CDC Public Health Incident Operations Center.

F. Protective Action Implementation

DBH actions during the response phase will focus on identifying adults, children and at-risk populations who would benefit from brief counseling and evidence-based behavioral health services and to begin treatments. *Source: National Response Framework*

Specific strategies for affecting a positive outcome during behavioral health responses include:

a) Use of seamless mental health triage, screening and assessment model for those individuals and communities at high risk for exposure to traumatic events
b) Immediate Crisis Intervention and stabilization by Crisis Response Agencies and DHHS personnel
c) Initiate Psychological First Aid and Skills for Psychological Recovery programs
d) Provide resiliency toolkits designed for specific populations, such as health care workers and first responders, MRC and CERT
e) Work with county emergency management and healthcare coalitions to coordinate disaster behavioral health training

a) Psychological First Aid (PFA)

Psychological First Aid was developed by the National Child Traumatic Stress Center and the National Center for PTSD for all individuals affected by a disaster and involves psychoeducation and supportive services to accelerate the natural healing process and promote effective coping strategies. PFA is an evidence-informed modular approach to help children, adolescents, adults and families in the ***immediate*** aftermath of disasters and terrorism. Psychological First Aid includes basic information-gathering techniques for providers to complete rapid assessments on survivor's immediate concerns and needs, and to implement supportive activities in a flexible manner. PFA emphasizes developmentally and culturally appropriate interventions for survivors of various ages and backgrounds, and includes handouts with important information for youth, adults and families over the course of their recovery.

Psychological First Aid is based on an understanding that disaster survivors and others affected by such events will experience a broad range of early reactions e.g., physical, psychological, emotional, behavioral, and spiritual. Some of these reactions will cause enough distress to interfere with adaptive coping, and recovery can be helped by

support from compassionate and caring disaster responders and trained community members. Disaster Behavioral Health Response Team members are trained in the basic guidelines and just-in-time PFA training is available to new *Maine Responds* volunteers and the people caring for others to utilize these skills following an emergency event.

b) Skills for Psychological Recovery (SPR)

Skills for Psychological Recovery are evidence-informed skill sets designed to address disaster survivors' and responders' needs and concerns in the ***weeks and months following*** a disaster and traumatic event. The goals of SPR are to help survivors gain additional skills to reduce ongoing distress and effectively increase self-efficacy and functioning. Skills for Psychological Recovery core skills help to:

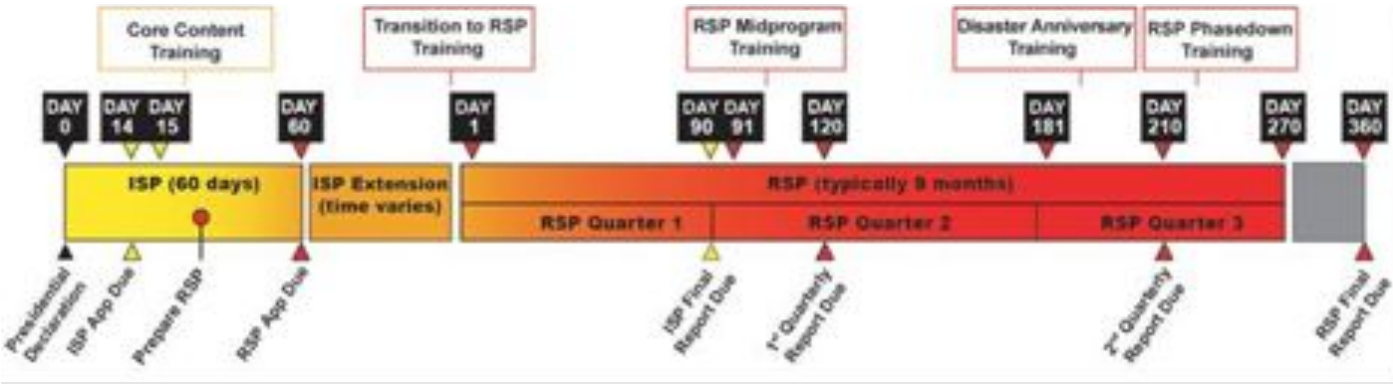
- Build problem solving skills
- Promote positive activities
- Promote helpful thinking
- Build healthy social connections
- Identify referrals for a higher level of psychological care

c) Crisis Counseling Assistance and Training Program (CCP)

In the aftermath of a presidentially declared disaster, the Stafford Act provides for a number of individual assistance programs, including Crisis Counseling Assistance and Training *(42 U.S.C. 5183).*

"The President is authorized to provide 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 disasters in order to relieve mental health problems caused or aggravated by such major disaster or its aftermath."

Crisis Counseling Program is a FEMA (Federal Emergency Management Agency) funded program and the U.S. DHHS (SAMSHA) provides grant administration, program oversight, training and technical assistance. The CCP services are focused on preventing or mitigating adverse psychological repercussions of a disaster. The diagram below depicts that tight timeframe that states must follow to seek reimbursement from the FEMA *Crisis Counseling Program*.



The CCP provides these support-centered services to survivors over a specific time periods beginning in the 2nd operational month through 9 months, and may extend to multiple years depending on the long-term impact of the event.

Eight key principals guide the Crisis Counseling Program process:

1. Strengths-based,
2. Community outreach, and
3. More practical than psychological in nature.
4. Diagnosis free: Crisis counselors do not classify, label or diagnose people and they keep no records or case files unless a referral to a higher level of care or safety reasons are required.
5. Conducted in non-traditional settings: face-to-face contact with survivors in their homes and communities
6. Culturally competent, and
7. Designed to strengthen and augment existing community support systems.
8. Promotes consistent program identity; i.e. websites, t-shirts, logos.

There are two additional *Crisis Counseling Program* services:

- Development and Distribution of Educational Materials includes flyers, brochures, tip sheets, educational materials or website information to be distributed by CCP workers to educate survivors and impacted community members.

- Specialized Crisis Counseling Services (SCCS) is an enhanced level of crisis counseling that can be requested by the state to assist people requiring more intensive services provided by licensed or certified mental health professionals.

d) SAMHSA Emergency Response Grants

Emergency Response 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 and the funding may not always be available.

e) Substance Abuse and Mental Health Services Administration Disaster Technical Assistance Center (D-TAC)

D-TAC staff members are knowledgeable about the experience of states that have confronted certain types of disasters, and provide best practices from these experiences. *Source:* https://www.samhsa.gov/dtac/CCPtoolkit/ISP.htm

SAMHSA Treatment Finder: 1-800-662-HELP (4357)
Website that connects to treatment resources for substance abuse or other mental health needs. www.findtreatment.samhsa.gov

f) SAMHSA Disaster Distress Hotline (DDH)

The first national hotline dedicated to providing year-round disaster crisis counseling. This toll-free; multi-lingual, crisis support service is available 24/7 via telephone at (1-800-985-5990) and SMS text *TalkWithUs* to 66746 to residents in the U.S. and its territories who are experiencing emotional distress related to natural or human-caused disasters. *Source:* https://disasterdistress.samhsa.gov/

g) Maine Responds

A statewide registry system to help pre-credential health care professionals (physicians, nurses, behavioral health providers) or non-medical individuals who volunteer their services during an emergency with significant public health issues. Liability protections exist for volunteers during a Governor-declared emergency and when deployed by the State of Maine. www.maineresponds.org

h) Office of Administration for Children and Families (ACF) Disaster Case Management Program

The Disaster Case Management Program augments state and local capacity to provide disaster case management services in the event of a major disaster declaration which includes individual assistance. In Maine, the Disaster Case Management program is operated through MEMA in coordination with DHHS. This website explores the options states can exercise: **http://www.acf.hhs.gov/programs/ohsepr/disaster-case-management**

National Disaster Interfaiths Network

i) Faith-Based Initiatives

Many different faith based organizations provide mental health counseling to communities impacted by disasters. A list of organizations is at: www.samhsa.gov/faith-based-initiatives

G. Short Term Response Needs

a) Coordination

During a declared event, Disaster Behavioral Health actions and capabilities may include:

Target Populations	Acute Phase	Response	Recovery Phase
Survivors and their Family Members	**Service Needs:** • Acute Care • Protection • Stabilization • Direction • Connection • Case Mgmt. • Triage **Intervention site:** Disaster impacted region/ shelters/hospitals Family Reunification Center Family Assistance Center Service Centers **Providers:** American Red Cross DBH Volunteers Crisis Agencies	**Service Needs:** • Outreach Assessments Referrals • Psychosocial Education • CBT-online or telephone • Initial follow-up • Large group activities • Case Consult with other providers • Assist w/ death notification **Intervention sites:** • Shelters • Hospitals • Reception Centers • Schools • Homes/hotels • Churches • PODs • Family Assistance Center **Providers:** • BH community • Red Cross • VOAD • DHHS	**Service Needs:** • Outreach • Psychosocial ED • Debriefings • PTSD Assessments • Referrals • Individual, Family, Couple support • Group Counseling • Case Consult • Advocacy Development • Support Groups • Memorial Services • Long Term Recovery Case Management **Providers:** • BH Community • DHHS staff • Disaster Case Managers • Long Term Recovery Board • Community Groups
First Responder	**Service Needs:** • Triage/Needs Assessment • Consultation • Stress Mgmt. • Crisis Intervention • Referrals **Intervention Sites:** • Impacted region • Work • Rest sites • Hospitals **Providers:** • Crisis Response Teams	**Service Needs:** • Assessment • Consultation • Initial Follow-Up • Referrals • Group Support **Intervention Sites:** • Work sites • Rest areas • Home offices • Hospitals **Providers:** • BH community • Red Cross/VOAD • Peer support	**Service Needs:** • Assessment • Referrals • Debriefings • Behavioral Health services/treatment • Commemoration/Memorials **Intervention Sites:** • Work sites • Rest areas • Home offices • Hospitals **Providers:** • BH community • Community BH providers

	• In house/EAP Supports		• Employee Assistance
Vulnerable Population	**Service Needs:** • Outreach • Triage/Needs Assessment • Protection • Client movement • Direction • Connect w/Treatment Providers • Medication Mgt. • Assure provision of: food, clothing, shelter	**Service Needs:** • Outreach • Triage/Needs Assessment • CBT- online and telephone • Referrals • Psychosocial ED • Medication Mgt. • Transportation • Case Coordination w/other providers	**Service Needs:** • Outreach • PTSD Assessment • Referrals • Debriefings • Psychosocial ED • Case coordination/long term recov • Advocacy • Support Groups • Commemoration events
	Intervention site: • Homes and residential facilities • Shelters • Treatment sites • Street • Schools • Elderly housing **Providers:** • Local crisis agencies • Nonprofits • Churches • DBH Volunteers	**Intervention site:** • Home/residential facilities • Shelters • Treatment sites • Street • Schools • Elderly housing **Providers:** • BH Community • DHHS staff • Red Cross/VOAD • Peer-Recovery groups	**Intervention sites:** • Home/residential facilities • Treatment sites • Street • Schools • Elderly Housing **Providers:** • BH Community • Healthcare Providers • Treatment Providers • Recovery groups • DHHS staff • Long term Recovery
Business	**Service Needs:** • Outreach needs • Assessment • Consultation • Treatment sites • Education	**Service Needs:** • Phone & on-site consultation • Employee support	**Service Needs:** • Phone & on-site consultation • Needs assessment • Educational info • Training w/ EAP staff
General Public	**Service Needs:** • Information Education **Providers:** • DHHS • MEMA/CDC • Joint Information Centers • Disaster Distress Hotline	**Service Needs:** • Psychosocial ED • Reports, brochures re: stress reduction & coping **Intervention Sites:** • Newspapers • Radio • TV/internet • Community Centers • Shopping Malls • Schools • Faith Centers	**Service Needs:** • Information & Education **Providers:** • Crisis Response Teams • Community Leaders • Faith Groups • Healthcare Providers • Schools/Colleges

		• Business Associations **Providers:** • DHHS/DBH • HealthCare Coalitions • MEVOAD	

H. Mobilizing DBH Response Teams

To maintain the core competencies within Maine's Disaster Behavioral Health Response Team for preparedness and response, the following activities must occur, and are managed by the Director of Disaster Behavioral Health.

Disaster Behavioral Health Volunteer Recruitment and Retention:

- Recruitment will continuously occur in order to develop and maintain an active roster of trained team members.
- Potential members must register as DBH Response Team member through the *Maine Responds* registry.
- Criminal background checks will be completed on all registered team members
- Licensure verification will occur on all potential team members who are licensed in a mental health or substance abuse or spiritual care discipline.
- Newsletters will be sent regularly to team members to maintain best practices.
- Mandatory training of the state DBH Critical Response curriculum will be kept up-to-date and available to potential members of the team.
- The Program Director will maintain a contact list of all team members.
- The Program Director may designate specialized teams e.g. teams trained to work with children, in a hospital, or with first responders.

Requirements for Volunteer Team Participation:

The following four steps must be completed to join the Maine DBHRT:

Step 1: Complete the two-day training FEMA/SAMHSA *Crisis Counseling Core Content Training* which is made of 2 8-hour days to cover the organization of a disaster or public health emergency event, skills-based experience to practice Psychological First Aid and crisis counseling techniques. Professional self-care and stress management.

*Step 2: Complete the Maine Responds Self-Registry application***.**

This form provides contact information, professional and licensure information, and information about experience and areas of expertise; and verification after completion of training requirements.

Step 3: At a minimum all DBHRT members must complete two courses:

A. the Incident Command System (IS-100: An Introduction to ICS) or an equivalent course ICS 100, Introduction to the Incident Command System, introduces the Incident Command System (ICS) and provides the foundation for higher level ICS training. This course describes the history, features and principles, and organizational structure of the

Incident Command System. It also explains the relationship between ICS and the National Incident Management System (NIMS).

B. The National Incident Management System (IS-700 NIMS: An Introduction)
The Homeland Security Presidential Directive 5 (HSPD-5) "*Management of Domestic Incidents"* requires States, territories, tribal entities, and local jurisdictions to adopt the National Incident Management System (NIMS). Implementing the NIMS strengthens our nation's prevention, preparedness, response, and recovery capabilities.

Breakdown of Required Training

Training	Required by responders?	Required by team leaders?	Required by incident management?	Where training can be found:
Crisis Counseling Core Content	**YES**	**YES**	**YES**	**Classroom settings. Email Kathleen.wescott@maine.gov for more information**
Psychological First Aid for Leaders	**NO**	**YES**	**YES**	**Kathleen.wescott@maine.gov for more information**
IS 100	**YES**	**YES**	**YES**	http://www.training.fema.gov/EMIWeb/IS/is100.asp
IS 200	**NO**	**YES**	**YES**	http://www.training.fema.gov/EMIWeb/IS/is200.asp
IS 700	**YES**	**YES**	**YES**	http://www.training.fema.gov/EMIWeb/IS/IS700.asp
IS 800	**NO**	**YES**	**YES**	http://www.training.fema.gov/emiweb/IS/is800a.asp

Step 4: All team members must have a satisfactory criminal background check
Criminal Background checks are completed by the *Maine Responds Volunteer Healthcare Credential System,* and upon satisfactory outcome, *T*eam members will:

- Provide current contact information to the Program Director and update their *Maine Responds* accounts
- Participate in drills, exercises, and non-mandatory trainings when available
- Follow policies and procedures indicated in DBH Response and FAC Annexes

Step 5: Maine CDC volunteers should be familiar with Maine DHHS policies on confidentiality and HIPPA. All volunteers will review and sign the DHHS Confidentiality Policy prior to deployment. During a large state-wide disaster or public health emergency, volunteers will complete the DHHS Confidentiality 101 and HIPPA/HITECH trainings. Copies of the updated Authorization of disclosure forms will be provided to team members to have survivors complete these forms during an operation.

Incident Command System (ICS):
All parties involved in disaster behavioral health response will utilize the ICS for centralized decision making and coordination of information. If the event does require ICS roles for DBHRT members, the leadership will determine which DBHRT members are best suited to these roles to support the efforts of the Team Leader. Depending on

the scope and magnitude of the event, the DBHRT located where the event is occurring will be activated first, with activation progressing through the next nearest localities. Additional teams may be placed on ALERT status for relief, to provide debriefing services to DBHRT members from the affected region or if the scope/magnitude of the event increases. *DBHRT team members should never self-deploy to a scene.*

Mobilizing the DBHRT members:

1. Once the disaster has been declared, locally, statewide or federally, the Program Director may begin to activate members of the DBHRT. The composition and size of the team will be determined by the type of disaster, the number and composition of those potentially requiring support and the location of the response sites.

2. The Program Director will review WebEOC situation reports and EMResource status reports to evaluate the disaster event requirements.

3. The names of potential volunteers being deployed will be sent to the MEMA Director for pre-approval to meet the liability requirements under the State of Maine 37B statute.

4. There may be instances in which a Regional DBHRT is placed on ALERT status through HAN/*Maine Responds*. This may occur when there is advance notice of a potential disaster:
    - Hurricane or weather events
    - Potential power outages
    - Ice Storms
    - Flooding
    - Public health threat

5. In large-scale events, *Maine Responds/HAN* notifications may be utilized to notify DBHRT members of:
    - The nature of the event
    - Where to report (location of volunteer staging area)
    - To whom to report
    - What to bring (DBHRT ID badge, Go Bag, see Pre-deployment Checklist)

6. In smaller scale events, the DBH Program Director/ Team Leader will contact DBHRT members by phone, text or e-mail to request their services. Specific information will be communicated to those DBHRT members who are able to respond:
    - The nature of the event
    - Where to report (location of volunteer staging area)
    - To whom to report, in most cases, Disaster Behavioral Health Team Leaders
    - What to bring (DBHRT ID badge, GO bag, etc.)

7. The DBHRT member will receive information on anticipated length of assignment and other information pertinent to the response. (See DBHRT Deployment Information form, Appendix B).

8. The team will be briefed by the designated Team Leader, and the Incident Safety Officer regarding the scope of the disaster, potential problems that may be encountered, i.e. special needs clients, the locations where survivors are being assisted, the services that they will be providing, concerns about safety issues, existing community resources. In addition, they will discuss communications, travel, contact persons with other organizations, reporting requirements/ documentation, schedule of work times, hazards at work sites, specific roles and responsibilities, and the frequency of meetings and periodic updates.

9. Team members will receive special instructions regarding safety issues and self-care and instructions for maintaining communications with the Team Leader and Safety Officers.

10. Team members will be given their assignments and deployed for a maximum shift of 12 hours. The Team Leaders will distribute forms, hand-held radios (if necessary) and key contact cell phone numbers to team members before they are deployed to the field.

11. Team Leaders may organize members into smaller teams (squads) for purposes of carrying out specific functions like debriefing responders, providing outreach to residences, shelters and congregate sites, etc.

12. Team members should record significant actions they have taken on the Disaster Action Log (Appendix B), recording only essential information of an identifying nature, noting details or any follow up actions needed. It is imperative that team members use only official forms to track information or record response activities.

13. The Disaster Behavioral Health Response Team Leader will ensure that a post deployment check-in plan is in place for members of DBHRT prior to their leaving their shift.

