Disaster Planning for Behavioral Health Service Programs

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Introduction

This Substance Abuse and Mental Health Services Administration Technical Assistance Publication (TAP), *Disaster Planning Handbook for Behavioral Health Service Programs*, will help you develop or improve your behavioral health service program's disaster plan. A disaster plan is an indispensable resource for program staff in a disaster—the planning process makes preparedness possible.

A disaster plan describes procedures for ensuring safety in a disaster, reducing the potential for damage from a disaster, and maintaining or rapidly resuming essential services during and after a disaster. The plan also details procedures for quickly and efficiently linking clients to other appropriate sources of care when the program itself cannot provide that care.

The TAP addresses planning issues for staff at programs that provide treatment for mental or substance use disorders, or both. This guidance addresses the planning needs specific to programs that offer prevention services, outpatient or residential treatment, medically supervised withdrawal, and pharmacotherapy. The TAP also covers planning issues for at-risk populations (e.g., children, older adults, pregnant women, people with chronic medical disorders, people with pharmacological dependency).

The guidance in the TAP supplements requirements by healthcare licensing or accreditation bodies (e.g., state licensing departments, CARF International, The Joint Commission) that relate to disaster planning. It is beyond the scope of this TAP to cover specific regulatory requirements. But all programs are required to comply with relevant federal and state laws and regulations.

Audience for This TAP

This TAP is intended for use by a behavioral health service program's disaster planning team and by others responsible for managing and overseeing preparedness. The team may include program administrators responsible for developing and activating the organization's disaster plan, as well as senior staff members and clinicians with leadership roles in developing and testing the plan, coordinating staff training on the plan, and activating the plan in an actual incident. The TAP may also help CEOs/executive directors and managers better understand their specific roles in the disaster planning process and the importance of their involvement and support.

State disaster behavioral health service coordinators may find the TAP helpful in supporting their efforts to promote disaster planning, disaster response, and restoration of mental health services and substance use disorder (SUD) treatment programs.

Organization of This TAP

Chapter 1 provides the rationale for the planning process. It also describes how to develop a written disaster plan. Creating the written document helps focus the disaster planning process, whereas the plan itself becomes a reference tool for use in any emerging disaster. Once completed, the plan must be regularly updated to ensure that it remains current and relevant. The plan must also be readily available to all staff.

Chapter 2 provides guidance for creating a disaster planning team and describes steps to develop each part of the disaster plan. Chapter 3 focuses on using a disaster plan to support continuity of operations. Chapter 4 provides guidance on managing prescription medications. Chapter 5 addresses content that goes into a pandemic appendix to the disaster plan. Chapter 6 provides information on completing the basic plan; testing, activating, deactivating, and updating the plan; and coordinating with the community as it recovers from the disaster.

The worksheets in Appendix B will help the disaster planning team draft the disaster plan and keep it up to date. The disaster planning team can refer to these worksheets to identify steps to take, document actions, and record agreements with other organizations. Many of the worksheets are checklists to guide the planning process. Others are templates that, when completed, can become part of the written plan. Abbreviations and acronyms used in this document are spelled out in Appendix C. Appendix D includes useful disaster planning web resources, and Appendix E provides a sample memorandum of agreement between opioid treatment programs.

Behavioral Health Terms

A few key terms from the behavioral health field are defined here, for clarity. Definitions followed by a citation are closely adapted or taken verbatim from the cited source.

behavioral health—Mental/emotional well-being and/or actions that affect wellness. The term "is also used to describe service systems that encompass . . . promotion of emotional health; prevention of mental and substance use disorders, substance use, and related problems; treatments and services for mental and substance use disorders; and recovery support" (Center for Substance Abuse Prevention, n.d., p. 36).

client—Any recipient of behavioral health services. The term "client" is inclusive.

patient—An individual in a medically directed residential treatment program, undergoing medically supervised withdrawal, or receiving medication for SUD (e.g., methadone maintenance treatment).

co-occurring disorders—Co-occurring mental disorder and SUD. A client with co-occurring disorders has one or more of both types of disorders.

program—A facility providing services for treating or preventing mental or substance use disorders, or both. The word "program" is also used to mean the people who work in the facility and who develop and execute disaster planning activities (e.g., "The program has an obligation to prepare for potential disasters because . . . ."). The TAP assumes that a program has only one disaster plan. However, a program with multiple facilities (i.e., buildings or sites) will need to tailor its plan for each location.

recovery—The remission of symptoms of mental or substance use disorders, or both. This TAP uses "recovery" as both a disaster-related term and behavioral health term (see below). The meaning in each instance should be clear from the context.

Disaster Terms

Below are key disaster terms as they are used in this TAP. Definitions followed by a citation are closely adapted or taken verbatim from the cited source.

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

emergency—Any incident, whether natural or human-caused, that requires responsive action to protect life or property. Under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, an emergency "means any occasion or instance for which, in the determination of the President, Federal assistance is needed to supplement state and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the United States" (FEMA, 2010a).[1]

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

guest client/patient—An individual who has been displaced by disaster from the program where he or she had been receiving treatment services and placed into a new program for these same services.

hazard—A natural, technological, or human-caused source or cause of harm or difficulty (FEMA, 2010a).

incident—An occurrence or event—natural, technological, or human-caused—that requires a response to protect life, property, or the environment. Incidents can include major disasters, terrorist attacks, terrorist threats, civil unrest, wildland and urban fires, floods, hazardous materials spills, nuclear accidents, aircraft accidents, earthquakes, hurricanes, tornadoes, tropical storms, tsunamis, war-related disasters, and public health and medical emergencies (FEMA, 2010a).

mitigation—Essential operations to reduce loss of life and property by lessening the impact of disasters. Mitigation includes measures to address communitywide risk reduction projects, efforts to improve the resilience of critical infrastructure and key resource lifelines, risk reduction for specific vulnerabilities from natural hazards or acts of terrorism, and initiatives to reduce future risks after a disaster has occurred (White House, 2011).

preparedness—A continual cycle of planning, organizing, training, equipping, exercising, evaluating, and taking corrective action to ensure effective coordination during incident response. Within the National Incident Management System, preparedness focuses on the following elements: planning, procedures and protocols, training and exercises, personnel qualification and certification, and equipment certification (e.g., conducting drills) (FEMA, 2011).

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

prevention—Actions to avoid an incident or to intervene to stop an incident from occurring. Prevention involves actions to protect lives and property (FEMA, 2010a). Examples include pandemic influenza sanitation measures, isolation, quarantine, building access control procedures, and security systems and cameras.

recovery—Actions to assist individuals and communities affected by an incident in recovering effectively, including rebuilding infrastructure systems; providing adequate interim and long-term housing for survivors; restoring health, social, and community services; promoting economic development; and restoring natural and cultural resources (White House, 2011). This TAP uses "recovery" as both a disaster-related term and behavioral health term (see above). The meaning in each instance should be clear from the context.

response—Immediate actions to save and sustain lives, protect property and the environment, and meet basic human needs after an incident has occurred. Response also includes the execution of plans and actions to support short-term recovery from disaster (FEMA, 2010a).

Threat and Hazard Identification and Risk Assessment (THIRA)—A three-step risk assessment that helps communities and organizations answer the following questions:

- What threats and hazards can affect our community?
- If they occurred, what impacts would those threats and hazards have on our community?
- Based on those impacts, what capabilities should our community have?

The THIRA helps communities understand the risks they face and determine the level of capability they need to address those risks. The results of this process help a community determine gaps in its capabilities and lay the foundation for planning, resource management, capability development, public education, and training and exercises (U.S. Department of Homeland Security, 2018). The THIRA process informs some of the disaster planning recommendations in this TAP. Another term for this assessment is "hazard identification and risk assessment."

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Chapter 1—Rationale and Process for Planning

IN THIS CHAPTER

- Essential Partners in National Preparedness
- Providers of Essential Services
- Partners in Community Preparedness
- Rationale for Disaster Planning
- All-Hazards Planning
- Federal Disaster Planning Policies
- Continuity Planning
- Overview of the Written Disaster Plan
- Drafting a Usable Plan

Worksheet (see Appendix B)

- B1 Checklist for the Written Disaster Plan

Disaster planning can save lives, lessen injury and emotional trauma, protect valuable equipment and property, and prevent or reduce interruptions in treatment. For all these reasons, your behavioral health service program should coordinate with the community before disaster strikes to plan and prepare for a rapid, effective response to disaster. Program staff members also need to document the plans so that they are easy to understand and use in the chaotic minutes and hours after disaster strikes, when time is critical.

This chapter covers the reasons for disaster planning, explains the basis for the kind of planning proposed in this Technical Assistance Publication (TAP), and provides an overview of the written disaster plan.

Essential Partners in National Preparedness

The National Preparedness Goal is: "A secure and resilient Nation with the capabilities required across the whole community to prevent, protect against, mitigate, respond to, and recover from the threats and hazards that pose the greatest risk" (U.S. Department of Homeland Security [DHS], 2015, p. 1). The DHS document *National Preparedness Goal* states that these risks include "natural disasters, cyber incidents, industrial accidents, pandemics, acts of terrorism, sabotage, and destructive criminal activity targeting critical infrastructure" (DHS, 2015, p. A-1).

The Goal document also states, "Preparedness is the shared responsibility of our entire nation. The whole community contributes, beginning with individuals and communities, the private and nonprofit sectors, faith-based organizations, and all governments (local, regional/metropolitan, state, tribal, territorial, insular area, and Federal)" (DHS, 2015, p. 1).

As these quotations suggest, disaster readiness is not accomplished hastily or in isolation. It is achieved systematically and in coordination with all stakeholders. Because behavioral health service programs exist in **and** serve their communities, they are essential partners in national preparedness.

Providers of Essential Services

Your behavioral health service program has a special obligation to prepare for disasters because it provides essential services. The Federal Government has identified 15 Emergency Support Functions (ESFs)—services that are needed to save lives, protect property and the environment, restore essential services and critical infrastructure, and help victims and communities return to normal after disasters. Disaster services that support behavioral health fall under ESF #8 (Public Health and Medical Services) of the National Response Framework (DHS, 2019). Restoring and improving capabilities and networks to promote the behavioral health and well-being of the whole community are listed as a Recovery Core Capability in the National Disaster Recovery Framework (NDRF; DHS, 2016).

Disasters are often violent, life-threatening events that affect behavioral health. Although most people who experience disaster come through without long-lasting behavioral health issues, many experience short-term mental consequences and some develop mental or substance use disorders, or both. Posttraumatic stress disorder, major depressive disorder, and substance use disorder (SUD) are some of the most common effects of living through a disaster (Goldman & Galea, 2014). There can be significant demand for behavioral health services as a result of a disaster and significant consequences if a program suddenly closes or has to reduce its services.

Disaster planning can help your program continue to provide behavioral health services to existing clients. Without such planning:

- Clients in recovery may relapse to substance use, or their psychiatric symptoms may worsen, at the very time they must cope with the uncertainties, traumas, and losses caused by the disaster.
- Patients undergoing medically supervised withdrawal for alcohol or drug use are at risk of serious medical and psychological complications if the process is interrupted.
- Patients in residential treatment programs that close suddenly may have no other safe place to go to continue treatment and recovery.
- Patients who receive medications for mental disorders at your program (e.g., antianxiety medications, antidepressants) are at risk of serious withdrawal symptoms (e.g., seizures, delirium tremens) or discontinuation syndromes if the medications are stopped abruptly. Similarly, patients receiving medication for the treatment of opioid use disorder (OUD) may develop withdrawal symptoms if their treatments are interrupted and would also be at greater risk of relapse and overdose.
- At-risk populations (e.g., children, older adults, pregnant women, people with chronic medical conditions, clients with pharmacological dependencies) may face unique hardships and challenges if suddenly deprived of your program's support.

Just as important, disaster planning can prepare your program to serve new clients:

- In the weeks and months following a disaster, your program may experience a surge in demand for services from individuals needing assessment or treatment and from relocated individuals previously treated elsewhere.
- If your program has not been affected by the disaster, it may be called on to aid other programs (e.g., treating guest clients, sharing supplies and medications, lending staff members) or other community organizations (e.g., sharing resources, reassigning staff).
- Staff members may be asked to provide emergency community-based behavioral health services (e.g., crisis counseling or intervention, psychological first aid, assessments and referrals).

Partners in Community Preparedness

Your behavioral health service program's disaster planning contributes to the overall preparedness of the community. Proper planning helps your program prepare for potential rapid surges of vulnerable populations needing behavioral health services. It will also help your program rapidly transition services to other locations when your resources and community are overwhelmed.

A variety of factors or "triggers" are thought to contribute to higher demand for behavioral health services in a disaster, including (McCabe, Semon, Thompson, et al., 2014):

- Restricted movement (e.g., quarantine, shelter stays, evacuation).
- Limited resources (including denial of, limitation of, or suspended access to care).
- Trauma (both direct and indirect, such as through media exposure).
- Limited information (including inaccurate information or rumors).
- Perceived danger.

Your program can contribute to disaster readiness by addressing with community planners the needs of people with mental and substance use disorders, including people with serious mental illness, people with disorders triggered by the disaster, and people who are receiving medication for the treatment of SUDs. Your program can also recommend and assist in training emergency responders and volunteers to recognize signs of severe psychological trauma, cognitive incapacity, or SUD so that these personnel know how to direct people displaying such signs to appropriate services.

Rationale for Disaster Planning

Disaster planning isn't just prudent and practical—it's required:

- Most states require a disaster plan for program licensure.
- The Joint Commission and CARF International each require a disaster plan for accreditation.
- Programs offering mental or substance use disorder treatment services must be in full compliance with licensure regulations, including those pertaining to disaster planning, to receive Medicaid reimbursement.
- Disaster planning is required for opioid treatment program certification.
- Behavioral health service programs that belong to healthcare coalitions receiving funds through the Hospital Preparedness Program are obligated to plan for responses to common medical disasters and conduct an annual surge test to ensure that they can direct overflow patients to partner facilities (Office of the Assistant Secretary for Preparedness and Response, n.d.).
- Medicare-participating providers and suppliers (i.e., federally qualified health centers, rural health clinics, and other primary care safety net providers) are required by the Centers for Medicare and Medicaid Services to develop an effective and robust emergency preparedness plan that addresses risk assessment and emergency planning, policies and procedures, a communication plan, and training and testing, using an all-hazards approach for disruptive events.

Ideally, the disaster planning process will help your program identify and obtain the resources and training it needs to respond effectively to a range of potential calamities. As staff members work together across departments or functions to create and test the plan, they can build relationships that will be important when they must work together under the intense conditions of a real disaster.

The planning process also provides your program staff with opportunities to meet and build relationships with other professionals from the community who will be key partners in the event of a disaster. As a result, the entire infrastructure of your program is strengthened and better prepared for responding to a disaster.

All-Hazards Planning

This TAP describes an all-hazards approach to planning. "All-hazards planning" means that your program will prepare to respond to a full range of threats and dangers but will focus on those incidents that it identifies through an extensive risk assessment as being most likely to occur in your area (Federal Emergency Management Agency [FEMA], 2010a).

After conducting this risk assessment, your program addresses the capabilities needed to respond to the risks identified. For example, if the risk assessment establishes that your facility is situated in an area susceptible to flooding, your program begins with establishing procedures for responding to flooding. Such procedures include taking preventive actions to protect the facility from flooding, developing an evacuation plan, creating plans for clients and patients to be treated outside the flood area, and ensuring that records are backed up in another location or the cloud.

The procedures that address the most likely disasters serve as a template that can be adapted to direct your program's response to all disasters. Chapter 2 discusses risk assessment in more detail.

Federal Disaster Planning Policies

The planning process described in this TAP aligns with recommendations for entities such as state, territorial, tribal, and local governments; planners in other fields and types of organizations (FEMA, 2010a); and courts (National Center for State Courts, 2010). This process is based on federal policies for disaster planning, including the National Preparedness System, NDRF, and the National Incident Management System (NIMS).

The National Preparedness System presents a collaborative, whole-community approach for building a secure and resilient nation that can confront any threat or hazard. Components include identifying and assessing risk, estimating the level of capabilities needed to address those risks, building or sustaining the required levels of capability, developing and implementing plans to deliver those capabilities, validating and monitoring progress, and reviewing and updating efforts to promote continual improvement (DHS, 2015).

NDRF states the principles guiding effective recovery from large-scale or catastrophic disasters. Its objective is to guide a unified and collaborative response for restoring, redeveloping, and revitalizing communities (DHS, 2016).

NIMS provides guidance on how governmental agencies, nongovernmental organizations, and the private sector should respond to disasters. Jurisdictions and organizations vary widely in their capacity, structure, management processes, and communication channels. NIMS offers all partners involved in a disaster response a common language and a standardized way to communicate about their responsibilities, activities, and functions. A NIMS-modeled disaster plan is flexible. It can be scaled up or down, depending on the size, scope, and complexity of the disaster, and it can be readily integrated into the plans of other responding organizations (FEMA, 2017).

A basic premise of NIMS is that incidents typically are managed at the local level. In the vast majority of incidents, local resources provide the first line of emergency response and management. If additional or specialized resources or capabilities are needed, state governors may request federal assistance. However, local jurisdictions may retain control over response activities in their areas, depending on the scope and type of disaster.

Your behavioral health service program—whether public, private, or nonprofit—should develop a disaster plan that complies with NIMS (Office of the Assistant Secretary for Preparedness and Response, 2015). As a NIMS-compliant program, you agree to manage disaster incidents using the Incident Command System (see Chapter 2) and to coordinate with other responders on decision making and public communication. Your program also agrees to train key staff members in NIMS preparedness, participate in internal and external training exercises, and incorporate NIMS concepts into your disaster plan.

Your behavioral health service program should use the NIMS approach to disaster planning and training because:

- NIMS is based on best practices and has been extensively tested throughout the country, proving its effectiveness in providing a framework for a coordinated disaster response.
- Almost all government and community training on disaster response is based on NIMS.
- A program that has staff members who can respond to a disaster using NIMS protocols will be better prepared to communicate with and receive help from other providers in the community.
- NIMS-prepared staff members will more readily integrate into their community's response activities (e.g., as members of the state's behavioral health disaster response team).

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

Continuity Planning

Your behavioral health service program needs to plan not only for responding to a disaster as it hits (disaster planning), but also for continuing essential operations under a broad range of circumstances that could follow a disaster (continuity planning). A vital part of your program's overall disaster plan is its business continuity plan, commonly referred to as a "continuity of operations plan" or "COOP plan."

Continuity planning requires your program's personnel to:

- Consider threats that could adversely affect essential functions.
- Determine the personnel, vital information (e.g., patient medical records, including prescription records), and other resources required to continue essential functions.
- Develop plans for providing essential functions onsite or at alternate locations if needed.
- Arrange for obtaining the resources necessary to support essential functions throughout the disaster and recovery phases.
- Plan for the safety of all personnel during these periods.

The continuity plan can be scaled up or down to accommodate the number and variety of clients who need services. The continuity plan may be activated by the program's director or Incident Commander (discussed in Chapter 2), whether or not a government official declares a disaster.

Here are examples of scenarios in which your program would implement a continuity plan:

- When your program must stop providing nonessential services because of a sudden reduction in resources, infrastructure, or available personnel (e.g., during a pandemic)
- When your program cannot provide essential services to clients at its original location (e.g., the facility is damaged by a fire, a blizzard has blocked access to the facility)
- When communitywide evacuation is recommended or mandated (e.g., because of an approaching hurricane)
- When staff and resources are diverted to provide urgent care to community members in distress

Continuity planning helps your program prepare to meet a possible surge in demand for services from existing, new, and temporary guest clients in the immediate aftermath of a disaster or in the months that follow. A study of survivors of the bioterrorism event in which anthrax was mailed to various offices on Capitol Hill found that even in the absence of physical injury or illness, there can be a surge in demand for health care (Chiao, Kipen, Hallman, et al., 2019). Characteristics (e.g., age, gender, culture, English-language proficiency, home location, types of behavioral health and medical conditions) of postdisaster guest clients or new clients may differ from those of your program's existing clients. Your program may have to adapt quickly to meet the various needs of:

- Current clients who face extra stressors arising from the disaster and need extra counseling, psychiatric monitoring, or other support to maintain recovery from a mental or substance use disorder.
- Guest clients who come to your program for short- or long-term assistance after a disaster because they don't have access to their treatment programs or primary care providers.
- Individuals who completed treatment or discontinued services before a disaster but whose recoveries are now threatened as a result of the event.
- Individuals with ongoing, untreated mental or substance use disorders or co-occurring disorders who need treatment to prevent escalation of harmful medical or psychological symptoms.
- Family members of clients who need assistance for their loved ones or themselves. These individuals may benefit from an established or temporary telephone hotline answered by trained crisis intervention and referral staff (possibly nonclinicians or prevention staff who have received crisis training).

On November 15, 2017, new requirements governing emergency preparedness went into effect for providers receiving Medicare and Medicaid funds. The Centers for Medicare and Medicaid Services' *Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers Final Rule* states that providers' emergency plans must:

- Document risk assessment using an all hazards approach.
- Include strategies to address events identified in the risk assessment, and plans for evacuating or sheltering in place and working with other providers in the area.
- Address patient populations, continuity of operations, and succession planning.
- Develop a process for cooperation/collaboration with local, tribal, regional, state, or federal emergency planning officials to ensure an integrated response.

- Patients who have been stabilized for long periods on antidepressants, antipsychotics, or medications for alcohol use disorder or OUD who are unable to obtain medications and are at risk of sudden medication withdrawal or relapse to psychiatric symptoms or OUD. These patients may need evaluation and referral to treatment programs or prescribers with the resources to help them. They may also need replacement medications if their medications were lost or destroyed in the disaster or event (see Chapter 4).
- Patients whose nonpsychoactive medications were lost or destroyed (i.e., patients on opioid pain medication who can't obtain services from their current provider or who are experiencing withdrawal) and request help from the treatment program. These patients may need a referral to a pain specialist, an emergency room, or an urgent care facility.

Overview of the Written Disaster Plan

Write the disaster plan in a general way so that it can apply to a number of different events but is also comprehensive in scope. Creating a plan that is flexible enough to apply to any possible disaster yet specific enough to be useful in a particular scenario can be challenging.

To help the disaster plan accomplish these goals, divide it into:

- A basic plan that applies to most disasters.
- Functional annexes describing specific functions that are part of a disaster response.
- Hazard-specific appendixes that describe the program's response to different types of disasters.

Make the organization of the plan simple and clear so that it is easy to refer to and carry out in a disaster situation. Chapters 2 and 3 describe how the disaster planning team gathers information, makes planning decisions, and compiles information into a well-organized written disaster plan. **Worksheet B1** (in Appendix B) is a checklist for assembling plan components into one document.

The Basic Plan

The introductory section of the **basic plan** contains the following information:

- A statement of purpose
- Objectives
- The scope of the plan
- The populations your program serves
- Your program's essential functions

The basic plan should also have a situation overview (e.g., the hazards your program is most likely to face, your program's response capabilities, the steps you've taken to reduce risk) and a section on planning assumptions.

The basic plan contains a statement of purpose and objectives (i.e., your organization's overall approach to disaster response). This statement should describe procedures for activating and deactivating the plan and the general sequence of actions to be taken before, during, and after an incident. The statement needs to specify who is responsible for all the actions described and should also provide:

- A list of the personnel positions authorized to make requests for outside aid.
- Likely scenarios under which your program will request aid.
- The procedures for managing requests to give aid.
- A list of the resources that can be used in those efforts.