Team Activation

Disaster Behavioral Health Response Team is a state asset, comprised of trained volunteer behavioral health and spiritual care providers who may work or live in the impacted area, or who can be requested when existing local resources are not sufficient to meet the needs of the impacted population. ***It is imperative that team members not self-deploy to an event site until officially activated by the DBH Director or MEMA/CDC.***

Any requests for Disaster Behavioral Health Services or activation of DBHRT must be approved by the state emergency management system in accordance with Maine Emergency Management Assistance Agency right to call for and employ assistance; 37-B M.R.S.A. §1784-A (see section III:3 Policy and Guidance). This request can be made either through the local or county emergency management agencies, Maine DHHS Commissioner, MEMA, Maine CDC Public Health Emergency Operations, or directly to the Director, Disaster Behavioral Health. If a locality or healthcare organization

determines that their existing resources are either insufficient or have become exhausted in response to an incident:

- Call DBH Director **24/7 at (207) 441-5466** to request assistance for disaster or public health emergency event, and the Director will notify MEMA if the DBH Team is activated, or
- Call MEMA Duty Officer on call 24/7 at (800) 452-8735 to request assistance for a disaster event with behavioral health consequences, or
- Call Maine CDC Emergency Consultation at (800) 821-5821 for Public Health emergencies and medical surge at healthcare facilities.
- Complete the request for *Maine Responds* Emergency Health Volunteer Services Request Form and submit to the Regional HealthCare Coalition Director or County Emergency Management Agency. (*Maine Responds* forms, "S" drive)
- Memorandums of Agreement with Maine VOAD and the American Red Cross of Maine may be activated to provide mutual aid at a *Family and Friends* Reunification and Family Assistance Center.

Coordination with other Behavioral Healthcare Organizations
The local crisis response agency director or healthcare organization in the impacted region should be in contact with the DBH Director or their County EMA's. The statewide crisis telephone line can be accessed at all times and provides a means for assessment and crisis response resources. Maine's 24/7 Crisis Hotline number is 1-888-568-1112**.**

Inter-jurisdictional Relationships
If a disaster expands to require out-of-region support, this will be handled by the Disaster Behavioral Health Director. If support is required through another state, this will be requested through MEMA or CDC using the Emergency Management Assistance Compact (EMAC).

Disaster Behavioral Health Response team roles may include:

- Activation of ESF #6 Shelter, Health and Human Services, and ESF#8 Health and Medical Services, specifically behavioral health disaster response plans, in coordination with pre-identified crisis response agency providers.
- Mental/behavioral health resource coordination with requesting emergency responders and volunteer agencies (ME-VOAD and American Red Cross).
- Mental/behavioral health assessment of disaster survivors and responders; including agency structures and operational impacts; accessing the Strategic National Stockpile for Medical Counter Measures, i.e. psychotropic medications.
- Provision of and/or referral to mental/behavioral health services.
- Development and dissemination of consistent messages and guidance concerning stress management, coping and normal and expected reactions, and substance use impacting survivors.

Disaster mental/behavioral health responders are typically assigned to:

Family Reception/Assistance Centers	Regional Red Cross Shelters

Family and Friends Reunification Centers	Disaster Recovery Centers
FEMA Service Centers	Schools, Business, Colleges
Places of Worship	Hospitals, healthcare outpatient clinics
Cooling & Warming Centers	Comfort Stations
Alternate Care Sites	Crisis Hotlines
County and Town Emergency Management	State Offices
Police/Fire/Correction facilities	Behavioral Health Hospitals and Facilities
Isolation, Quarantine sites	Points of Medication Dispensing (PODs)
Local Assistance Centers	Hospice Centers/Funeral Homes

Volunteer Reporting Area
The Volunteer Reporting Area will be established in concert with local officials and the Incident Command. Upon arrival to the reporting area, the DBHRT member will check in with assigned contact person (the Team Leader or the Safety Officer), As team members arrive at the reporting area, the specific contact information for the team member must be recorded by the Team Leader (*see Deployment Check-In Appendix B).*

DBHR Team Members will wear their *Maine Responds* Photo I.D. badge in a visible place and, to the extent possible, wear the blue vest or jacket issued by the DBHRT. The location of the Director, DBH will be situation dependent.

H. Disaster Behavioral Health Communication Plan

Emergency Contact Information
The DBH Director will work with Disaster Behavioral Health Liaisons, Crisis Response Agency Leadership and members of the Disaster Behavioral Health Response Teams to communicate via Maine HAN and Maine Responds about the disaster response according to the procedures outlined for activating the plan.

Media/Public Information
All communication with the public and media regarding any disaster situation must be coordinated through a Public Information Officer (PIO) to ensure that information is given in a consistent and appropriate manner.

I. DBHRT Post-Deployment

After an assignment, DBHRT members are also encouraged to follow post-deployment instructions included in *Returning Home from a Disaster Assignment Checklist*, Appendix C. The Team leader will collect all materials such as radios, forms, etc. and record the time out on the DBHRT Deployment Check-in form and Disaster Action Log. Checkout is an opportunity for all team members for the team to share impressions of the disaster event, address their emotional responses, discuss specific roles and evaluate effectiveness in providing services.

In Appendix C, the following ICS forms can be utilized within DBH teams and for individual members depending on the scope, length and physical/psychological impacts of their deployment:

- Team Assignment Debriefing (ICS 204A)

- Demobilization Checkout (ICS 221)
- Individual Unit Log Form (ICS 214)
- Volunteer Feedback Form
- Incident Personnel Performance Rating (ICS 225)

J. Long Term Needs/Recovery Phase

a) Recovery Coordinating Resources

Resource coordination is a key logistical function outlined in the State of Maine Intra-Agency Disaster Recovery Plan. Three important public health activities to be undertaken during the recovery phase are to (1) assess continuing and delayed impacts of the disaster (2) advocate for those in need and (3) collaborate with key agencies to address unmet psychological needs including efforts at early reunification of children with their families.

Disasters accompanied by secondary stressors and hardships during recovery can include relocations to temporary housing, completing complex insurance or reimbursement requests, delays in financial assistance to begin property clean-up and repair or replacement, and family member's separation and conflict. Six months following Hurricane Sandy, a cross-section survey of 200 older adults residing in beach communities directly exposed to the storm found that 20 percent sought professional counseling, and 30 percent experienced Posttraumatic stress symptoms. In contrast, if children and adults receive sufficient and sustained support, many emerge with new skills (posttraumatic growth) to cope with future adversities.

Outcomes for the #8 Recovery Support Functions include*:* *source: National Recovery Support Functions (RSF) for Health and Human Service Outcomes (2016)*

- Restore the capacity and resilience of essential health and social services to meet ongoing and emerging healthcare needs.
- Encourage behavioral health systems to meet the behavioral health needs of affected individuals, response and recovery workers, healthcare personnel and the community.
- Promote self-sufficiency and continuity of the health and well-being of affected individuals, particularly the needs of children, seniors, people living with disabilities whose members may have additional functional needs, people from diverse origins, people with limited English proficiency and underserved populations.
- Assist in the continuity of essential health and social services, including schools and child-care services, and behavioral health programs and services.
- Reconnect displaced populations with essential health and social services.
- Complete after action reports with *Lessons Learned* to help mitigate recovery

activities.

- Promote clear communications and public health risk communications on grief and loss, self-care and coping, recovery strategies and financial resources.

b) Inter-jurisdictional Relationships

Mental health reactions and substance use disorders may emerge or intensify during recovery, and can impede individual and community resilience. Recovery coordination activities for behavioral health may include*:*

- On-going assessment of disaster-related structural, functional, and operational impacts to behavioral health facilities and programs;
- Initiate recovery program with *Skills for Psychological Recovery* to help survivors identify their most pressing needs and concerns, and to begin future planning;
- Initiate a media campaign about stress and anxiety with appropriate coping strategies
- Initiate *First Responder Mental Health Resiliency Program* (source: Crisis and Counseling Services)
- Continue to coordinate as necessary the identification, location, procurement, mobilization and deployment of additional behavioral health resources; e.g. Response Teams, Medical Counter Measures, Long Term Un-Met Needs resources, etc.
- To follow the CCP grant requirements for training, reporting and financial accounting;
- Advocate as necessary at the state level for consideration of anniversary events, memorials, and remembrances activities.

When planning for a disaster or public health emergency, healthcare organizations should take into consideration that the signs of psychological trauma may be delayed or difficult to recognize. Behavioral Health plans should be scalable and flexible and may entail plans for individual, family and group crisis counseling, distribution of educational literature on coping and stress management, and an outline of how the healthcare organization will connect staff, patients/clients, and their families, and members of the community with internal and external resources that they may need to restore psychological wellbeing after an emergency event.

Considerations for Behavioral Health Recovery Planning for healthcare organizations:

- Does your organization have a plan to deal with the short and long term behavioral health needs in relation to events exacerbated by the disaster?
- How will your organization provide emotional and psychological care to employees and their families and to patients and impacted clients?
- How do you determine population exposure following an incident? How are the disaster mental health needs estimated and assessed?
- How do you track and record behavioral health counseling that your organization provides during and following an event?
- Does your healthcare organization promote psychological first aid and/or psychological resiliency among your staff, patients, clients and family members?

What routine services or outreach is available to staff, patients, clients and family members?

- Who are employees instructed to turn to when they are concerned about the wellbeing of a colleague, patients/client or family member?

III. ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

A. Direction

In a regional crisis, there will be behavioral health organizations who will oversee their own agency personnel, in addition to CCP staff members. The DBH Director will report to the command personnel at the Maine Emergency Management Agency as well as the Commissioner of the Department of Health and Human Services; or during a public health emergency, to the Manager, Maine CDC Public Health Operations.

B. Coordination

a.) Lead State Agency

Maine Department of Health and Human Services, Maine Center for Disease Control and Prevention, Public Health Operations

- Administers Maine's disaster behavioral health program, identifies and mobilizes available DHHS resources to support response activities and supports Healthcare Coalitions in assessing psychological health risks to survivors, healthcare and emergency personnel.
- Coordinates with providers of care and shelter to address mental health issues and the provision of crisis counseling services.
- Monitors availability of psychotropic medications within healthcare systems and pharmacies; in the event National Strategic Stockpile (MCM) medications are required.
- Provides assistance with Maine HAN messaging capabilities.
- Coordinate with local, state and federal government, healthcare partners and BH agencies to provide disaster-related mental/behavioral health services.

Maine Responds Emergency Healthcare Volunteer Management

This state-based advance registration system maintains a database of pre-credentialed healthcare volunteers, and can include licensed behavioral health treatment counselors and other clinicians. This program is administered by Maine CDC Public Health Operations.

b.) Supporting State Agencies/Departments

Maine Emergency Management Agency (MEMA)

- Coordinates requests for FEMA *Crisis Counseling Program* with Maine DHHS, following a presidentially declared disaster.

- Staffs the state Voluntary Agency Liaison position to work with voluntary agencies and other non-profits to bring in services, including disaster behavioral health.
  - Administrator for the State of Maine Long Term Recovery Committee which can solicit funds for unmet disaster survivor needs.
- Retains oversight of the Individual Assistance Grants to include Disaster Case Management and Crisis Counseling program, and submits grant application to FEMA with appropriate Governor's Authorized Representative signatures for both.
- Accesses state and federal Victims of Crime programs to provide counseling services following certain events (terrorism).

c.) *Federal Support Agencies*

Lead Federal Agency-Health and Human Services/Office of the Assistant Secretary for Preparedness and Response (ASPR)

- Preventing, preparing for, and responding to the adverse health effects of public health emergencies and disasters
- During an emergency or disaster, deployment of medical professionals to ASPR's National Disaster Medical System to augment state and local capabilities

Domestic Violence and Disaster Specialized Resource Collection

A collection of fact sheets and resources highlights the disproportionate vulnerability of women and children to domestic and sexual violence in disasters and emergency situations. http://www.vawnet.org/special-collections/DisasterPrep.php

Domestic Violence Hotline

The National Domestic Violence Hotline is a 24-hour, confidential, toll-free hotline that connects a caller to a service provider in their state. Trained advocates provide support, information, referrals and safety planning in 170 languages at 1-800-799-SAFE (7233) http://www.thehotline.org/

FEMA- Federal Emergency Management Agency

Administers the *Crisis Counseling Program* consisting of two grant programs: Immediate Services Program (ISP; 60 days in duration) and Regular Services Program (RSP; 9 months in duration)

Federal Office of Health Emergency Assistance Programs (EAP) SERVICES

EAP Emergency Response Teams report to impacted agencies requesting services and can provide post-deployment education, support, and referrals to first responders.

U. S. Department of Health and Human Services (HHS)/Administration for Children and Families

- ACF programs fund disaster case management, i.e. assistance in navigating recovery services; and helps specifically with mental health issues and medication management.

- Conducts surveillance through its Family Violence Prevention and Services Program, which monitors the National Domestic Violence Hotline and maintains contact with family violence service agencies to identify increases in domestic violence behaviors caused by disasters and public health emergencies.

HHS/Administration on Aging (now Administration for Community Living)

- Directs a comprehensive, coordinated system to help elderly individuals maintain their health and independence in their homes and communities.
- Works with ACF and ASPR to develop and review state, territory and local emergency response plans and coordinate ESF#8 and ESF#6 activities.

HHS/Centers for Medicare and Medicaid Services

Administers all aspects of the Medicare and Medicaid and Children's Health Insurance Programs (CHIP), to include mental/behavioral health:

- **Administers 1135 Waivers** when a President declares an emergency under the Stafford Act and the HHS Secretary declares a public health emergency, the Secretary is authorized to temporarily waive or modify certain Medicare, Medicaid, and CHIP requirements.
- Ensures flexibility to agencies during emergencies and disasters to meet the needs of individuals enrolled in Social Security programs; and relaxes time periods that providers can submit requests for reimbursements and exempts them from sanctions.

HSS/Health Resources and Services Administration

Primary federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable, and provides grants to support community-based mental/behavioral health care provision, which contributes to community resiliency

HSS/Indian Health Services

- Direct response partner for emergencies and disasters across tribal nations.
- Assists tribal partners by providing emergency and disaster services in contracted or compacted tribal programs and reservations.

HSS/Substance Abuse and Mental Health Services Administration (SAMHSA)

- When an incident occurs with the potential to overwhelm state, territory and tribal mental/behavioral health resources, SAMHSA Emergency Operations coordinates resources and steady state programming, i.e. National Child Traumatic Stress Network, Suicide Prevention, Lifeline, etc. to meet requests for assistance.

- Maintains close linkage with state behavioral health coordinators and engages in preliminary needs assessments throughout the response phase.
- When Stafford Act declarations with Individual Assistance are approved; will work with the FEMA *Crisis Counseling Program* and State DBH Program Director.

SAMHSA's Disaster Distress Hotline

A confidential and multilingual, 24/7 crisis support service offered via telephone **1-800-985-5990 and SMS/Text 'Talk with Us' to 66746** and is available to U.S. residents in both federally declared and non-declared disasters.

National Child Traumatic Stress Network

Website: http://www.samhsa.gov/traumaJustice

This can be accessed by visiting the SAMHSA website and select the related link On-line training and manuals for *Psychological First Aid* for specific populations

HHS/Office of Force Readiness and Deployment

Manages U.S. Public Health Services response teams that provide behavioral health services in emergencies and large scale disasters, including deployment of (5) Mental Health teams.

HHS/Office of Disability:

Maintains relationships with behavioral health disability consumer advocacy and rights groups throughout the country, to disseminate DBH information and planning guidance.

d.) Non-Governmental Organizations

American Red Cross

- Coordinates with approximately 5000 licensed disaster mental health providers nationwide, trained to assist in all phases of disaster work.
- Has memorandum of understanding with the American Psychological Association, National Association of Social Workers, American Association of Marriage and Family Therapists, and several others, to use members of all the major professional mental health associations to provide disaster services.

Maine Voluntary Organizations Active in Disaster (MEVOAD)

- Members of Maine VOAD form a coalition of national nonprofit organizations that respond to disasters as part of their overall mission.
- Effective service through the four C's—communication, coordination, cooperation and collaboration—by providing mechanisms and outreach for all people and organizations involved in disasters.
- VOAD.net is an online interactive platform for member organizations. Their platform enables members to communicate and coordinate requests for and

sharing of needed resources during disasters, as well as share best practices and lessons learned.

National Organization for Victim Assistance (NOVA)

- Program funds short term counseling services to help survivors recover from a violent or traumatic event, including certain disasters.
- Trained Crisis Response Teams provide trauma mitigation and education in the aftermath of a critical incident, either small-scale or mass-casualties.

Salvation Army- Northern New England

- The Salvation Army is a large provider of social services, including food preparation and volunteer management during disaster events.
- Programs encompass direct social services, after-school programs, temporary shelter and feeding programs, financial assistance and disaster response.
- Salvation Army serves on Maine's Long Term Recovery Un-Met Needs Committee.

Maine Funeral Directors Association

Statewide association of professional Funeral Directors who are available to assist with fatality management, brief grief counseling and logistical support during a mass fatality or public health emergency with coordination through MEMA or the Public Safety Commissioner.

Maine 2-1-1

2-1-1 Maine is a comprehensive statewide directory of over 8,000 health and human services and programs available in Maine. The toll free 2-1-1 hotline connects callers to trained call specialists who can help 24 hours a day, 7 days a week or go to: www.211maine.org

Cumberland County TIP

Trained volunteers who provide the Trauma Intervention Programs (TIP) within Cumberland County and respond at police/fire/accident scenes. Funding for their training and supervision is provided by Maine Health.

C. **Responsibilities of the Program Director of Disaster Behavioral Health Services**

The Program Director is responsible for managing the state behavioral health response to community disasters and public health emergencies, by assessing the nature and extent of disaster behavioral health service needs for psychological supports, volunteers and programs, obtaining and organizing statewide resources and response strategies.

D. Support Functions

a) *Responsibilities of Volunteer Team Leader*

- Manages local or regional operations of DBHRT
- Provides communication link to the Director, Disaster Behavioral Health

- Remains adaptable and flexible. Leaders need to be adaptable in order to provide the type of care needed by the population affected.

b) Responsibilities of the Volunteer DBH Responder

- Provides behavioral health triage and supportive counseling, technical assistance
- Practices *Psychological First Aid and Skills for Psychological Recovery, FEMA crisis counseling*
- Remains adaptable and flexible.
- Follows proper self-care practice in all operations

IV. ADMINISTRATIVE ISSUES AND AGREEMENTS

A. Reporting and Preservation of Records

Records will be kept of type of services provided in a disaster and basic information regarding who the services are provided to (gender, approximate age, location service has been provided). Copies of DBHRT applications, training certificates and personal information will be maintained as confidential information by Ad Care Educational Institute of Maine and within *Maine Responds.*

B. Agreements and Understandings

An agreement is in place between the Department of Health and Human Services and the Maine American Red Cross and Maine VOAD. Specific crisis agencies in Maine who are invested in disaster behavioral health planning and response have signed Memorandums of Agreements (MOA) with County Emergency Management Agencies. Copies of the (2007) MOA's are maintained by the Program Director, Disaster Behavioral Health.

V. Annex Development and Maintenance

A. Responsibilities

The Standard Operating Procedures and Disaster Behavioral Health Plan Annex are developed and maintained by the Director, Disaster Behavioral Health with input and guidance from the statewide Disaster Behavioral Health Preparedness and Response Planning Committee.

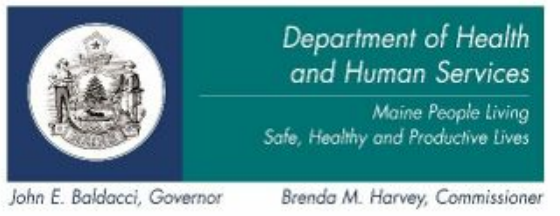
B. Review and Update Procedures

Any updates and revisions to the plan are noted in the table on Page Two.