The concept of operations section should also describe how and how often:

- Your program's plan will be updated.
- Changes will be communicated to staff.
- Staff will be trained on the plan.

Functional Annexes

One of the more important decisions your disaster planning team should make early in the planning process is determining which functions will be addressed in separate annexes. A "functional annex" is a set of instructions for a specific procedure your program will use to respond to a given hazard. Annexes focus on operations; they describe functions and who is responsible for carrying them out. Each annex is a separate attachment to the disaster plan. Using this structure avoids cluttering the basic plan with too much detail. This structure also makes it easier to update and revise individual components of the disaster plan as needed.

A functional annex can be just a paragraph or several pages long. An example of a functional annex topic would be procedures for the emergency phase, such as facility evacuation, sheltering in place, distributing personal protective equipment, and handling the media. The continuity plan is a functional annex that is often the largest section of the overall disaster plan. Development of this functional annex is addressed in Chapter 3.

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

Hazard-Specific Appendixes

In its initial work, your disaster planning team conducts or gathers from partner agencies in the community a Threat Hazard Identification and Risk Assessment (THIRA). This assessment identifies the specific types of hazards most likely to occur and the potential impact of each type on your program. The THIRA is discussed in detail in Chapter 2.

In response to each identified hazard, the disaster planning team develops response procedures based on industry safety standards and regulations (e.g., those issued by the Occupational Safety and Health Administration). Attach these procedures as hazard-specific appendixes to the basic plan. For example, if the THIRA identifies hurricanes and hazardous materials spills as possible hazards to your program, the planning team would develop two appendixes, one for each hazard.

A hazard-specific appendix should not repeat information in either the basic plan or a functional annex, whose instructions apply to all hazards. The appendix should add only those details specific to the hazard being addressed. If there aren't many details, you may not need separate hazard-specific indexes. Instead, the information can be presented in a few sentences at the end of each functional

annex. For example, a functional annex of instructions for backing up and saving computer data either at a remote location or in the cloud may include separate procedures for tornado scenarios, which allow little time to act, and hurricane scenarios, which have more advance warning.

Alternatively, you can add an appendix that contains all special instructions connected with a particular type of hazard. Insert each specific appendix after the basic plan and the functional annexes. The disaster planning team should format its hazard-specific information in a way that makes the most sense for the people who will use the disaster plan when an incident occurs. Chapter 5 provides guidance on preparing a pandemic-specific appendix.

Implementing Instructions

Material that helps staff members perform essential tasks during a disaster is referred to as "implementing instructions." Attach the implementing instructions to the back of the basic plan and distribute copies to relevant personnel. Typically, the material includes your program's safety-related policies and procedures, which should be reviewed and updated on a regular basis. Your program should have a schedule in place for when to communicate changes in implementing instructions to staff and when to provide training on them.

Implementing instructions can also include job-related aids that staff can use to perform disaster response tasks. Such aids might be:

- Checklists.
- Worksheets.
- Laminated wallet cards or sheets.
- Scripts for staff to use when providing disaster-related information to consumers and the public.
- List of important contact information.

Other materials to attach to the plan include memorandums of agreement (see Chapter 2 and Appendix E), building floor plans, community maps, and one or more of the completed worksheets from Appendix B, such as **Worksheet B6**, Incident Command System Positions. The types of implementing instructions that you can attach to the basic plan are discussed in subsequent chapters and are included in the **Worksheet B1** checklist, located in Appendix B.

Drafting a Usable Plan

When drafting a plan, organize material so that program staff can find information immediately when needed and take quick action. The plan is a guide, not a script. It is a useful tool for training staff, evaluating exercises and drills, and sharing with other community partners that participate in disaster response. In an actual disaster, the people who execute the plan will have to adjust their actions as the situation dictates and as facts replace planning assumptions.

The disaster planning team should aim for a simple and flexible plan. A plan that attempts to cover all possible contingencies will be too complicated to follow. Write the plan in easy-to-understand language that uses agreed-on and defined terms and that provides concrete, actionable guidance (FEMA, 2010a).

You can maintain the plan in electronic form if it is accessible to all key personnel. Keep paper backup copies in a few safe but easily accessible locations in case of electrical power interruption or computer systems failure. Date the paper versions of the plan and replace and destroy old versions to eliminate confusion.

Electronic version control is also important. It can be helpful to:

- Record changes on a separate table or spreadsheet attached to the document.
- Replace the date when a new version of the plan is saved.
- Archive old versions so that only the most current version can be accessed.

Your program should regularly update staff about changes to the disaster plan as part of standard safety practice.

Example of a Behavioral Health Disaster Response Plan

The All Hazards Disaster Behavioral Health Response Plan for Washington, DC, describes how the District's behavioral health department will respond to different emergencies. It includes the disaster plan elements discussed in this chapter. You may find DC's plan instructive, even if the scale of your program's response will differ. To access the plan, visit https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/website.%20All%20Hazards%20Disaster%20Behavioral%20Health%20Response%20Plan.%20October%202015%20%281%29.pdf.

Chapter 2—Disaster Planning and Preparation

IN THIS CHAPTER

- Assemble the Disaster Planning Team
- Review Requirements for Disaster Planning
- Coordinate Planning With Others
- Educate the Community About Behavioral Health Services
- Prepare a Threat and Hazard Identification and Risk Assessment
- Specify Planning Objectives and Assumptions
- Prepare for Disaster
- Support Clients in Disaster

Worksheets (see Appendix B)

- B2 Checklist for Disaster Planning
- B3 Checklist of State and Community Representatives and Groups
- B4 Checklist of Disaster Planning Discussion Topics
- B5 Sheltering-in-Place Checklist
- B6 Incident Command System Positions
- B7 Requirements for Alternate Facilities
- B8 Alternate Facility Arrangements by Disaster Scenario
- B9 Checklist for Relocation Planning

This chapter provides guidance on forming a disaster planning team, obtaining clarity on the team's scope and responsibilities, gathering information on potential hazards, mitigating risk, and promoting staff and client readiness. A key step in this process is integrating with other entities in the community whose efforts, when disaster occurs, will be organized through an Incident Command System (ICS). The ICS is a standardized, on-scene, all-risk incident management approach. Planning activities recommended in this chapter are in checklist form in **Worksheet B2** (in Appendix B).

Assemble the Disaster Planning Team

Disaster planning is a cycle that begins with planning and moves through training, testing, evaluating, revising, and additional planning as circumstances change. This cyclical process helps your program create a suitable disaster plan and keeps that plan current. Because of the continual nature of this process, your program's disaster planning team needs to be a permanent part of the organization. Its ongoing responsibilities can include:

- Making revisions to the plan (based on insights gained through testing or actual disaster response, or because your program services or scope have changed).
- Monitoring the plan as a whole to ensure that it remains coherent.
- Coordinating testing and training based on the plan.
- Participating in local, regional, and state emergency management associations.

If your program has a small staff, every employee may be on the disaster planning team. If your program is large enough, the team will comprise representatives from various departments. If your program has several locations, you will generate one disaster plan, but each separate facility (or its function) will be represented on the disaster planning team to ensure that its particular needs, vulnerabilities, and client population are reflected in the plan. Site-specific safety personnel or leadership are logical members of the disaster planning team.

As another option, one of your program's existing standing committees (e.g., safety committee) can double as the disaster planning team. Ideally, the committee you select should include individuals or departments representing all aspects of the organization (e.g., clinical, medical, finance, facility maintenance, IT, housekeeping, risk management, quality assurance).

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

Select a Team Leader

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

Typically, the team leader:

- Convenes and conducts team meetings.
- Ensures that team members receive the training they need to contribute effectively to disaster planning.
- Works with team members to gather information and leads the development of the plan.
- Ensures that the plan is developed, tested, and maintained.
- Informs your organization's leadership and departments of the disaster plan and their roles in its implementation.
- Represents your organization at disaster planning meetings in the community.
- Acts as the liaison for your program as it engages in local or regional disaster planning exercises.

The person who leads the disaster planning team is not necessarily the person assigned to lead the organization during its response to a disaster. The latter role is referred to as the "Incident Commander"; the position and its duties are described later in the chapter.

Select Team Members

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

Staff members who do not serve on the planning team will become involved in later stages of planning, when sections of the draft plan are circulated for comment and when the plan is tested in exercises and drills. Feedback from these staff members can be used to improve the plan. Chapter 6 describes this testing process.

Your program needs to involve all staff members either on the disaster planning team or in support of the team's work because:

- Broad staff involvement ensures that the plan addresses all critical operations.
- Ongoing input from all staff members can keep the disaster planning team aware of changes in equipment or procedures that may affect disaster operations.
- Staff members are more likely to follow a plan they helped develop.
- Staff members already familiar with their roles and the disaster response plan are more likely to respond quickly and helpfully when the plan must be implemented and are less likely to panic.
- Staff members who helped develop the plan may be more likely to create emergency plans for their homes. During a disaster, having home plans can reduce staff members' anxiety over their families' safety and enable those staff members to focus on their job functions.

Obtain Support From the Organization's Leadership

Disaster planning comes with costs. Management shows its support by taking account of the expenses associated with the planning process—as well as disaster preparation, response, and recovery activities—and by allocating resources from your organization to the team (e.g., space to meet; necessary equipment and supplies; compensated time for team members to obtain training, attend meetings, and work on assigned team tasks). To fully prepare your organization for continuity of operations, management may need to include line items for disaster planning in its multiyear budget plan.

Your program's leader can contribute to the success of disaster planning by encouraging all staff to cooperate with the planning team's work. A direct line of communication between your program's leader and the disaster team leader will ensure that management receives regular updates on disaster planning and response activities.

Management's participation in the team indicates the importance of disaster planning to your program. Leadership can consider specifying disaster planning responsibilities in the job descriptions for team members and taking those duties into account during each employee's annual review.

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

Review Requirements for Disaster Planning

The disaster planning team should review pertinent accreditation (e.g., CARF International, Council on Accreditation, National Committee for Quality Assurance, The Joint Commission), licensing (e.g., state and local departments of behavioral health, social services children's division, state Medicaid office), and reimbursement requirements (e.g., managed care organizations, third-party insurers), as well as federal, state, and local laws or regulations governing disaster planning (e.g., state emergency management agency, FEMA, grantors). Your team also should identify the program's planning requirements and become familiar with federal guidelines on disaster planning from:

- FEMA, www.fema.gov/.
- FEMA's National Incident Management System, www.fema.gov/emergency-managers/nims.
- FEMA's National Disaster Recovery Framework, www.fema.gov/emergency-managers/national-preparedness/frameworks/recovery.
- FEMA's Ready website, www.ready.gov/.
- The Substance Abuse and Mental Health Services Administration's (SAMHSA) Disaster Technical Assistance Center (DTAC), www.samhsa.gov/dtac.

Your program may be required to conduct general disaster planning, as well as specific planning for pandemic influenza. Chapter 5 provides detailed information on addressing pandemic issues in disaster planning.

To receive state funding, programs may be required to have staff members (who are trained, credentialed, and ready) participate in a behavioral health disaster response team, which means they can be called on to provide behavioral health services throughout the state after a disaster. When a disaster occurs, such teams may be mobilized by the state behavioral health department to provide:

- Psychological first aid and crisis intervention.
- Behavioral health needs assessments and referrals to ongoing services.
- Community outreach and public information.
- Behavioral consultation and prevention efforts.
- Other services as determined by the state authority (e.g., transition to recovery, mitigation, preparedness).

Teams also may be mobilized to provide crisis debriefing and support the behavioral health of emergency responders and volunteers; Exhibit 2.1 provides an example of this type of support after an earthquake.

EXHIBIT 2.1. Mobilization of Behavioral Health Responders To Assist Earthquake Emergency Responders

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

Source: National Biodefense Science Board (2010, p. 15).

Coordinate Planning With Others

Your program should develop its disaster plan in coordination with:

- Local and regional behavioral health service programs.
- The state disaster behavioral health coordinator.
- The state's or local jurisdiction's public health department or both.
- The local and regional healthcare coalitions.
- Federal coordinating agencies (e.g., the Drug Enforcement Administration [DEA], U.S. Department of Homeland Security [DHS], Office of the Assistant Secretary for Preparedness and Response [ASPR], Centers for Disease Control and Prevention [CDC], Centers for Medicare and Medicaid Services, National Disaster Medical System, SAMHSA, FEMA).
- Voluntary and emergency response organizations (e.g., Community Organizations Active in Disaster, National Voluntary Organizations Active in Disaster [VOAD], American Red Cross, Community Emergency Response Team, Catholic Charities USA, Samaritan's Purse, Medical Reserve Corps [MRC]).
- Neighboring businesses.
- Local media.

Coordinating in advance can make your program's efforts and the assistance it receives in a disaster situation more productive and efficient. Programs are advised to participate in community coordination before disaster recovery planning as outlined in the National Disaster Recovery Framework (DHS, 2016, pp. 6, 26).

Coordination with neighboring facilities and organizations is especially important because, in a disaster, the first assistance will likely involve neighboring facilities and communities (FEMA, 2017). Your behavioral health service program may receive less help in community recovery efforts if neighbors don't understand that your program provides essential services. Your program is also less likely to be included in recovery efforts if neighbors don't know about the contributions that your program and its staff can make in responding to disaster.

Furthermore, coordinating disaster planning with the community can help ensure the well-being of your program's clients during a disaster. For example, letting the community's disaster planning team know that general population shelters may need to accommodate individuals with substance use or mental disorders (FEMA, 2010b) can help prevent the types of discrimination seen in previous disasters (as described in Exhibits 2.2 and 2.3). Likewise, your program should let the community's disaster planning team know that program counselors will need access to shelters (see "Ensure Counselor Access to Shelters" below in this chapter).

Exhibits 2.4 and 2.5 provide examples in which behavioral health service programs networked with other community agencies to improve their disaster preparedness. The various groups with which a program's disaster planning team can coordinate are described in the following sections and are presented in a checklist in **Worksheet B3** (in Appendix B).

EXHIBIT 2.2. Discriminatory Attitudes That Affected Care for People With Mental Disorders

After a devastating tornado forced some clients of a behavioral health service provider to stay in a shelter, the shelter's rules kept them from receiving attention and treatment there. Even with direct intervention by the provider and the state department of mental health, the provider was denied timely entrance to treat those clients suffering from the complicated effects of the tornado, sheltering, and lack of medications and services. As a result, clients decompensated, and issues occurred at the shelter that could have been prevented. Several individuals were even hospitalized because they went without needed treatment. The behavioral health service provider was invited in only after one resident who had been trying to ask for help caused major concerns for the staff and other shelter residents.

To compensate for the lack of entry into the shelter, the behavioral health service provider set up onsite rapid psychiatry visits across from the shelter. Shelter residents who were current clients could access refills on their prescriptions and in many cases received free samples because their medications had been destroyed. Ultimately, a significant number of clients residing in the shelter took advantage of the service and improved.

To prevent future shelter challenges, the local behavioral health service provider, the state department of mental health, and the state emergency management agency worked with the shelter provider to jointly develop a memorandum of understanding (MOU). Behavioral health service providers now maintain a copy of the MOU to show onsite shelter staff.

Source: Jenny Wiley, personal communication, August 2020.

EXHIBIT 2.3. Discriminatory Attitudes That Affected Care for People With Substance Use Disorders

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

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

Source: Podus, Maxwell, & Anglin (n.d.).

EXHIBIT 2.4. Networking To Improve Readiness for Disaster (Example 1)

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

To avoid problems of this nature, ask law enforcement authorities about the circumstances under which access to your facility may be restricted and negotiate in advance an access plan for staff and patients.

Source: Podus et al. (n.d.).

EXHIBIT 2.5. Networking To Improve Readiness for Disaster (Example 2)

A behavioral health service program faced problems with its community's emergency evacuation traffic measures. In an evacuation, the highway becomes a one-way thoroughfare heading out of town. Once a vehicle enters the highway, it cannot exit to local streets. This presents the risk that clients and staff who are delayed at the clinic to complete dispensing of take-home medications when the emergency traffic pattern is implemented won't be able to return home to prepare for the community's evacuation.

To avoid problems of this nature, ask local authorities for information about possible disaster traffic-control measures and road closures and ask community traffic planners for guidance on routes around potential roadblocks. However, program disaster planners should keep in mind that, in an actual disaster, alternative routes might not be available and detours can greatly increase travel time, especially if power outages turn intersections with traffic lights into four-way stops.

Source: Podus et al. (n.d.).

Local Behavioral Health Service Programs

As a first step in collaboration, the disaster planning team should reach out to representatives from other behavioral health service programs located in the community and region. Programs need to collaborate so that they are prepared to assist clients displaced from programs affected by disaster. Collaboration helps ensure that various programs' plans do not conflict with one another. Exhibit 2.6 describes coordination efforts to consider when developing plans with other programs.

Programs can share information and resources on disaster planning and coordinate participation in the broader community's local emergency planning. Exhibit 2.7 explores the benefits of healthcare coalitions that include behavioral health partners. Participation in regional or statewide healthcare networks or coalitions can act as a "force multiplier" for local programs.

In Missouri's case, behavioral health strike teams respond quickly in a disaster. The state disaster behavioral health coordinator can facilitate these connections with other behavioral health service programs and with wider networks and coalitions.

State Disaster Behavioral Health Coordinator

Your state's disaster behavioral health coordinator is an important source for disaster planning information, support, and coordination. This official typically works for the state agency focused on behavioral health (e.g., division of behavioral health services, department of mental health). Some states have one person in this role. Other states have two disaster coordinators—one for mental health services and one for SUD treatment—sometimes operating out of different agencies.

To simplify things, this section describes the roles of a state disaster behavioral health coordinator who combines both positions. The coordinator serves as a liaison to other federal, state, and local disaster responding agencies (e.g., the National Guard). He or she oversees the state's behavioral health service response plans and may work closely with programs within the state to support coordination of efforts in response to disaster. The coordinator may also be able to offer disaster training for your program.

Part 1 of **Worksheet B4** (in Appendix B) contains a checklist of topics that representatives of the disaster planning team can address with your state disaster behavioral health coordinator to better prepare your program to respond to a disaster.

Following a disaster, the state disaster behavioral health coordinator may help your program apply for disaster-related funds. These include any available federal and state funds.[2] Federal funds include those available through the Robert T. Stafford Disaster Relief and Emergency Assistance Act[3] and those from Crisis Counseling Assistance and Training Program (CCP) grants, which FEMA funds and SAMHSA administers; information about CCP grants is available at www.samhsa.gov/dtac/ccp.

[2] In 2020, SAMHSA made a limited number of grants available to private and nonprofit organizations through the Disaster Response Grants Program. The grants, up to $1 million, were to provide SUD treatment, crisis counseling, and other related supports to people affected by hurricanes, wildfires, or earthquakes during 2018 and 2019.

[3] The Stafford Act, originally passed in 1988, has been amended several times, most recently by the Disaster Recovery Reform Act of 2018, which increased funding available for hazard mitigation after a disaster is declared.

EXHIBIT 2.6. The Importance of Coordinating and Testing Plans With Others

The Joint Commission has expanded the requirement for disaster planning to include testing the plan in conjunction with other community partners. One example of the importance of testing with partners involved a behavioral health service program focused on providing treatment across three counties. The program diligently conducted early planning and training for each site, and program staff expressed confidence in implementing those plans. Early planning included written agreements for sheltering with the local schools and daycare facilities and priority transportation by the private ambulance company.

Testing the plan and conducting simulations within the program went very well. However, when each site reached out to their collaborative partners to conduct joint exercises, flaws became apparent. The behavioral health service program found out that the local school had also contracted with a skilled nursing facility for the same space. The ambulance company was found to have decreased its number of rigs, making it impossible to accommodate all the patients in a safe manner.

The behavioral health service program went back to the planning stage, reevaluating next steps to correct and improve its plan. The program reached out to additional partners to address sheltering and transportation during and after a disaster. Program staffs also included specific instructions on activating and deactivating their plan at each program site.

Source: April Naturale, Ph.D., M.S.W., personal communication, September 2020.

EXHIBIT 2.7. Behavioral Health: A Pivotal Partner in Healthcare Coalitions

Missouri was an early adopter of healthcare coalitions as required by the U.S. Department of Health and Human Services' (HHS) ASPR and maintains three robust, inclusive healthcare coalitions covering the entire area and population of the state. Each healthcare coalition has membership from four core groups: hospitals, emergency medical services, public health, and emergency management. Behavioral health service partners, while not required by ASPR, are embraced by Missouri's healthcare coalitions as necessary to emergency planning, mitigation, response, and recovery efforts.

Missouri has used funding from both the CDC's Public Health Emergency Preparedness program and ASPR to build our behavioral health strike teams and respond to emergencies in our state, including mass fatality incidents, tornadoes and other severe weather events, civil unrest, and infectious disease outbreaks. In addition, the Missouri Department of Health and Senior Services hosts a biannual meeting of healthcare coalition leaders known as the "Leadership Partnership." Missouri's behavioral health service providers have provided invaluable insight into the behavioral health aspects of disaster response and helped healthcare partners statewide recognize and respond to our citizens' behavioral health needs.

In addition to being involved at the leadership level, behavioral health service providers in Missouri are active in their regional healthcare coalitions, joining public safety and public health partners in the common cause of making communities safer, healthier, and more resilient.

Source: Paula F. Nickelson, M.Ed., CHEP, Office of Emergency Coordination, MDHSS, personal communication, September 2020.

Your state disaster behavioral health coordinator can connect your program with external emergency response teams from the U.S. Public Health Service Commissioned Corps or teams coordinated by the National VOAD (see "Voluntary Organizations" below in this chapter). These teams, which can include behavioral health specialists, go into communities to respond to public health crises and national emergencies. Some state disaster behavioral health coordinators are responsible for assembling behavioral health disaster response teams comprising staff members from programs in the state.

SAMHSA's DTAC supports SAMHSA's efforts to prepare states, territories, tribes, and local groups to deliver effective behavioral health response during disasters. DTAC specialists can help your program link with the disaster behavioral health coordinator for your state, and they can answer questions and provide guidance on CCP grants. The DTAC website links to a resources list of more than 1,500 materials. For technical assistance, contact DTAC at 1-800-308-3515 or www.samhsa.gov/dtac.

In response to a disaster, the state disaster behavioral health coordinator may help your program obtain precredentialed volunteer assistance through the Emergency System for Advance Registration of Volunteer Health Professionals. This state-based registration system verifies the licenses, credentials, accreditations, and hospital privileges of volunteer health professionals. It includes licensed behavioral health counselors and other clinicians. Behavioral health professionals who wish to register as volunteers can do so at www.phe.gov/esarvhp/Pages/Registrationold.aspx.

In some states, the state disaster behavioral health coordinator responds to disasters or critical incidents when local behavioral health resources have been depleted or are overwhelmed. The goal is to provide an organized response to individual victims, family members, survivors, or the community affected by critical incidents or disasters. Working with the local behavioral health organization, the state behavioral health coordinator can assist with training and organizing the onsite response until additional organizational staff can be hired and trained.