Glossary of Terms

CISM	**Critical Incident Stress Management**
DBHRT	**Maine Disaster Behavioral Health Response Team**

DHHS	**Maine Department of Health and Human Services**
Director	**Director, Disaster Behavioral Health**
EMA	**Emergency Management Agency**
EOC	**Emergency Operations Center**
ERT	**Emergency Response Team**
FEMA	**Federal Emergency Management Agency**
HSPD-5	**Homeland Security Presidential Directive**
ICS	**Incident Command System**
MeCDC	**Maine Center for Disease Control and Prevention**



Acknowledgements

This Maine Disaster Behavioral Health Response Teams were created with funding and guidance from the Maine Center for Disease Control and Prevention, Office of Public Health Emergency Preparedness, Hospital Preparedness Planning and ASPR funding.

The subcommittee for the design of the Standard Operating Procedures provided important contributions toward the creation of the teams. Specifically, Darla Chafin, Pat Conner, Jon Forti, Elsie Freeman, Josh Frances, Jan Frost, Kris Gammon, Bill Lowenstein, Karen Mason, Tammy McLaughlin, Heidi Rioux, Steve Sherretts, Pam Holland, Richard Higgins, and Joan Smyrski provided expert input on the creation of this document.

Appendix A

At-Risk Populations in Maine

Each population group is vulnerable in unique ways to the stressors of a disaster. Different issues and concerns become relevant during their emotional recovery. The behavioral health focus during a disaster response would be to focus on at-risk populations. Knowledge of risk factors for adjustment difficulties can serve as a basis for behavioral health triage and interventions. This Plan's vulnerability assessment will provide a snapshot of key findings for identified at-risk populations in Maine.

This Appendix will discuss specific at-risk populations:

1. Children
2. Elderly
3. Emergency Responders
4. Tribal Nations
5. Culturally Diverse communities
6. Socio-Economic Factors
7. Individuals challenged by chronic mental health, substance use or disabilities

1) CHILDREN

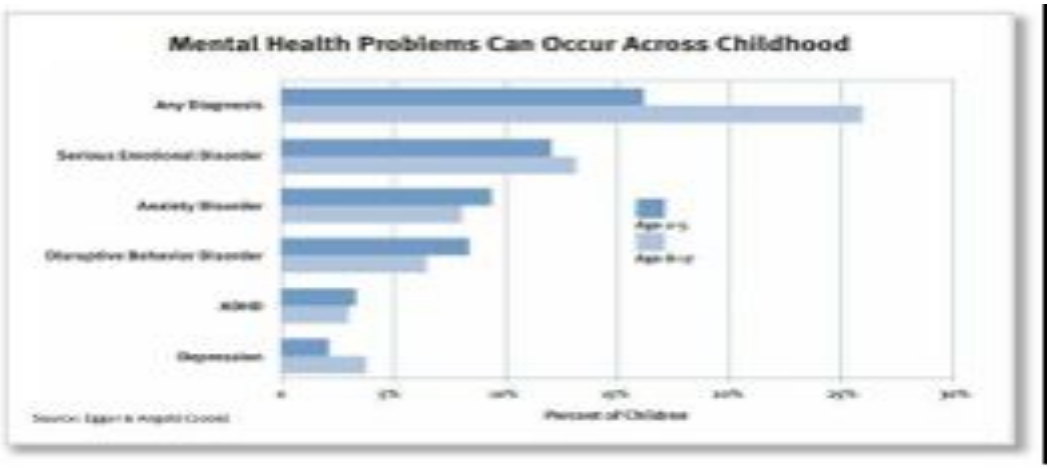
A disaster is emotionally confusing and frightening, and results in children needing significant instrumental and emotional support from adults. Norris and her colleagues (2007) in their definitive review of disaster mental health outcomes in more than 60,000 disaster survivors concluded that children and adolescents are among the most vulnerable populations in terms of long term psychological disorders and associated functional impairments. Their research demonstrates that after a major disaster, a large proportion of children in the affected community will develop adjustment disorders, often related to trauma, anxiety and depression. In a study conducted 6 months after the terrorist attacks of September 11, 2001, involving a sample of 8000 students in grades 4 through 12 attending NYC public schools, 27% met criteria for one or more psychiatric disorders.

Children differ from adults in physiology, developing organ systems, behavioral, emotional and developmental stage impacts to potentially traumatic events. For children, their age and development determine their capacity cognitively to understand what is occurring around them and to regulate their emotional reactions. Other risk factors for children include a history of prior exposure to potentially traumatic experiences, female gender, insufficient or inappropriate caregiver support or response, and the mental health status of caregivers.

Children can be vulnerable as they lack the experience and skills to independently meet their own behavioral health needs and will require special considerations and planning. "Children lack the developmental and physical ability to flee hazards, or they may approach them out of curiosity or inadequate comprehension of risk. Limited ability to understand the nature of the disaster can lead to stress, fear, anxiety, inability to cope, and exaggerated responses to media exposure. All of these responses can manifest as developmental regression, withdrawal, clinginess, tantrums, or somatic complaints. Other common reactions may include reliving the events through play, activities and artwork. Young children cannot care for themselves and require age-appropriate foods as well as assistance in feeding, toileting and clothing. Safe housing and safety in shelters are critical." "*Providing Psychosocial Support to Children and Families in the Aftermath of Disasters and Crisis*" American Pediatrics Association, October 2015, Volume 135/Issue 4

Disasters often lead to separation and loss. Children typically do not carry personal identification and may become separated from parents/caregivers. Depending upon their age and cognitive development, they may not be capable of readily conveying medical history. Also, children are at higher risk for abduction and abuse during disasters. In the immediate aftermath of Hurricane Katrina, many children experienced challenges related to shortages of food, clean water, safe evacuation or even their own survival. One-third of 4th to 12th grade students reported that they were separated from their parents or caregivers during or after the disaster. Of those sampled, 20 percent reported an injury to one or more family members, and 15 percent reported a disaster-related death in their family.

Depression and anxiety disorders are prevalent among youth; for example, an estimated 25 % of 13 to 18-year-olds have an anxiety disorder. Surveys also suggest that less than a third of youth with anxiety and just over 40 percent with mood disorders receive treatment. These disorders can have serious consequences for affected youth; depression and anxiety can compromise education, employment, and relationships with friends and family. *Source: National Institute of Mental Health 2017*



There is no doubt that children impacted by a disaster need emotional support. From initial triage to family reunification, behavioral health professionals take an active role in assessing children, providing comfort, offering distraction, education and assisting with risk communications and tracking.

Children and adolescents with greater family support and less caregiver distress tend to experience lower levels of behavioral health symptoms in the immediate aftermath and weeks following exposure to a potentially traumatic event. "It will be important to identify children and adolescents who need more intensive support and therapy because of profound grief or other extreme emotional responses. A list of symptoms and behaviors to help parents, teachers and other caring adults can help identify a child at more serious risk. For the majority of children, schools are where signs and symptoms of potential response to trauma –withdrawal or aggression, change in grades or activities- are first identified. Schools represent the largest child service system with opportunities to identify and provide school-based programs to directly impact those children suffering from disaster-related trauma. School programs that provide trainings on managing stress and education on substance use have the best outcomes." *Source: Curie Testimony on the Effects on Children and Role of Mental Health.* *www.hhs.gov/asl/testify/tO20610.html*

For Maine, the 2010 U.S. Census reports that 5% of the residents are children less than 5 years old, and 18 % of the residents are under 18 years old. Maine had a higher percentage of children with special health needs than the U.S. (ME=24%; U.S. =19%) and the percentage has increased since 2010 reports the *2015 Shared Community Health Needs Assessment (SCHNP).* Unfortunately, Maine has high rates of nonfatal child maltreatment at 14% and the numbers have increased since 2008. Adults need to take

care of their own physical and psychological needs so that they can attend to children's needs.

For children at greatest risk, it will be important to coordinate disaster behavioral health services with the Maine DHHS Office of Child and Family Services, and community based child serving organizations skilled in working with children exposed to potentially traumatic events. As in other New England states, Maine's sixteen county governments do not manage the social service needs of their communities. Services are primarily funded by contracts to local behavioral health service providers. These services for at-risk children and adolescents include:

- Early Childhood, Mental Retardation, and Autism Services: Direct services include case management; crisis services; in-home supports; infant/toddler group services; preschool integrated support; family support; respite, social and recreation services.

- Children's Mental Health Service provides case management; crisis services; flexible funds; information and referral; family and community integration; in-home supports; family mediation; outpatient counseling and therapies; home based family services; respite services, medication management; day treatment; school-based assessment and services; social and recreational programs; and residential treatment services.

- Crisis Intervention and Stabilization Services are accessed through a single statewide, toll- free **1-888-568-1112** Crisis Telephone line. Services include crisis outreach services, respite, short term crisis stabilization in home, school and other community settings, and acute hospitalization. Services are available 24 hours a day, 7 days a week.

- Facilities: Elizabeth Levinson Center, Bangor, is the state operated ICF/MR Nursing Facility that provides both residential and respite care for up to 20 children, birth through age 20, who are medically fragile and who have severe or profound mental retardation.

- Inpatient Services: Children's Mental Health Services are available at inpatient hospitals in South Portland, Mid-coast region and Bangor, and a hospital in New Hampshire.

Families and caregivers should be strongly encouraged to develop family emergency plans for their homes; learn about their children's school evacuation and communication plans; and when family members are separated to ensure successful reunification and protections are in place, especially for very young children.

2) ELDERLY ADULTS

According to the U.S. Census, Maine is the oldest state based on a median age of 44 years. Current projections forecast that 65-to-74-year-olds will be Maine's fastest growing population, rising from about 104,000 in 2008 to about 184,000 by 2020. The 65-and older age group is 18% of the total population and will be over 21% of Maine's total by 2020. *Source: Woods and Poole Economics, Inc., "2008 New England State Profile: State and County Projections to 2040"*

Studies show that older adults typically fare well after disasters based on previous life experiences. However, some factors can impact their stress levels, "such as the extent of their losses and whether they have repeated losses from the disaster, their personal health and access to healthcare, financial and family resources, and perceived threats to their independent living. In addition, seniors may be less likely to respond to warnings, acknowledge hazards, or access behavioral health resources". *(Source: AARP, 2010)*

Factors that can cause some seniors to be particularly vulnerable in disasters include "physical frailty, chronic illness, having cognitive impairments with an impaired capacity to make decisions and execute tasks, mobility and sensory issues, reliance on devices such as hearing aids and glasses, and limited transportation options. 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 rely on on-line applications and computer related tasks, and concern about loss of entitlements." *Source: TAP 34, SAMSHA 2015*

Complex variations in the health status, living environments, and social situations of seniors with functional and access needs make it hard to plan for this population during emergencies:

- Losses: Seniors may lose a spouse, retire, experience a decrease in income, have social networks reduced, etc. Losses associated with a disaster may be more significant, especially if these losses hold psychological significance, for example, loss of photographs or family mementos

- Sensory impairment: may not be able to hear or see well, and this can lead to anxiety in unfamiliar settings or change in routines

- Fear of institutionalization: fear loss of independence if limitations are discovered; some may deny or under-report needs as a result

- Isolation: lack sufficient knowledge to access available disaster services, or the physical ability to leave their homes and stand in line for assistance

- Lack of social connectedness: includes emotional support (sharing experiences, problems); informational support (advice and guidance); and instrumental support, such as assistance with activities of daily living, transportation, housekeeping, etc.

- Crime victimization: susceptibility to exploitation and abuse, often are targets

for scams, even in the absence of a disaster or public health emergency

- Mental Health stigma: some deny symptoms of psychological distress or minimize traumatic experiences, but will endorse physical symptoms

- Suicide: screening and assessment is important because statistics demonstrate that U.S. senior white males are at greater risk for death by suicide

If some seniors are not able to get the medications, equipment, or special care they need, they can be at increased risk of complications and death during an emergency. Some are likely to not have access to a car, and many use medical equipment or assistive devices that are hard to transport. Even older adults with cars may need more time to evacuate than younger adults because of difficulty driving in heavy traffic or medical conditions that make it unsafe for them to sit in traffic for long periods.

Elderly Poverty Rates:

Maine had a larger share of its overall population (13.6%) living below the federal poverty level than any other New England state in 2013. Between 2005 and 2009, Aroostook County had a higher proportion of its older population living below the Federal Poverty Level (16%) than any other county. In Maine, seniors accounted for more than 12 percent of food stamp recipients in 2012, up from 9 percent in 2010. "Women age 75-and-above (12.9%) were nearly twice as likely to live in poverty as were men of the same age group (6.7%). These differences reflect the same phenomenon observed at the national level. Researchers have ascribed the difference in male and female elder poverty rates to several causes, including higher rates of widowhood for women, gender inequalities in the Social Security law, and the number of surviving widows who had been impoverished by the institutionalization of their late spouse."
Source: U.S. Census Bureau 2005-2007 American Community Survey 3-Year Estimates

Disabilities in the Elderly:
Across the state of Maine, people aged 65 and older using health services have common health diagnoses such as heart disease, respiratory illness, cancer and arthritis. One in four seniors who are older than 55 will have a mental health condition during their lifetime with the most common conditions being anxiety, depression and cognitive impairment. Hurried evacuations can result in problems accessing prescription medications that may lead seniors to seek assistance in emergency departments.

Researchers at the Harvard T.H. Chan School of Public Health found that elderly people who had been uprooted from their destroyed homes and lost touch with their neighbors following the 2011 Tsunami in Japan were more likely to experience increased symptoms of neurocognitive decline and dementia than those who were able to stay in their residences. "It appears that relocation to a temporary shelter after a disaster may have the unintended effect of separating people not just from their homes, but from their neighbors—and both may speed up cognitive decline among vulnerable people. Depression and social withdrawal from friends and neighbors appeared to play a role in

the link". (Chan, 2015)

Home Healthcare agencies, long term care skilled nursing facilities, and family caregivers care for a high proportion of people with neurocognitive disorders such as dementia and Alzheimer's disease. The number and percentage of people in Maine's long term care and home care system who have dementia is 54% of the patient populations. As the disease progresses, so does the need for greater supervision, more help with activities of daily living with a higher level of healthcare needed. Older adults with dementia may be unable to recognize limitations or use appropriate judgments. Following a disaster, for example, an older adult may not recognize that electrical power outages occurred, thus, may be at increased risk for consuming spoiled food.

Cognitive impairment increases with age, from 10% of those aged 71 to 79 years to 30% for those aged 90 or older. In Maine, the number of individuals with Alzheimer's disease will dramatically increase from the 37,000 individuals to over 53,000 by 2020; and is a leading cause of death in two counties, Piscataquis and York." *Source: Maine's Plan for Alzheimer's disease and Dementia, DHHS, Office of Aging and Disability Services, 2013.* In fact, Maine's death rate due to Alzheimer's at 32 % was significantly higher than the national rate of 19% or the rate of other New England states. *Source: Chart book, Older Adults and Adults with Disabilities, OADS, 2010*

Emergency Responders and healthcare professionals must have at least a basic understanding of cognitive impairments because they are going to encounter persons who have it. Alzheimer's disease and dementia affects much more than memory. It affects a person's language and their ability to speak coherently. Patients are often disoriented, not only to place and time, but even to whom they are. *Source: Lessons Learned, AARP 2010*

Rural Elderly living alone: Maine is not only the oldest state in the nation by median age; it is also the most rural state. According to 2014 U.S. Census, 18% of Mainers are age 65 or older and 61% of these Mainers live rurally. This is a challenge since 90% of older Mainer residents report wanting to remain in their homes and communities as they age. "Maine's demographics show some interesting gender challenges as well. In 2010, the majority of Maine adults 65 or older who were living alone were women. In addition, more than 72% of those 85 and older in Maine were women." *Source: OADS, Maine's State Plan on Aging 2012-2016*

A sense of independence and self-determination may be displayed by residents in rural areas. Family, close friendships and a highly developed sense of community combine to create a sense of self-sufficiency that persists even in the most difficult circumstances. Residents of rural areas often are not aware of services available or how to access them. They may think the process is too cumbersome or intrusive. Also, rural community members may not even apply for assistance due to an underestimation of loss, or a belief that others are more in need of help.

3) EMERGENCY SERVICE RESPONDERS

Emergency Services Response is a unique occupation that provides critical public health and safety services to communities. Emergency Response professionals are represented by Police Officers/Sheriffs/State Troopers, Game Wardens, Corrections Officers, Firefighters, Emergency Medical Technicians, Healthcare workers, Behavioral Health clinicians, Public Health workers, Nurses and Physicians, military and National Guard personnel, emergency management and disaster response volunteers.

These professionals routinely find themselves in uniquely stressful, high risk and potentially traumatizing pursuits as part of their paid or volunteer work. Their "emotional labor" during disasters can be highly strenuous. The long hours, great needs and professional demands, ambiguous roles and exposure to human suffering, e.g. personal exposure to severe injury, illness or traumatic death, can adversely affect even the most experienced professionals. While the work may be gratifying and life-changing, many experience intense emotions and thoughts of loss. Some common psychological reactions in disaster settings may include:

- Physical and emotional exhaustion
- Identification with the victims- "It could have been my children, my spouse…"
- Feelings of grief, hopelessness, helplessness, sadness and self-doubt
- Drastic changes in sleep, avoidance of sleep or not wanting to wake or out of bed
- Guilt over not being able to do more, or having enough resources
- Frustration and anger at the healthcare delivery system or response command
- Compassion fatigue: demoralization, alienation, resignation
- Attempts to over-control in professional or personal situations
- Un-necessary risk taking
- Conflict and instability within their relationships and families
- Social isolation due to fear of exposure to infectious disease for self and family
- Becoming overly preoccupied with work, poor work-family life balance
- Public health concerns about sanitation, nutrition, safe housing, transportation access, worsening health conditions, medication mismanagement
- Depression accompanied by hopelessness which has the potential to place individuals at higher risk for suicidal thoughts and actions
- Complicated grief
- Inadequate bereavement services, faith resources, substance use treatment and recovery services

Emergency personnel are the first to respond and many times the last to admit that they need help. Special considerations for working with emergency service responders are: *Source: Center for Disease Epidemiology and Emergency Preparedness, Leonard Miller School of Medicine, University of Miami, 2010.*

- Culture of not seeking help as it signals a fitness-for-duty concern
- High performance expectations
- Delay in seeking help
- Preference for talking to peers

- Stigma of seeking mental health support

The behavioral health services during a disaster will focus on strategies to help the professionals anticipate and reduce adverse responses to potentially traumatic exposures by developing a balanced lifestyle, sustain a practice of self-awareness, the availability of peer support and to apply stress reduction techniques. Stress management and practicing self-care strategies are critical for emergency responders due to the chronic stress of their jobs. It will be important to identify self-care, peer-to-peer strategies with reminders about their positive impacts in their communities, and conscious attempts to reduce compassion fatigue and vicarious traumatization.

5) Maine's Tribal Nations

The original inhabitants were Algonquian-speaking, part of the Wabanaki group of tribes who continue to make up the 9,000 Native American people in Maine. The recognized tribal communities in Maine are the Aroostook Band of Micmac's, Houlton Band of Maliseet Indians, Passamaquoddy Tribe of Indian Township and Pleasant Point, and the Penobscot Nation. In Washington County, 5 percent of the population identified as Native American, primarily from Penobscot Nation. 3000 Penobscot Tribal Members were accounted for in U.S. Census 2010 reports for Maine, and it is likely underreported on the last census. It is important to remember that each Native American tribe is a sovereign nation with a unique history and political status.