Your state's disaster behavioral health coordinator may offer preparedness training in disaster mental health/psychological first aid to health and mental health care providers, school personnel, community-based volunteer organizations, emergency responders, law enforcement personnel, mental health service consumers, and the faith-based community. The disaster behavioral health coordinator may also develop informational factsheets about the emotional impact of disasters on different populations and common reactions to disaster and be involved in ongoing initiatives such as mental health emergency planning, planning for the needs of children, and continuity of operations planning. State disaster behavioral health coordinators in some states offer emergency planning workshops, including education in continuity of operations.

SAMHSA Disaster Mobile App

A free app for iPhones and Android devices gives behavioral health first responders immediate access to vital information for all phases of disaster response: predeployment preparation, on-the-ground assistance, and postdeployment resources.

With the SAMHSA Disaster Mobile App, first responders can:

- Access resources including tip sheets; guides for responders, teachers, parents, and caregivers; and a directory of behavioral health service providers in the impacted area.
- Download information on their phones before deployment in case of limited Internet connectivity in the field.
- Review key preparedness materials to help them provide the best support possible.
- Send information to colleagues and survivors via text message or email or transfer information to a computer for printing.
- Find interventions to help survivors of infectious disease epidemics.

The SAMHSA Disaster Mobile App can be downloaded for free from the SAMHSA Store at https://store.samhsa.gov/product/samhsa-disaster.

State and Local Health Departments

Your state health department is in a unique position to take the lead role in disaster planning and implementation at the state level (including determining when to implement the state disaster plan) because of its expertise in population-based public health; already established local, regional, state, and federal connections; legal powers to use public health emergency response authorities; and role in ensuring the representation of appropriate stakeholders (e.g., officials at regional and local levels).

State health departments typically have a range of public health, healthcare, and emergency response system responsibilities and in collaboration with other state agencies:

- Have an obligation to assume authority when local health agencies cannot perform their duties or when there is no coverage by a local health department.
- Provide oversight of and support to local health departments.
- Oversee emergency medical service agencies.
- Monitor the health status of the population.
- Conduct disease surveillance and control.
- Collaborate on grants and programs with federal health partners.
- Administer Public Health Emergency Preparedness and Hospital Preparedness Program cooperative agreements that HHS provides for state, local, and hospital preparedness.

- Participate in state-level management of emergencies (e.g., as the state's lead Emergency Support Function [ESF] #8 [Public Health and Medical Services] agency).
- Develop pandemic, medical surge, and other emergency response plans (e.g., hospital room and emergency department overflow, mass fatality management and hospital evacuation).
- Coordinate state and local components of federal response programs (e.g., Cities Readiness Initiative for mass dispensing of antimicrobials following an anthrax attack or vaccines in response to pandemic influenza).
- Plan for the allocation and prioritization of scarce resources (e.g., vaccines, ventilators, personal protective equipment) during responses.
- Coordinate registration and credentialing systems for healthcare volunteers (e.g., Emergency System for Advance Registration of Volunteer Health Professionals [ESAR-VHP]) and healthcare response teams (e.g., MRC).
- Manage stockpiles of medicine (e.g., antivirals).
- Identify and develop plans for alternate care sites.
- Establish healthcare emergency communication systems.
- Establish contact-tracing protocols and guide their implementation.
- Regulate the state's healthcare industry and practitioners, which may include identifying when to relax certain state regulations or requirements (e.g., expanding practitioners' scopes of practice).

State health department officials' legal authorities and powers help identify resource needs and facilitate statewide disaster response. While these authorities and powers vary by state, they may include authorizing certain response actions and provide liability protections for responders; initiating and facilitating emergency requests for federal (e.g., HHS) health and medical resources, technical assistance, emergency declarations and waivers, and interstate support (e.g., through the Emergency Management Assistance Compact); accessing state, regional, and local health information and resources for providing situational awareness; establishing quarantine and isolation orders; and modifying or providing specific treatment protocols.

Local health departments are essential in disaster planning and implementation and are often the first responders to incidents that affect public health. They are well positioned to provide a bridge between the state government structure and local community stakeholders and health systems. Your local health department is in the best position to appreciate the needs and interests of the local populations, to know what resources are available and what planning efforts are underway (e.g., local healthcare coalitions), and to understand how best to achieve planning objectives (e.g., through implementation of the state emergency plan at the local level). Local health department responsibilities vary by jurisdiction but may include:

- Assessing and providing local and regional information (e.g., demographic data, emergency and resource needs) to ensure continuity of essential functions and to avoid interruption of patient and client care.
- Conducting joint planning with response partners (e.g., developing contracts to share resources and establishing shared communications systems).
- Operating temporary medical care facilities or shelters for people who need medical care.
- Supporting healthcare partners in resource management and coordination.
- Conducting biosurveillance activities.

- Dispensing medical countermeasures on a large scale directly to residents.
- Conducting mass vaccination.
- Coordinating training for healthcare personnel in advance of a disaster.

The remainder of this section provides more detail about the role of the local health department in disaster planning. Part 2 of **Worksheet B4** (in Appendix B) contains a checklist of topics that can help guide your disaster planning team's discussions with the public health department and local emergency planners.

The CDC's Public Health Preparedness Capabilities are 15 distinct, yet interrelated, capability standards that advance the emergency preparedness and response capacity of state and local public health systems. These standards require public health departments to coordinate disaster planning with the community's behavioral health service systems (CDC, 2018). For example, the Capability Standard for Community Preparedness notes that (CDC, 2018, p. 11):

Community preparedness is the ability of communities to prepare for, withstand, and recover from public health incidents in both the short and long term. Through engagement and coordination with a cross-section of state, local, tribal, and territorial partners and stakeholders, the public health role in community preparedness is to:

- Support the development of public health, health care, human services, mental/behavioral health, and environmental health systems that support community preparedness.
- Participate in awareness training on how to prevent, respond to, and recover from incidents that adversely affect public health.
- Identify at-risk individuals with access and functional needs that may be disproportionately impacted by an incident or event.
- Promote awareness of and access to public health, health care, human services, mental/behavioral health, and environmental health resources that help protect the community's health and address the access and functional needs of at-risk individuals.
- Engage in preparedness activities that address the access and functional needs of the whole community as well as cultural, socioeconomic, and demographic factors.
- Convene or participate with community partners to identify and implement additional ways to strengthen community resilience.
- Plan to address the health needs of populations that have been displaced because of incidents that have occurred in their own or distant communities, such as after a radiological or nuclear incident or natural disaster.

Standards in other capability areas (e.g., Community Recovery and Mass Care) also require coordination with providers of behavioral health services.

The local health department is responsible for services that come under ESF #8 at the local emergency planning committee. Every jurisdiction has such a committee to pursue federally directed objectives for emergency planning. The local health department also may represent behavioral health and medical functions at the Emergency Operations Center that the community establishes during a disaster.

Another role potentially played by the local health department would be to relay requests for community assistance from behavioral health service programs to the state emergency management agency in a disaster situation. The local health departments coordinate their efforts with those of the state department of health.

The local health department's emergency manager can provide planners from behavioral health service programs with targeted planning assistance and can serve as a link between the programs and broader disaster planning and incident response efforts. Ideally, your program will collaborate with other behavioral health service programs in the community on initial planning. Then together you can approach the health department's emergency manager to be integrated as a group into the community's planning activities.

Strengthening Emergency Response Through a Healthcare Coalition: A Toolkit for Local Health Departments supports the creation of healthcare coalitions. Developed by the King County (WA) Healthcare Coalition, the toolkit can be accessed at www.apctoolkits.com/kingcountyhc. Although this website is no longer being updated, it remains active and useful.

Some states organize local health departments by county. In this case, all the programs in the county collaborate to work as a unit with their state health department.

Exhibit 2.8 describes how a regional network of healthcare organizations collaborates extensively for disaster planning.

Emergency Response Organizations

Coordinating disaster response with local emergency responders (e.g., emergency medical services, police and fire departments) is part of the planning process. Provide them a copy of your program's facility floor plan. The floor plan should indicate where people usually work. Tell local emergency responders whether controlled substances (e.g., barbiturates, methadone) that may require special protection during emergencies are stored onsite and where they are located. Additionally, notify local emergency responders whether people onsite will need special assistance in exiting the facility. To find the right department for filing a floor plan, call the nonemergency phone number of the police or fire department.

In some evacuations, the choice of where to take people is made by emergency responders who don't have access to information about clients' needs (National Council on Disability [NCD], 2019). A representative of the disaster planning team can educate local emergency response organizations about:

- The characteristics of the program's residential patients.
- The needs of these individuals during and after transport.
- The types of settings that would be most appropriate for them to be relocated to.
- The specific locations (e.g., another residential treatment program) that have agreed to accept patients in an evacuation, if such prearrangements exist (see "Negotiate MOAs and Mutual Aid Agreements" below in this chapter).

Your program can work with emergency responders to ensure that in an evacuation your patients are not automatically routed to special-needs shelters, institutions, nursing homes, or hotels rather than to a general population emergency shelter that is more likely to offer a fuller range of support services

(e.g., assistance in transitioning back to permanent housing). A 2019 federal report found that in the wake of Hurricanes Harvey, Irma, and Maria, many people with physical or psychiatric disabilities were institutionalized without necessary supports or were needlessly segregated from the general population. People with mobility issues also face barriers such as having to wait in long lines for food and water or bathrooms that are not accessible to them (NCD, 2019).

EXHIBIT 2.8. Collaborative Planning by Healthcare Organizations

The Northwest Healthcare Response Network (https://nwhrn.org/about-us/our-coalitions-history/) in the State of Washington is a nonprofit network of healthcare organizations that brings together more than 3,000 healthcare organizations and 178,000 healthcare workers representing:

- Hospitals.
- Ambulatory care organizations.
- In-home services.
- Blood, dialysis, and lab services.
- Long-term care providers.
- Behavioral health service providers.
- First responders.
- Public health departments.
- Emergency management departments.
- Tribal nations.

The Network provides a critical link among healthcare facilities, public health departments, and other key government partners. It does so by developing and maintaining a comprehensive system that helps ensure coordination, effective communications, and optimal use of available health resources in response to emergencies and disasters for all hazards.

The Network is the Western Washington administrator of WATrac (Washington System for Tracking Resources, Alerts, and Communication), Washington State's web-based healthcare resource tracking and alert system for statewide collaboration on a daily basis and during emergency responses. Information about WATrac is available at www.doh.wa.gov/ForPublicHealthandHealthcareProviders/EmergencyPreparedness/WATrac.

The Network facilitates regionwide planning with healthcare and other emergency response organizations to establish relationships, leverage expertise, and develop plans and tools.

The Network maintains six committees:

- Acute Infectious Disease Advisory Group
- Training and Exercise Advisory Workgroup
- Disaster Clinical Advisory Committee
- State Supply Chain Resiliency Workgroup
- Long Term Care Response Team
- Western Washington WATrac Advisory Committee

Before disaster strikes, the Network operates behind the scenes preparing and training healthcare providers in innovative emergency response and recovery practices. During an emergency, it functions as the eyes and ears of the healthcare community, providing critical situational awareness, patient tracking, resource sharing and coordination, and collaborative response and policy.

Patients have a right to expect from general population emergency shelters support services that enable them to maintain their independence (FEMA, 2010b). This includes access to treatment services and medications to maintain physical health, mental health, and function; refrigeration for medications; and assistance that may be required because of cognitive and intellectual disabilities.

Local Office of the DEA

The local DEA agent monitors and reviews how your program deals with controlled substances in a disaster (e.g., relocating a methadone supply to an alternate facility). Chapter 4 provides more on this topic. Your program's disaster planning team can inform the local DEA agent about which controlled substances are prescribed or dispensed to patients and stored at the facility (e.g., antianxiety medications such as benzodiazepines, central nervous system stimulants such as methylphenidate [Ritalin] for treatment of attention deficit hyperactivity disorder, and methadone for opioid use disorder [OUD]). The team can also invite the DEA agent to participate in its disaster planning. These actions may expedite DEA decisions affecting your facility during a disaster. The State Opioid Treatment Authority can help your team make contact with the local DEA official.

Organizations of Precredentialed Volunteers

ESAR-VHP is a federal program through which states and territories register health professionals who can provide volunteer service in disasters and public health and medical emergencies.

The Citizen Corps is a national service program that mobilizes volunteers for emergency preparedness and assistance in recovery after a disaster or terrorist attack. The program provides training and coordinates volunteer services. Each community has a Citizen Corps Council (CCC) to carry out the national program's objectives locally. For more information and to find a CCC near you, go to www.ready.gov/citizen-corps.

MRC is a grassroots, nationwide network of volunteer medical and public health professionals who contribute their skills and expertise throughout the year and in times of community need. If no local MRC unit exists, the disaster planning team may want to work with community leaders to establish one. More details are available at https://mrc.hhs.gov/HomePage.

To get help in a disaster from the ESAR-VHP or a CCC or MRC, your behavioral health service program should contact the community's Emergency Operations Center or a state coordinator.

Appendix D, Disaster Planning Web Resources, provides links to organizations of precredentialed volunteer organizations.

Voluntary Organizations

Local nonprofit or nongovernmental groups, especially those affiliated with the National VOAD—a coalition of nonprofit organizations that respond to disasters—can serve as facilitators and gatekeepers for emergency services. These groups include:

- **American Red Cross.** A prominent provider of disaster shelter, supplies, and services, including tools for communicating with volunteers and partners in disaster conditions, the organization provides disaster services training through certification courses (held online and at local chapters) for potential volunteers, including medical professionals who may be called on to assist in Red Cross shelters.

- **Faith-based organizations, service fraternities and sororities, and community clubs.** These groups often have resources, trained volunteers, and facilities to support the response efforts of disaster teams.
- **Mutual-help and recovery groups or advocates** (e.g., mutual-help groups for recovery from mental or substance use disorders, individuals credentialed by the National Alliance for Medication Assisted Recovery). These programs and people provide psychological support to individuals in recovery.
- **Consumer advocacy groups.** These groups help coordinate disaster support for particular client populations, such as people with cognitive or intellectual disabilities (see "Prepare Clients for a Disaster" below in this chapter).

Depending on the type of organization and the circumstances, a wide variety of help may be available to your program's clients in a disaster:

- Meals
- Water
- Housing
- Clothing
- Toiletries
- Grant-writing help
- Replacement furniture and equipment
- Cleanup and reconstruction supplies, tools, and labor
- Assistance with medication pickup
- Transportation to appointments
- Help contacting family members

Some volunteer groups provide disaster case management services, which can especially benefit clients with disabilities (Phillips, 2015). In a disaster situation, your program can request help from volunteer organizations through the ESF #8 lead at the Emergency Operations Center. This is most likely the emergency manager at the local health department (see "State and Local Health Departments" above in this chapter).

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

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

- Procedures for certifying and credentialing medical professionals and volunteers for accessing, and providing services in, that organization's shelters. Access to some shelters may be blocked by security or law enforcement personnel for anyone without such credentials.
- Procedures to assist individuals in obtaining medications prescribed to them.
- Procedures for enabling clients in emergency shelters to meet with treatment counselors, recovery advocates, housing specialists, case managers, or mutual-help groups.
- Admitting procedures at shelters for people who have psychiatric medications or take-home medications for the treatment of SUD in their possession. Chapter 4 provides more information addressing shelter requirements.
- Procedures for handling SUD treatment medications (e.g., documenting in writing whether any medications brought into the shelter by individuals are turned over to staff for dispensing or are confiscated).
- First aid principles for identifying and assisting shelter residents who have psychotic symptoms, are in withdrawal, or have other symptoms of mental or substance use disorders.
- Education on local 24-hour crisis intervention services.

Vendors and Other Nearby Businesses

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

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

Local Media

Local radio stations still broadcasting despite power disruptions can be a powerful resource for coordination. Your program should have access to battery-operated, hand-cranked, or solar radios for use when power is down. The disaster planning team can request that local radio and TV stations inform the public of your program's operating status (e.g., open, closed, delayed opening, operating in another location).

FEMA and Nextdoor Partner To Provide Local Disaster Information

Nextdoor is an app that serves as a newsletter for neighborhoods, listing information of local interest. FEMA is working with Nextdoor to provide emergency and disaster preparedness information that is targeted to individual neighborhoods. In a disaster, the first source of help is often neighbors. FEMA will use this partnership as a way to distribute crucial information before, during, and after disasters.

In a disaster situation that affects more than just your program, messages to the general public should be coordinated with the community via the Public Information Officer of the community's ICS (see "Designate Personnel To Assume Command for Incident Response" below in this chapter).

Educate the Community About Behavioral Health Services

Educating the community about the importance of behavioral health services in disaster situations will help your program make connections with the community. In coordination with local behavioral health service programs, the disaster planning team can communicate to others (e.g., community leaders, private and public partner organizations, volunteer agencies, representatives from the faith-based community) your program's mission, the treatment and recovery services your program provides, and the contributions your program can make to the community's behavioral health disaster preparedness.

One way of educating the community about behavioral health services is to invite community partners to disaster trainings for staff and provide the materials free of cost. Doing so can underscore the importance of individual and community preparation. Part of that preparation is understanding how people respond after a disaster and how individuals and the community can help. Everyone who sees or experiences a disaster is affected by it in some way. Exhibit 2.9 provides an example of mental health information that your program can share with a community recovering from a disaster.

Your program can present general information about the special populations it serves (e.g., adolescents, older people, pregnant and postpartum women) to community stakeholders and ensure that disaster planning takes into account their special needs. Your program can also emphasize to local leaders that, during a disaster, individuals who need behavioral health services (e.g., support and medication for mental or substance use disorders) should have the same priority as individuals who need care for other conditions (e.g., support and medication for epilepsy, diabetes, heart ailments, asthma).

Regularly convey information to community leaders about your clients' specific needs so that, in a time of disaster, they are taken into consideration as community response efforts and resources are allocated.

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

A valuable contribution that a behavioral health service program can make to community disaster planning is to introduce planning partners to the NIDAMED Clinical Resources website for medical and health professionals. This initiative can help primary care providers expand the services they offer to address SUDs. In doing so, they will also expand the capacity of the community to respond in a disaster. NIDAMED provides resources and information about how providers in primary care settings can conduct alcohol, tobacco, and drug screening (including an online interactive drug use screening tool); brief interventions; and treatment. It is located at www.drugabuse.gov/nidamed-medical-health-professionals.

EXHIBIT 2.9. Coping With Disaster—Constructive Messages for Individuals and Communities

Understand the individual effects of a disaster:

- It is normal to feel anxious about your own safety and that of your family and close friends.
- Profound sadness, grief, and anger are normal reactions to an abnormal event.
- Acknowledging your feelings helps you recover.
- Focusing on your strengths and abilities helps you heal.
- Accepting help from community programs and resources is healthy.
- Everyone has different needs and different ways of coping.

Anger and grief may show up as:

- Trembling or shakiness.
- Muscle weakness.
- Nausea and trouble eating.
- Trouble sleeping and difficulty breathing.
- Dry mouth.
- Nightmares.
- Social withdrawal.
- Lack of interest in usual activities.

When adults have the following signs, they might need crisis counseling or stress management assistance:

- Difficulty communicating thoughts
- Difficulty sleeping
- Difficulty maintaining balance in their lives
- Low frustration tolerance
- Increased use of drugs/alcohol
- Limited attention span or difficulty concentrating
- Poor work performance
- Headaches/stomach problems
- Tunnel vision/muffled hearing
- Disorientation or confusion
- Reluctance to leave home
- Depression, sadness, or feelings of hopelessness
- Mood-swings and bouts of crying
- Overwhelming guilt and self-doubt
- Fear of crowds, strangers, or being alone

The following are ways to ease disaster-related stress:

- Talk with someone about your feelings, even though it may be difficult.
- Seek help from professional counselors who deal with postdisaster stress.
- Do not hold yourself responsible for the disastrous event or be frustrated because you feel you cannot help directly in the rescue work.
- Take steps to promote your own physical and emotional healing by eating healthily, resting, exercising, relaxing, and meditating.
- Maintain a normal family and daily routine, while trying to limit demanding responsibilities on yourself and your family.
- Spend time with supportive family members, friends, or spiritual groups.
- Participate in memorials.

Sources: Adapted from FEMA's "Coping with Disaster" (n.d.); SAMHSA (2017).

EXHIBIT 2.10. Components in a Community THIRA

Source: Adapted from DHS (2018).

Prepare a Threat and Hazard Identification and Risk Assessment

Once the disaster planning team has formed, become familiar with its mission and scope, and identified planning partners in the community, its next priority is to review an assessment of your community's particular vulnerabilities. Most communities will already have such a document, referred to as the "Threat and Hazard Identification and Risk Assessment" (THIRA). Your program's disaster planning team can request a copy from the public health department or your community's emergency manager. The THIRA identifies the types and scopes of hazards most likely to occur in your jurisdiction. Exhibit 2.10 displays the components that make up the THIRA.

Using your community's THIRA as a foundation, the disaster planning team can make informed decisions about its own priorities for disaster planning, assess your program's capacity to respond to such hazards, and plan to address any gaps in its ability to respond. Your disaster planning team can also coordinate its disaster response with the response plans of other local programs and the community. The THIRA should go in the planning assumptions section of the basic plan. Use the THIRA to determine which hazard-specific appendixes to prepare and document in the plan.

Hazard risks differ depending on their type and scope. Hazards can be:

- Natural (events related to weather, geography, or pandemic infectious disease).
- Technological (potential disasters involving human-made materials and stemming from technological or industrial accidents or negligence).
- Human caused (potential disasters caused by human accident, civil unrest, or deliberate action).

The scope of a hazard can be:

- Internal (only one aspect or location of the program is affected).
- Local (the program in one locality, its community, and the local infrastructure are affected, including nearby hospitals, businesses, and schools).

- Regional or national (the hazard affects a broad geographical area).
- International (the entire world is affected by a global pandemic).

All hazards present risks of injury, psychological trauma (including panic symptoms), or death for clients and staff members, as well as health risks to clients who experience sudden interruptions in care. Examples of other risks to behavioral health service programs include:

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

Program-specific factors can affect your program's vulnerability to hazards, as well as its strengths in responding to a disaster. For example, a program in a rural location might be far from emergency rescue stations, hospitals, and other resources, but its isolation might protect it from some disasters (e.g., the spread of viral infections) and the program itself might be more self-reliant. A program in an urban location might be swamped by demand for services after a disaster, but its relationships with nearby programs may mean that it can refer its overflow clients.

Depending on the characteristics of the disaster, a program may be able to continue operations by relying on its resources, or it may need assistance from the community or local, state, and federal authorities.

Specify Planning Objectives and Assumptions

To draft a clear and useful plan, the disaster planning team should first establish planning objectives based on accurate assumptions and include these objectives and assumptions in the basic plan.

Planning objectives describe the outcomes the disaster plan seeks to achieve, such as the following:

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

Each annex to the plan may include additional objectives. For example, the annex containing the continuity of operations plan can include objectives such as the following (FEMA, 2018a):

- Identify functions that are essential to operations, staff positions responsible for maintaining those functions, and position descriptions.

- Decide who will take the place of people whose positions maintain operations if those people are unavailable.
- Ensure that operations related to the continuity of the business are sustainable for a given number of days.
- Ensure that operations that have been shut down because of the disaster can resume within a given number of days.