The multi-generational aspect of trauma continues to be an issue for Native American and Alaska Native tribal members. Historical trauma is the cumulative, multigenerational, collective experience of emotional and psychological injury in native communities and their descendants. This type of trauma can complicate individual and community recovery. In some cases, traumatic events have disrupted the healing traditions and social connections within the tribe itself. Some historical events that have contributed to tribal historical trauma include: (*Source: Maria Yellow Horse Brave Heart, Ph.D.; Historical Trauma)*

- Outlawing of language and spiritual care practices;
- Death of generations of elders due to infectious disease or war;
- Structural and chronic discrimination; and
- Exposure of multiple generations to violent colonization and assimilation policies.

Currently, American Indian and Alaska Native tribes, tribal health clinics and Leaders are attempting to address health disparities in response to these traumas that present as survivor guilt, depression and psychic numbing, chronic health issues, anxiety and anger, and may lead to self-destructive behaviors, such as substance misuse and higher incidences of interpersonal violence. Native American Disaster Preparedness Resources may include behavioral health: http://www.phe.gov/Preparedness/planning/abc/Pages/tribal-preparedness.aspx

It will be important to respect and support the values of the tribe while emphasizing the community's responsibility in disaster recovery. If DBH is requested to assist the Tribal Leaders, responders will need to incorporate the tribal wisdom of tribal leaders and use of traditional healing practices within their interventions.

5) Culturally Diverse communities

Culture refers to the values and knowledge of groups in a society. It consists of approved behaviors, norms, and involves attitudes and beliefs that are passed down through generations. These patterns involve language, religious beliefs, institutions, artistic expressions, ways of thinking, and patterns of social and interpersonal relations. Culture also represents worldviews—encompassing assumptions and perceptions about the world-- and how it works. Although much is known about trauma generally, there are problems in applying this knowledge broadly to culturally diverse groups.

- Culture affects symptom expression, help-seeking patterns, healing mechanisms, meaning ascribed to trauma, and the type of trauma experience.
- Considerations in cultural diversity may include bereavement, cultural trauma, and intergenerational trauma.
- Refugee experiences affect ongoing stressors regarding acculturation and discrimination.

According to the 2012 U.S. Census, 95 percent of Maine's population is White, non-Hispanic, followed by 1.4 percent Hispanic, 1.3 percent who are Black, 1.1 percent who are Asian, and 0.7 percent who are Native American. One-third of the 2.9% foreign-born residents in 2000 entered Maine between1990–2000. Earlier immigration in Maine was primarily from Canada and Ireland. *Source:* *http://www.maine.gov/dhhs/mecdc/healthy-maine/documents/oppforall/b04raeth.pdf*

A refugee is a person who has been forced to flee their country of origin due to war and violence. They have been persecuted because of their race, religion, nationality or social group. An asylum seeker is someone who has formally applied for legal and physical protection in another country. An immigrant is someone who voluntarily leaves their country to make a new life in another country.

Countries of origin for culturally diverse groups resettled in Maine from 1982–2010:

Cambodia	Vietnam	Poland	Afghanistan
Former Soviet Union	Bosnia Herzegovina	Somalia	Sudan
Iran	Ethiopia		

According to the 2010 U.S. Census, 7 % of Maine residents over the age of five are

estimated to speak a language other than English at home. There are also immigrants who have come from countries where the likelihood of experiencing potentially traumatic events was high due to the violence associated with drug or human trafficking; or trauma experienced as fear of deportation and separation from families. Behavioral health risk factors of new immigrants, in particular for refugees, are that they experience many losses. They often:

- are severely traumatized by their past experiences in conflict regions or in refugee camps, and many suffered under government persecution;
- need to adapt to a new language and assimilate to a new culture, which leaves them more vulnerable during a crisis as they have lost much of their prior identity;
- have been separated from their social support systems, e.g., family, friends, communities while trying to establish new ones;
- need to focus on securing employment and financial stability;
- have different levels of acculturation resulting in changing family member roles e.g., unfamiliar dependency on children who learn English quickly, or adults desire to maintain a more traditional household rather than assimilate; and
- suffered from political persecution so distrust authority figures, such as law enforcement, the military, social service workers, and government employees, making it hard to seek out and accept help from traditional community support systems.

Franco-American

In the late 19th century, many French Canadians arrived from Quebec and New Brunswick to work in the textile mill cities such as Lewiston and Biddeford. By the mid-20th century, Franco-Americans comprised 30% of the state's population. According to the 1990 Census, one-third of state residents declared French, French Canadian or Acadian origin. Of that number, approximately 80,000 used the French language on a daily basis. *Source: Healthy Maine 2010: Opportunities for All* Aroostook and Androscoggin counties have the highest number of population who self-identify as Franco-American. Within Androscoggin County, the number of French speakers is concentrated in Lewiston. In Aroostook County, Fort Kent has the highest number of French speakers followed by Frenchville and Van Buren.

Hispanic/Latino Population

"About 40% of Maine's Latino permanent residents reside in Cumberland and York counties. Maine's Hispanic/Latino Population Ancestry total is 9,360 in 2000 Census; Mexican descent at 2,756, Puerto Rico at 2,275 and Cuba/other nations at 4,329. The Spanish language was spoken by 9% of this total population in 2010. Hispanic migrant workers from Central America are employed during the summer and fall in the forestry industry, broccoli, and blueberry harvests. Hispanic migrant workers usually come to Maine as a family unit of 1–14 members." *source: Healthy Maine 2010:*

Southeast Asian

"There are roughly 2,500 Cambodian immigrants living in Maine, with a majority living in Portland, Sanford and the Berwick. The Buddhist Temple in Portland is often felt to be the center of the Cambodian community in Maine." *Source: Healthy Maine 2010: Opportunities for All.* U.S. Census 2010 reports Asian immigrant totals for Maine are 1.1% with Native Hawaiian and other Pacific Islanders alone total 0.1%. Again, it will be necessary to work in collaboration with faith-based and culturally sensitive community social service providers and organizations that have a trusted relationship within immigrant and refugee communities.

Somali Population

Androscoggin and Cumberland counties have the most diverse communities from many ethnic backgrounds due to refugee resettlement programs. The majority of Somali people living in Maine came here as refugees as a result of being displaced by civil war in their country. Diet, exercise and being surrounded by family play a supportive role in their mental health. Being seen as part of a minority population, and also as Muslim all contribute to increased stress, depression and other mental health issues.

In the 2000's, Somali immigrants in the United States began a secondary migration to Maine. As of 2012, the Somali population comprised around 8,000 individuals in Maine, with about 4,000 living in Portland and the reminder living in Lewiston. There are about 1,000 Bantu immigrants living in Lewiston as of 2012. Bantus are a minority ethnic sub-group in Somalia. During the Somali Civil War, many Bantus were evicted from their lands by various armed factions of Somali clans. *Catholic Charities Maine* is the refugee resettlement agency that provides the bulk of the services for the Bantu and Somali resettlement. *Catholic Charities* reports "many of the Somali population suffered or witnessed torture of family members before coming to the U.S ...there is resistance to talking about personal problems to others as it feels like a betrayal of trust. In Somali culture, individuals would go to a great aunt or a spiritual leader in order to protect the family secrets. These are the very structures that are dismantled by war and migration." *Source: Portland Press Herald, 2016*

The concept of "mental health" and "behavioral health" does not exist in Somali culture. Mental illness does exist and is heavily stigmatized. It is important to identify and focus on the physical symptoms that characterize mental health concerns such as sleeplessness and loss of appetite. Mental illness definitions in the United States are based on the biomedical approach to problem-solving. It does not take into account the concept of *soul sickness* that is prevalent in other cultures. *Source:* http://ethnomed.org/clinical/mental-health/somali-refugee-mental-health-cultural-profile

Migrant/Seasonal Workers

People who move to different geographical regions on a seasonal basis, according to job

availability are migrant workers. Maine has a number of migrant workers, many of whom have Hispanic or Haitian origins. There are an estimated 5,225 migrant farmworkers on an annual basis in Maine. They are accompanied by children and other dependents, not working on the harvest. There are also 15,000 seasonal farmworkers in Maine. Seasonal farmworkers are those who work in farming on a seasonal basis, but do not move from their home base. Migrant and seasonal farmworkers are most commonly found in the blueberry, apple, broccoli, egg, and forestry industries. Additionally, many of the seasonal farmworkers are historically Passamaquoddy Tribal members from the Canadian Maritime Provinces. *See the Maine Department of Labor 2015 report:* http://www.maine.gov/labor/labor_laws/migrantworker/summary.html

Culture, language, lifestyle, and general economic barriers can cause migrant and seasonal farmworkers difficulty in accessing healthcare for chronic medical conditions and behavioral health services. In addition, most migrant workers have few connections to the local community and may live in social isolation.

Seasonal residents

Maine's natural beauty and proximity to large East Coast cities made it a major tourist destination as early as the 1850s. Summer resorts such as Bar Harbor, Ogunquit and Islesboro sprung up along the coast. Maine's seasonal residents and tourism visitors are higher during specific months, as many Maine resort and island communities triple in population size during those months. In 2015, Maine was home to nearly 16,000,000 overnight visitors annually and nearly 19,000,000 day visitors annually. This would have a direct impact on disaster behavioral health response activities and services.

6) SOCIO-ECONOMIC FACTORS

Maine is a diverse state economically. The median household income between years 2009-2013 according to Maine BRFSS data was $48,423; lower than the United States median income of $53,046; and the number of adults living in poverty was 13.6% and children living in poverty was 18.5%. Single parent families (2013) accounted for 29% of the population. Lower socioeconomic status influences secondary impacts during a disaster, such as limited financial resources, psychological stress and reduced access to healthcare and public services.

Income varies greatly by Maine regions similar to population density. The most economically prosperous regions are the southern coastal counties, such as Cumberland County at median income of $57,491, where most of the population is located; from a low of $36,646 in Piscataquis County, with the lowest population density. Health care coverage was positively correlated with increased education, income and age. 85% of Maine adults with household incomes of $50,000 or more have health care coverage; and nearly all (94%) adults 66 years and older had health care coverage in Maine. *Source: Maine State Epidemiological Profile 2015, Community Epidemiology Surveillance Network*

Low-income survivors have fewer resources and greater vulnerability when disasters occur. The National Institute of Medicine identified post-disaster reconstruction and relocation as steep hurdles for individuals and families with low economic status (LES). Upgraded construction codes, mitigation requirements, and changes in insurance rates are major challenges for all persons, but particularly for the elderly and low income families. These at-risk populations may lack the support and housing from family or friends, and many do not have insurance coverage or monetary savings. If they are renters, they may experience increases in rent due to disaster-caused repairs or become dislocated to temporary housing and removed from their regular social supports and school systems. Relocation can make transportation and getting to appointments more difficult.

Homelessness

People who do not have a residence are less able to prepare for emergencies, e.g. stockpile supplies or to identify a safe part of their residence for shelter in place. In addition, people without a home may have limited access to electronic means of communication, e.g. TV, radio, internet, phones, thus may be slower to learn about emergency warnings and calls for evacuation. For a variety of reasons, people who do not have a home may have difficulty or concerns about entering shelters, and difficulty transitioning out of shelters, especially if the locations where they formally took refuge are no longer habitable.

6) MENTAL HEALTH/SUBSTANCE USE/ DISABILITES

Mental Health

A person's ability to carry on productive activities can be affected by physical health, as well as mental health. In the U.S. about one in four adults and one in five children have diagnosable mental health disorders, and they are the leading cause of disability among ages 15-44. *Source: World Health Organization. 2014.* A SAMHSA Report (2015) highlighted the correlation of exposure to potentially traumatic events to the occurrence of post-traumatic stress symptoms (PTSS) and negative health and behavioral health outcomes. This report was developed from a study on the characteristics of adults exposed to potentially traumatic events (PTEs) and adults who had symptoms with health and behavioral health conditions. The study found that adults with negative exposure to PTEs tended to be older, former military members and non-Hispanic whites. It also found that they tended to have other health conditions, such as asthma, high blood pressure, sinusitis, ulcers, and doctor-diagnosed anxiety and depression.

Clinicians have long struggled with why disaster survivors, when exposed to identical trauma and tragedy, respond with considerable variability. Some individuals are able to incorporate the experience into their lives and move on relatively soon. Other individuals continue to feel devastated and overwhelmed for longer periods of time. Those exposed to one or more PTEs were more likely to engage in illicit drug use, binge

drinking and heavy drinking than adults who had not experienced PTEs. Similarly, those who had experienced PTE's were more likely to have behavioral health conditions, including Posttraumatic Stress Disorder (PTSD), general psychological distress, anxiety, major depressive episodes and suicidal thoughts in the past year. This study is important because potentially traumatic exposure and PTSD are associated with significant social, personal, and economic costs. (Source: *The Correlates of Lifetime Exposure to One or More Potentially Traumatic Events and Subsequent Posttraumatic stress among adults in the U.S.* SAMHSA 2008-2012)

Several stressors may occur during a disaster impact that may result in negative consequences for a person. These stressors include threat to life and encounter with death, felt helpless and powerless, felt responsible or inadequate to do the task, and inescapable horror at being trapped, or fear as the result of deliberate human actions. Stigma, additional chronic health issues and disrupted access may prevent many individuals from receiving adequate treatment for their behavioral health issues.

An individual with cognitive or intellectual disabilities and mental health issues may need special help and assistive devices during a disaster event. They may need individual support when unexpectedly discharged, evacuated or transferred. Individuals with severe pre-existing behavioral health conditions who rely on the behavioral health care system for their well-being and independence may be greatly impacted by any disaster damage to that system.

Health status is an important factor that drives mental/behavioral healthcare services. Overall, 15% of Maine adults reported fair to poor health. From the Maine SCHNA 2015, 23% of adults reported being diagnosed with lifetime depression, and 17% have lifetime anxiety; and almost a quarter of high school students reported feeling sad or helpless for two weeks in a row with 14 % of teens seriously considering suicide. Maine women and girls have higher rates of mental health indicators; and Native American and Hispanic populations have higher rates for most of the indicators. In the *Maine Shared Community Health Needs Assessment* of *2015*, 71% of the stakeholders ranked mental health and access to treatment as a major or critical problem in their counties.

In SCHNA 2011, Oxford, Washington, and Somerset counties had the highest rates for individuals at risk for mental health problems, including depression, general affective disorders and anxiety disorders based on the PHQ-9. Kennebec, Sagadahoc and York counties have high numbers of individuals who received a diagnosis of lifetime depression. *Source: "Statewide Community Health Needs Assessment 2010" produced by The Center for Community and Public Health, revised November 2011*

Psychiatric Hospitals: Maine has two state-operated psychiatric hospitals: Riverview Psychiatric Center is a 92-bed facility located in Augusta and Dorothea Dix Psychiatric Hospital is a 51-bed hospital located in Bangor. Both hospitals function under the State of Maine Department of Health and Human Services and serve only adults. The state

hospital requires an admissions referral from a community-based psychiatric facility. Acadia Hospital, part of the Eastern Maine Health Systems, is a 100-bed acute care psychiatric hospital that serves children and adolescents, and has a substance abuse treatment program for adults and an outpatient mental health clinic in Bangor. Spring Harbor Hospital, part of *Maine Health* system, is a 100-bed facility that serves children and adolescents, and has a 10-bed adult unit for crisis stabilization.

The state rate for senility and serious mental illness was 28 out of 100,000 residents. Franklin County had a rate of 15.4% for those diagnosed with other psychiatric disorders and for those diagnosed with developmental delays/learning disabilities. Androscoggin County exceeded the state rates for overall and all age groups for state hospital admissions for psychosis, bipolar disorder, schizophrenia and anxiety. It also exceeded the state hospital admissions for anxiety among those aged 0-17. Androscoggin, Kennebec, Knox, Penobscot and Waldo Counties exhibited consistently high patterns of hospital admission use for a range of mental health conditions. *Source: "Statewide Community Health Needs Assessment 2010" produced by The Center for Community and Public Health, revised November 2011*

Suicide Mortality: Overall, Maine appears to have higher rates of suicide mortality (15 per 100,000) than the U.S. as a whole at (13 per 100,000). Suicidal behavior is complex and frightening. Residents diagnosed with mental distress, depression or anxiety will be 7-8 times more likely to report suicidal thinking, plans and attempts. Suicide was the second leading cause of death for Maine residents aged 15-34 in 2014. Annually, there was an average of 181 suicides per year, and out of every 5 completed suicides, 4 were male. Firearms were used in 53% of suicide deaths. *Source: www.maine.gov/suicide*

Substance Use Disorders:

The use and misuse of harmful substances has a serious impact on the quality of life for Maine residents and their ability to adapt to a potentially traumatic event. Feelings of sadness, hopelessness, fear and confusion are common, and people use whatever coping strategies they are familiar with. Some use substances to avoid thinking about what happened or to dull feelings of anxiety or guilt. Clients in recovery may relapse to substance use, or their psychiatric symptoms may reoccur, at the very time they must cope with the uncertainties, trauma, and losses caused by the disaster.

The ASPR *All Hazards Response Planning Guide for State Substance Abuse Services* suggests some groups impacted by substance use may be at a higher level of risk during and following a disaster event:

- First emergency responders who are working directly in the disaster impact area
- Patients who need methadone or other medications and are unable to access their programs
- Children in prevention programs in their schools or community

- Current clients who abuse substances may need intensive services
- Persons in recovery who fear relapse
- Patients in hospital detoxification programs, or clients in residential or outpatient treatment programs
- Persons who "self-medicate" due to the stress caused by the disaster
- Substance users who are not known to the treatment community

Alcohol remains the substance most often used by Mainers across the lifespan and in the age group of 18 to 25 year olds, about two in five (32%) reported heavy alcohol use. *Source: www.maine.gov/dhhs/osa* The 2015 *Maine State Health Assessment* reports that 22 % of Maine adults were involved in binge drinking; drug- induced deaths accounted for 17 out of 100,000; and the percentage of alcohol use reported by Maine high school students was at 23%. Higher rates of youth substance use occurred in Sagadahoc and Oxford Counties with 7 percent reported misuse of prescription drugs and 26% of Oxford County students reported binge drinking and marijuana use. (*Source: DHHS, Office of Substance Abuse and Mental Health, 2015)* In addition, the U.S. DHHS found that 17 percent of adults age 60 and older have abused alcohol or drugs. Despite these statistics, Maine's system of care offers limited resources. The Maine Alzheimer's Association reports only 22 geriatric behavioral health providers statewide – or approximately one provider for every 11,000 seniors.

Substance use disorders in Maine disproportionately affect Native Americans, Pacific Islanders, Hispanics, as well as gay and lesbian youth. Prescription drugs and marijuana are two more commonly abused substances in this State. Maine residents are increasingly misusing available prescription drugs including stimulants and opiates. The criminal nature of non-prescription use of prescription medications discourages users from disclosing their use to health care providers. In 2010, lifetime prescription drug misuse rates was highest among adults between the ages of 26 and 35; nearly one in ten adults reported having misused prescription drugs within their lifetime. Abuse of prescription drugs may lead to consequences such as unintentional poisonings, overdose, dependence and increased crime. (*Source: One Maine Health Collaborative "Statewide Community Health Needs Assessment 2010" produced by The Center for Community and Public Health, revised November 2011)*

Heroin use is a problem of rising concern. In Maine, new formulations and low street costs combined have made heroin a more potent and affordable illicit drug. Opioid and heroin treatment was most common among 26 to 34 year olds. (*Source: State Epidemiological Profile 2015)* Some statistics reflect that:

- From 2013 to 2014, the number of drug overdose deaths involving pharmaceutical drugs increased by 77%; and those due to illicit drugs increased by 60%
- Almost 6 out of 10 admissions for substance use treatment also had a previously diagnosed mental health disorder; and this rate has steadily increased since 2010
- One in three drug overdoses involved benzodiazepines, one in four involved heroin use and one in five involved fentanyl

- Rates of drug-related OD's were highest in Washington, Androscoggin, Cumberland, Kennebec, York and Somerset counties.

Behavioral Health treatment agencies that provide services for substance abuse or pharmacological dependence must be prepared to adapt quickly to accommodate a variety of clients and needs during and following a disaster. (Source: *TAP 34, SAMHSA, 2013)*

- Individuals with an ongoing, untreated mental health or substance use disorders need treatment to prevent further deterioration or to prevent an escalation of medical or psychological symptoms.

- Guest clients from other treatment programs or under physician care who have been displaced by the disaster and who come to new programs 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 who have been stabilized for long periods on anti-depressants, antipsychotics, or medications for opioid addiction and not able to obtain prescription refills, are in danger of sudden medication withdrawal or relapse to psychiatric or addiction symptoms may require crisis stabilization, evaluation and referrals to a higher level of psychological care or even hospitalization.

- Patients on opioid medications for pain management, who cannot obtain services from their physician, are facing or experiencing withdrawal, and request help from treatment programs. These patients may need referrals to pain specialists.

Behavioral Health Treatment Programs should be explicit in describing how a disaster can affect a community, e.g. electrical outages, interruptions in water service, access issues; and within the behavioral health treatment program specifically, e.g. program closure, reduction in services, services provided at an alternate facility and provider availability.

Functional Disabilities

The National Organization on Disability (NOD) identified three types of disabilities of concern for emergencies and disasters: sensory, mobility and cognitive. The following definitions are from NOD's Emergency Preparedness Initiative:

Sensory: Persons with hearing or visual limitations, including total blindness or deafness.

Mobility: Persons who have little or no use of their legs or arms. They generally use wheelchairs, scooters, walkers, canes, and other devices as aids to movement

Cognitive: The terms “developmental” and “cognitive” most commonly include conditions that may affect a person’s ability to listen, think, speak, and read, write, do math, or follow instructions

Individuals with functional and access needs include (but are not limited to) people that have physical, sensory, mental health, and cognitive and/or intellectual disabilities affecting their ability to function independently without assistance. Others who may have functional needs include older adults, women in late stages of pregnancy and individuals needing bariatric equipment.

Functional Needs Support Services (FNSS) are defined as services that enable individuals to maintain their independence in a general population shelter. Plans should direct that, at a minimum, medical care that can be provided in the home setting (e.g., assistance in wound management, bowel or bladder management, or the administration of medications or use of medical equipment) is available to each general population shelter.

Medical Needs Individuals

Individuals who are not self-sufficient or who do not have adequate support from caregivers, family members or friends may need assistance with managing unstable, terminal or contagious conditions that require observation and ongoing treatment; managing intravenous therapy, tube feeding, and vital signs; receiving dialysis, oxygen, and suction administration; managing wounds; and operating power dependent equipment to sustain life. These individuals require support of trained medical professionals.

Persons with medical needs may have exhausted all other resources (family, neighbors, agency and public transportation, etc.) and still need assistance for evacuation and/ or sheltering before, during, and possibly after a disaster or emergency. These individuals typically reside in single family homes or multiple dwellings in the state and are not residents of hospitals, residential health care facilities, or any community-based services that are already subject to emergency planning requirements.

In Maine, there are a number of programs managed through the DHHS Office of Aging and Disabilities (OADS) to provide contracted services using local service providers. These include:

- In home supports and related infrastructure
- Residential supports, including 24/7 residences and supported living
- Day time supports:
  a. “Employment first” supports,
  b. Day centers,
  C. and Community-based programs

- Specialized supports to address complex or unique needs provided through Case Management using contracted Community Providers in Maine http://www.maine.gov/dhhs/oads/disability/ds/resource_directory/certified_providers.htm

The Developmental Services (DS) crisis system, under the OADS program, is for anyone with an intellectual disability or brain injury. DS Crisis provides assistance to individuals, families, guardians, and healthcare providers to maximize individuals' opportunities to remain in their homes and local communities during and after crisis incidents. Developmental Services crisis system is made up of six major components:

- Prevention Services - provides wellness checks and identify ways to help people work through potential crisis. Prevention Services might include a visit at the request of a supporter to check a person's well-being or in times of public emergencies to check on people living alone.

- OADS Crisis Telephone Services - 1-888-568-1112 is available statewide 24 hours/ 7days to provide information, referral, and action plan development. These are often the first point of contact with the Developmental Services system for a consumer, guardian, or family member. Serious reportable events that occur after-hours must be immediately reported to a DS Crisis Worker. This includes allegations of abuse, neglect, or mistreatment, serious injury, rights violation, lost or missing person, suicide attempt, assault, death, or any other dangerous situation which imposes risk of imminent harm, of any individual served by Developmental Services.

- Mobile Crisis Outreach Services - provides on-site or wherever needed Crisis Outreach Services. This could be at the person's home or assisted living residence, police station or jail, homeless shelter, work site, hospital, or anywhere in the community. Crisis staff can provide on-site assessments, consultations, education, crisis stabilization and crisis plan development. Whenever possible, crisis workers help the person stay in their home.

- In-home Crisis Services - assists people to become stabilized in their home. This reinforces their existing support system and prevents potential adverse effects of having a person leave their home. Services include consultation, assessment, and planning.

- Crisis Residential Services - provides very short-term, highly supportive and supervised residential settings where the consumer can stabilize and readjust to community living. Staff members are present 24 hours a day to assess safety and functional skills, assist in planning, promote independent living skills, monitor medications, and assist with transportation.

- After-Hours Public Guardianship meets the on-going health and safety needs for

individuals under public guardianship. Agencies are able to contact a public guardian representative through the DS Crisis Team on nights, weekends and holidays for permission to treat. This might include medication changes, emergency hospital visits, and allegations of abuse, neglect or mistreatment.

The disruption of a structured routine or lack of access to medications and special dietary considerations or consultations required with case managers and designated family members may hamper the recovery process during and following a disaster event for persons with functional disabilities.

The HHS emPOWER Map, an interactive online tool was designed to meet the emergency needs of community residents who rely on electrically powered medical and assistive equipment to live independently at home. The HHS emPOWER Map shows the monthly total number of Medicare fee-for-service beneficiaries' claims for electricity-dependent equipment at the national, state, territory, county, and zip code levels.

Opioid Treatment during a Disaster

Program Emergencies and Guidance for Treating OTP Patients:

Guidance was provided in areas affected by Hurricane Katrina on the emergency closure of programs in the event of a disaster; (**August 31, 2005**) SAMHSA provided guidance to State Methadone Authorities (SMA's) and Opioid Treatment Providers (OTP's) and addressed patients in OTP's, as well as persons dependent on opioids who were not enrolled in addiction treatment.
http://www.samhsa.gov/csatdisasterrecovery/featuredReports/hurricanePhysicianRecommendations.pdf

Guidance: Programs receiving displaced patients should make every effort to contact the home treatment program of people who have had to evacuate an area in which they live after an emergency or disaster. Information about the program may be obtained from the OTP directory on the DPT Website or at the SAMHSA Substance Abuse Treatment Facility Locator. In an emergency, program personnel may disclose information to the program medical director, program physician, registered nurses or dosing nurses without a patient's signed consent. If unable to contact the patient's home program, the OTP receiving the displaced patient should follow procedures listed below, along with existing emergency plans:

a) The emergency guest patient should show a valid picture identification that includes an address in close proximity to the area affected.
b) The patient should show some type of proof that indicates the patient was receiving services from a clinic located in the affected areas, for example, a medication bottle, program identification card, or a receipt for payment of fees, etc. In cases which the patient does not have any items of proof including photo identification, the physician should use

their best medical judgment, combined with stat drug testing for the presence of methadone.

c) OTP staff may administer the amount of medication that the patient reports as their current dose. Remind patients that the dose that is reported will be verified with their home program as soon as possible. It may be prudent to observe an unknown patient for several hours post-administration to ensure that the dosage was correct; or take appropriate medical action.
d) 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 the initial dosing procedures for routine admission.
e) Emergency guest patients should be medicated daily with take-home dosages 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; and according to the State and Federal regulations (42CFR Part 8).
f) 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 hardships, take-home medication for unsupervised use may be considered using the SMA-168 "Request for Exception" process.
g) Documentation of services provided to the displaced patient should be a priority for OTP's. The OTP should assign a client's 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 each day, date and amount of medication administered to each patient and observations made by the staff.

Opioid Dependent Displaced Persons 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. OTP's may admit, treat, and dose these patients under existing guidelines and regulations. A Patient new to medication-assisted treatment may be appropriate for initiation on buprenorphine products.

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 the local physician, particularly a pain management specialist. SAMHSA guidelines provide the following guidance:

a) Patients, in general, are not admitted to OTP's to receive opioids for pain, but there are exceptions.
b) Patients with chronic pain disorder and physical dependence are managed by multi-disciplinary 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 the patient's need and best utilization of available resources.
c) "Tapering" (discontinuation of opioid medications used during an acute pain treatment episode) in the Narcotic Addiction Treatment Act and the Drug Addiction Treatment Act (DATA) were established to allow for the maintenance and detoxification treatment, using certain opioid controlled substances.
d) Patients who are diagnosed with physical dependence and a pain disorder are not prohibited from receiving methadone or buprenorphine therapy for either maintenance or withdrawal in an OTP, if such a setting provides expertise or is the only source of treatment.

SMA-168 "Request for Exception" process to treat OTP participants

Request for Exceptions under Section 8.12 of Federal Regulation 42 CFR sets forth Federal standards for the administration and management of opioid treatment. Included in the standards are a schedule of maximum allowable unsupervised use (i.e., take-home medications) and standards for the provision of detoxification treatment.

On occasion, patients may need exceptions from the Federal opioid treatment standards due to transportation hardships, employment, vacation, medical disabilities, etc. In these instances, the physician must submit to SAMHSA and (where applicable) the State Opioid Treatment Authority an "exception request" for approval to change the patient care regimen from the requirements specified in Regulation 42.
http://www.dpt.samhsa.gov/regulations/exrequests.aspx

To get started with on-line SMA-168 exception requests by contacting the SAMHSA OTP Exception Request Information Center at 1-866-OTP-CSAT (1-866-687-2728),
http://otp-extranet@opiod.samhsa.gov

National Resource Center on Psychiatric Directives

Psychiatric advance directives (PADs) are relatively new legal instruments that may be used to document a competent person's specific instructions or preferences regarding future mental health treatment, in preparation for the possibility that the person may lose capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness.
http://www.nrc-pad.org/

Treating Survivors in the Acute Aftermath of Traumatic Events

Center for PTSD (2005)

Summary: Treatment of survivors in the acute aftermath of traumatic events is complex. Survivor's concrete needs may be very urgent, secondary stressors may still be operating, expressions of distress are volatile and highly reactive to external realities, and symptoms expressed may not reflect psychopathology. Normal healing processes are already operating, and significant assistance is provided by natural supporters and healers, e.g. relatives, community leaders, and should not be interfered with. Professional helpers and DBH responders are often enduring significant stress themselves and do not operate in their usual environment.

Traumatizing elements of events can include:

- **Fear and Threat-** the intensity of the threat, its perception by the individual and the immediate bio-psychological response are important predictors of subsequent psychopathology.
- **Exposure to grotesque and disfigured human bodies-**emotional and physical pain of others, dehumanization, degradation, humiliation; exposure to extreme agony of others, human cruelty, degradation and humiliation can shatter reassuring assumptions and coping mechanisms.
- **Forced relocation-** Separation from and/or lack of information about loved ones, cutting off social support can result in loneliness and social isolation.

- **Damaging appraisals of survivor's behaviors and responses-** memories of a traumatic event can be influenced by social appraisals of behaviors during or following the event, e.g. shameful, virtuous, dishonorable, heroic, cowardly.

Phases of coping with traumatic stress

- **Acute phase-** being under stress, use of extreme defenses, and a focus on physical and emotional survival
- **Reappraisal phase-** reevaluation, psychological task of assimilation of events and their consequences, including intrusive recollections
- **Success in survivor's ability to:**
    - Continue task-oriented activity
    - Regulate emotions
    - Sustain positive self-value
    - Maintain and enjoy rewarding interpersonal contacts

Symptom expression

Initial symptoms are varied, complex and unstable. They can include exhaustion, stupefaction, sadness, anxiety, agitation, numbness, dissociation, disorientation, confusion, depression, physical arousal, and blunted affect. Some responses are "normal" in the sense of affecting most survivors, being socially acceptable, psychologically effective and self-limited.

Indicators of effective coping include: a low degree of distress (not confused with numbing or blunted affect); intrusive recollections that lead a survivor to recruit sympathy and help; upon repetition, the trauma narrative becomes richer, includes other elements and takes on a reflective tone; nightmares change from mere repetition of the event to more remote renditions.

Indications of more pathological responses include: continuous distress without periods of relative calm or rest; severe dissociation symptoms that continue following a return to safety; intense intrusive recollections that are fearfully avoided, experienced as a torment or seriously interfering with sleep; extreme social withdrawal; and the inability to think about rather than just emotionally experience the trauma.

Assessment and evaluation

Exposure to traumatizing elements includes death of loved ones, injury, relocation, loss of property, social network, previously held beliefs, cognitive schemata, identity, honor, peace of mind, sense of continuity with previous life, (e.g. " I am not the same person anymore.").

Interventions:

- Protect from further exposure to stress, contain the immediate physiological and psychological responses, and increase controllability of the event
- Be aware of and responsive to survivor's comfort and dignity, e.g. covering body, avoid intrusive looks of others and media
- Reorient survivor within the rescuing environment, identify self and role
- Continuously inform survivors about steps to be taken, e.g. evacuate to hospital, medication given, and other information
- Provide genuine information, including admitting lack of information
- Maintain human contact with survivors throughout rescue efforts
- Bring in natural helpers, i.e. relatives, friends, and support them with advice and information
- If survivors have difficulty expressing their experience verbally, use other expressions of help. For example, comforting touch with respect to gender and social boundaries; physical comforts such as blankets, hot showers, clean clothes, favorite food

Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services
Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Maine Disaster Behavioral Health Response Team (DBHRT) Application

Applicant Information

Name: _____

Credentials or Licensure (e.g., LCSW, Ph.D., RN, etc.): _____

**Please include a copy of credentials or license with this application.

Professional Discipline

❑ Psychiatrist ❑ Psychologist ❑ Psychiatric Nurse ❑ Social Worker ❑ Mental Health Counselor

❑ Spiritual Care Professional ❑ Substance Abuse Counselor ❑ Other (Caseworker, nurse, EMT, guidance counselor, etc.) _____

Contact Information

Date of Birth: _____ Social Security Number (for criminal background check only): _____

Facility/Agency: _____

Street Address: _____

_____

City: _____ State: _____ Zip Code _____

Home phone: ( ) _____ Work phone: ( ) _____ Mobile phone: ( ) _____

E-mail address: _____ Pager number: ( ) _____

Required Training

I have completed the two-day training **Crisis Counseling Core Content** in its entirety.

Training Location: _____

Training Dates: _____

Other Disaster Trainings

Please list any disaster related training you may have completed. Use additional pages as necessary.

Name of Training	Sponsoring Agency	Training Dates	# of Hours

Previous Experience

Please list any previous disaster response experience you have had. Use additional pages or attach information as necessary

Type of Disaster (flood, fire, etc.)	Date and Location of the Disaster	Role in response

Special Skills

Please list any special skills you may have (languages spoken, understanding of specific populations, etc.).

Criminal Background Check

Have you ever been convicted of a crime other than a minor traffic violation? Yes No If yes, please describe in detail the date(s), crime(s), and submit a copy of the court judgment(s) as well as a letter from you explaining the circumstances surrounding your conviction.
Has your application for professional licensure ever been denied by any state board governing your particular professional practice? Yes No If yes, please attach an explanation.
Has your professional license ever been suspended, revoked, or subject to any disciplinary action by any state or jurisdiction? □ Yes □ No If yes, please attach an explanation.

Signature Date

By my signature, I affirm that all information provided in connection with this application is true to the best of my knowledge and belief. I further authorize all law enforcement agencies and officials thereto to release to the Program Director of Disaster Behavioral Health Services any and all criminal history record information pertaining to myself.

Instructions

Please enclose the following with your completed application:
❑ Copy of professional licensure (if applicable)
Register in *Maine Responds* Emergency HealthCare Volunteer Registry www.maineresponds.org
❑ Copy of certificate of completion for FEMA course IS 100
❑ Copy of certificate of completion for FEMA course IS 700

Completed applications should be forwarded to:

Program Director, Disaster Behavioral Health Services
Maine CDC Office of Public Health Emergency Preparedness 286 Water St, 4th Floor, 11 SHS
Augusta, ME 04333-0011
Kathleen.wescott@maine.gov
PH: (207) 287-3796 FAX: (207) 287-4612

Requirements for Team Participation

The following three steps must be completed to join the Maine Disaster Behavioral Health Response Team (DBHRT):

Step 1: Complete the two-day training "Crisis Counseling Core Content Training".

The training program is offered in two 8-hour sessions. Day One of the training provides an educational overview of disasters, disaster reactions and how the local, state and federal response to disasters operates. Day Two focuses on skill-building, using hands-on exercises where new techniques are practiced. Participants will also learn about how to become disaster behavioral responders and how notification and deployment will occur. Individuals must attend both training days to become certified members of DBHRT.

Contact the Program Director of Disaster Behavioral Health Services at (207) 287-3796 for upcoming dates and locations or email at Kathleen.wescott@maine.gov

Step 2: Complete the Disaster Behavioral Health Response Team (DBHRT) application.

After completing the two-day training you will receive the responder application to fill out. If you are interested in becoming a disaster behavioral health responder you must fill this out and submit it to the Program Director of Disaster Behavioral Health Services. This form will provide us with your contact information, professional and licensure status, along with information about your experience and areas of expertise. The Program Director coordinates the team and will contact you after receiving your application to let you know if it has been approved. You may then be notified in the future to respond with the team in during emergencies. The Responder application should be mailed or faxed to the Program Director of Disaster Behavioral Health Services upon completion.

Step 3: Complete the *Maine Responds* Emergency Healthcare Volunteer Registry application by going to www.maineresponds.org and select "DBH group" for inclusion after completing your training.

Step 4: Complete online or classroom trainings about the National Incident Management System (IS-700) and Introduction to the Incident Command System (IS-100) class and obtain certificate of completion.

The Incident Command System (IS-100: An Introduction to ICS)
IS 100, Introduction to the Incident Command System, introduces the Incident Command System (ICS) and provides the foundation for higher level ICS training. This course describes the history, features and principles, and organizational structure of the Incident Command System. It also explains the relationship between ICS and the National Incident Management System (NIMS).

IS-100 can be found at http://www.training.fema.gov/EMIWeb/IS/is100.asp. This course should be taken online or in a classroom setting. Please visit www.maine.gov/mema for classroom opportunities.

After successful completion of this course you will receive email notification that you passed and a link to view and print your certificates. If you've taken the courses in a classroom setting, you will receive your certificates by mail. These certificates should then be sent by fax or email to the Program Director of Disaster Behavioral Health Services at (207) 287-3796 or Kathleen.wescott@maine.gov.