Planning assumptions are the planning team's best guesses about the parts of your program's physical environment, equipment, operations, and other assets that can be lost or destroyed when a disaster occurs. When identifying vulnerabilities in the disaster plan, recognize internal and external factors that will most likely affect each asset. Examples include:

- The amount of time it takes emergency responders (e.g., police, firefighters, emergency medical technicians) to reach the facility under normal conditions.
- A typical number of staff, clients, family members, and visitors on the premises or in residence at any one time.
- The hours of operation when staff and clients are on the premises and services are provided.
- The quantity and types of medications stored at the facility, especially controlled substances (e.g., benzodiazepines, methadone, naloxone). Chapter 4 provides detailed information on the management of prescription medication.
- The frequency (e.g., daily, weekly) and method (e.g., printed and filed, migrated electronically to a remote server, stored in the cloud) with which client records are updated.
- Recognition that a disaster can occur at any time and during any shift and can significantly reduce the size of the workforce available to perform essential functions.
- Recognition that disaster response relies primarily on staff preparation, equipment, and memorandums of agreement (MOAs) that your program has in place before the disaster occurs.
- Recognition that communications may be challenging. An adequate communication system needs to be in place so that team members can learn immediately when a disaster has occurred and communicate coordination of the disaster response.
- Anticipation of the weaknesses in the transportation system for people and materials so that alternate delivery methods can be planned.

Prepare for Disaster

Once your behavioral health service program's disaster planning team has formed, oriented itself to its tasks, forged connections with community planning partners, and reviewed risk assessments, it can progress to identifying important preparedness activities. The next sections provide guidance on risk mitigation, MOAs and mutual aid agreements, the ICS, and readiness support to clients and staff.

Mitigate Risk

Working with management, the disaster planning team can help your program avoid discontinuation of essential services by mitigating the impact of a disaster. Your program's THIRA will help determine actions to take to lessen the impact of a disaster. Examples include:

- **Making changes to the building and grounds to improve your facility's capacity to withstand a specific disaster**—Secure shelves and appliances to wall studs to prevent them from falling if earthquake is a likely hazard. Clear your facility's outdoor property of flammable material and debris if wildfire is a risk.
- **Preparing to shelter in place for disasters in which it would be either impossible or unsafe for your staff and clients to leave the premises**—Identify and prepare a safe room in the basement or interior of your building for sheltering from a tornado. Ensure that there is enough space for the average number of people (i.e., clients, staff members, and visitors) on your premises at any one time. **Worksheet B5** (in Appendix B) provides a shelter-in-place checklist.
- **Planning for building evacuation**—Stock evacuation chairs or slings and other equipment to enable swift removal of people who need assistance. Train staff to use the equipment.
- **Stocking supplies**—Store cots, linens, and nonperishable food items for emergencies that may require staff members to stay overnight.
- **Preparing staff and clients onsite for personal disaster response**—Stock portable bags (also called "personal go kits"), one per person at the facility, that include emergency evacuation supplies (e.g., water bottle, flashlight with batteries). Exhibit 2.11 describes what one program stocks in its welcome bag for new clients and guest clients who have been reassigned because of a disaster and in its go kits for its staff and clients if they must be temporarily housed at another facility.

To limit the effect of a disaster on staff members, your program's disaster planning team can identify ways to support staff in home disaster planning. Staff should know and follow federal guidance on disaster readiness for individuals and families (e.g., preparing a family emergency supply kit, developing a family emergency plan for evacuation and for staying in contact, becoming familiar with appropriate actions to take during an emergency). Your program will work more effectively with clients if staff members know that their families are prepared for an emergency.

EXHIBIT 2.11. Welcome Bags and Personal Go Kits

Our team has created welcome bags for our residential intake clientele that contain toiletries as well as comfort items such as a blanket, a journal, a deck of cards, and a novel or book of meditation. We also put clothing (sweat suits and t-shirts—sized at admission) into the welcome bags of patients who are emergency intakes and have not had time to prepare for admission. We prepare 20–30 welcome bags at a time so that we always have an adequate inventory and try to have 10 for each gender on hand at all times. The welcome bags are backpacks with designated ID tags and space for storage of medication should the need arise for evacuation.

We also store about 40 smaller emergency go kits in the same location. These contain water, high-energy food bars, and other foods with long shelf life, such as dehydrated fruits. The go kits are stored near the welcome bags to be placed in the backpacks or provided to staff as needed.

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

EXHIBIT 2.12. Preparing for Power Failure

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

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

EXHIBIT 2.13. Examples of Disaster Mitigation Specific to a Behavioral Health Service Program

- Store medications in a safe, locked area that can be protected from the most likely hazards. For example, programs in flood-prone areas can store medications above ground level; programs in earthquake-prone areas can store medications in cabinets secured to an interior wall.
- Maintain a 3-day supply of water, food, linens, garbage bags, sanitation products, and other provisions to sustain the maximum number of people (e.g., clients, staff members, volunteers, visitors) who may be on your premises at any one time. The supply should include provisions needed by people who may be on the premises and who are defined as at risk (e.g., children, senior citizens, pregnant women, those with chronic medical disorders, those with pharmacological dependency) as well as provisions for any pets or service animals on the premises (HHS, 2012). Keep an inventory of these supplies, and check the expiration dates as necessary to ensure their safety and effectiveness.
- Keep coolers onsite for use when transferring refrigerated medications to another site.
- Ensure that electricity-dependent systems, such as security alarms or water pumps, have battery backups or connect to generators that start automatically if power is lost.
- Ensure that all means of exit from buildings will be accessible if power is lost (e.g., test emergency lighting in hallways, stairways, and exits to ensure it works properly).

Exhibit 2.12 demonstrates the importance of preventive action in lessening the impact of a disaster, and Exhibit 2.13 contains examples of mitigation specific to behavioral health service programs.

Negotiate MOAs and Mutual Aid Agreements

In the context of disaster preparedness, an MOA (also called a memorandum of understanding, or "MOU") is a document that defines how one organization will assist another on request. When two or more organizations agree to help another, the document may be referred to as "a mutual aid agreement." MOAs can be arranged among all programs within a county or state, and they can be

EXHIBIT 2.14. Negotiation for Mutual Aid Following a Major Snowfall

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

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

arranged among states to plan for disasters with wide geographic interstate impact (e.g., the opioid epidemic). Statewide or regional healthcare coalitions can help connect programs and facilitate mutual aid agreements. The optimal situation is to have written agreements prepared in advance and reviewed by all parties, either annually or when relevant circumstances change. If needed, they can be arranged after the disaster, as described in Exhibit 2.14.

Issues that an MOA might cover include:

- Arrangements for use of alternate facilities.
- Agreements to provide essential services on a temporary basis to another program's clients when needed.
- Agreements to support computer system needs in a move to an alternate location.
- Provision of evacuation transportation assistance.
- Personnel sharing to temporarily fill key staffing gaps, as described in Exhibit 2.15.
- Payment arrangements for any of the above.

Other details that a mutual aid agreement typically covers include:

- The roles and the scope of responsibilities of each party.
- Procedures for requesting, providing, and ending aid.
- Procedures for allocating costs between the parties to the agreement and for handling reimbursement.
- Communications compatibility issues (e.g., for running client record software on another program's hardware systems; see "Ensure Interoperable Communications" in Chapter 3).
- Mechanisms for invoking and revoking the agreement.
- Liability and immunity issues (National Fire Protection Association, 2013).

EXHIBIT 2.15. Staff Issues To Consider in Mutual Aid Agreements

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

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

Source: Podus et al. (n.d.).

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

In a disaster, organizations that don't provide behavioral health services may need information about people receiving addiction treatment from your program. Such organizations may include voluntary organizations, local emergency responder organizations, and alternate service providers (e.g., drug testing providers). Your program should ask these organizations to sign a qualified service organization agreement (QSOA), as required under 42 CFR Part 2, so that they can receive information about the clients' treatment.

Appendix E includes a sample MOA used by OTPs in King County, WA, that can be used as a template or adapted. Your program should keep a record of all MOAs, mutual aid agreements, and QSOAs. The disaster planning team can consult with the state disaster behavioral health coordinator for advice on drawing up MOAs, mutual aid agreements, and QSOAs. Because of the legal implications, programs are advised to consult an attorney when negotiating such agreements.

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

Designate Personnel To Assume Command for Incident Response

Federal guidelines for disaster planning suggest that organizations follow the ICS management approach (FEMA, 2018b). The ICS allows for a flexible response to any incident and provides common terminology that all responders can use so that they can communicate clearly with one another. As part of the ICS, each organization names its leaders for disaster response. In a large-scale incident, these leaders can readily integrate into the hierarchy of the whole community's disaster response leadership.

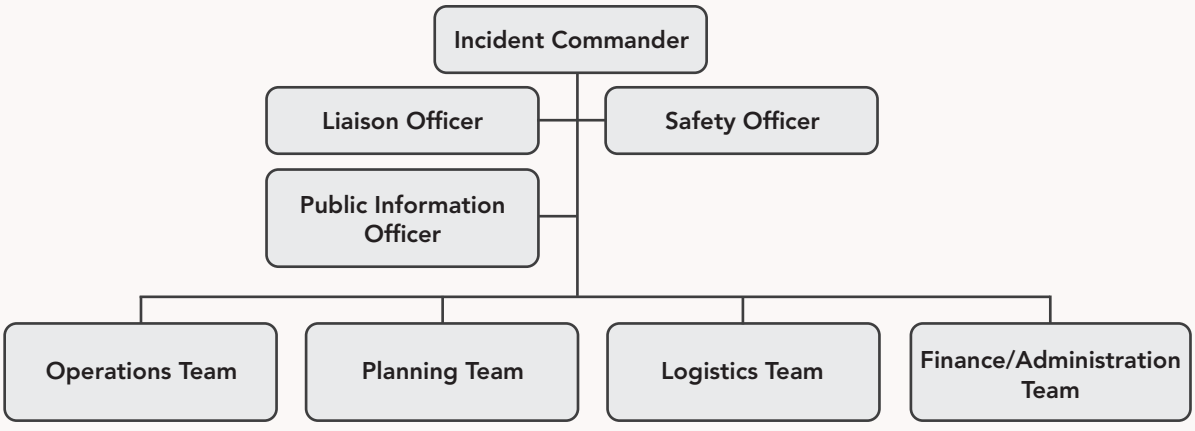
When a disaster occurs, your behavioral health service program's director or administrator activates the disaster plan and appoints an Incident Commander. If your program has a small staff or if the effects of the disaster are relatively limited, the director may double as the Incident Commander.

During the disaster and in its immediate aftermath, the director focuses on the organization's essential functions, while the Incident Commander takes charge of disaster response. The Incident Commander independently manages response activities that may include:

- Evacuating the premises.
- Coordinating with rescue workers.
- Assessing damage.
- Arranging for temporary quarters and coordinating transportation to that site.
- Contracting for supplies or repairs.
- Periodically communicating incident status to the director.

Disaster planning teams are encouraged to assign other incident response positions in accordance with the ICS (FEMA, 2018b). Exhibit 2.16 shows the ICS structure.

EXHIBIT 2.16. Incident Command System



Source: FEMA (2018b).

The position of Incident Commander is the only one that must be filled when the disaster plan is activated (FEMA, 2018b). If the incident is small in scope or short lived, the Incident Commander may choose to retain all responsibility for disaster response. For a larger or expanding incident, the Incident Commander may assign duties to other command officers, if they have been appointed (i.e., Liaison, Public Information, and Safety).

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

One advantage of organizing personnel into an ICS is that the unambiguous hierarchy facilitates effective management and accountability. The size of the responding group can be changed, depending on immediate needs and the scope and duration of the incident. Another advantage is that personnel can readily integrate into the teams of other organizations involved in disaster response.

External response groups (e.g., those headed by a county emergency manager or fire department) will be organized using the ICS structure. For example, the Operations Team of an external response group might conduct search and rescue or fire suppression. Your behavioral health service program's key personnel should know the names and functions of ICS positions in case they need to interact with external response groups that also use an ICS.

To clarify how an ICS works, Exhibit 2.17 presents a hypothetical example. **Worksheet B6** (in Appendix B) can be used to assign staff members to ICS positions.

Go to https://training.fema.gov/is/ to access online courses on the ICS offered through the Independent Study Program of FEMA's EMI.

Prepare Clients for a Disaster

Reactions that individuals may have during or following disaster include:

- Psychological distress.
- Severe depression.
- Physical symptoms.
- Posttraumatic stress disorder (PTSD).
- Changes in the amount and type of substance use.

Your program's clients will vary in their resilience, depending on many interacting factors, including social supports, previous experience with trauma, preexisting medical and behavioral health status, gender, ethnicity, and socioeconomic status (Benevolenza & DeRigne, 2019; Blackmon, Lee, Cochran, Jr., et al., 2017; Santos-Burgoa, Sandberg, Suárez, et al., 2018; Zhang, Kinney, Rich, et al., 2020).

People with health issues may respond more slowly in disaster situations and may be unable to respond adequately, placing them at greater risk. They may also be more susceptible to disaster effects, such as extreme weather conditions or limited food and water supplies (Stough, Sharp, Resch, et al., 2016). Young people are at particular risk for negative mental health effects after a disaster (Wolf-Fordham, Curtin, Maslin, et al., 2015).

EXHIBIT 2.17. Hypothetical Example of an ICS in Action

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

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

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

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

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

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

The behavioral health issues your program's clients face will be shaped by the disaster they experienced (e.g., the impact in terms of injury, loss, or displacement; the passage of time since the disaster). For example, the main behavioral health issue for 182 survivors of the Oklahoma City bombing 6 months after the incident was symptoms of PTSD; for 421 evacuees 2 weeks after Hurricane Katrina, the issues were preexisting chronic mental and substance use disorders (North, 2010).

Your clients' resilience and individual needs can't be fully predicted. But all clients can benefit from preparation. People prepare better for disaster when they consider the basic service interruptions that could occur (McNeill, Dunlop, Heath, et al., 2013). For this reason, your program should clearly describe how a disaster can affect the community at large (e.g., electrical outages, interruptions in water service) and your behavioral health service program specifically (e.g., closures, reductions in services, services provided at an alternate facility).

Your program can educate clients about how to take care of their own needs in a disaster. Appendix D provides links to many resources in the section titled "Emergency Planning for Staff and Clients."

> The National Child Traumatic Stress Network has disaster preparedness resources for individuals and families. These resources include tips and materials (e.g., wallet cards for recording emergency contact information) in English and several other languages. Visit www.nctsn.org/resources/all-nctsn-resources to access these materials.

Your clients need to know:

- How they will be informed if your program closes or changes its hours of operation.
- What they should do if your program closes or is providing services in another location.
- What they should do if they cannot access prevention, treatment, or recovery services for several days.
- What they should do if they begin to experience a physical or behavioral health issue.

Your program can give clients maps that contain directions to the facility using different routes and modes of transportation if the primary route becomes inaccessible. The map can also indicate routes to the alternate care facility clients are advised to use if the program closes (based on a previously developed MOA).

Maps should be in a format that is accessible for your client population (e.g., in large type, in Braille, in languages other than English that are prevalent in the community). They should list street addresses, phone numbers, email addresses, and website URLs for more information.

Let clients know what items and information an alternate site will need from them, such as:

- The name of your program.
- The name of their treating clinician.
- An ID card issued by your program or another form of personal photo ID (e.g., a driver's license).
- Medications and dosage information (see Chapter 4).

Your program should discuss with clients the need for disaster preparedness. Do this at intake and at regular intervals during their treatment (e.g., at the start of each hurricane season). Counselors can provide clients with instructions for self-care related to their treatment on a laminated wallet card. They also can direct clients to disaster preparedness planning information for individuals and families.

Your program can prepare in advance a recorded phone message that clients can access and text messages that will be pushed out to clients telling them what to do if the program is closed because of a disaster. These emergency instructions can also be readied for posting on the facility's front door and on social media.

Members of each client's support network (e.g., family members, partner) also need to have emergency instructions and should be informed as soon as possible if clients are unexpectedly discharged or relocated. To the extent possible, coordinate any evacuations or relocations with each client's support network so that the client can be accompanied to the new location. List individuals to contact in an emergency in client records and have appropriate and signed authorizations/releases in place.

Your program can help each client prepare an emergency health information card, which lists the client's special needs and provides guidance to emergency responders on appropriate methods for assisting and communicating with the client and on interpreting his or her behavior. Such a card will help your clients quickly communicate pertinent information to rescuers and personnel working at evacuation and shelter sites.

> The Independent Living Resource Center of San Francisco offers a series of tip sheets on emergency preparedness for people with disabilities at www.ilrcsf.org/access-resources/publications/.

Obtain Client Locator Information

A disaster may displace clients from their regular residences and surroundings. Collecting sufficient contact information at intake will make it easier for your program to locate clients after a disaster and to reengage them in services. The disaster planning team can work with program staff members who administer intake forms with clients to determine whether sufficient emergency contact information is collected and regularly updated if necessary.

The intake form should request:

- Client contact information (e.g., address, cell phone and landline numbers, email address).
- Emergency contact information for one or more relatives, friends, or professionals with whom the client interacts (e.g., employer, probation officer, mutual-help group sponsor).
- An out-of-area contact person.
- Locations that the client frequents (if this information is available).
- A physical description or photo of the client.

The form should have a place for the client's signature indicating that release of the information is permitted for tracking the client for reengagement. Counselors should explain the intent behind the form and use this discussion to introduce the topic of disaster preparedness.

> Researchers use client locator forms to find subjects from a study for follow-up interviews. Such forms can be used as models by your behavioral health service program to supplement its intake form with enough information to find displaced clients in a disaster situation. For an example of two types of client locator forms— a long form and a mini-locator—see *Staying in Touch: A Fieldwork Manual of Tracking Procedures,* published by the University of California, Los Angeles, Integrated Substance Abuse Programs. The revised third edition includes sections on adopting a trauma-informed approach and using social media. The manual can be found at http://www.uclaisap.org/ca-hubandspoke/docs/provider-resources/GDTA_SIT-Manual_Final.pdf.

Arrange for Alternate Facilities

Your program's disaster planning team should evaluate alternate facilities for continuing essential operations in the event of a disaster, keeping in mind that some disasters may require moving operations far from your program's location. For each option, the team should consider whether the prospective alternate facility (FEMA, 2019b):

- Is located at a safe distance from the area—such that it would not be compromised by the hazard that forces relocation.
- Can become operational in 12 hours or less.
- Has sufficient space, equipment, supplies, and support services so that staff can perform essential functions.

Other considerations include whether the proposed facility has the necessary compatible communications system and computer infrastructure to maintain essential services and can meet food, lodging, health, sanitation, and security needs of essential staff and clients either onsite or nearby. Some programs may already have offsite hosting of software supporting various functions, including electronic health records. This may prove beneficial if essential services are relocated.

After leadership has considered the alternate facilities, the program director should establish MOAs with them. When a disaster occurs, a displaced program can move to the most practical prearranged alternate facility, given the circumstance (e.g., another space within the building, another location of the organization, space borrowed from or shared with another organization in the community, a site that is miles away or out of state).

Each disaster planning team determines its criteria for alternate facilities. In addition to meeting the criteria identified above, the team may look for an alternate facility that is licensed by the state authority, as required (e.g., for an alternate residential, OUD, or child and adolescent treatment program). Another feature the team may prioritize is space that can be configured for providing essential services (e.g., a client waiting room, private rooms for counseling, large space for group therapy) and that has necessary furnishings (e.g., beds for residential services, tables for serving meals, chairs for group rooms, secured storage area such as lockable file cabinets).

Other features to consider are whether the alternate facility:

- Is physically accessible under Americans with Disabilities Act requirements.
- Is affordable (in terms of reserving in advance and using the space).
- Meets security needs (e.g., provides secure space for storing medication, records, and drug testing specimens).
- Is appropriate for the population your program serves (e.g., youth, women with young children).

Worksheet B7 (in Appendix B) can be used to collect data necessary to evaluate possible alternate facilities. **Worksheet B8** (in Appendix B) can be used for recording information about the facilities that are most appropriate for internal, local, regional, or national disasters.

Your program has several options when arranging for alternate facilities. It can negotiate with another behavioral health service program with similar infrastructure, each agreeing to provide space for the other. These sorts of mutually beneficial arrangements are best arranged in advance and in writing

(see "Negotiate MOAs and Mutual Aid Agreements" above in this chapter). Alternatively, the program can arrange to use space at another type of healthcare facility (e.g., nursing home, hospital), or it can negotiate for space at another type of facility (e.g., college dormitory, sports complex, motel, community center).

You may need to divide essential services among more than one alternate site if no single site meets all requirements. A situation may arise in which no alternate location is available or staff members cannot work at or reach the alternate location. To prepare for this contingency, your disaster plan should include a section on temporarily transferring clients to another program that will treat them as guest clients. Advance arrangements are needed, especially if the plan calls for dispersing clients among multiple programs (see "Prepare for Transfers of Patients" in Chapter 4).

Your disaster plan needs to account for situations when relocation will occur on short notice, such as when the facility has been compromised or the entire community has been ordered to leave the area. **Worksheet B9** (in Appendix B) provides a checklist for relocation planning.

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

Encourage Staff To Make Plans for Personal Preparedness

Your program's staff members should be strongly encouraged to develop emergency plans for their own households. Having personal plans will make staff members and their families safer and increases the likelihood that staff members will be available to respond to their professional duties.

> Find information on personal preparedness on the FEMA Ready website at www.ready.gov.

> The American Red Cross has developed a series of mobile apps that provide users with real-time information on what to do before, during, and after emergencies. Access them at www.redcross.org/get-help/how-to-prepare-for-emergencies/mobile-apps.html.

Prepare To Connect Clients to Disaster Case Management

People affected by disaster often face complex challenges as they seek to recover housing and other resources. The process can be especially difficult for people with psychiatric disabilities who, in past disasters, have faced discrimination with regard to evacuation, emergency shelters, and relief services (National Council on Disability, 2019).

Some jurisdictions have plans in place for providing citizens with disaster case management (i.e., personal assistance in navigating recovery services). The federal Disaster Case Management Program (DCMP) may rapidly allocate funds for case management assistance to disaster survivors once the President declares a disaster and the state governor requests the funds. Funds are requested through

FEMA but administered by the HHS Administration for Children and Families. Case management services are offered via existing state, local, and voluntary programs. DCMP funds unmet needs, which can include food, clothing, shelter, first aid, emotional and spiritual care, household items, home repair, or rebuilding. In the first phase—Immediate Disaster Case Management—DCMP pairs a case manager with a survivor. The case manager assesses the client's disaster-related needs, helps the client develop a goal-oriented plan outlining the steps necessary for recovery, organizes and coordinates resources that match the client's needs, monitors progress, and advocates on behalf of the client, if necessary (FEMA, 2019a).

A representative of your behavioral health service program's disaster planning team can contact the local office of emergency management to determine whether the community has a disaster case management program equipped to provide services to clients with behavioral health issues and, if so, how to refer clients to it. In addition, your program can work with the National VOAD, whose case managers have expertise in issues related to disabilities or mental or substance use disorders.

The disaster planning team may want to work with your program's management to train counselors to provide disaster-specific case management and to develop a list of community resources to which counselors can refer clients for disaster recovery support. Alternatively, your team can work with program management to develop policies for identifying and prioritizing clients for referral to disaster case management available from other community providers.

Ensure Counselor Access to Shelters

During Hurricane Katrina, professional counselors and members of mutual-help groups (e.g., Narcotics Anonymous, Alcoholics Anonymous) were sometimes prohibited from entering shelters to assist evacuees in need of behavioral health services (SAMHSA, 2009). As a result, federal guidelines for emergency shelters now state that people with mental health expertise as well as people with disabilities, access issues, or other functional needs must be included in planning (FEMA, 2010b).