The National Incident Management System (IS-700 NIMS: An Introduction)
Homeland Security Presidential Directive 5 "Management of Domestic Incidents" requires States, territories, tribal entities, and local jurisdictions to adopt the National Incident Management System (NIMS). Implementing the NIMS strengthens our nation's prevention, preparedness, response, and recovery capabilities.

The National Incident Management System integrates effective practices in emergency preparedness and response into a comprehensive national framework for incident management. The NIMS enables responders at all levels to work together more effectively to manage domestic incidents no matter what the cause, size or complexity.

The NIMS online training found at http://www.training.fema.gov/EMIWeb/IS/IS700.asp. and NIMS web site offers an interactive web-based course. Once successfully completed, a certificate will be sent by email. Please forward this to the Program Director of Disaster Behavioral Health Services at Kathleen.wescott@maine.gov

This course can also be taken in a classroom setting. Please visit www.maine.gov/mema for opportunities. Once successfully completed, a hard copy certificate will be sent to you by mail. Please send a copy of this to the Program Director of Disaster Behavioral Health Services at Kathleen.wescott@maine.gov

Maine Disaster Behavioral Health Response Team

Employer Memorandum of Understanding

It is not the intention of the Maine Disaster Behavioral Health Response Team (DBHRT) to create a situation whereby a community becomes underserved due to an exodus of volunteer behavioral healthcare providers in a time of emergency or disaster. Even in a time of emergency or disaster, members of the Maine Disaster Behavioral Health Response Team hold a primary responsibility and obligation to provide behavioral healthcare within their local community.

The employee listed below is a mission critical member of the Maine Disaster Behavioral Health Response Team and without his or her availability the safety of a deployment may be compromised. We ask that you make the employee listed below available to deploy with the Maine Disaster Behavioral Health Response Team, in times of emergency or disaster.

For the purposes of worker's compensation and long-term disability, members of the Maine Disaster Behavioral Health Response Team will be registered as volunteers with the Maine Emergency Management Agency. Upon activation of the Maine Disaster Behavioral Health Response Team, or during training activities, they will become State Employees for liability as well as worker's compensation and disability purposes for the length of their activation (37-B MRSA § 822-823).

Please contact the Program Director of Disaster Behavioral Health Services at (207) 287-3796 or email at Kathleen.wescott@maine.gov with any questions.
Name of Team Member: _____

Signature of Member: _____

Name of Employer: _____

Name and Title of Employer's Representative: _____

Signature of Employer's Representative: _____

I. **Date:** _____

Appendix B

Responder Health and Safety

The Disaster Behavioral Health Program provides support to response team volunteers during three phases: 1) pre-deployment after a volunteer has been assigned to an incident; 2) deployment phase when a volunteer is working on an assignment; and 3) post-deployment when a volunteer has completed their assignment and will be released.

Pre-Deployment

Stressors	DBH Support and Services available
• Making travel arrangements • Local disaster impacts on self/family • Anticipation of the unknown • Difficult to access accurate information • "Hurry up and Wait"	• Interview and screen individuals for appropriate deployments • Provide training to make self-care a priority and to develop professional resilience strategies • Psychological First Aid training • *First Responders, Coping with Disasters* brochures • Education on identified environmental and work-related exposures for the incident, including force protections, i.e. PPE's

Deployment

Stressors	DBH Support and Services Available
• Environmental exposure • Work-related exposure • Managing common stress reactions • Secondary traumatization • Compassion Fatigue	• Staff orientation • Self-care and coping strategies • Promote self-screening tools • Safety Officer monitors environmental and work-related exposures; initiates prevention activities • Monitor and provide constructive feedback to leadership to reduce staff stressors • Collaborate with HICS Health and Well-Being Leader

Post-deployment

Stressors	DBH Support and Services Available
• Transition back to pre-deployment activities and home life • How to incorporate deployment activities into a meaningful experience • Lack of self-care • Spiritual crisis	• Provide many opportunities to discuss emotional reactions to events and working with individuals and groups exposed to traumatic events • Normalize post-deployment reactions • Identify resilience strategies • Provide information on available supportive programs and referrals, e.g. community BH and faith-based services

Maine Disaster Behavioral Health Response Team

Pre-Deployment Checklist

This checklist provides a guideline for what to pack for a disaster assignment should you be called outside your local community. Use this checklist each time you pack your Go-bag. Include items that you feel are essential. Some of the items are more critical in longer deployments and may not be necessary for shifts of twelve hours or less.

- ☐ Copy of professional license (if applicable)
- ☐ Copy of driver's license
- ☐ Other professional identification
- ☐ Necessary Forms
- ☐ _____

- ☐ Business cards
- ☐ Steno pad of paper
- ☐ Pens / crayons
- ☐ Envelopes for expense receipts
- ☐ Copies of psycho educational pamphlets

- ☐ Easy-care clothing (enough for 10 days without laundry)
- ☐ Casual slacks (no jeans, as these may not be appropriate for memorial services or funerals)
- ☐ Casual shirts or tops
- ☐ One set of dress clothes
- ☐ Jacket (appropriate to climate/conditions)
- ☐ Sweater
- ☐ Rain gear
- ☐ Comfortable shoes (appropriate to conditions, no open toe shoes)
- ☐ Extra pair of glasses
- ☐ Sunglasses
- ☐ _____

- ☐ Toilet articles, facial tissues
- ☐ Bath towel and washcloth
- ☐ Antibacterial hand wipes
- ☐ Leisure time materials (books, camera, music)
- ☐ Comfort foods and list of special dietary restrictions
- ☐ Water bottle
- ☐ Limited amount of cash
- ☐ Credit card
- ☐ Copy of car insurance policy
- ☐ Photos of family and friends
- ☐ Journal
- ☐ _____

- ☐ Flashlight and batteries
- ☐ Portable radio (battery powered and receives weather/emergency announcements)
- ☐ Extra batteries
- ☐ Sleeping bag/bed roll/blanket and pillow
- ☐ Sewing kit
- ☐ Travel alarm clock
- ☐ _____

- ☐ Contact lens solution
- ☐ Prescriptions/medicines (including a list of all medication names, dosages, prescribing physician, telephone numbers.)
- ☐ Copy of medical insurance card
- ☐ Personal first aid kit
- ☐ Sunscreen
- ☐ Bug spray
- ☐ _____

Appendix B

Initial Community Needs Assessment

Name _____ Date_____

Town _____ County _____

Fill out separate form for each town

Description of the event:

Response Entities on Scene (including behavioral health resources):

Estimated Impact

Loss Categories	Number of Persons
Type of Loss	Number
Dead	
Hospitalized	
Non-hospitalized Injured	
Homes destroyed	
Homes "Major Damage"	
Homes "Minor Damage"	
Disaster Unemployed	
(Others—Specify)	

Locations where survivors are being assisted:

Estimated behavioral health needs in the community:

Paul R. LePage, Governor Mirko Hamilton, Commissioner

Authorization to Release Information

We are committed to the privacy of your information.
Please read this form carefully.

Which DHHS office(s) should help you? Please check.

❒Office of MaineCare Services	❒ Substance Abuse and Mental Health Services
❒Office for Family Independence and Medical Review Team	❒ Office of Child and Family Services
❒ Maine Center for Disease Control and Prevention	❒ Office of Aging and Disability Services
❒ Dorothea Dix Psychiatric Center	❒ Office of Administrative Hearings
❒ Riverview Psychiatric Center	❒ Other:

Whose information is being released? Please print clearly.

Individual's Name		Date of Birth	Social Security #
Home Address	Town/City	State	Zip Code
Telephone ( ) -	Email address @		

What information should DHHS release? Please check all that apply.

General permission:

❒**All** health information from the DHHS office(s) checked above
❒Claims or encounter data (information about visits to health care providers)
❒Billing, payment, income, banking, tax, asset, or data needed to see if you qualify for DHHS program benefits
❒Limit to the following date(s) or type(s) of information: (for example "Lab test dated June 2, 2017" or "Claims from 2015-2017")

_____

❒Other: _____

Special permission: Drug/Alcohol Referral or Services

❒Include **all** drug/alcohol information in the release
❒Include only the **specific** drug/alcohol records checked:

❒Diagnosis and treatment
❒Clinical notes and discharge summaries
❒ Drug/Alcohol history or summary
❒Payment or claims information
❒Living situation and social supports
❒Medication, dosages or supplies
❒Lab results
❒Other: _____

Special permission: Mental/Behavioral Health Services

❒Include this information in the release

❒I want to review my mental health behavioral health record before release. I understand that the review will be supervised.

Please note: Maine law allows us to share this information with other health care providers and health plans to coordinate your care (to help take care of you) so long as we make a reasonable effort to notify you of the release.

Special permission: HIV/AIDS Status/Test Results

❒Include this information in the release

Please note: Maine law requires us to tell you of possible effects of releasing HIV/AIDS information. For example, you may receive more complete care if you release this information, but you could experience discrimination if your data is misused. **DHHS** will protect your HIV data, and all your information, as the law requires.

Are you asking DHHS to send your information by EMAIL? ❒ Yes.

Although DHHS has privacy and security protections for my information, I understand that email and the internet have risks that DHHS cannot control. It is possible that my emailed information could be read by a third party. I ACCEPT THOSE RISKS and still ask DHHS to send my information by email. **INITIAL HERE** _____

Where should DHHS send your information by email? Please print the email address clearly:

DHHS Authorization Form 1-18
Page 1 of 2

What is the purpose of the release? Please check or write a response.

❒ **To coordinate or manage my care** ❒ **For a legal matter, including to provide testimony**
❒ **A personal request** ❒ **To see if I qualify for benefits or insurance** ❒ **Other** _____

Please check and print clearly below: ❒Send my information to ❒Get my information from

Name	Name
Address	Address
City, State, Zip Code	City, State, Zip Code
Phone Fax No.	Phone Fax No.

I understand and agree that:

- "Information" may be in written, spoken and/or electronic format.
- This form will expire **one year** from the date below unless I revoke (take back) my permission sooner.
- To take back my permission, I will fill out the Revocation Form found at http://www.maine.gov/dhhs/privacy/index.shtml and send it to the office where I receive services. It will not apply to the information that DHHS already released with my permission.
- If I take back my permission or refuse to release some or all of my information, my choice could lead to an improper diagnosis or treatment, or denial of insurance coverage.
- I permit the people and/or offices listed on this form to speak to each other for the purpose(s) on this form.
- Health information from other providers (such as doctors, hospitals, and counselors) in my DHHS file is included in this release.
- Unless I am applying for benefits, DHHS will not base my treatment, payment for services, or benefits on whether I sign this form.
- DHHS offices will keep my information confidential as required by law. If I choose to share my information with others who are not required by law to keep it private, it may no longer be protected by federal confidentiality laws.
- If alcohol or drug treatment or program (substance use disorder) records are included in this release, DHHS will include a notice saying that such information may not be re-released or shared without my written permission.

I am signing this form voluntarily. I have the right to a signed copy of this form if I request one.

Date: _____ **Signature**_____

Personal Representative's authority to sign: _____

PATIENT FAMILY ASSISTANCE BRANCH DIRECTOR
HICS 2014

Mission: Organize and manage the delivery of assistance to meet patient family care needs, including communication, lodging, food, health care, spiritual, and emotional needs that arise during the incident.

Position Reports to: Operations Section Chief

Receive appointment:
• Obtain briefing from the Operations Section Chief on:
  o Size and complexity of incident
  o Expectations of the Incident Commander
  o Incident objectives
  o Involvement of outside agencies, stakeholders, and organizations
  o The situation, incident activities, and any special concerns
• Assume the role of Patient Family Assistance Branch Director
• Review this Job Action Sheet
• Put on position identification (e.g., position vest)
• Notify your usual supervisor of your assignment

Assess the operational situation:
• Assess the status of actual and projected patient family needs
• Provide information to the Operations Section Chief of the status

Determine the incident objectives, tactics, and assignments:
• Document branch objectives, tactics, and assignments on the HICS 204

• Based on the incident objectives for the response periods consider the issues and priorities:
  o Determine which Patient Family Assistance Branch functions need to be activated:
    - Social Services Unit
    - Family Reunification Unit
  o Make assignments, and distribute corresponding Job Action Sheets and position identification
  o Determine strategies and how the tactics will be accomplished
  o Determine needed resources

• Brief branch personnel on the situation, strategies, and tactics, and designate time for next briefing

Activities:
• Ensure the provision of patient family assistance resources to children, families, and those with special needs
• Coordinate external community resource requests with the Liaison Officer
• Ensure the following are being addressed:
  o Family reunification

- Social Service needs
- Cultural and spiritual needs
- Communication with law enforcement, outside government and non-governmental agencies, and media through the Liaison Officer and Public Information Officer
- Documentation and record keeping
- Patient family assistance area security
- Share up-to-date information with patients and their families

• Provide status updates to the Operations Section Chief regularly, advising of accomplishments and issues encountered
• Consider development of a branch action plan; submit it to the Operations Section Chief if requested
• Provide regular updates to branch personnel and inform them of strategy or tactical changes, as needed

Documentation
• HICS 204: Document assignments and operational period objectives on Assignment List
• HICS 213: Document all communications on a General Message Form
• HICS 214: Document all key activities, actions, and decisions in an Activity Log on a continual basis
• HICS 252: Distribute Section Personnel Time Sheet to section personnel; ensure time is recorded appropriately, and submit it to the Finance/Administration Section Time Unit Leader at the completion of a shift or end of each operational period

Resources
• Determine equipment and supply needs; request from the Logistics Section Supply Unit Leader and report to the Operation Section Chief
• Assess issues and needs in branch areas; coordinate resource management
• Make requests for external assistance, as needed, in coordination with the Liaison Officer

Communication
Hospital instructions for use and protocols for interface with external partners; determine need for cell phones, radios, other communication devices for team

Safety and security
• Ensure that all branch personnel comply with safety procedures and instructions
• Observe all staff and volunteers for signs of stress and inappropriate behavior and report concerns to the Safety Officer and the Logistics Section Employee Health and Well-Being Unit Leader
• Provide for staff rest periods and relief
• Ensure physical readiness through proper nutrition, water intake, rest, and stress management techniques
• Ensure personal protective equipment (PPE) is available and utilized appropriately

Demobilization/System Recovery
Time:

Activities

• Transfer the Patient Family Assistance Branch Director role, if appropriate
    - o Conduct a transition meeting to brief your replacement on the current situation, response actions, available resources, and the role of external agencies in support of the hospital
    - o Address any health, medical, and safety concerns
    - o Address political sensitivities, when appropriate
    - o Instruct your replacement to complete the appropriate documentation and ensure that appropriate personnel are properly briefed on response issues and objectives (see HICS Forms 203, 204, 214, and 215A)

• Assist the Operations Section Chief and unit leaders with restoring family assistance areas to normal operations
• Ensure the return, retrieval, and restocking of equipment and supplies
• As objectives are met and needs decrease, return branch personnel to their usual jobs and combine or deactivate positions in a phased manner in coordination with the Planning Section Demobilization Unit Leader
• Notify the Operations Section Chief when demobilization and restoration is complete
• Coordinate reimbursement issues with the Finance/Administration Section
• Upon deactivation of your position, brief the Operations Section Chief on current problems, outstanding issues, and follow up requirements
• Debrief branch personnel on issues, strengths, areas of improvement, lessons learned, and procedural or equipment changes as needed
• Submit comments to the Planning Section Chief for discussion and possible inclusion in an After Action Report and Corrective Action and Improvement Plan.
• Participate in stress management and after action debriefings

TEAM ASSIGNMENT DEBRIEFING	TASK#	FOR OPERATIONAL PERIOD #
ASSIGNMENT #	TASK NAME:	DATE COMPLETED: TIME COMPLETED:
TEAM NAME:	TEAM LEADER::	DEBRIEFED BY (PLANNING):

EXPLAIN WHAT YOUR TEAM ACTUALLY DID (INCLUDE TIMES AND GPS COORDINATES IF AVAILABLE):

☐ MAP ATTACHED (Y)

ESTIMATED POD%	IF RESPONSIVE:	IF NON-RESPONSIVE:

DESCRIBE AND GIVE THE TIME AND LOCATION (GPS) OF ANY CLUES/ITEMS DISCOVERED:

CURRENT STATUS OF CLUES/ITEMS:

DESCRIBE DIFFICULTIES OR GAPS IN COVERAGE:

DESCRIBE ANY HAZARDS OR DANGERS IN SEARCH AREA(S)

SUGGESTIONS, IDEAS, RECOMMENDATIONS

TEAM LEADER SIGNATURE:	ICS 204A

REV 98/04/15

Attachment C: Demobilization Checkout Form – ICS 221

DEMOBILIZATION CHECKOUT		
1. Incident Name/Number	2. Date/Time	3. Demobilization No.
4. Unit/Personnel Released		
5. Transportation Type/No.		
6. Actual Release Date/Time	7. Manifest? ☐ Yes ☐ No Number	
8. Destination	9. Notified: ☐ Agency ☐ Region ☐ Area ☐ Dispatch Name: Date:	
10. Unit Leader Responsible for Collecting Performance Rating		
11. Unit/Personnel		
You and your resources have been released subject to sign off from the following: *Demobilization Unit Leader check the appropriate box*		
Logistics Section ☐ Supply Unit ☐ Communications Unit ☐ Facilities Unit ☐ Transportation Unit		
Planning Section ☐ Documentation Unit		
Finance Section ☐ Time Unit		
Other		
12. Remarks		
13. Prepared by (include Date and time)		

Updated April 2013

Attachment C: Individual/Unit Log Form – ICS 214

UNIT LOG	1. Incident Name	2. Date Prepared	3. Time Prepared
4. Unit Name/Designation	5. Unit Leader (Name and Position)		6. Operational Period

7. Personnel Roster Assigned

Name	ICS Position	Home Base

8. Activity Log

Time	Major Events

9. Prepared by: (Name and Position)

Updated April 2013

Attachment B: Sample Volunteer Deployment Feedback Form

Volunteer Feedback Form

Response/Deployment for (*list mission*):	**Date(s) of Deployment:**	
We would appreciate your providing us your name and email address so we can follow up with you; however, you are free to submit this form anonymously. We will use your comments, criticisms, and suggestions to improve our volunteer deployment procedures.		
Name (optional):	**Email (optional):**	
List your role(s) during the deployment (example: usher, medication dispenser, registration clerk):		
Was this your first deployment as a volunteer? (*check one*):	**Yes**	**No**
Please comment on the phone/email notification message you received? (*i.e., efficiency of the process, clarity of the message*). We are especially interested in your suggestions for improvement.		
Please comment on the volunteer check-in process during your deployment and provide suggestions for possible improvement, if applicable.		
Were you provided adequate training to perform your responsibilities while on deployment? If no, what aspect of the training was inadequate or missing?		
What could have been done differently to make this response/deployment a better experience for you as a volunteer?		

Updated April 2013

Appendix C

INCIDENT PERSONNEL PERFORMANCE RATING (ICS 225)

THIS RATING IS TO BE USED ONLY FOR DETERMINING AN INDIVIDUAL'S PERFORMANCE ON AN INCIDENT/EVENT			
1. Name:	2. Incident Name:		3. Incident Number:
4. Home Unit Name and Address:		5. Incident Agency and Address:	
6. Position Held on Incident:	7. Date(s) of Assignment: From: Date To: Date	8. Incident Complexity Level: ☐1 ☐2 ☐3 ☐4 ☐5	9. Incident Definition:

10. Evaluation

Rating Factors	N/A	1 – Unacceptable	2	3 – Met Standards	4	5 – Exceeded Expectations
11. Knowledge of the Job/ Professional Competence: Ability to acquire, apply, and share technical and administrative knowledge and skills associated with description of duties. (Includes operational aspects such as marine safety, seamanship, airmanship, SAR, etc., as appropriate.)	☐	Questionable competence and credibility. Operational or specialty expertise inadequate or lacking in key areas. Made little effort to grow professionally. Used knowledge as power against others or bluffed rather than acknowledging ignorance. Effectiveness reduced due to limited knowledge of own organizational role and customer needs.	☐	Competent and credible authority on specialty or operational issues. Acquired and applied excellent operational or specialty expertise for assigned duties. Showed professional growth through education, training, and professional reading. Shared knowledge and information with others clearly and simply. Understood own organizational role and customer needs.	☐	Superior expertise; advice and actions showed great breadth and depth of knowledge. Remarkable grasp of complex issues, concepts, and situations. Rapidly developed professional growth beyond expectations. Vigorously conveyed knowledge, directly resulting in increased workplace productivity. Insightful knowledge of own role, customer needs, and value of work.
12. Ability To Obtain Performance/Results: Quality, quantity, timeliness, and impact of work.	☐	Routine tasks accomplished with difficulty. Results often late or of poor quality. Work had a negative impact on department or unit. Maintained the status quo despite opportunities to improve.	☐	Got the job done in all routine situations and in many unusual ones. Work was timely and of high quality; required same of subordinates. Results had a positive impact on IMT. Continuously improved services and organizational effectiveness.	☐	Maintained optimal balance among quality, quantity, and timeliness of work. Quality of own and subordinates' work surpassed expectations. Results had a significant positive impact on the IMT. Established clearly effective systems of continuous improvement.
13. Planning/ Preparedness: Ability to anticipate, determine goals, identify relevant information, set priorities and deadlines, and create a shared vision of the Incident Management Team (IMT).	☐	Got caught by the unexpected; appeared to be controlled by events. Set vague or unrealistic goals. Used unreasonable criteria to set priorities and deadlines. Rarely had plan of action. Failed to focus on relevant information.	☐	Consistently prepared. Set high but realistic goals. Used sound criteria to set priorities and deadlines. Used quality tools and processes to develop action plans. Identified key information. Kept supervisors and stakeholders informed.	☐	Exceptional preparation. Always looked beyond immediate events or problems. Skillfully balanced competing demands. Developed strategies with contingency plans. Assessed all aspects of problems, including underlying issues and impact.
14. Using Resources: Ability to manage time, materials, information, money, and people (i.e., all IMT components as well as external publics).	☐	Concentrated on unproductive activities or often overlooked critical demands. Failed to use people productively. Did not follow up. Mismanaged information, money, or time. Used ineffective tools or left subordinates without means to accomplish tasks. Employed wasteful methods.	☐	Effectively managed a variety of activities with available resources. Delegated, empowered, and followed up. Skilled time manager, budgeted own and subordinates' time productively. Ensured subordinates had adequate tools, materials, time, and direction. Cost conscious, sought ways to cut waste.	☐	Unusually skilled at bringing scarce resources to bear on the most critical of competing demands. Optimized productivity through effective delegation, empowerment, and follow-up control. Found ways to systematically reduce cost, eliminate waste, and improve efficiency.
15. Adaptability/Attitude: Ability to maintain a positive attitude and modify work methods and priorities in response to new information, changing conditions, political realities, or unexpected obstacles.	☐	Unable to gauge effectiveness of work, recognize political realities, or make adjustments when needed. Maintained a poor outlook. Overlooked or screened out new information. Ineffective in ambiguous, complex, or pressured situations.	☐	Receptive to change, new information, and technology. Effectively used benchmarks to improve performance and service. Monitored progress and changed course as required. Maintained a positive approach. Effectively dealt with pressure and ambiguity. Facilitated smooth transitions. Adjusted direction to accommodate political realities.	☐	Rapidly assessed and confidently adjusted to changing conditions, political realities, new information, and technology. Very skilled at using and responding to measurement indicators. Championed organizational improvements. Effectively dealt with extremely complex situations. Turned pressure and ambiguity into constructive forces for change.
16. Communication Skills: Ability to speak effectively and listen to understand. Ability to express facts and ideas clearly and convincingly.	☐	Unable to effectively articulate ideas and facts; lacked preparation, confidence, or logic. Used inappropriate language or rambled. Nervous or distracting mannerisms distracted from message. Failed to listen carefully or was too argumentative. Written material frequently unclear, verbose, or poorly organized. Seldom proofread.	☐	Effectively expressed ideas and facts in individual and group situations; nonverbal actions consistent with spoken message. Communicated to people at all levels to ensure understanding. Listened carefully for intended message as well as spoken words. Written material clear, concise, and logically organized. Proofread conscientiously.	☐	Clearly articulated and promoted ideas before a wide range of audiences; accomplished speaker in both formal and extemporaneous situations. Adept at presenting complex or sensitive issues. Active listener; remarkable ability to listen with open mind and identify key issues. Clearly and persuasively expressed complex or controversial material, directly contributing to stated objectives.

INCIDENT PERSONNEL PERFORMANCE RATING (ICS 225)

1. Name:	2. Incident Name:	3. Incident Number:

10. Evaluation

Rating Factors	N/A	1 – Unacceptable	2	3 – Met Standards	4	5 – Exceeded Expectations
17. Ability To Work on a Team: Ability to manage, lead and participate in teams, encourage cooperation, and develop esprit de corps.	☐	Used teams ineffectively or at wrong times. Conflicts mismanaged or often left unresolved, resulting in decreased team effectiveness. Excluded team members from vital information. Stifled group discussions or did not contribute productively. Inhibited cross functional cooperation to the detriment of unit or service goals. ☐	☐	Skillfully used teams to increase unit effectiveness, quality, and service. Resolved or managed group conflict, enhanced cooperation, and involved team members in decision process. Valued team participation. Effectively negotiated work across functional boundaries to enhance support of broader mutual goals. ☐	☐	Insightful use of teams raised unit productivity beyond expectations. Inspired high level of esprit de corps, even in difficult situations. Major contributor to team effort. Established relationships and networks across a broad range of people and groups, raising accomplishments of mutual goals to a remarkable level. ☐
18. Consideration for Personnel/Team Welfare: Ability to consider and respond to others' personal needs, capabilities, and achievements; support for and application of worklife concepts and skills.	☐	Seldom recognized or responded to needs of people; left outside resources untapped despite apparent need. Ignorance of individuals' capabilities increased chance of failure. Seldom recognized or rewarded deserving subordinates or other IMT members. ☐	☐	Cared for people. Recognized and responded to their needs; referred to outside resources as appropriate. Considered individuals' capabilities to maximize opportunities for success. Consistently recognized and rewarded deserving subordinates or other IMT members. ☐	☐	Always accessible. Enhanced overall quality of life. Actively contributed to achieving balance among IMT requirements and professional and personal responsibilities. Strong advocate for subordinates; ensured appropriate and timely recognition, both formal and informal. ☐
19. Directing Others: Ability to influence or direct others in accomplishing tasks or missions.	☐	Showed difficulty in directing or influencing others. Low or unclear work standards reduced productivity. Failed to hold subordinates accountable for shoddy work or irresponsible actions. Unwilling to delegate authority to increase efficiency of task accomplishment. ☐	☐	A leader who earned others' support and commitment. Set high work standards; clearly articulated job requirements, expectations, and measurement criteria; held subordinates accountable. When appropriate, delegated authority to those directly responsible for the task. ☐	☐	An inspirational leader who motivated others to achieve results not normally attainable. Won people over rather than imposing will. Clearly articulated vision; empowered subordinates to set goals and objectives to accomplish tasks. Modified leadership style to best meet challenging situations. ☐
20. Judgment/Decisions Under Stress: Ability to make sound decisions and provide valid recommendations by using facts, experience, political acumen, common sense, risk assessment, and analytical thought.	☐	Decisions often displayed poor analysis. Failed to make necessary decisions, or jumped to conclusions without considering facts, alternatives, and impact. Did not effectively weigh risk, cost, and time considerations. Unconcerned with political drivers on organization. ☐	☐	Demonstrated analytical thought and common sense in making decisions. Used facts, data, and experience, and considered the impact of alternatives and political realities. Weighed risk, cost, and time considerations. Made sound decisions promptly with the best available information. ☐	☐	Combined keen analytical thought, an understanding of political processes, and insight to make appropriate decisions. Focused on the key issues and the most relevant information. Did the right thing at the right time. Actions indicated awareness of impact of decisions on others. Not afraid to take reasonable risks to achieve positive results. ☐
21. Initiative Ability to originate and act on new ideas, pursue opportunities to learn and develop, and seek responsibility without guidance and supervision.	☐	Postponed needed action. Implemented or supported improvements only when directed to do so. Showed little interest in career development. Feasible improvements in methods, services, or products went unexplored. ☐	☐	Championed improvement through new ideas, methods, and practices. Anticipated problems and took prompt action to avoid or resolve them. Pursued productivity gains and enhanced mission performance by applying new ideas and methods. ☐	☐	Aggressively sought out additional responsibility. A self-learner. Made worthwhile ideas and practices work when others might have given up. Extremely innovative. Optimized use of new ideas and methods to improve work processes and decisionmaking. ☐
22. Physical Ability for the Job: Ability to invest in the IMT's future by caring for the physical health and emotional well-being of self and others.	☐	Failed to meet minimum standards of sobriety. Tolerated or condoned others' alcohol abuse. Seldom considered subordinates' health and well-being. Unwilling or unable to recognize and manage stress despite apparent need. ☐	☐	Committed to health and well-being of self and subordinates. Enhanced personal performance through activities supporting physical and emotional well-being. Recognized and managed stress effectively. ☐	☐	Remarkable vitality, enthusiasm, alertness, and energy. Consistently contributed at high levels of activity. Optimized personal performance through involvement in activities that supported physical and emotional well-being. Monitored and helped others deal with stress and enhance health and well-being. ☐
23. Adherence to Safety: Ability to invest in the IMT's future by caring for the safety of self and others.	☐	Failed to adequately identify and protect personnel from safety hazards. ☐	☐	Ensured that safe operating procedures were followed. ☐	☐	Demonstrated a significant commitment toward safety of personnel. ☐

24. Remarks:

25. Rated Individual (This rating has been discussed with me):
Signature: _____ Date/Time: _____

26. Rated by: Name: _____ Signature: _____
Home Unit: _____ Position Held on This Incident: _____

ICS 225 Date/Time: Date

ICS 225
Incident Personnel Performance Rating

Purpose. The Incident Personnel Performance Rating (ICS 225) gives supervisors the opportunity to evaluate subordinates on incident assignments. THIS RATING IS TO BE USED ONLY FOR DETERMINING AN INDIVIDUAL'S PERFORMANCE ON AN INCIDENT/EVENT.

Preparation. The ICS 225 is normally prepared by the supervisor for each subordinate, using the evaluation standard given in the form. The ICS 225 will be reviewed with the subordinate, who will sign at the bottom. It will be delivered to the Planning Section before the rater leaves the incident

Distribution. The ICS 225 is provided to the Planning Section Chief before the rater leaves the incident.

Notes:

- Use a blank ICS 225 for each individual.
- Additional pages can be added based on individual need.

Block Number	Block Title	Instructions
1	**Name**	Enter the name of the individual being rated.
2	**Incident Name**	Enter the name assigned to the incident.
3	**Incident Number**	Enter the number assigned to the incident.
4	**Home Unit Address**	Enter the physical address of the home unit for the individual being rated.
5	**Incident Agency and Address**	Enter the name and address of the authority having jurisdiction for the incident.
6	**Position Held on Incident**	Enter the position held (e.g., Resources Unit Leader, Safety Officer, etc.) by the individual being rated.
7	**Date(s) of Assignment** • From • To	Enter the date(s) (month/day/year) the individual was assigned to the incident.
8	**Incident Complexity Level** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	Indicate the level of complexity for the incident.
9	**Incident Definition**	Enter a general definition of the incident in this block. This may be a general incident category or kind description, such as "tornado," "wildfire,", "bridge collapse,", "civil unrest," "parade," "vehicle fire," "mass casualty," etc.
10	**Evaluation**	Enter "X" under the appropriate column indicating the individual's level of performance for each duty listed.
	N/A	The duty did not apply to this incident.
	1 – Unacceptable	Does not meet minimum requirements of the individual element. Deficiencies/improvements needed must be identified in Remarks.
	2 – Needs Improvement	Meets some or most of the requirements of the individual element. IDENTIFY IMPROVEMENT NEEDED IN REMARKS.
	3 – Met Standards	Satisfactory. Employee meets all requirements of the individual element.
	4 – Fully Successful	Employee meets all requirements and exceeds one or several of the requirements of the individual element.
10	5 – Exceeded Expectations	Superior. Employee consistently exceeds the performance requirements.

APPENDIX C
Post Deployment Checklist

Use the following checklist as a reminder for the activities that you will engage in as you prepare to return home from each assignment.

Preparing for the Transition Back Home from a Disaster Assignment outside your Community

- Make travel arrangements
- Alert people at home once arrangements have been made.
- Return any extra supplies and/or vehicle.
- Settle your financial accounts, including reimbursements.
- Write a narrative about your disaster experience.
- Reflect on your role and responsibilities.
- Identify any challenges you faced in your role.
- Identify any broader systems issues for which you have recommendations or suggestions.
- Reflect on the most rewarding part of your experience.

Disengaging from "Disaster Mode"

- Brief the arriving (or replacement) team.
- Prepare documents the new team may need.
- Help the new team make a smooth transition.
- If you want to say goodbye with whom you have developed a connection.
- Decide whether or not bringing home gifts is appropriate.

Returning to Family and Work

- Anticipate that not everyone at home will want to hear your stories or comprehend what you have done.
- Expect sudden changes in emotions (mood shifts)
- Listen to your children and let them share in your experiences.
- Anticipate piles on your desk when returning to work.
- Expect mixed responses from co-workers on your absence and the importance of what you have done.

Attending to Post-Disaster Self-care

- Rest
- Give yourself time for your body and mind to reorient.
- Adjust your pace downward to those around you.
- Assess how much information sharing should take place.
- Be sensitive to the lives of those who stayed at home, and managed your work load.
- Seek help if unable to settle back in after ONE month; discuss your feelings and thoughts with behavioral health or spiritual care professional.

APPENDIX D

Memoranda of Understanding/Agreement

I. Maine Crisis Agencies

Specific Crisis Agencies in Maine have signed MOU/Agreements in coordination with other agencies and the county EMA offices. Crisis Agency's MOU/A's are maintained at AdCare Educational Institute of Maine, Augusta, Maine 04330.

II. The American Red Cross of Maine and DHHS/Maine CDC DBH Memorandum of Agreement, see attachments

III. The Maine VOAD and DHHS Maine CDC DBH Memorandum of Agreement; see attachments.

Memorandum of Agreement
the Department of Health and Human Services
Maine Center for Disease Control and Prevention

AND

The American Red Cross of Maine

I. Parties

This Memorandum of Agreement (MOA) is between the Maine Department of Health and Human Services' Maine Center for Disease Control and Prevention (Maine CDC) and The American Red Cross of Maine heretofore referred to as the Participating Partner.

II. Purpose

This MOA is a component of the Statewide emergency operations response plan fo disasters and public health emergencies that may occur in Maine.
The purpose of this agreement is to define the working relationship between the Maine CDC, Office of Public Health Emergency Preparedness' Disaster Behavioral Health Program and the Participating Partner related to providing the best possible continuity of care for impacted residents seeking our services. The resources of the Participating Partner and the Disaster Behavioral Health Response Team may be coordinated in order to improve the quality of our efforts through our resources ar partnership, and to provide maximum support to affected at-risk populations.

III. Definitions

Maine CDC Disaster Behavioral Health includes all phases of disaster (mitigation, preparedness, response and recovery) and is distinguished from other forms of mental/behavioral health in that it is specifically focused on the impact of disasters The MOA recognizes that disaster behavioral health response is focused on short- and long-term psychological and health services interventions with individuals and groups experiencing the impact of disasters. These interventions involve the

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counseling goals of assisting disaster survivors and responders in understanding their current situation and reactions; sharing information; reviewing their options; provide emotional support; and to encourage linkages with other individuals and agencies that can help them recover to their pre-disaster level of functioning.

The American Red Cross of Maine is a humanitarian organization led by volunteers and guided by its congressional charter and the fundamental principles of the International Red Cross Movement, which provides relief to victims of disaster and helps people prevent, prepare for and respond to emergencies.
American Red Cross Disaster Services program goal is to reduce human suffering by working with affected families to meet their immediate disaster related needs and help them develop a plan for long-term recovery. Disaster Action Teams offers emotional support and immediate shelter, food, clothing, prescriptions, eyeglasses and direct mental health counseling throughout Maine.

IV. Ongoing Responsibilities

By way of this Memorandum of Agreement (MOA) between the Maine CDC and the Participating Partner, both parties agree to the following terms and conditions:

A. The Participating Partner agrees to:

1. Provide emergency contact information to Maine CDC for inclusion in the Health Alert Network (HAN). This will include name(s), and contact information, including multiple methods of contact (email, text, addresses, telephone numbers, etc.)
2. Update the emergency contact and their contact information to the HAN System Coordinator for the Maine CDC, at least annually, and as necessary whenever personnel changes occur.
3. Acknowledge that both organizations provide local and State disaster resources, there may be instances when the Participating Partner and the Disaster Behavioral Health Response Teams work together in outreach teams during a natural disaster or public health emergency. When collaboration occurs, each organization will adhere to their protocols and report to supervisors of their respective assignments.
4. When necessary to support vulnerable, "at risk" populations, information may be shared in compliance with all applicable State and federal laws governing confidentiality of individual health information; with the expressed written permission of the individual or individual's guardian. Referral and diagnostic information and will provide services to these populations in accordance with their respective program guidelines.
5. Coordinate the continuity of care for impacted residents served mutually shall exist through telephone, written or direct verbal communications. This may include advisement regarding changes in scope of services or policy decisions which directly affect the care of impacted residents.

The American Red Cross of Maine

Primary Contact:

Name:	Laurie Levine
Title:	State Relations Disaster Liaison, The American Red Cross of Maine
Office Phone:	(207).624.4435
Cell Phone:	(207) 754-5529
Emergency Phone:	800.425.8735
Fax :	(207).287-3178
E-mail:	Laurie.levine@maine.gov
Physical address:	Maine Emergency Management Agency 72 State House Station 45 Commerce Dr. Augusta, Maine 04333

Secondary Contact:

Name:	Patricia Murtagh
Title:	Regional Chief Executive Officer, The American Red Cross of Maine
Office Phone:	(207) 874-1192 x 119
Cell Phone:	(207) 272-8941
Fax :	(207) 874-1976
E-mail:	Patricia.murtagh@redcross.org

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Memorandum of Agreement
the Department of Health and Human Services
Maine Center for Disease Control and Prevention

AND

Maine Voluntary Organizations Active in Disaster

I. Parties

This Memorandum of Agreement (MOA) is between the Maine Department of Health and Human Services' Maine Center for Disease Control and Prevention (Maine CDC) and Maine's Voluntary Organizations Active in Disaster (MEVOAD), heretofore referred to as the Participating Partner.