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

Prepare for Financial Resiliency

A study of OTPs in New York and New Jersey after Hurricane Sandy found that, as a consequence of the disaster, the "clinics faced sudden loss of income resulting from the cancellation of services. Financial problems were exacerbated by the need to continue paying staff members regardless of their ability to make it to work, to pay overtime to front-line staff, and to cover accommodation expenses in hotels for staff who did not or could not return home" (Salamanca-Buentello, Cheng, Upshur, & Sud, 2020, p. 6).

In other disasters, outpatient programs have been particularly affected because of declines in client attendance and retention. Programs with substantial numbers of clients on Medicaid or clients able to access emergency Medicaid experienced fewer financial problems.

This experience suggests that your behavioral health service program should consider how to support client retention through active outreach following a disaster. Your program's staff members should learn about procedures for enrolling clients in Medicaid under emergency conditions. It will also be helpful for staff members to educate payers about modified counseling services (e.g., telephone and web-based counseling, which have been widely used during the COVID-19 pandemic) that may be instituted in disaster situations. Doing so may help facilitate reimbursement. Management can establish a contingency or reserve fund or a line of credit for unexpected cash flow issues (e.g., maintaining payroll for staff when billing is disrupted).

Programs can also make plans for persevering through a period of low revenue following a disaster by:

- Planning ahead for emergency grant proposal writing.
- Temporarily modifying fees.
- Conducting intensive marketing and outreach.
- Expanding into community disaster-specific behavioral health response and support activities.
- Carefully tracking and documenting services provided during the disaster so that reimbursements are facilitated.

Communication among OTPs in a community or region can help after a disaster. Clinics can share information about sources of emergency funding and availability of medications (Salamanca-Buentello et al., 2020).

CCP grants become available after the President makes an "individual assistance" disaster declaration. An individual assistance disaster declaration allows federal aid to be used for services such as supportive crisis counseling, psychoeducational, and resource linkage, including "financial assistance to State or local agencies or private mental health organizations to provide such services or training of disaster workers, to victims of major disaster in order to relieve mental health problems caused or aggravated by such major disaster or its aftermath" (FEMA, 2019c, p. 55).

CCP-funded projects include:

- Crisis counseling.
- Education.
- Coping skills development.
- Assessments.
- Referrals.
- Linkages to services.

Staff members who work at your program should be aware of **SAMHSA's Disaster Distress Helpline** (www.samhsa.gov/find-help/disaster-distress-helpline) so that they can share resource information with clients or access help themselves. The Helpline provides crisis counseling for people dealing with the effects of human-caused or natural disasters and infectious disease outbreaks like COVID-19. The toll-free Helpline is available 24 hours a day, every day of the year. Trained crisis counselors provide multilingual counseling in the middle of disasters and referrals to local disaster-related services for follow-up support. Call 1-800-985-5990 or text TalkWithUs to 66746 to access the Helpline.

The grants provide funds for either 60 days (Immediate Services Program grants) or 9 months (Regular Service Program grants) after the disaster declaration.

Your program should work with the state disaster behavioral health coordinator in advance of any disaster to identify options for funding after a disaster. Exhibit 2.18 lists some financial aid opportunities.

Support Clients in Disaster

The disaster planning team can arrange for staff trainings that address disaster-related behavioral health topics such as:

- Recognizing symptoms of psychological trauma in clients.
- Referring clients to psychological first aid services provided in the community.
- Supporting clients' coping skills.
- Adopting a trauma-informed approach.

EXHIBIT 2.18. Financial Aid Opportunities After Disasters

The Federal Government, foundations, and some organizations have made grant funds available to help jurisdictions and organizations rebuild after disasters and to support them in preparing for future emergencies. Many of the opportunities listed below have eligibility requirements based on agency affiliation and disaster need.

- ASPR Grants Management (HHS): www.phe.gov/about/amcg/grants/Pages/default.aspx
- Community Mental Health Services Block Grant (HHS, SAMHSA): www.samhsa.gov/grants/block-grants/mhbg
- Crisis Counseling Assistance and Training Program (DHS, FEMA): www.fema.gov/recovery-directorate/crisis-counseling-assistance-training-program
- U.S. Department of Justice, Office of Justice Programs: www.ojp.gov/funding/explore/current-funding-opportunities
- Disaster Case Management Program (DHS, FEMA): www.phe.gov/Preparedness/planning/abc/Documents/disaster-case-management.pdf
- Disaster Relief & Recovery Program (Conrad N. Hilton Foundation): www.hiltonfoundation.org/programs/disaster-relief-recovery
- Disaster Relief Emergency Grants (Legal Services Corporation): www.lsc.gov/grants-grantee-resources/our-grant-programs/disaster-relief-emergency-grant
- Emergency & Response Funding (HHS, CDC): www.cdc.gov/cpr/readiness/funding.htm
- Emergency Response (Bill and Melinda Gates Foundation): www.gatesfoundation.org/What-We-Do/Global-Development/Emergency-Response
- Project School Emergency Response to Violence (U.S. Department of Education): www2.ed.gov/programs/dvppserv/index.html

Additional financial grants are listed on SAMHSA's Disaster-Related Funding Opportunities webpage at www.samhsa.gov/dbhis-collections/funding-opportunities.

Training can benefit not only direct service staff members, but also administrative staff members—particularly those who answer phones or frontline employees who greet clients as they enter the building.

SAMHSA's Disaster Behavioral Health Information Series provides resources and toolkits pertinent to the disaster behavioral health field on topics such as psychological first aid, resilience, and stress management. For a list of topics, visit www.samhsa.gov/dtac/dbhis-collections.

Live in-person or virtual disaster training offers the best approach. It allows trainers to focus on the roles of participants and how disaster may affect their jobs. Live training also allows staff to raise issues of particular concern to them. Your program can supplement live training with online training as appropriate (such as for yearly refresher training).

Exhibit 2.19 provides recommendations for the type of psychological first aid that first responders (emergency and disaster response workers) can administer to disaster victims. Although much of this advice will already be familiar to behavioral health service staff members, they may find it useful to review these recommendations to ensure that they are sensitive and helpful in their initial contacts with clients after a disaster.

Peer Recovery Support Specialists and Partner Organizations

Some programs employ peer recovery support specialists. A peer recovery support specialist is someone in recovery who has lived experience in addiction plus skills learned in formal training. Peer recovery support specialists can provide nonclinical recovery support services to individuals in recovery from addiction and to their families.

Programs that do not have peer recovery support specialists on staff may wish to train certain clients so that they can provide peer support in preparing for a disaster and in coping after a disaster. Having these trained individuals on the disaster response team, or available to assist other staff in working with clients under disaster conditions, provides an additional resource for the program (National Mental Health Consumers' Self-Help Clearinghouse & the Temple University Collaborative on Community Inclusion, 2018). Peer organizations are run by peers and provide people with support in recovery from mental or substance use disorders.

The National Mental Health Consumers' Self-Help Clearinghouse and the Temple University Collaborative on Community Inclusion have compiled *The Roles of Peer Specialists Before Disasters Strike: Helping People With Mental Health Conditions Prepare for Disasters*. This trainer's guide is designed to help people with mental health conditions prepare for disaster. It includes lecture notes, discussion questions, exercises, activities, and review sessions and can be downloaded at www.tucollaborative.org/wp-content/uploads/Sept18-Disaster-Update.pdf.

EXHIBIT 2.19. Psychological First Aid

Promote Safety:

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

Promote Calm:

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

Promote Connectedness:

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

Promote Self-Efficacy:

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

Promote Help:

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

Do Not:

- Force people to share their stories with you, especially very personal details.
- Give simple reassurances like "Everything will be okay" or "At least you survived."
- Tell people what you think they should be feeling or thinking or how they should have acted earlier.
- Tell people why you think they have suffered by alluding to their personal behaviors or beliefs.

Source: SAMHSA (2005b).

Exhibit 2.20 provides examples of how peer organizations can help out after disaster strikes.

EXHIBIT 2.20. Working With Regional Partners After a Disaster

Over the years, many partner organizations have been helping one another following a disaster. One example involves a mental health service provider that lost more than half of its facilities in a tornado. Several destroyed facilities provided housing to individuals with serious mental illness. These residents needed immediate referral and transition to another facility. A partner organization located in the same region was finishing work on a new residential facility and offered the site as an option. Residents were quickly transferred to this empty new site until more permanent arrangements could be made.

In another example, a behavioral health service provider was overwhelmed with volunteer calls while trying to reach and reassign staff, locate clients, and find alternative treatment sites following a disaster. A partner organization created a virtual human resources site that allowed all volunteers to be directed to one website where activities were being coordinated.

The site required volunteers to complete an application and upload resumes, licensure and other credentialing information, and critical details used for verifying credentials and conducting background screenings. The partner organization managed the site for 6 weeks, ensuring that the community had access to volunteers who were highly qualified and credentialed with appropriate experience. It organized, scheduled, and transported the selected volunteers. This support allowed the behavioral health service provider to organize staff, locate alternative facilities, find existing clients, and begin to plan a community response.

Source: Vicky Mieseler, M.S., BCCP, NP, personal communication, August 2020.

Clients With Cognitive or Intellectual Disabilities

Clients with cognitive or intellectual disabilities may need simplified disaster preparedness education that is reinforced through multiple means and repeated frequently. These clients may need individual support during unexpected discharges, evacuations, or transfers. Counselors may also need to work with surrogate decision makers (e.g., parents, other family members, guardians) to plan and prepare clients for disasters. Your program can recommend clients with cognitive or intellectual disabilities for priority disaster case management by organizations that provide that service (see "Prepare To Connect Clients to Disaster Case Management" above in this chapter).

Clients With Mobility Issues

Clients with mobility issues may need special help and assistive devices during building evacuation and relocation, especially if your program occupies the upper floors of a building. Inform such clients in advance of the evacuation methods that will be used to help them exit the premises (e.g., the use of wheelchairs, gurneys, evacuation slings, two-person hand carrying).

Regular safety-related drills ensure that staff knows how to respond to fires, bomb threats, and chemical hazards and how to help clients needing assistance (e.g., people in wheelchairs). They also provide opportunities for clients and staff to become familiar with special evacuation plans and methods. All licensing and credentialing bodies require such drills to ensure safe and efficient transportation of clients with mobility issues.

Developing Cultural Competence in Disaster Mental Health Programs is a SAMHSA-published guide that can help states and communities plan, design, and implement culturally appropriate mental health services for survivors of natural and human-caused disasters of all scales. The guide is one component of the SAMHSA Disaster Kit, which includes a range of materials for disaster recovery workers. Other items in the kit include brochures for the general public and guidance on dealing with the stress of disaster response. You can order or download the kit from https://store.samhsa.gov/product/samhsas-disaster-kit/sma11-disaster.

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

Test disaster-related messages with clients who have limited reading ability. Such messages could include:

- Evacuation instructions.
- Messages about facility closures.
- Instructions to clients on accessing treatment during a disaster.

Provide messages via phone, text, social media, and the program's website in clients' primary languages and in a manner appropriate to their cultures. Your program staff shouldn't assume that clients are literate and can follow written directions. Present key messages orally and frequently. Staff members who have had cultural competence training will be better able to communicate with your clients during a disaster.

Your disaster planning team may wish to consult with community members who have expertise in the cultural preferences and languages of clients to ensure that disaster planning concepts and instructions are effectively communicated. Interpreters can be included in disaster planning and exercises. Ideally, interpreters will have experience interpreting for clients who use behavioral health services and will know how to translate relevant terminology.

A 5-year examination of more than 200 federal and independent emergency management agencies showed that they often transmitted important information by Twitter. But programs gave little thought to the fact that the vulnerable populations they served might not have access to needed technology (e.g., computers, smartphones) or be able to read English (Majid & Spiro, 2016). Exhibit 2.21 illustrates challenges some programs face when trying to prepare clients with limited English proficiency for disasters.

Clients Who Are at Risk of Acute Episodes of Psychiatric Illness

A psychiatric advance directive (PAD) may help protect clients who could become destabilized in a disaster. A PAD is a legal document, accepted in most states, through which an individual can indicate preferences and instructions for treatment of mental disorders at times when he or she is not competent to express his or her own wishes. PADs can include instructions on refusal or consent regarding hospital admission, particular medications, and treatments. PADs can also contain other important information, such as guidance about the type of care that could help the individual avoid hospitalization (or, if hospitalization is needed, help the individual accommodate to it).

EXHIBIT 2.21. Challenges in Disaster Preparedness for Clients With Limited English Proficiency

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

In a 2015 study, Ike, Calhoun, Angulo, Meischke, and Senturia found that among populations with limited English proficiency, medical interpreters and bilingual school support staff could be effective conduits of disaster-related information.

A PAD is used to guide healthcare decisions only when an authority (one or more physicians or a judge, depending on the state) determines that the individual lacks capacity to make decisions. Your program counselors can assist clients in understanding and drafting PADs that are accepted in your state. Your counselors can also assist clients in distributing copies of their PADs to their primary care provider, local hospital (for inclusion in their health record), and reliable friends or family members. Also advise clients to keep a copy of their PAD with them when relocating during a disaster.

Children and Youth

Your program can share age-appropriate information about disasters with young people. Doing so can support their ability to cope well during and after a disaster (Culler & Saathoff-Wells, 2018). The information can include what to expect before, during, and after a disaster, as well as provide an opportunity to ask questions.

In October 2020, SAMHSA introduced a mobile app to help people with serious mental illness (SMI) make and share a PAD. My Mental Health Crisis Plan allows individuals with SMI to:

- Clearly state treatment preferences, including treatments, medications, healthcare facilities, and doctors and other mental health professionals.
- Designate a trusted person as a decision maker on their behalf.
- Identify whom to notify in the event of a mental health crisis.
- Share the plan with others, including doctors, other healthcare professionals, and family and friends.

The app includes state-specific requirements for completing the PAD (such as signatures, witnesses, notary public), and allows it to be shared via PDF or QR code with whomever an individual chooses. Download the app at www.samhsa.gov/newsroom/press-announcements/202010010505.

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

Your program should encourage families of young clients to develop a family response plan, to include young family members in making preparations (e.g., in assembling the family's go kit), and to periodically review and discuss the response plan with family members. Direct parents and caregivers of children and youth to resources that will help them develop a family response plan and prepare their young family members. A list of available resources is presented in Appendix D under the section titled "Emergency Planning for Staff and Clients."

Your program should coordinate evacuations or relocations with the clients' support networks so that families and significant others are aware of these plans and have a way to contact clients in the new location. To the extent possible, keep family members continually informed of changing circumstances. Young people in residential treatment, along with their families, may need extra help transitioning their care to alternate providers or locations, reuniting with loved ones, and handling the psychological effects of the disaster.

Your program should try to provide youth-oriented treatment services and supports at any new location (e.g., offering separate group meetings for youth, connecting relocated young clients with clinicians who have training and experience working with that age population). Youth may need assistance transitioning to a new school if the disaster has forced a transfer or relocation, as happened after Hurricane Katrina. Youth may also need activities to keep them safely occupied if schools close. They may also need help getting access to laptops, wifi, and quiet places to do schoolwork, if school is being conducted solely online because of extended closures, such as during the COVID-19 pandemic. Despite changed conditions, try to promote an atmosphere of normalcy (Murray, 2018).

> Help Kids Cope is a mobile app developed by the Ozark Center and the National Child Traumatic Stress Network with funding from SAMHSA. The app helps parents talk to their children about 10 different types of disasters (e.g., earthquakes, extreme weather, floods, hurricanes, tornadoes, wildfires). In addition to discussing how to explain, prepare, respond, and heal from various disasters, the app gives guidance on talking to preschool, school-age, and adolescent children about disasters. The app can be found at www.nctsn.org/resources/help-kids-cope.

Pregnant Clients or Clients With Dependents

Pregnant clients will need close monitoring to ensure that they can maintain a healthy pregnancy despite disaster conditions. They may need extra counseling on disaster-related medical treatment that best protects them and their fetus. Special protections to provide during the COVID-19 pandemic are provided in Exhibit 5.1, "Pregnant Women at Special Risk From Influenza," in Chapter 5.

Patients who have children with them in residential treatment and who require relocation will need transfers to facilities that can accommodate families. The facilities will need to provide a safe and secure environment for those children, with access to child care, schools, or remote learning as appropriate.

Some clients may be unwilling to disclose information on the behavioral health services they receive to care providers at a new location for fear of losing custody. These clients need to be educated in advance about how to advocate for their needs without risking loss of custody.

Clients Who Are Experiencing Homelessness

People who do not have a residence are less able to prepare for an emergency (e.g., stockpile supplies, identify a safe part of a house in which to shelter). In addition, people without a home may have limited access to electronic means of communication (e.g., TV, radio, Internet) and thus may not learn quickly about emergency warnings and calls for evacuation.

For a variety of reasons, people who do not have a home may have concerns about entering shelters. They may also have difficulty transitioning out of shelters, especially if the locations where they formerly took refuge (e.g., encampments) are no longer habitable (Tierney, 2019).

Toolkit for Disaster Planning and Preparedness for People Who Are Homeless

In 2017, the U.S. Departments of Veterans Affairs, Health and Human Services, and Housing and Urban Development convened an interagency workgroup to identify resources to help communities address the disaster-related needs of people experiencing homelessness. The interagency work resulted in *Disaster Preparedness To Promote Community Resilience: Information and Tools for Homeless Service Providers and Disaster Professionals* (www.va.gov/HOMELESS/nchav/education/VEMEC-Toolkit.asp). This toolkit comprises three sections:

- Section 1 is for homeless service providers and government entities. It guides those entities in developing collaborative relationships to ensure that services are available to address homeless populations' disaster needs.
- Section 2 is for nonprofit homeless service providers. It offers these organizations guidance on creating disaster response plans.
- Section 3 is designed to help public health officials and healthcare systems develop the capacity to provide care to homeless populations during disasters.

Your behavioral health service program can support clients experiencing homelessness by making sure they receive disaster planning education and aids (e.g., emergency kits, emergency health information cards). In addition, your program can request that its outreach workers be included in the local community's emergency notification systems so that they can quickly mobilize to communicate emergency situations to clients experiencing homelessness. Your program can also recommend that these clients receive priority disaster case management from organizations providing that service (see "Prepare To Connect Clients to Disaster Case Management" above in this chapter).

Older Clients

Factors that can cause some older clients to be particularly vulnerable in disaster include (Cloyd & Dyer, 2010):

- Physical frailty.
- Chronic illness.

- Cognitive impairment (including impaired capacity to make decisions and execute tasks).
- Mobility and sensory issues.
- Reliance on devices such as hearing aids and glasses.
- Limited transportation options.
- Susceptibility to exploitation and abuse.

Other age-related factors that may keep clients from obtaining necessary aid include a preference for self-reliance, difficulties navigating bureaucratic recovery systems (especially those that require online applications), and concerns about loss of entitlements. Because older adults engage in less introspection and express fewer emotional changes than young people, disaster response may manifest itself in physical rather than psychological distress (Sakauye, Streim, Kennedy, et al., 2009).

Staff training on the particular needs of older clients, as well as coordination with community services for older adults, can facilitate support to this client population in a disaster.

Clients on Medications

Assisting clients taking prescription medications is covered in Chapter 4.

Chapter 3—Continuity Planning

IN THIS CHAPTER

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

Worksheets (see Appendix B)

- B10 Identify Essential Functions and Staff Positions
- B11 Essential Staff Roster
- B12 Checklist for Continuity Planning
- B13 Checklist for Maintaining Communications With Essential Groups
- B14 Checklist of Records and Databases To Ensure Interoperable Communications
- B15 Checklist for Protecting Records and Databases
- B16 Checklist for Managing Human Capital

Continuity responsibility and planning should not be a separate and isolated function performed by only a few planners in each organization. Organizations must fully integrate continuity into all aspects of their daily operations, creating a culture of continuity (Federal Emergency Management Agency [FEMA], 2018a). This chapter addresses the tasks required to ensure business continuity, commonly referred to as a "continuity of operations plan" or "COOP plan." Include a continuity of operations plan as an annex to your program's basic plan. Chapter 4 provides additional guidance on continuity planning for programs that manage prescription medications for treating substance use disorders (SUDs; especially opioid use disorder) and mental disorders.

Identify Essential Functions

To identify your program's essential functions, the disaster planning team first works with management to inventory all functions performed at your facility. From this comprehensive list, the team and management identify those functions that are essential because they (FEMA, 2018a):

- Provide vital services to clients.
- Are required by law or regulation.
- Are required to maintain onsite safety for clients, clients' family members, and staff members.
- Are required to maintain protections for certain classes of people based on race, color, religion, national origin, age, sex, or disability.
- Are necessary for performing other essential functions.

Prioritize these essential functions according to what would happen if the program delays performing or doesn't perform the function. Exhibit 3.1 provides examples of what a program might decide are essential and nonessential functions. Each program makes its own determinations of what is essential. **Worksheet B10** (in Appendix B) can be used to identify essential functions.

Your program should consider several factors when prioritizing essential functions (FEMA, 2018a):

1. Recovery time: How quickly must this function resume if disrupted?
2. Impact if function is not conducted: What are the impacts of not conducting or of delaying this function? Is this function necessary for another part of your program or another organization to complete its essential functions?
3. National Essential Functions (NEFs): Does this function have an impact on an NEF? Chapter 2 of FEMA's 2018 *Continuity Guidance Circular* provides a detailed description of the eight core NEFs, which are the primary focus of the Federal Government before, during, and after a catastrophic emergency; the document is available at www.fema.gov/sites/default/files/2020-07/Continuity-Guidance-Circular_031218.pdf.

EXHIBIT 3.1. Examples of Essential and Nonessential Functions

Program Type	Essential Functions	Nonessential Functions
All Programs	• Provide for the physical safety of all clients and visitors at your facility. • Provide crisis stabilization, crisis intervention, or other emergency services to clients and the community. • Conduct basic screening, intake, treatment, and discharge procedures. • Track clients affected by dispersal and evacuation to ensure that they continue to receive needed behavioral health services. • Provide behavioral health services at shelters and temporary housing sites. • Assist clients in accessing and replacing needed medications. • Conduct drug testing for mandated clients as required (check with relevant authorities on whether requirements have changed because of a disaster). • Adhere to applicable state licensing standards. • Maintain treatment and billing records in accordance with payer and regulatory requirements.	• Perform extended intake and discharge procedures. • Conduct nonmandated drug testing. • Offer routine counseling and education. • Provide psychological testing. • Provide routine lab tests. • Provide non-disaster-related educational awareness activities. • Provide nonemergency transportation. • If residential facility is not safe, provide alternative residential treatment options. • Deliver psychosocial rehabilitation services.

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EXHIBIT 3.1. Examples of Essential and Nonessential Functions, *cont.*

Program Type	Essential Functions	Nonessential Functions
All Programs	• Document transfer of clients and their records to another provider. • Protect client rights and privacy, which include ensuring the integrity of protected health information records. • Provide disaster mental and substance use disorder services to the community as requested by the Emergency Operations Center or Emergency Support Function (ESF) #8 coordinator (see Chapter 2 for a discussion of Emergency Operations Centers and ESF #8). • Provide prevention guidance specific to the present disaster to reduce the likelihood of traumatic stress in your program's clientele and other members of the community.[4] • Identify staff members to work at the Multi-Agency Resource Center (MARC), if one is established. A MARC brings together multiple service providers in a single location to deliver services to people affected by a disaster. • Evaluate funding opportunities, including those that arise as a result of a disaster (e.g., grants issued by the U.S. Department of Health and Human Services [HHS] to address the COVID-19 pandemic).	