II. Purpose

This MOA is a component of the Statewide emergency operations response plan for disasters and public health emergencies that may occur in Maine.

The purpose of this Agreement is to define the working relationship between the Maine CDC, Office of Public Health Emergency Preparedness' Disaster Behavioral Health Program and the Participating Partner related to providing the best possible continuity of care for impacted residents seeking our services. The resources of the Participating Partner and the Disaster Behavioral Health Response Team may be coordinated in order to improve the quality of our efforts through our resources and partnership and to provide maximum support to affected at-risk populations.

The MOA recognizes that disaster behavioral health response is focused on short- and long-term interventions with individuals and groups experiencing the psychological impact of disasters. These interventions involve the counseling goals of assisting disaster survivors and responders in understanding their current situation and reactions; sharing information; reviewing their options; provide

emotional support and to encourage linkages with other individuals and agencies that can help them recover to their pre-disaster level of functioning.

III. Definitions

Disaster Behavioral Health includes all phases of disaster (mitigation, preparedness, response and recovery), and is distinguished from other forms of mental/behavioral health in that it is specifically focused on the impact of disasters. Behavioral Health team members can direct psychological intervention and crisis counseling efforts on helping people to set disaster priorities and develop plans on how best to manage the many tasks involved in their own recovery.

Maine Voluntary Organizations Active in Disaster (MEVOAD) The Maine VOAD is the State chapter of the National VOAD. The VOAD consists of organizations active in disaster response throughout the State of Maine. The VOAD's role is to bring organizations together and enable them to understand each other and work together during times of disaster preparedness, response, relief and recovery.

IV. Ongoing Responsibilities

By way of this Memorandum of Agreement, both parties agree to the following terms and conditions:

A. The Participating Partner agrees to:

1. Provide emergency contact information to Maine CDC for inclusion in the Health Alert Network (HAN). This will include name(s), and contact information, including multiple methods of contact (email, text, addresses, telephone numbers, etc.)
2. Update the emergency contact and their contact information to the HAN System Coordinator for the Maine CDC, at least annually, and as necessary whenever personnel changes occur.
3. Acknowledge that both organizations provide local and State disaster resources, there may be instances when the Participating Partner and the Disaster Behavioral Health Response Teams work together in outreach teams during a natural disaster or public health emergency. When collaboration occurs, each organization will adhere to their protocols and report to supervisors of their respective assignments.
4. When necessary to support vulnerable, "at risk" populations, information may be shared in compliance with all applicable State and federal laws governing confidentiality of individual health information; with the expressed written permission of the individual or individual's guardian such as; referral and information services to these populations in accordance with their respective program guidelines.
5. Both organizations may provide case consultation on residents requesting services from one or more agencies on an as needed basis. Qualifying

community-based organizations and long-term recovery groups use Coordinated Assistance Network (CAN) to share case management information during a response and recovery operation.

6. Coordinate the continuity of care for impacted residents served mutually shall exist through telephone, written or direct verbal communications. This may include advisement regarding changes in scope of services or policy decisions which directly affect the care of impacted residents.
7. Participate in planning and execution of exercises and response related to the operations of a Family Assistance Center. The Participating Partner can function within the Family Assistance Centers, set up by Disaster Behavioral Health, but will remain under the clinical supervision of the Family Assistance Center Operations Chief and Clinical Specialists.
8. Provide information to the Maine CDC through an after action report following a disaster or public health emergency response, an exercise, or a system test.

B. Maine CDC agrees to:

1. Provide emergency contact information to MEVOAD Leadership to include name(s), and contact information, including multiple methods of contact (email, text, addresses, telephone numbers, etc.) for the Disaster Behavioral Health Director and Team Leaders.
2. Update the emergency contact and their contact information on Disaster Behavioral Health Director and Team Leaders, at least annually, and as necessary whenever personnel changes occur.
3. Acknowledge that both organizations provide local and State disaster resources, there may be instances when the Participating Partner and the DBH Response Teams work together in outreach teams during a natural disaster or public health emergency. When collaboration occurs, each organization will adhere to their protocols and report to supervisors of their respective assignments.
4. When necessary to support vulnerable, "at risk" populations, information may be shared in compliance with all applicable state and federal laws governing confidentiality of individual health information; with the expressed written permission of the individual or individual's guardian such as; referral and information services to these populations in accordance with their respective program guidelines.
5. Both organizations may provide case consultation on individuals and families requesting services on an as needed basis. Qualifying community-based applicant organizations and long-term recovery groups use Coordinated Assistance Network (CAN) to share case management information during a response and recovery operation. As a state entity, Maine CDC will have read only access to CAN information sharing.
6. Coordinate the continuity of care for impacted residents served mutually shall exist through telephone, written or direct verbal communications. This

may include advisement regarding changes in scope of services or policy decisions which directly affect the care of impacted residents.

7. Coordinate planning and execution of exercises and responses related to the operations of a Family Assistance Center (FAC). Disaster Behavioral Health will provide clinical supervision of Family Support Workers, DBH Volunteers, and the Participating Partner in their Family Assistance Center and supervision will be provided by the FAC Operations Chief and Clinical Specialists.
8. Coordinate and collaborate with the Participating Partner on creating an after action report following a disaster or public health emergency response, an exercise, or a system test.

C. Both Parties Mutually agree that:

1. Each party to this MOA is a separate and independent organization with responsibilities for establishing its own policies, procedures and financing of its own actions. Within the mandate for provision of support services during a disaster or public health emergency, each organization may be called upon to deploy volunteers in support of those affected.
2. The confidentiality and protection of patients and patient medical and personal information will be maintained as written and enforced by the Privacy Act of 1974, 5 U.S.C. § 552a, Public Law No. 93-579, the Federal Freedom of Information Act (FOIA), 5 U.S.C. § 552, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 may apply.
3. To the extent that this Agreement involves the use, disclosure, access to or acquisition or maintenance of information that actually or reasonably could identify an individual, both parties agree to a) maintain the confidentiality of such information as required by applicable State and federal laws, rules, regulations and Department policy, b) contact the other party within 24 hours of a privacy or security incident that actually or potentially could be a breach of such information, and c) cooperate with the other party in its investigation and potential reporting of such incident.
4. Both parties agree to review this partnership at least annually, or when changes or concerns arise
5. This Memorandum will not supersede any laws, rules, or polices of either party.
6. No reimbursement or compensation will be made by either party to the other for responsibilities described herein.

V. Terms of Agreement

This Agreement shall be effective upon signature of both parties. This Agreement shall be reviewed and resigned every five years. All parties understand that this Agreement may be terminated at any time by written notification from either party

PFA

Provider Worksheets

Survivor Current Needs

Date: _____ Provider: _____

Survivor Name: _____

Location: _____

This session was conducted with (check all that apply):

☐ Child ☐ Adolescent ☐ Adult ☐ Family ☐ Group

Provider: Use this form to document what the survivor needs most at this time. This form can be used to communicate with referral agencies to help promote continuity of care.

1. Check the boxes corresponding to difficulties the survivor is experiencing.

Behavioral	Emotional	Physical	Cognitive
☐ Extreme disorientation	☐ Acute stress reactions	☐ Headaches	☐ Inability to accept/ cope with death of loved one(s)
☐ Excessive drug, alcohol, or prescription drug use	☐ Acute grief reactions	☐ Stomachaches	☐ Distressing dreams or nightmares
☐ Isolation/ withdrawal	☐ Sadness, tearfulness	☐ Sleep difficulties	☐ Intrusive thoughts or images
☐ High risk behavior	☐ Irritability, anger	☐ Difficulty eating	☐ Difficulty concentrating
☐ Regressive behavior	☐ Feeling anxious, fearful	☐ Worsening of health conditions	☐ Difficulty remembering
☐ Separation anxiety	☐ Despair, hopelessness	☐ Fatigue/exhaustion	☐ Difficulty making decisions
☐ Violent behavior	☐ Feelings of guilt or shame	☐ Chronic agitation	☐ Preoccupation with death/destruction
☐ Maladaptive coping	☐ Feeling emotionally numb, disconnected	☐ Other _____	☐ Other _____
☐ Other _____	☐ Other _____		

PFA

2. Check the boxes corresponding to difficulties the survivor is experiencing.

- ☐ Past or preexisting trauma/psychological problems/substance abuse problems
- ☐ Injured as a result of the disaster
- ☐ At risk of losing life during the disaster
- ☐ Loved one(s) missing or dead
- ☐ Financial concerns
- ☐ Displaced from home
- ☐ Living arrangements
- ☐ Lost job or school
- ☐ Assisted with rescue/recovery
- ☐ Has physical/emotional disability
- ☐ Medication stabilization
- ☐ Concerns about child/adolescent
- ☐ Spiritual concerns
- ☐ Other: _____

3. Please make note of any other information that might be helpful in making a referral.

_____

_____

4. Referral

- ☐ Within project (specify) _____
- ☐ Other disaster agencies
- ☐ Professional mental health services
- ☐ Medical treatment
- ☐ Substance abuse treatment
- ☐ Other community services
- ☐ Clergy
- ☐ Other: _____

5. Was the referral accepted by the individual?

- ☐ Yes
- ☐ No

PFA

Provider Worksheets

Psychological First Aid Components Provided

Date: _____ Provider: _____

Location: _____

This session was conducted with (check all that apply):

☐ Child ☐ Adolescent ☐ Adult ☐ Family ☐ Group

Place a checkmark in the box next to each component of Psychological First Aid that you provided in this session.

Contact and Engagement

- ☐ Initiated contact in an appropriate manner
- ☐ Asked about immediate needs

Safety and Comfort

- ☐ Took steps to ensure immediate physical safety
- ☐ Gave information about the disaster/risks
- ☐ Attended to physical comfort
- ☐ Encouraged social engagement
- ☐ Attended to a child separated from parents
- ☐ Protected from additional trauma
- ☐ Assisted with concern over missing loved one
- ☐ Assisted after death of loved one
- ☐ Assisted with acute grief reactions
- ☐ Helped with talking to children about death
- ☐ Attended to spiritual issues regarding death
- ☐ Attended to traumatic grief
- ☐ Provided information about funeral issues
- ☐ Helped survivor after body identification
- ☐ Helped survivors regarding death notification
- ☐ Helped with confirmation of death to child

Stabilization

- ☐ Helped with stabilization
- ☐ Used grounding technique
- ☐ Gathered information for medication referral for stabilization

Information Gathering

- ☐ Nature and severity of disaster experiences
- ☐ Death of a family member or friend
- ☐ Concerns about ongoing threat
- ☐ Concerns about safety of loved one(s)
- ☐ Physical/mental illness and medications(s)
- ☐ Disaster-related losses
- ☐ Extreme guilt or shame
- ☐ Thoughts of harming self or others
- ☐ Availability of social support
- ☐ Prior alcohol or drug use
- ☐ History of prior trauma and loss
- ☐ Concerns over developmental impact
- ☐ Other _____

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Practical Assistance

- ☐ Helped to identify most immediate need(s)
- ☐ Helped to clarify need(s)
- ☐ Helped to develop an action plan
- ☐ Helped with action to address the need

Connection with Social Supports

- ☐ Facilitated access to primary support persons
- ☐ Discussed support seeking and giving
- ☐ Modeled supportive behavior
- ☐ Engaged youth in activities
- ☐ Helped problem-solve obtaining/giving social support

Information of Coping

- ☐ Gave basic information about stress reactions
- ☐ Gave basic information on coping
- ☐ Taught simple relaxation techniques(s)
- ☐ Helped with family coping issues
- ☐ Assisted with developmental concerns
- ☐ Assisted with anger management
- ☐ Addressed negative emotions (shame/guilt)
- ☐ Helped with sleep problems
- ☐ Addressed substance abuse problems

Linkage with Collaborative Services

- ☐ Provided link to additional service(s) _____
- ☐ Promoted continuity of care _____
- ☐ Provided handout(s) _____

Psychological First Aid

Field Operations Guide
2nd Edition

Appendix E:

- Handouts for Survivors
  - Connecting with Others: Seeking Social Support (for adults and adolescents)
  - Connecting with Others: Giving Social Support (for adults and adolescents)
  - When Terrible Things Happen (for adults and adolescents)
  - Parent Tips for Helping Infants and Toddlers (for parents/caregivers)
  - Parent Tips for Helping Preschool-Age Children (for parents/caregivers)
  - Parent Tips for Helping School-Age Children (for parents/caregivers)
  - Parent Tips for Helping Adolescents (for parents/caregivers)
  - Tips for Adults (for adult survivors)
  - Basic Relaxation Techniques (for adults, adolescents, and children)
  - Alcohol and Drug Use after Disasters (for adults and adolescents)

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Tips for Survivors:

COPING WITH GRIEF AFTER A DISASTER OR TRAUMATIC EVENT

Grief is the normal response of sorrow, heartache, and confusion that comes from losing someone or something important to you. Grief can also be a common human response after a disaster or other traumatic event.

This tip sheet contains information about grief, the grieving process, and what happens when the process is interrupted and complicated or traumatic grief occurs. It also offers tips and resources for coping with both types of grief.

Secondary Traumatization Signs

Sources: Figley, 1995; Saakvitne et al. 1996; Newell & MacNeil, 2010

The following are some indicators that Disaster Volunteers, First Responders and Family Members may experience through secondary traumatization

Psychological Distress

- Distressing emotions, grief, depression, anxiety, dread, fear, rage, shame
- Intrusive imagery of others' traumatic experiences, including nightmares, flashbacks
- Numbing of emotional states; avoidance to working with survivors
- Somatic issues: sleep disturbances, headaches, gastrointestinal distress, heart palpitations, chronic psychological arousal
- Addictive/compulsive behaviors: substance abuse and compulsive eating, working, or spending money
- Impaired functioning: missed or cancelled appointments, lack of self-care, isolation and alienation from supportive relationships

Cognitive Shifts

- Chronic suspicion about others
- Heightened sense of vulnerability
- Extreme sense of helplessness; or exaggerated sense of control over others or situations
- Loss of personal control or freedom
- Bitterness or cynicism
- Blaming the victim or seeing everyone as a victim

Relational Disturbances

- Decreased intimacy and trust in personal/professional relationships
- Distancing or detachment from helping disaster survivors, including labeling them, diagnosing them, judging them, cancelling appointments, or avoiding them
- Over-identification with the Survivors or Victims, a sense of being paralyzed in responding

Frame of Reference

- Disconnection from one's sense of identity
- Dramatic change in fundamental beliefs about the world
- Loss or distortion of values and principles
- Loss of faith in something greater than themselves or disconnect from faith-based practices
- Existential despair and loneliness

Spirituality and Trauma: Professionals Working Together

PTSD: National Center for PTSD

What is spirituality?

Spirituality is a personal experience with many definitions. Spirituality might be defined as "an inner belief system providing an individual with meaning and purpose in life, a sense of the sacredness of life, and a vision for the betterment of the world". Other definitions emphasize a "connection to that which transcends the self. This connection might be to a God, a higher power, a universal energy, the sacred or to nature". Researchers in the field of spirituality have suggested three useful dimensions for thinking about one's spirituality:

- Beliefs
- Spiritual Practices
- Spiritual Experiences

Many individuals describe religion or spirituality as the most important source of strength and direction for their life. Because is plays such a significant and central role in their lives, it is likely to be affected by their exposure and reaction to a potentially traumatic event.

Relationship to trauma to spirituality

Evidence suggests that trauma can produce both positive and negative effects on the spiritual experiences and perceptions of individuals. Some individuals may experience increased appreciation of life, greater perceived closeness to God, increased sense of purpose in life, and enhanced spiritual well-being following a disaster or public health emergency. For others, trauma can be associated with loss of faith, diminished participation in religious or spiritual activities, questioning of previously sustaining beliefs, feelings of being abandoned or punished by their God, and loss of meaning and purpose of living. Guilt and shame, anger and irritability are possible negative outcomes following a traumatic experience. Spirituality may lead to self-forgiveness, and an emphasis on compassion toward self and others.

Research has been conducted on the pathways by which spirituality might affect the recovery trajectory for survivors of traumatic events. Spirituality may improve post-trauma outcomes through (1) reduction of behavioral risks through healthy religious lifestyles, e.g. less drinking or smoking; (2) expanded social support through involvement in spiritual communities; (3) enhancement of coping skills and helpful ways of understanding trauma that result in meaning-making; and (4) physiological mechanisms, such as activation of the "relaxation response" through prayer or

meditation. Feelings of isolation, loneliness and depression related to grief and loss may be lessened by the social support of a spiritual community who can provide encouragement and emotional support, as well as possible instrumental support, e.g. home repairs, food pantries, or financial assistance programs.

What issues most often involve spirituality?

Making meaning of the trauma experience

Spiritual beliefs may influence the survivor's ability to make meaning out of the traumatic experience. Some researchers suggest that traumatic events challenge one's core beliefs about safety, self-worth and shared beliefs. Survivors may question their belief in a loving, all-powerful God when innocent people, especially young children, are subjected to traumatic victimization, e.g. school shooting, terrorism. Recovery of meaning in life may be achieved though changed ways of thinking, involvement in meaningful activities, or through rituals experienced as part of their spiritual involvement.

Grief and bereavement

Grief and loss can be significant issues that survivors must cope with in the aftermath of traumatic events and disasters. Researchers noted that after the 9/11 terrorist attacks, that 90% of respondents reported turning to "prayer, religion or spiritual practices" as a coping mechanism. In general, the positive association between spirituality and grief recovery is that spirituality can provide a frame through which survivors can "make sense" of the loss. Additionally survivors will benefit from the supportive relationships often provided by their faith communities.

Post Deployment Checklist

Use the following checklist as a reminder for the activities that you will engage in as you prepare to return home from each assignment.

Preparing for the Transition Back Home from a Disaster Assignment outside Your Community

- Make travel arrangements.
- Alert people at home once arrangements have been made.
- Return any extra supplies and/or vehicle.
- Settle your financial accounts, including reimbursements.
- Write a narrative about your disaster experience.
- Reflect on your role and responsibilities.
- Identify any challenges you faced in your role.
- Identify any broader systems issues for which you have recommendations or suggestions.
- Reflect on the most rewarding part of your experience.

Disengaging from "Disaster Mode

- Brief the arriving (or replacement) team.
- Prepare documents the new team may need.
- Help the new team make a smooth transition.
- Say goodbye to everyone with whom you have developed a connection.
- Decide whether or not bringing home gifts is appropriate.

Returning to Family and Work

- Anticipate that not everyone at home will want to hear your stories or comprehend what you have done.
- Expect sudden changes in emotions (mood shifts).
- Listen to your children and let them share in your experiences, when appropriate.
- Anticipate piles on your desk when returning to work.
- Expect mixed responses from co-workers on your absence and the importance of what you have done.

Attending to Post-Disaster Self-care

Self-care plans need to include physical self-care; psychological self-care; emotional self-care; and spiritual self-care. A duty to perform as a helper within DBHRT cannot be fulfilled if there is not, at the same time, a duty to self-care. Activities that help DBHRT members to find balance and cope with the stress of working with individuals with trauma-related symptoms include:

- Rest, take breaks, exercise, sleep.
- Give yourself time for your body and mind to reorient.
- Engage in spiritual activities that provide meaning and perspective, i.e. meditation, self-reflection, time in nature, arts and music, and faith-based practices.
- Participate in social activities with family and friends.
- Adjust your pace downward to those around you.
- Assess how much information sharing should take place.
- If distressful symptoms continue after 1 month, seek emotional and psychological help to discuss your feelings and thoughts with a behavioral health and/or spiritual care professional.