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[4] Coordinate disaster-related public messages with the Public Information Officer of your community's Incident Command System (see Chapter 2).

EXHIBIT 3.1. Examples of Essential and Nonessential Functions, *cont.*

Program Type	Essential Functions	Nonessential Functions
All Programs	• Check availability of alternate treatment sites. Alternate sites identified as part of disaster planning may become unavailable in an actual disaster, so this can be an ongoing process. • Staff the first responder debriefing team. • Identify staff members available to provide services.	
Outpatient Treatment Programs	• Assist with case management activities such as linking to resources, including helping clients obtain medication replacements or refills, as appropriate. • Secure support from other providers to meet the needs of clients whose medications were destroyed. • Provide crisis stabilization, crisis intervention, or other emergency services to outpatients.	• Provide regular outpatient services. • Host onsite mutual-help group meetings. • Donate meeting space for community groups.
Residential Treatment Programs	• Provide residential care for patients who do not meet discharge criteria. • Stabilize patients undergoing nonmedical detoxification (see next row for essential functions of a program providing medically supervised withdrawal). • Continue medications and supportive counseling to patients to prevent decompensation or escalation of symptoms of mental or substance use disorders, or both. • Coordinate or address transportation needs for accessing medical services. • Provide case management services, as appropriate, to move patients toward discharge readiness. • Transfer clients to area residential providers if your program's facility is unusable or destroyed.	• Provide residential care for patients who can be discharged.

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EXHIBIT 3.1. Examples of Essential and Nonessential Functions, *cont.*

Program Type	Essential Functions	Nonessential Functions
Medically Supervised Withdrawal Programs	• Follow established medically supervised withdrawal protocols. • Medically stabilize patients; closely monitor patients' withdrawal symptoms. • Transfer patients who require a higher level of medical care than your program can provide to an appropriate facility; provide residential care for patients who remain at the facility. • Confirm that essential supplies and services are available.	• Medically detoxify patients who cannot be safely transferred to and detoxified in another setting.
Opioid Treatment Programs (OTPs)	• Confirm identities and dose information for patients receiving medication. • Provide or facilitate access to prescribed or dispensed medications (e.g., methadone, buprenorphine). Staff members must at all times include a provider who is waivered by the Drug Enforcement Administration (DEA) to write prescriptions for buprenorphine (also known as having an "X" waiver). • Provide case management to assist with medically appropriate transfer or discharge.	• Provide other case management services beyond those determined essential.

Exhibits 3.2 and 3.3 provide examples of programs that worked to continue essential operations during crisis events.

Identify Essential Staff Members

Once the disaster team and program management have identified essential functions, they work together to identify the staff positions required to perform those functions and the staff members who can serve in those positions. These staff members must have the knowledge, skills, and abilities for their roles, as well as the required certifications and licenses. Some personnel may be able to assume the duties of multiple positions.

The goal is to assemble a roster of the minimum number of people who can perform all essential functions. Assign multiple backups for all positions in case the designees become unavailable for any reason. **Worksheets B10** and **B11** (in Appendix B) can be used to complete this task. During a disaster, your program should clearly communicate which staff members are essential and should report for work. Only essential staff members report for work onsite or in the new location (if your facility has moved). Other available staff members either stay at home or remain available to work on a rotating schedule.

To develop an essential staff roster, the disaster planning team can ask program management to prepare staff members for the possibility that they will have to perform additional duties or work under changed schedules in a disaster situation. Direct supervisors in consultation with the disaster planning team will need to brief staff members on the scope of their responsibilities in the disaster plan, and staff members need to be willing to carry out those duties. For example, a mental health counselor may be asked to pass out blankets and water bottles when assisting evacuees at a shelter.

Your program's job descriptions should state whether the positions are essential or nonessential. Expectations for essential staff members to report to work during a disaster can also be clearly stated in policies and covered in annual reviews. Your program should also help essential staff members make contingency plans for dependent care so that they can still report as needed during a disaster.

Management can work with staff members who usually perform an essential function to develop a written plan for maintaining that function in a disaster situation. The disaster planning team can incorporate these plans into the continuity of operations plan annex. **Worksheet B12** (in Appendix B) lists some questions for the team to address while drafting the continuity of operations plan.

Your program should save the credentials and state licenses of essential staff members as electronic files in case this documentation is needed at an alternate location or receiving facility (see "Protect Vital Records and Databases" below in this chapter).

Provide for Continuity of Leadership

Leadership is essential in a disaster. As the disaster plan is put together, your program needs to identify alternate leaders in case personnel normally in the chain of command are unavailable during a disaster. For each position, management must approve the order of succession and the delegation of authority.

EXHIBIT 3.2. Continuity of Essential Operations During a Winter Storm

A major winter storm stranded residential program staff members in their homes and resulted in on-duty staff members extending their shifts to nearly 72 hours. Travel was not advised, and access to the interstate highway was closed. Food was not an issue because the program had stored a 2-week supply of provisions.

The program had recently purchased and implemented a web-based client management system that clinical supervisory staff could access from home to create and modify treatment plans that could be implemented by clinical staff. This system allowed staff to document client progress and medical updates with no interruption to client services.

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

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

EXHIBIT 3.3. Getting Help With Essential Operations During a Pandemic

The **Missouri Coalition for Community Behavioral Healthcare** represents Missouri's not-for-profit community mental health centers, addiction treatment agencies, and affiliated community psychiatric rehabilitation service providers. Our mission is to enable access to quality mental health services while maximizing human potential and quality of life through a statewide network of providers. During the first week of the COVID-19 pandemic, we learned that our members were in desperate need of personal protective equipment (PPE). Missouri community mental health centers were dedicated to ensuring safe treatment was readily available to those who depend on them, but employee safety was paramount to keeping service lines open during the pandemic. Our providers quickly found themselves competing in a large medical market without established vendor relationships.

Our staff organized quickly and contacted vendors that could deliver large bulk orders. We used funding from canceled in-person conferences, trainings, and regular meetings and started purchasing significant quantities of PPE for our members. We ordered shipping boxes, set up shipping accounts, started assembling the packages in a large conference room, and began delivering PPE to all 33 member organizations. As of August 2020, we had delivered more than 275,000 disposable masks, 200 touchless thermometers, 25,000 gloves, 9,000 bottles of hand sanitizer, and 1,000 face shields. We've fulfilled our mission of enabling access to Missouri's mental health system in a way we never imagined.

Source: Brent McGinty, CEO, MCCBHC, personal communication, August 2020.

Order of Succession

An order of succession officially passes authority from one person in the chain of command to another. Depending on the size of your program's facility and staff, several successors may be named for each position. Multiple successors are especially important for a pandemic scenario, as discussed in Chapter 5. If possible, the order of succession for a multifacility program should include individuals from different facilities in case all leaders at one facility are unavailable. Exhibit 3.4 gives examples of order of succession for leadership positions at a behavioral health service program.

Delegation of Authority

A delegation of authority describes the allowable range of actions for a successor. The scope of authority can be determined in advance for each successor, based on his or her qualifications. For example, if the CEO/executive director is not on duty when a disaster occurs that calls for immediate evacuation, a successor may assume authority to make decisions about the move and, through prior arrangement, have the authority to use funds to arrange transportation to a new location.

EXHIBIT 3.4. Examples of Order of Succession at a Behavioral Health Service Program

Leadership Position	Example Order of Succession
CEO/Executive Director	1. Chief Clinical Officer 2. Chief Financial Officer 3. Chief Operating Officer
Chief Clinical Officer	1. Clinical Program Directors 2. Clinical Nurse Supervisor
Medical Director or Chief Psychiatrist	1. Staff psychiatrist 2. Staff physician 3. Advanced registered nurse practitioner (or other staff member with independent prescribing authority) 4. Certified physician assistant (or other staff member with independent prescribing authority) 5. Provider who is waivered by the DEA to write prescriptions for buprenorphine
Chief Financial Officer	1. Director of Accounting 2. Director of Patient Accounts 3. Director of Human Resources 4. Director of Purchasing
Chief Operating Officer	1. Director of Facilities Management 2. Director of Support Services 3. Director of IT 4. Director of Quality and Risk Management

Authority can be limited so that the successor can't make decisions about long-range matters. Once the CEO/executive director resumes leadership, the successor's authority ends.

Ensure Interoperable Communications

To continue providing essential services after a disaster, essential staff members need systems and equipment that allow them to communicate with one another—whether onsite, at home, or traveling—and to retrieve and record data in client records and other files. They also need systems and equipment that enable them to communicate with:

- Frontline emergency responders.
- Staff at alternate facilities.
- Nonessential staff.
- Clients in residential settings, at their homes, or at alternate facilities.
- Client family members and other care providers.
- Insurers and other payers.
- Vendors.
- The public.

The following are examples of useful communications systems to have in place (not every program can arrange for or afford all of them):

- Most important, at least one dedicated landline phone on the premises for use in case of a power failure. Most cordless telephones do not work without electricity, and cell phone systems can jam from overuse. Individual cell or cordless phones will need recharging. Corded phones may run out of power after several hours if they are linked by fiber-optic (as opposed to copper) cables to the telephone company's central office.
- Cell phones, tablets or other handheld devices, or Internet-based meeting/conferencing platforms.
- Two-way radios (e.g., inexpensive walkie-talkies), satellite phones (rented or purchased), and other devices for person-to-person communications when cell and landline phones are inoperable. Some communications devices may not be secure, so providers must be careful when relaying client information.
- A private, password-protected backup site for your intranet that only authorized users can access and that your program can use to receive status information from, and provide information to, employees in a disaster situation.
- An offsite telephone number that employees can call to report status and obtain information. Programs can partner with programs in other localities to provide one another with emergency calling numbers.
- Battery-operated laptops with software and memory capacity enabling access to clinical data stored on an offsite or in a cloud server if the primary facility network is inoperable.
- Computers at other sites that are providing guest services or dosing to your clients, with software capable of running the program's necessary files and databases or that have the ability to access the program's hosted software site containing this information.
- Emergency contact information in multiple formats (e.g., stored in a computer database; entered on paper copies stored at the office, at home, and in vehicles; programmed into office phones for speed-dialing; stored in cell phones). This would include the contact information collected in **Worksheet B3** (in Appendix B).

- Memorandums of understanding with amateur radio (ham) operators for assistance in emergency communications.
- An agreement with local TV and radio stations to communicate the program's status to the public in emergencies.
- Routine reminders to staff members to back up their computer-based personal calendars and address books, such as by synchronizing them to a handheld device that can be password protected.
- Multiple means of broadcasting alerts to staff and clients (e.g., intercom for within-facility communications; out-of-town phone number that dispersed staff members can call for information about program status; group messaging via cell phone, email, or Internet; social networks such as Twitter; closure listings via TV and radio).
- A communication tree, which is an arrangement that distributes responsibility among staff members to contact all personnel in case of emergency, as shown in Exhibit 3.5.

Exhibit 3.6 provides information on three priority services that can help behavioral health service programs communicate in emergencies. Your disaster planning team can research whether your program is eligible for these services.

EXHIBIT 3.5. Communication Tree

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

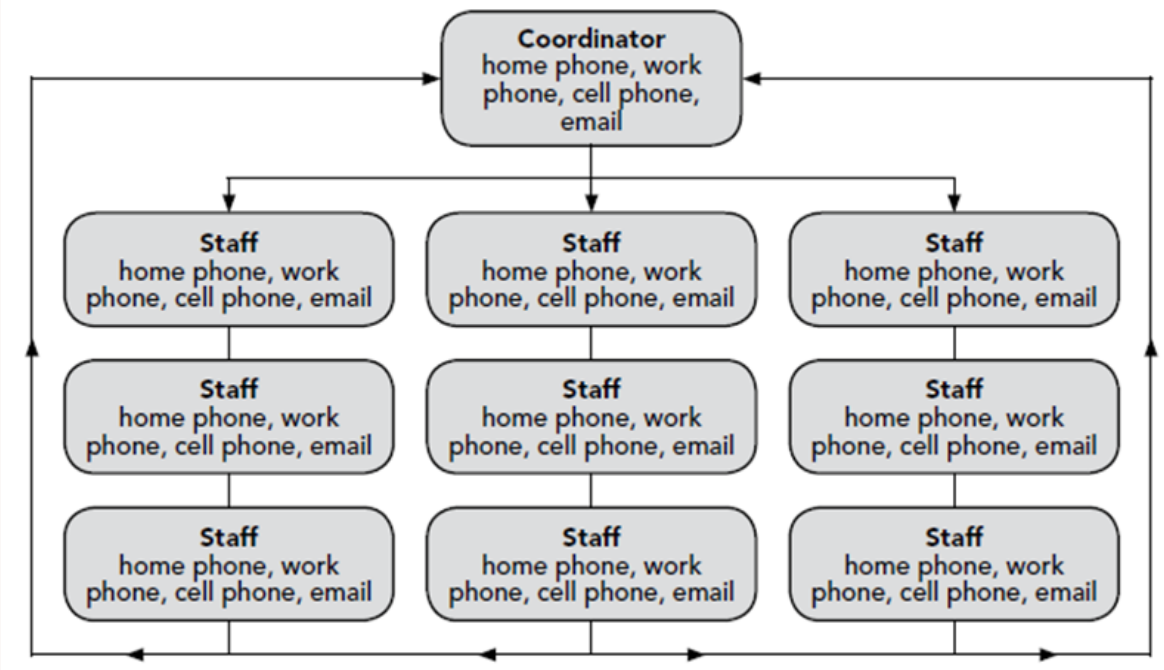

EXHIBIT 3.6. Priority Communications in an Emergency

Service	Description
Government Emergency Telecommunications Service	GETS is a program of the U.S. Department of Homeland Security (DHS) Office of Emergency Communications that prioritizes calls over landline networks. Users receive an access card (GETS card), which has both the universal GETS access number and a personal identification number. *To get priority access over cellular communications networks, you need to use the Wireless Priority Service (WPS) program, described below. GETS and WPS can be used in combination.* This service is most useful during an event when telephone systems are not damaged but the circuits are overloaded. In this situation, the caller usually hears a very fast or very slow busy signal after the number is dialed, indicating that too many people are making calls at the same time. By using a GETS card, subscribers have priority access to the circuit, which allows their calls to go through. Applying for and obtaining a GETS card is free. A charge of up to 10 cents a minute (at the time of publication) applies to calls made through GETS. For more information, see www.fcc.gov/general/government-emergency-telecommunications-service.
Wireless Priority Service	WPS is a federal program that authorizes cellular communications service providers to prioritize calls over wireless networks. Participating in the WPS program is voluntary and requires an application. Authorized users dial *272 on a WPS-enabled device to receive calling queue priority. This service is most useful in situations when the cellular infrastructure is intact but the circuits are overloaded by a large number of callers. In these situations, the caller usually receives a message indicating that the call cannot be completed or receives a fast busy signal. WPS calls do not preempt calls in progress but provide priority access over cellular communications networks. A small one-time activation fee and a small monthly fee apply, as does a per-minute charge (75 cents at the time of publication). For more information, see www.fcc.gov/general/wireless-priority-service-wps.
Telecommunications Service Priority	TSP is a federal program that directs telecommunications service providers (landline and wireless phone companies) to give preferential treatment to users enrolled in the program when they need to add new lines or have their lines restored following a disruption of service, regardless of the cause. The Federal Communications Commission (FCC) sets the rules and policies for the TSP program and DHS manages it. Federal sponsorship is required to enroll in the TSP program. Contact the FCC or DHS to determine your federal sponsor. In your application, you will need to designate those lines meeting emergency preparedness requirements. Enrollment and monthly fees are generally set at the state level by public utility or public service commissions. For more information, see www.fcc.gov/general/telecommunications-service-priority.
Each program is in effect at all times; the programs are not contingent on a disaster or emergency situation taking place.	

The disaster planning team can inventory your program's current communications systems to ensure that redundant, compatible systems have been created for person-to-person and data communications and that the personnel authorized to use those systems in a disaster situation have access to authentication procedures and passwords. The team can also seek advice and assistance from the local disaster planning body and the state disaster behavioral health coordinator on obtaining the equipment, "gateway" devices (data communication devices that provide a remote network with connectivity to a host network), or patches that enable interoperability, as well as permissions for communicating with emergency responders in a disaster.

The team can use **Worksheets B13 and B14** (in Appendix B) to check that it has considered a range of options for ensuring interoperable communications.

Protect Vital Records and Databases

Programs should consider housing vital records and databases offsite at specialized data centers, which offer customers a safe, secured environment with redundant systems ensuring uninterrupted processes. If your program still uses paper medical records, consider converting to an electronic health record (EHR) system.

Taking these two steps helps avoid many records-related problems that can occur in a disaster. For example, an EHR system stored via a cloud-based service (Exhibit 3.7) or at a secure offsite server, such as one hosted by a medical records software company, can be accessed during a disaster and can be efficiently and securely transferred to another provider as needed, even if your program has relocated.

To ensure that all appropriate records remain accessible or are transferred as needed in a disaster situation, your program needs to have a list of them ready. The disaster planning team should begin by working with management to confirm a current inventory of records and databases (e.g., temporary and permanent records, those stored in all formats and media). The inventory also needs to list current software versions necessary to support functions and files and contact information for the software and hardware companies.

From this comprehensive inventory, designated personnel identify the records, databases, and software necessary to perform essential functions and to restore normal operations after a disaster. Your program can use **Worksheet B15** (in Appendix B) to ensure that arrangements are in place for protecting all vital records and databases.

> You can obtain information on EHR systems, cloud-based servers, and other health IT topics from HHS's Office of the National Coordinator for Health Information Technology at www.healthit.gov. In 2011, the Centers for Medicare and Medicaid Services established the Medicare and Medicaid EHR Incentive Programs (now known as the Promoting Interoperability Programs) to encourage eligible professionals and hospitals to adopt, implement, upgrade, and demonstrate meaningful use of certified EHR technology. For more information on these incentive programs and related requirements, see www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms.

EXHIBIT 3.7. Cloud-Based EHR Storage

Cloud-computing platforms provide scalable, on-demand access to IT services. The cloud can allow you to rapidly launch an EHR system while minimizing management effort and cost. However, it's important to thoroughly understand the benefits and challenges associated with a cloud-based EHR system.

Common benefits:

- Reduces upfront hardware and software costs
- Reduces ongoing maintenance costs
- Lets you start small and increase IT allocations as needed
- Provides higher levels of IT service availability than in-house IT services
- Reduces run-time failures

Common challenges:

- Makes data security a shared responsibility between your program and your cloud clinician
- Offers a lower level of data access and control than an onsite EHR system

Source: Office of the National Coordinator for Health Information Technology (2020).

The disaster planning team can check to confirm whether IT staff has a schedule in place for regularly updating each vital record or database and backing up each update on a secure, remote server. The team should also ensure that paper copies can be kept at an alternate location or in a waterproof and fireproof case that can be carried to an alternate facility as needed. This case is typically referred to as a "facility go kit" to distinguish it from the personal go kit discussed in Chapter 2.

Any electronic forms needed for continuity of operations and emergency response should be available in paper copies as backup when the power is down or systems are inoperable. Examples are:

- Forms for reporting and recording disaster response measures, such as daily situation reports.
- Records of expenditures and obligations.
- Prescription pads and client intake, assessment, treatment planning, and discharge forms.

These forms can be kept in the facility go kit, along with forms required for medications ordering, administration, and management, as well as client progress note forms and other client forms (e.g., drug testing forms).

Computer applications and data should be prioritized by management staff responsible for this function so that those most critical to operations are recovered and brought back online first following a disaster. Your program should have a checklist or established procedure for disassembling, transporting, and reassembling any necessary equipment in an evacuation.

Ensure Confidentiality

Your program must maintain client confidentiality when sharing information with other sites for client transfers and when creating duplicate records, such as for the facility go kit (per requirements of Title 42 of the Code of Federal Regulations [CFR] Part 2, the Health Insurance Portability and Accountability Act [HIPAA], and the Health Information Technology for Economic and Clinical Health Act).

Exhibit 3.8 and Exhibit 3.9 provide guidance on confidentiality issued by the Substance Abuse and Mental Health Services Administration (SAMHSA) at the onset of the COVID-19 crisis. HHS may issue updated guidance in future disasters.

EXHIBIT 3.8. HIPAA Privacy and Disclosures in Emergency Situations

Even without a waiver, the HIPAA Privacy Rule always allows patient information to be shared for the following purposes and under the following conditions.

Treatment—Under the Privacy Rule, covered entities may disclose, without a patient's authorization, protected health information about the patient as necessary to treat the patient or to treat a different patient. Treatment includes the coordination or management of health care and related services by one or more healthcare providers and others, consultation between providers, and the referral of patients for treatment. See 45 CFR §§ 164.502(a)(1)(ii), 164.506(c), and the definition of "treatment" at 164.501.

Public Health Activities—The HIPAA Privacy Rule recognizes the legitimate need for public health authorities and others responsible for ensuring public health and safety to have access to protected health information that is necessary to carry out their public health mission. Therefore, the Privacy Rule permits covered entities to disclose needed protected health information without individual authorization:

- ***To a public health authority***, such as the Centers for Disease Control and Prevention (CDC) or a state or local health department that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability. This would include, for example, the reporting of disease or injury; reporting vital events, such as births or deaths; and conducting public health surveillance, investigations, or interventions. A "public health authority" is an agency or authority of the United States Government, a state, a territory, a political subdivision of a state or territory, or Indian tribe that is responsible for public health matters as part of its official mandate, as well as a person or entity acting under a grant of authority from, or under a contract with, a public health agency. See 45 CFR §§ 164.501 and 164.512(b)(1)(i). For example, a covered entity may disclose to the CDC protected health information on an ongoing basis as needed to report all prior and prospective cases of patients exposed to or suspected or confirmed to have COVID-19.
- ***At the direction of a public health authority, to a foreign government agency*** that is acting in collaboration with the public health authority. See 45 CFR 164.512(b)(1)(i).

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EXHIBIT 3.8. HIPAA Privacy and Disclosures in Emergency Situations, *cont.*

- ***To persons at risk*** of contracting or spreading a disease or condition if other law, such as state law, authorizes the covered entity to notify such persons as necessary to prevent or control the spread of the disease or otherwise to carry out public health interventions or investigations. See 45 CFR 164.512(b)(1)(iv).

Disclosures to Family, Friends, and Others Involved in an Individual's Care and for Notification—A covered entity may share protected health information with a patient's family members, relatives, friends, or other persons identified by the patient as involved in the patient's care. A covered entity also may share information about a patient as necessary to identify, locate, and notify family members, guardians, or anyone else responsible for the patient's care of the patient's location, general condition, or death. This may include, where necessary, to notify family members and others, the police, the press, or the public at large. See 45 CFR 164.510(b).

- The covered entity should get verbal permission from individuals or otherwise be able to reasonably infer that the patient does not object, when possible; if the individual is incapacitated or not available, covered entities may share information for these purposes if, in their professional judgment, doing so is in the patient's best interest.
- For patients who are unconscious or incapacitated: A healthcare provider may share relevant information about the patient with family, friends, or others involved in the patient's care or payment for care, if the healthcare provider determines, based on professional judgment, that doing so is in the best interests of the patient. For example, a provider may determine that it is in the best interests of an elderly patient to share relevant information with the patient's adult child but generally could not share unrelated information about the patient's medical history without permission.
- In addition, a covered entity may share protected health information with disaster relief organizations that, like the American Red Cross, are authorized by law or by their charters to assist in disaster relief efforts, for the purpose of coordinating the notification of family members or other persons involved in the patient's care, of the patient's location, general condition, or death. It is unnecessary to obtain a patient's permission to share the information in this situation if doing so would interfere with the organization's ability to respond to the emergency.

Disclosures To Prevent or Lessen a Serious and Imminent Threat—Healthcare providers may share patient information with anyone as necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public—consistent with applicable law (such as state statutes, regulations, or case law) and the provider's standards of ethical conduct. See 45 CFR 164.512(j). Thus, providers may disclose a patient's health information to anyone who is in a position to prevent or lessen the serious and imminent threat, including family, friends, caregivers, and law enforcement, without a patient's permission. HIPAA expressly defers to the professional judgment of health professionals in making determinations about the nature and severity of the threat to health and safety. See 45 CFR 164.512(j).

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EXHIBIT 3.8. HIPAA Privacy and Disclosures in Emergency Situations, *cont.*

Disclosures to the Media or Others Not Involved in the Care of the Patient/Notification—Except in limited circumstances, affirmative reporting to the media or the public at large about an identifiable patient, or the disclosure to the public or media of specific information about treatment of an identifiable patient, such as specific tests, test results, or details of a patient's illness, may not be done without the patient's written authorization (or the written authorization of a personal representative who is a person legally authorized to make healthcare decisions for the patient). See 45 CFR 164.508 for the requirements for a HIPAA authorization. Where a patient has not objected to or restricted the release of protected health information, a covered hospital or other healthcare facility may, upon a request to disclose information about a particular patient asked for by name, release limited facility directory information to acknowledge an individual is a patient at the facility and may provide basic information about the patient's condition in general terms (e.g., critical or stable, deceased, treated, and released). Covered entities may also disclose information when the patient is incapacitated, if the disclosure is believed to be in the best interest of the patient and is consistent with any prior expressed preferences of the patient. See 45 CFR 164.510(a).

Minimum Necessary—For most disclosures, a covered entity must make reasonable efforts to limit the information disclosed to that which is the "minimum necessary" to accomplish the purpose. (Minimum necessary requirements do not apply to disclosures to healthcare providers for treatment purposes.) Covered entities may rely on representations from a public health authority or other public official that the requested information is the minimum necessary for the purpose, when that reliance is reasonable under the circumstances. For example, a covered entity may rely on representations from the CDC that the protected health information requested by the CDC about all patients exposed to or suspected or confirmed to have COVID-19 is the minimum necessary for the public health purpose. In addition, internally, covered entities should continue to apply their role-based access policies to limit access to protected health information to only those workforce members who need it to carry out their duties. See 45 CFR §§ 164.502(b), 164.514(d).

Safeguarding Patient Information—In an emergency situation, covered entities must continue to implement reasonable safeguards to protect patient information against intentional or unintentional impermissible uses and disclosures. Further, covered entities (and their business associates) must apply the administrative, physical, and technical safeguards of the HIPAA Security Rule to electronic protected health information.

HIPAA Applies Only to Covered Entities and Business Associates—The HIPAA Privacy Rule applies to disclosures made by employees, volunteers, and other members of a covered entity's or business associate's workforce. Covered entities are health plans, healthcare clearinghouses, and those healthcare providers that conduct one or more covered healthcare transactions electronically, such as transmitting healthcare claims to a health plan. Business associates generally are persons or entities (other than members of the workforce of a covered entity) that perform functions or activities on behalf of, or provide certain services to, a covered entity that involve creating, receiving, maintaining, or transmitting protected health information. Business associates also include subcontractors that create, receive, maintain, or transmit

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EXHIBIT 3.8. HIPAA Privacy and Disclosures in Emergency Situations, *cont.*

protected health information on behalf of another business associate. The Privacy Rule does not apply to disclosures made by entities or other persons who are not covered entities or business associates (although such persons or entities are free to follow the standards on a voluntary basis if desired). There may be other state or federal rules that apply.

Business Associates—A business associate of a covered entity (including a business associate that is a subcontractor) may make disclosures permitted by the Privacy Rule, such as to a public health authority, on behalf of a covered entity or another business associate to the extent authorized by its business associate agreement.

Health Information Exchanges (HIEs)—HHS's Office for Civil Rights will not impose penalties on a business associate HIE for disclosing protected health information to a public health authority during the COVID-19 public health emergency. An HIE may transmit patient test results it receives in its role as a covered healthcare provider's business associate, in response to a public health authority's request, regardless of whether the HIE's business associate agreement with the provider permits such disclosure. The Privacy Rule permits a covered entity to disclose protected health information through an HIE to a public health authority for public health activities without a direct request. (For example, a covered healthcare provider, acting on its knowledge that the city health department is using HIEs to track COVID-19, may transmit summary records containing protected health information for all tested individuals to the HIE for reporting to the city health department, and this disclosure would not violate the minimum necessary standard.) A business associate HIE will not face penalties for violating the Privacy Rule if the HIE transmits protected health information it receives as a covered entity's business associate to a public health authority, provided that (1) the protected health information is for public health activities and (2) the business associate informs the covered entity within 10 calendar days after the disclosure occurs. (For example, an HIE that is in a business associate relationship with a covered entity will not be subject to HIPAA penalties if the HIE transmits summary records about individuals diagnosed with COVID-19 to the city health department, which is collecting the information to track COVID-19, and notifies the covered entity within 10 days after it first transmitted the information to the city health department.)

Sources: Excerpted and adapted from HHS (2020) and HHS, Office for Civil Rights (2020).

EXHIBIT 3.9. COVID-19 Public Health Emergency Response and 42 CFR Part 2 Guidance

In response to the COVID-19 pandemic, SAMHSA is providing this guidance to ensure that substance use disorder treatment services are uninterrupted during this public health emergency. SAMHSA understands that, in accordance with CDC guidelines on social distancing, as well as state or local government-issued bans or guidelines on gatherings of multiple people, many substance use disorder treatment provider offices are closed or have limited hours, or patients are not able to present for treatment services in person. Therefore, there has been an increased need for telehealth services, and in some areas without adequate telehealth technology, providers are offering telephonic consultations to patients. In such instances, providers may not be able to obtain written patient consent for disclosure of substance use disorder records.

The prohibitions on use and disclosure of patient identifying information under 42 CFR Part 2 would not apply in these situations to the extent that, as determined by the provider(s), a medical emergency exists. Under 42 U.S.C. §290dd-2(b)(2)(A) and 42 CFR §2.51, patient-identifying information may be disclosed by a Part 2 program or other lawful holder to medical personnel, without patient consent, to the extent necessary to meet a bona fide medical emergency in which the patient's prior informed consent cannot be obtained. Information disclosed to the medical personnel who are treating such a medical emergency may be redisclosed by such personnel for treatment purposes as needed. We note that Part 2 requires programs to document certain information in their records after a disclosure is made pursuant to the medical emergency exception. **We emphasize that, under the medical emergency exception, providers make their own determinations whether a bona fide medical emergency exists for purposes of providing needed treatment to patients.**

Source: SAMHSA (2020a).

If your program's staff members need to break confidentiality, they should first contact the state behavioral health agency to explain the situation. If that is impossible, they should document the circumstances and report the breach as soon as possible.

Develop Resources To Manage Human Capital

As discussed in the "Mitigate Risk" section of Chapter 2, your disaster planning team can take steps in advance to limit how much a disaster affects staff members. The team can also create in advance a list of social service providers that may be available to support staff members with personal emergency needs (e.g., medical assistance, crisis counseling, temporary housing).

An effective disaster plan provides for informing staff members when it has been activated and how each person should respond (i.e., as an essential staff member who should report immediately for duty or as a nonessential staff member who should wait for further instructions). If your program has a different chain of command in a disaster, the disaster planning team needs to have that chain clearly delineated and familiarize staff members with it through training and other means.

Your program also needs to have a contact list of all staff members, including emergency contact information and afterhours locations. Personal contact information, such as phone numbers, should be shared on a need-to-know basis through the chain of command, and the information should be used only for appropriate purposes.

Multiple means of communicating among staff need to be in place (see the "Ensure Interoperable Communications" section above in this chapter). Information on staff credentials and levels of expertise will be useful to ensure that staff members aren't moved into assignments they aren't trained or prepared for.

Factors that can influence a staff member's willingness to work in a disaster include the type of disaster, workplace preparedness and leadership, sense of professional duty, and concerns about personal and family safety (Arbon, Cusack, Ranse, et al., 2013). The disaster planning team should recommend policies that support staff members while they serve during the disaster. Examples of such policies are:

- Providing staff members with advance training in disaster self-care (see Exhibits 6.5 and 6.6 in Chapter 6 for more information on self-care and recovery during a disaster).
- Ensuring that staff members have access to behavioral health services via telehealth (e.g., video, telephone, text).
- Ensuring that staff members have access to phones or the Internet to check on family members while working through a disaster situation.
- Allowing for adjustments to shift schedules to enable staff to perform essential functions while managing personal responsibilities (maintaining 8-hour or shorter work shifts if possible).
- Compensating employees who work additional hours in the disaster situation.
- Relaxing some human resources policies during the disaster response (e.g., not requiring staff members to take paid time off if they aren't essential or needed for their regular shifts; continue benefits regardless of hours worked).
- Assisting staff in obtaining safe and appropriate transportation, if needed.
- Developing an employee emergency fund to assist with needed repairs (e.g., to a home or vehicle) and replace necessary items (e.g., clothing, kitchen supplies, cleaning supplies).

The disaster planning team and human resources personnel should review personnel policies to ensure that they support continuity of operations in a disaster. A central issue is educating and preparing staff members so that they are willing to report for and stay on duty during an actual event (Exhibit 3.10).

Your program can use **Worksheet B16** (in Appendix B) as a tool for reviewing the personnel policies that apply in disaster situations.

EXHIBIT 3.10. Building Staff Willingness To Respond in a Disaster

One OTP reported that during a hurricane, staff members abandoned their posts over concerns that they wouldn't be able to get home to protect themselves and their families. To avoid a recurrence of that situation, the program developed a detailed disaster plan that, among other things, clearly advised staff members of their roles in a disaster and stated policies for compensating staff if the program closed because of a disaster. As a result, the OTP was better staffed in subsequent hurricanes.

Source: Podus, Maxwell, & Anglin (n.d.).

Chapter 4—Management of Prescription Medications

IN THIS CHAPTER

- Carefully Oversee Clients on Prescription Medications
- Help Clients Access Prescription Medications
- Provide for Continued Methadone Dosing
- Prepare for Transfers of Patients
- Treat Guest Patients on MMT
- Address the Needs of Displaced Patients on Buprenorphine
- Address the Needs of Patients on Psychiatric Medications
- Refer or Treat Pain Patients, as Appropriate
- Manage Supplies of Controlled Substances

Worksheet (see Appendix B)

- B17 Checklist for Management of Prescribed Medications

This chapter covers disaster planning to support clients who take prescribed medications for mental or substance use disorders or for other medical conditions and who may lose access to these medications during a disaster. The chapter also discusses managing onsite controlled substances during a disaster.

Worksheet B17 (in Appendix B) is a checklist of planning steps to support patients who take prescribed medications and to manage controlled substances in a disaster.

Carefully Oversee Clients on Prescription Medications

During a crisis or disaster, your program needs to monitor clients on prescription medications to determine whether the unusual circumstances have interrupted or altered their medication usage. Depending on the client and the situation, the effects of medication changes can include withdrawal, resumption of symptoms, or adverse drug reactions, including drug interactions.

Drug interactions occur when the amount or action of a drug in the body is changed—usually increased or decreased—by the presence of another drug or multiple drugs. For example, adverse reactions can occur from the interaction of prescribed medications (including methadone), illicit drugs, over-the-counter products, and other substances.

In cases involving patients on a complex drug regimen—such as multidrug therapies for severe mental illness—your program will need to consult with specialists to manage any transitions resulting from a disaster situation.

The Protecting Patient Access to Emergency Medications Act of 2017 (PPAEMA) lays out federal guidelines for stockpiling and prescribing controlled substances under emergency conditions. PPAEMA allows emergency medical services personnel to adminis-

ter Schedule II, III, IV, or V controlled substances without having an authorizing medical professional present, as long as state law allows it and there is a standing or verbal order from an authorizing medical professional. For more information, see Healthcare Ready material on PPAEMA at https://healthcareready.org/wp-content/uploads/2020/01/Controlled-Substance-and-PPAEMA.pdf.

Help Clients Access Prescription Medications

Clients with mental disorders may take prescribed medications like antipsychotics, benzodiazepines, and selective serotonin reuptake inhibitors. Clients with substance use disorders (SUDs) may take one or more prescribed medications such as buprenorphine, naltrexone, disulfiram, and acamprosate. In addition, clients may take prescribed medications for medical conditions (e.g., hepatitis C, HIV, diabetes, high blood pressure, pain). Your program should write all clients—except those being treated solely for alcohol use disorder—a prescription for naloxone or supply them with a naloxone kit. Given the presence of fentanyl in many illicit drugs, people face risk of overdose regardless of the drug sought. Likewise, people relapsing to opioid use after a period of abstinence are at risk of overdose because of their reduced tolerance.

A disaster can be a life-changing experience that impels people to enter treatment. For example, a disaster may disrupt distribution of street drugs, causing individuals dependent on illicit opioids and not in treatment to turn to a clinic that treats SUDs for help. Clients may lose access to—or run out of—prescribed medications. SUD treatment clinics should anticipate a potential surge of new patients. Clients who miss their regular doses may experience one or more of the following adverse effects (depending on their diagnoses and medications):

- Sudden return of psychotic symptoms (e.g., hallucinations, delusions)
- Recurrence of other psychiatric symptoms (e.g., depression, anxiety)
- Withdrawal symptoms
- Relapse to substance use
- Deteriorating physical condition
- Social isolation
- Retraumatization

Some of these effects can be life threatening. They can also lead to unnecessary or lengthy hospitalization or institutionalization, especially if emergency care providers don't know the cause and treatment of a client's presenting conditions.

To lessen the likelihood that clients will experience such problems, educate them on how to handle emergency situations. For example, your program can routinely:

- Review with clients how to obtain prescription replacements and refills under various scenarios, such as if the clinic or the primary pharmacy is closed or if they are relocated without advance notice.
- Make sure prescribing staff members are aware of federal regulatory changes during emergency situations that may allow for clients to receive a greater supply of take-home medications (see Exhibits 4.3 and 4.4).
- In the case of a declared or impending disaster, consider prescribing for an extended amount of time (e.g., 90 days vs. 30 days) if allowable.

- Advise clients to pack all their medications if they are relocated, even temporarily.
- Advise clients to pack the following items so that they can more easily obtain needed medication refills from a new medication-dispensing facility:
  - A photo ID
  - Medication containers of currently prescribed medications (even if empty)
  - Written prescriptions, if relevant
  - Packaging labels with dose, prescriber, and refill information
  - Any payment receipts that contain medication information

A 2006 review of the response to Hurricanes Katrina and Rita found that locations receiving evacuees were not prepared to support the prescription replacement/refill needs of arriving individuals. The report noted, "For some people with psychiatric disabilities, this remains one of their chief concerns for the next hurricane season" (National Council on Disability [NCD], 2006, p. 18). NCD's 2019 report, *Preserving Our Freedom: Ending Institutionalization of People With Disabilities During and After Disasters,* indicated that this is still a concern, as is reinstitutionalization because of prescription-related issues.

Your program should address the topic of medication maintenance for clients with local disaster planning committees, and especially with the operators of shelters and sites that receive evacuees. Include continued client access to prescription medications in tabletop or functional exercises that test your program's disaster plan. Testing of state and community disaster plans should also cover this topic. Strategies for conducting disaster exercises are detailed in Chapter 6.

Your program's CEO/executive director or other designated representative can talk to state and local public health departments to find out whether psychoactive or SUD medications are included in the public stockpile. Such communications also offer an opportunity to learn about the disaster conditions under which your program's clients would have access to these stockpile medications.

Provide for Continued Methadone Dosing

Methadone is a Schedule II substance under the Controlled Substances Act, which means that prescribing, dispensing, and transporting methadone is tightly regulated by the Drug Enforcement Administration (DEA), under Title 42 of the Code of Federal Regulations (CFR), Section 8.12. Many patients on methadone maintenance treatment (MMT) for opioid use disorder (OUD) may receive their daily dose only at their opioid treatment program (OTP), with rare exceptions. Such patients can experience withdrawal symptoms and are at increased risk of relapse when a disaster cuts them off from the OTP and their daily dose of methadone.

To ensure continued dosing in all circumstances, an OTP will need access to patient dosing information or will need to give that information to another program that will provide guest dosing. This will be difficult if computer-based records are inaccessible or lost in a disaster. If your program operates an OTP, it should store and regularly update patient medical records (including dose levels and take-home privileges) at a secure location (e.g., in a cloud-based server, at an offsite server located in a reinforced building). The program should also be ready to quickly and securely transfer patient records and supporting software to an alternate location (see "Protect Vital Records and Databases" in Chapter 3).

Some OTPs provide patients with personalized ID cards. Each card contains the patient's photograph and encrypted medical information. If your program uses such cards, ensure that other OTPs to which your patients may be transferred have the equipment (and the backup electric or battery power) to read the cards. Your program should provide a backup method for transferring medical records and verifying patient status and identity, because patients affected by disaster may lose all their possessions, including their ID cards.

Some State Opioid Treatment Authorities (SOTAs) maintain a central database with identifying information on patients on MMT, including dosage levels, admission dates, and take-home privileges. If your program operates an OTP, the disaster planning team should check with your state's behavioral health agency to learn the procedures for accessing OTP patient records in emergencies. Issues to cover include:

- How an OTP accesses its own patient records when they are destroyed or inaccessible.
- How a guest OTP accesses the records of guest patients.
- Whether a guest OTP can rely on dosage information provided by guest patients when their home OTPs are not able to verify the information.
- Whether a guest OTP will have to obtain patient releases for that information.

To ensure clinically appropriate communications and access to SUD care in the context of declared emergencies resulting from natural disasters, 42 CFR Part 2 was revised effective August 14, 2020, to state: "Declared emergencies resulting from natural disasters (e.g., hurricanes) that disrupt treatment facilities and services are considered a 'bona fide medical emergency,' for the purpose of disclosing SUD records without patient consent under Part 2." Exhibits 3.8 and 3.9 in Chapter 3 provide more information on modifications to federal confidentiality and disclosure regulations during a disaster or national emergency.

Some states have developed statewide healthcare communications systems that can securely transfer dosing information. For details on one such system, the State of Washington's WATrac Tracking and Alert System, see www.doh.wa.gov/ForPublicHealthandHealthcareProviders/EmergencyPreparedness/WATrac.

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

Exhibit 4.1 illustrates some challenges in patient dosing after a disaster.

Your program may submit exception requests to SAMHSA online, by fax, or by mail. According to SAMHSA, OTPs that submit requests online will typically have a decision, viewable online, within 1 hour of the submission. A SAMHSA webpage provides instructions on how to request exceptions to the federal opioid treatment standards at www.samhsa.gov/medication-assisted-treatment/otp-resources/submit-exception-request.

EXHIBIT 4.1. Distant Dispersal of OTP Patients

An OTP administrator reported that his clinic prepared for disaster situations by backing up its data to an offsite location. Other clinics owned by the same company could directly access this database. In addition, the administrator retained hard copies of patient names and dosing histories. However, this preparation proved insufficient to deal with the impact of a major hurricane. In its aftermath, the administrator had to spend hours on the phone with staff members at non-company-owned facilities throughout the United States, verifying data and dosing information for relocated patients.

"Planning is great and having channels and [cooperative agreements] with other programs is great," he said, "but you have to understand that people are going to end up almost anywhere." The administrator was particularly frustrated by the reluctance of some alternate facilities to accept his verification. Instead, they requested a signed faxed document authorizing the patient transfer. Power outages made complying with this request extremely difficult.

Source: Podus, Maxwell, & Anglin (n.d.).

Prepare for Transfers of Patients

In an impending disaster, a behavioral health service program may have little time to activate its continuity of operations plan, or COOP plan, as described in Chapter 3. This situation presents a particular challenge to a residential program that provides medically supervised withdrawal or to an OTP, both of which must rapidly complete several extra steps in their continuity of operations plan.

Exhibit 4.2 provides an example of a model OTP continuity of operations plan executed in response to the COVID-19 pandemic.

A program that provides onsite medically supervised withdrawal must prepare for evacuation, which will involve transferring patients and their medical information to an alternate location or to another program with which it has a memorandum of agreement (MOA)—and staying informed about the patients while they're at the guest site. Transfers should be documented in the patient's electronic health record. Similarly, an OTP must prepare to transfer patients receiving methadone, buprenorphine, or naloxone to an alternate location or to another clinic able to provide guest dosing and to track these patients while they're at the guest site. Include steps to accomplish these transfers in your program's continuity of operations plan.

Treat Guest Patients on MMT

Every OTP should have procedures for how to handle people who arrive without advance arrangement and who request courtesy methadone dosing after a disaster. If your program operates an OTP, the disaster planning team needs to consider how many of these patients your facility can handle.

EXHIBIT 4.2. A Model OTP Continuity of Operations Plan Made in Response to COVID-19

The first U.S. case of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the strain of coronavirus that causes COVID-19, was confirmed in the State of Washington, as was the first COVID-19 death. In response, Evergreen Treatment Services, the state's largest OTP, began developing a pandemic response plan.

The organization serves more than 2,600 patients, providing treatment medication for OUD as well as critical psychosocial and medical services, including HIV screening and referral to treatment. The program consists of three sites, the largest in Seattle, a region with numerous early COVID-19 cases. Located in an urban area, this site serves some of Seattle's most vulnerable residents, with up to 63 percent of patients reporting homelessness.

Evergreen's transdisciplinary Infection Control Committee undertook preparations for site readiness that included stocking personal protective equipment and medication, ensuring sanitation systems were functioning, clarifying signage and communication, and providing guidance for managing congestion. Evergreen also clarified policies on COVID-19 screening, which included separating symptomatic patients, limiting contact, providing information on universal precautions/hygienic practices, and defining essential staff and services.

Social distancing at an OTP can be complicated given that most patients come almost daily for medication dosing. Evergreen's Phase II planning addressed this issue by modifying eligibility requirements for take-home doses, increasing take-homes provided, and balancing the risks of possible medication diversion and drug poisonings (among both patients and the community).

To that end, Evergreen submitted an exception request to SAMHSA proposing take-home status changes for four methadone patient categories:

1. Patients with COVID-19 symptoms (assessed by medical provider) or confirmed disease receive up to 2 weeks of medication.
2. Patients who have earned at least one take-home dose receive 1 week of medication.
3. Patients older than 60 or with medical comorbidities can receive 1–2 weeks' worth of medication.
4. All patients not fitting one of the above categories are put on a staggered take-home schedule where half the patients show up in person on Mondays, Wednesdays, and Fridays and the other half on Tuesdays, Thursdays, and Saturdays; remaining doses are provided as take-homes.

Patients who couldn't safely manage take-home dosages continued daily dosing. These categories were outlined in a comprehensive Infection Control Response document submitted to support the exception request. On March 16, 2020, SAMHSA released Evergreen's infection response document as guidance for all OTPs in the State of Washington. Exhibit 4.4 below presents SAMHSA's adjusted rules for prescribing take-home medications in OTPs in response to the COVID-19 pandemic.

Sources: Peavy, Darnton, Grekin, et al. (2020); SAMHSA (2020c).

A small program that doesn't have the resources to treat guest patients should consider developing plans and procedures for referring them elsewhere. This can be formally accomplished through an MOA with a larger provider (see "Negotiate MOAs and Mutual Aid Agreements" in Chapter 2). The SOTA may also be able to assist with this process. SAMHSA provides a list of SOTAs (by state or territory) at https://dpt2.samhsa.gov/regulations/smalist.aspx.

Programs that have the capacity to treat guest patients should follow guidance provided by SAMHSA to State Methadone Authorities and OTPs after Hurricane Katrina (SAMHSA, 2005b) and included in the *Federal Guidelines for Opioid Treatment Programs* (SAMHSA, 2015) and in Exhibit 4.3. Exhibits 4.4 and 4.5 present the expansion of exceptions allowed by SAMHSA in the wake of the COVID-19 pandemic.

Address the Needs of Displaced Patients on Buprenorphine

Hundreds of thousands of patients receive buprenorphine products for the treatment of—or medically supervised withdrawal from—OUD. Most of these patients see DATA-waived healthcare providers in settings other than OTPs. Buprenorphine patients displaced by disasters may be treated in OTP settings. Hurricane Sandy closed many New York City hospitals along with their methadone clinics but had less of an effect on office-based buprenorphine administration. Researchers conducted interviews with providers of both treatments on the barriers to and facilitators of treatment continuity (McClure, Mendoza, Duncan, et al., 2014). They found that there was greater continuity of OUD treatment with patients taking buprenorphine, despite some pharmacies running out of the medication. However, the guest dosing policies of methadone clinics gave these patients more cross-coverage than those taking buprenorphine. You can find additional buprenorphine treatment resources at SAMHSA's Buprenorphine Practitioner Locator at www.samhsa.gov/medication-assisted-treatment/practitioner-program-data/treatment-practitioner-locator or https://findtreatment.gov/. Providers who can prescribe buprenorphine and have not submitted or updated their information for inclusion should do so.

Address the Needs of Patients on Psychiatric Medications

Abrupt discontinuation of psychiatric medications can have severe consequences. Patients may experience withdrawal symptoms, worsening psychiatric symptoms, new-onset psychiatric symptoms, thoughts of harm to self or others, psychosis, or cravings. These issues may be particularly problematic for patients receiving antidepressants, antipsychotics, benzodiazepines, or medication for treating OUD. Clinicians need to develop action plans for any patients who are receiving scheduled benzodiazepine dosing to prevent abrupt withdrawal if a disaster occurs.

The Centers for Disease Control and Prevention maintains stockpiles of emergency medications, but these supplies focus on medications to combat infection. In these caches, there are no psychiatric medications other than diazepam, which is stocked for its ability to combat the effects of nerve agents.

If your program cannot serve some clients because their mental status has deteriorated or because their home clinic closed as a result of a disaster, you should refer them to a program that specializes in treating mental disorders, a local crisis center, or county or state mental health organizations. Your program should have a list of phone numbers and websites of on-demand mental health services (e.g., hotlines, chat rooms, telehealth sources).

EXHIBIT 4.3. SAMHSA Guidance for OTPs in the Event of a Disaster

SAMHSA's guidance for OTPs dealing with disaster is found in a 2005 Dear Colleague Letter issued in the immediate aftermath of Hurricane Katrina and in the 2015 *Federal Guidelines for Opioid Treatment Programs*. Below are two relevant excerpts from these documents.

2015 *Federal Guidelines for Opioid Treatment Programs*

In the event of an emergency leading to temporary closure of a program, an up-to-date plan for emergency administration of medications should be maintained. An alternative dosing location should be secured in advance because DEA registration of the new location may be required if it is not already an OTP. Facilities should have the capability to respond to emergencies on a 24-hour basis. Designated staff persons should have access to a record of active patients, their medication dose, schedule, and last dose administered in order to provide accurate dosing at an alternative location. In addition, the plan should include a mechanism for informing patients of emergency arrangements, alternative dosing locations; and a procedure for notifying SAMHSA, DEA, and state authorities of the situation. To review specific disaster guidance provided by SAMHSA, access www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/dear_colleague_letters/2005-colleague-letter-hurricane-katrina-guidance.pdf.

Source: Excerpted from SAMHSA (2015, pp. 13–14).

2005 Dear Colleague Letter

Every effort should be made to contact the person's home program. . . . If you are unable to contact the patient's home program, the following procedures should be combined with your existing emergency plans:

1. The emergency guest patient should show a valid picture identification which includes an address in close proximity to the area impacted by Hurricane Katrina.
2. The patient should show some type of proof that indicates he or she was receiving services from a clinic located in one of the affected areas, e.g., medication bottle, program identification card, receipt for payment of fees, etc. *In cases where the patient does not have any items of proof including a picture ID,* the physician should use his or her best medical judgment, combined with a stat drug test for the presence of methadone (lab test w/quick turn-around, dip stick, etc.).
3. An OTP may administer the amount of medication that the patient reports as his or her current dose; however, remind each patient that the dose that is reported will be verified with the home program as soon as possible. In cases where the reported dose appears questionable, it is best to use good medical judgment when determining the dose level.
4. Emergency guest patients should be medicated daily with take-home doses provided only for days that the program is closed (Sundays and holidays). If the patient's current take-home status can be verified, take-home doses may be provided in accordance with state and federal regulations (42 CFR Part 8). In the case of a patient who is unable to

continued on next page

EXHIBIT 4.3. SAMHSA Guidance for OTPs in the Event of a Disaster, *cont.*

travel to the program daily due to a medical or other hardship, take-home medication for unsupervised use may be considered via the SMA [State Methadone Authority]-168 Request for Exception process.

5. Documentation of guest patient services should be a priority for OTPs. Each guest patient should be assigned a clinic identification number and issued a temporary chart. Reasonable efforts should be made to periodically contact the patient's home program to verify patient information prior to dispensing medication. The results should be recorded in the temporary chart. The OTP should record the day, date, and amount of medication administered to each patient, along with any observations made by the staff. As time passes and affected OTPs reopen, some patients may elect to remain in treatment at your facility and change from guest to permanent status. Upon conclusion of the emergency treatment period, a summary of the total number of patients treated, services rendered, and disposition of the patients' care should be compiled and reported to your SMA and to CSAT. Additional information may be forthcoming. Please do your best to accommodate them as their lives will still be in a state of flux.

Source: Excerpted from SAMHSA (2005a, pp. 1–2).

EXHIBIT 4.4. OTP Guidance in Response to COVID-19

SAMHSA issued the following guidance on March 16, 2020, and updated it on March 19, 2020.

SAMHSA recognizes the evolving issues surrounding COVID-19 and the emerging needs OTPs continue to face.

SAMHSA affirms its commitment to supporting OTPs in any way possible during this time. As such, we are expanding our previous guidance to provide increased flexibility.

FOR ALL STATES

The state may request blanket exceptions for all stable patients in an OTP to receive 28 days of Take-Home doses of the patient's medication for opioid use disorder.

The state may request up to 14 days of Take-Home medication for those patients who are less stable but who the OTP believes can safely handle this level of Take-Home medication.

Source: SAMHSA (2020c).

EXHIBIT 4.5. Providing Methadone and Buprenorphine To Treat OUD During COVID-19

Q: Can a practitioner admit a new patient with OUD to an OTP using telehealth (including use of telephone)?

A: No, in the case of methadone. The requirement for an in-person medical exam before prescribing methadone remains in place.

A: Yes, in the case of buprenorphine. Requirements for an in-person exam have been waived for buprenorphine prescribing if a medical professional determines that buprenorphine can safely be prescribed via a telehealth exam.

Q: Can patients who are already being treated with methadone or buprenorphine continue to be treated via telehealth?

A: Yes.

Q: Can a practitioner with a Drug Addiction Treatment Act of 2000 (DATA) waiver treat new and existing buprenorphine patients outside of an OTP?

A: Yes.

Q: Can an OTP dispense methadone or buprenorphine based on an evaluation conducted via telehealth (including by telephone, if needed)?

A: Yes, up to 14 doses for clinically less stable patients and 28 doses for clinically stable patients.

Q: Can midlevel practitioners in an OTP continue to dispense and administer medication for the treatment of OUD without direct physician supervision if the supervisor is unavailable?

A: Yes, as long as the practitioners are licensed and registered under state law to provide the medication.

Q: May an OTP request an exemption to allow midlevel practitioners to perform regulatory functions normally performed by an OTP physician or the medical director (under 42 CFR § 8.12) if the medical director or physician cannot perform the functions?

A: Yes, an OTP may request an exemption so that midlevel practitioners can perform functions related to admitting patients, ordering unsupervised take-home medication, or changing medication doses during the COVID-19 emergency if consistent with applicable state law and the midlevel practitioner's scope of licensure.

For related guidance, consult the full list of FAQs at www.samhsa.gov/sites/default/files/faqs-for-oud-prescribing-and-dispensing.pdf.

Source: SAMHSA (2020b).

Refer or Treat Pain Patients, as Appropriate

During a disaster, some people on opioid medication for pain may lose access to medication and experience withdrawal. Some may seek help from an OTP. SAMHSA (2005b) recommends referring such people to a local physician, preferably a pain management specialist. Additional SAMHSA guidance is provided in Exhibit 4.6.

Exhibit 3.8 in Chapter 3 provides a detailed discussion of 2020 modifications to Health Insurance Portability and Accountability Act (HIPAA) confidentiality and disclosure regulations brought about by COVID-19, and Exhibit 3.9 provides COVID-related guidance issued by SAMHSA on 42 CFR Part 2.

Manage Supplies of Controlled Substances

Your behavioral health service program should develop emergency plans for all psychiatric medications they prescribe. Document and discuss with your clients any necessary considerations for those who take medications that require more intensive monitoring, such as lithium or clozapine. Programs, emergency responders, and healthcare workers need to work together to prepare for major disasters to avoid withdrawal and other consequences of disrupted access to psychiatric medications.

EXHIBIT 4.6. SAMHSA's Guidance on Working With Displaced Patients Treated by Pain Clinics

SAMHSA's guidance for treating displaced patients with chronic pain is found in two places:

- A 2005 Dear Colleague Letter that addresses OTPs affected by Hurricane Katrina, which states that "evacuees who were being treated by a physician with methadone for pain in a clinic or other setting and are now out of medication" (SAMHSA, 2005a)
- The 2015 *Federal Guidelines for Opioid Treatment Programs* (SAMHSA, 2015)

Further guidance on dealing with pain patients who have been displaced is the same as guidance for OTP patients who need opioids for pain:

> OTP patients are permitted to receive both medication-assisted treatment and adequate doses of opioids or other analgesics for pain when medically necessary. OTPs should make careful diagnostic distinctions between the physical dependence associated with the chronic administration of opioids for pain relief and an opioid use disorder. Patients with co-occurring pain should receive treatment from both pain management and addiction medicine specialists who employ a multidisciplinary approach. When possible and appropriate, programs refer patients with chronic pain for consultation with a specialist in pain medicine (SAMHSA, 2015, pp. 38–39).

For further guidance, refer to Treatment Improvement Protocol 54: *Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders* (https://store.samhsa.gov/product/TIP-54-Managing-Chronic-Pain-in-Adults-With-or-in-Recovery-From-Substance-Use-Disorders/SMA13-4671).

Before a disaster occurs consider the following questions:

- Which medications would be available through disaster relief efforts and how long might it take to get access to these medications?
- As relief efforts unfold and some psychiatric medications become available, what basic formulary should be anticipated?
- If the medication supply is disrupted, which patients are likely to have the most severe discontinuation syndromes and which ones will otherwise be at the greatest risk as a result of not having their medication?
- Have supplies of vital medications like methadone been ordered from multiple distributors in different geographic regions to avoid disruption of the supply chain during a disaster?
- Is there capacity to store at least a 4-week supply of vital medications and their individual patient containers to avoid disrupting patient dosing?
- Should the pharmacy consider maintaining a supply of certain medications, and, if so, which classes/medications? What are the related considerations (e.g., reasonable measures to secure pharmaceuticals, expiration management, temperature controls)?

Discuss treatment plans and contingency planning with clients, particularly those in regions most likely to be affected by a disaster. Instruct clients to refill medications before a foreseeable disaster and to maintain a personal stockpile of medications when appropriate.

OTPs should take steps to ensure that an adequate supply of approved OUD treatment medications (e.g., methadone, buprenorphine) are on hand for emergency dosing and other purposes. In addition to medications, OTPs should ensure an adequate supply of bottles and labels. Chapter 5 provides details on pandemic disease preparations.

In some emergencies, a behavioral health service program will need to remove controlled substances such as methadone from the premises during evacuation or relocation. Your program needs to know in advance the legal procedures for requesting such a move and the process for actually moving the substances. Your local DEA agent or your SOTA can provide the most current advice on these processes.

> For information on how to submit emergency requests to DEA for authorization to move controlled substances in response to a disaster, visit the Diversion Control Division website at www.deadiversion.usdoj.gov/disaster_relief.htm.

To facilitate the request process, the disaster planning team can inform your jurisdiction's DEA agent about the controlled substances that your facility stocks and about the potential need for expedited permissions in emergencies. Your program can foster your relationship with the DEA agent by participating in your community's disaster preparedness planning and related practices or drills.

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

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

You can contact the DEA Diversion Control Division at www.deadiversion.usdoj.gov/disaster_relief.htm 24 hours a day, 7 days a week if your program faces any of the following situations:

- The relocation of your DEA-registered facility to a new location
- Need for approval of a new address to dispense controlled substances
- Questions concerning the destruction of damaged controlled substance inventory
- Need for help obtaining controlled substances from a wholesaler
- The transfer of an existing DEA registration number from an out-of-state location to the state where the disaster has occurred

To expedite your request, you can email the following specific information to Natural.Disaster@usdoj.gov:

- Email subject line: Domestic Request (or International Request)
- Registrant name
- Your current DEA registration number
- Contact information:
  - Your name
  - A telephone number where you can be reached
  - Email address
- Specific and detailed information that describes the exact type of assistance you will need from the DEA

Chapter 5—Planning Issues for a Pandemic Disease

IN THIS CHAPTER

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

Healthcare Workers: Information on COVID-19, a webpage developed by the Centers for Disease Control and Prevention (CDC), can be referenced in conjunction with this chapter. It is available at www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html

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

Influenza has long been considered the infectious disease most likely to become a pandemic. Pandemics related to the H1N1 influenza A virus occurred in 1918 (called "the Spanish flu"; World Health Organization [WHO], 2020a) and 2009 (known as "swine flu"; WHO, 2020b). Since the start of 2020, the world has been facing the challenge of novel coronavirus disease 2019 (COVID-19). With no vaccine in existence until well after the outbreak, COVID-19 spread quickly throughout the world.

A pandemic presents such a unique disaster scenario that your behavioral health service program should develop a specific emergency plan to respond to it. The disaster planning team can develop this plan, or it can delegate the task to a pandemic planning committee. The pandemic response plan should be included in the basic plan as an appendix. This chapter presents the information that your program should consider including in this appendix and draws on lessons learned from the influenza pandemics of 1918 and 2009 and COVID-19.

Potential Effects of a Pandemic Disease

When a disease outbreak becomes a pandemic, it can affect the operations of your behavioral health service program in many ways. Significant numbers of staff members, clients, and residential patients (if your program has them) may become ill or die. Staff shortages may occur because workers have been quarantined, want to avoid exposure, or must care for themselves or ill family members. Staff and clients may experience increased mental stress. Isolation and travel bans can cause clients being treated for mental or substance use disorders to develop unstable emotional states or other co-occurring disorders. Your program should ensure that sufficient mental health care is available to staff and clients (Sun, Bao, Kosten, et al., 2020).

A pandemic will likely recur in waves that may last for months or longer. The 1918 Spanish flu lasted for roughly 14 months (Yang, Petkova, & Shaman, 2014), whereas the 2009 swine flu pandemic lasted for more than a year and a half (WHO, 2010). A community affected by a pandemic may only partially recover before experiencing another wave of illness. Because a pandemic affects an entire region simultaneously, the response and recovery help that might otherwise be available could be limited.

Specific client populations may be at special risk of illness or complications. In the case of influenza, this includes women who are pregnant (Exhibit 5.1) and people from racial and ethnic minority groups (Exhibit 5.2). Other groups that may be at special risk include children younger than 5 and people who are age 65 or older; smokers; people who are homeless; patients who have asthma or other chronic pulmonary, cardiovascular, hepatic, hematological, neurologic, neuromuscular, or metabolic disorders such as diabetes; individuals who are immunocompromised; or residents of a nursing home or other residential facility (Kong, Chu, & Giles, 2020).[5]

As of March 2021, CDC (2021a) had established the following demographic trends among overall confirmed COVID-19 cases and deaths in the United States:

- **Race/ethnicity**—White non-Hispanics accounted for the most confirmed cases and deaths (55.9 percent of cases and 63.1 percent of deaths), Hispanics/Latinos accounted for 20.7 percent of cases and 12.2 percent of deaths, while African Americans accounted for 12.2 percent of cases and 14.7 percent of deaths.
- **Age group**—Although the 18–64 age range accounted for 74.1 percent of all cases, the 50–85+ age group accounted for 95.5 percent of all deaths, demonstrating a particular vulnerability among older adults.
- **Gender**—Although men accounted for less than half of confirmed cases (47.8 percent), they accounted for 54.3 percent of all deaths, suggesting a slightly higher vulnerability among men.

EXHIBIT 5.1. Pregnant Women at Special Risk From Influenza

Pregnant women who contract influenza are at increased risk for severe illness or death, and babies born to them have increased risk of adverse outcomes (Rasmussen, Smulian, Lednicky, et al., 2020). The disaster planning team should consider actions your program can take to mitigate risk for pregnant clients during a pandemic outbreak, such as the following:

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

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

Vulnerable subgroups of COVID-19 were still being actively determined at this publication's release; however, risk factors and demographic trends are emerging. Exhibit 5.3 provides an overview of the most prevalent risk factors identified in hospitalized patients diagnosed with COVID-19.

EXHIBIT 5.2. Racial and Ethnic Minorities Disproportionately Affected by Influenza

Historically, people from racial and ethnic minority groups have been disproportionately affected by severe influenza because of higher rates of underlying health conditions as well as cultural, educational, and linguistic barriers that interfere with adoption of intervention strategies (Krishnan, Ogunwole, & Cooper, 2020). Issues related to structural racism and inequality often mean members of ethnic and racial minorities have little choice but to continue to work during pandemics. This places such individuals at higher risk of exposure. To minimize disparities, your program can:

- Involve members of racial and ethnic minorities in its pandemic preparedness and response planning and facilitate their participation in community pandemic planning.
- Advocate for equitable allocation of resources, including antiviral medications and vaccines.
- Offer culturally and linguistically sensitive educational materials and interpreters for non-English-speaking clients, when providing pandemic planning education and services.

EXHIBIT 5.3. Prevalence of Specific Underlying Medical Conditions Among Hospitalized Adults With COVID-19

Underlying Medical Condition	Prevalence Among Hospitalized Cases (N = 5,416)
Obesity	2,674 (55%)
Hypertension	2,658 (49%)
Diabetes	1,793 (33%)
Severe Obesity	769 (16%)
Asthma	702 (13%)
Chronic Kidney Disease	640 (12%)
Coronary Artery Disease	506 (9%)
Chronic Obstructive Pulmonary Disease	328 (6%)
History of Stroke	227 (4%)
Any Underlying Medical Condition	3,938 (73%)

Source: Adapted from Ko, Danielson, Town, et al. (2020).

Exhibit 5.4 lists potential effects of a pandemic on specific types of behavioral health service programs.

EXHIBIT 5.4. Potential Effects of a Pandemic on Behavioral Health Service Programs

Program Type	Potential Pandemic Effects
Outpatient Treatment Programs	Client drop-in and attendance at individual appointments and group events may decline or need to cease. Alternatively, client drop-in and attendance may surge because of concern, panic, or lack of other psychological or medical support. In the context of a COVID-19-like pandemic, all client contact may need to be virtual (via telehealth or telephone services). Clients may not heed instructions to stay home if experiencing disease symptoms and consequently transmit the illness to other clients and staff. Programs must have a screening process in place (e.g., temperature checks) to ensure that people who are symptomatic do not enter the facility. Emergencies for mental health issues may increase as the result of a disruption in client support and access to ongoing treatment. Mental health hotlines should be available for clients to access 24/7. Services may have to be provided using procedures to reduce disease transmission (see "Procedures To Reduce Disease Transmission" below in this chapter). Staffing shortages may occur as clinicians and other staff become ill, stay at home to care for ill family members, or self-isolate to avoid possible transmission. The entire program may close or specific services may be unavailable during local outbreaks of disease. Revenues may decline dramatically, affecting the financial viability of the program. Staff will need access to personal protective equipment (PPE) and infection control training.
Residential Treatment Programs	Patients may become symptomatic and need to be isolated. Exposed staff and/or patients may need to be quarantined. Staff may need to take care of patients who become ill. Staff will need access to PPE and infection control training. Visits may need to be suspended or highly restricted. Electronic visits may replace onsite visits. Programs must have a screening process in place (e.g., temperature checks) to ensure that people who are symptomatic do not enter the facility.

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EXHIBIT 5.4. Potential Effects of a Pandemic on Behavioral Health Service Programs, *cont.*

Program Type	Potential Pandemic Effects
Medically Supervised Withdrawal Programs	Beds may be redirected for use by patients with a pandemic disease. Medical and nursing staff may be redirected to care for patients with a pandemic disease. Necessary antiviral drugs may be slow in arriving or not be available at the necessary levels. Disease symptoms (e.g., fever, nausea, respiratory distress, diarrhea) may be difficult to differentiate from withdrawal symptoms. A surge in patients may occur that includes people who are infected with the pandemic disease, people who misinterpret disease symptoms as withdrawal symptoms, and people who seek psychological or medical support. Staff will need access to PPE and infection control training.
Opioid Treatment Programs (OTPs)	An OTP may need to provide patients with take-home methadone doses for longer periods than usual (following guidelines from the Substance Abuse and Mental Health Services Administration [SAMHSA], Center for Substance Abuse Treatment [CSAT], Division of Pharmacologic Therapies). The program may need to provide patients with take-home doses earlier in their recovery than usual (again, following CSAT's guidelines). Increased numbers of patients may need to have doses brought to them because they have contracted a communicable disease. Hospital emergency departments may be operating at capacity and unavailable for methadone maintenance treatment of patients whose home OTP has closed. Patients in fear of not receiving scheduled doses may overwhelm the program as they seek additional take-home supplies or support. Programs may be at increased risk of theft or diversion of medications. Programs may need to develop curbside delivery of medications following telehealth follow-up. Staff will need access to PPE and infection control training.
Prevention Programs	The program may be discontinued until the local pandemic crisis is over.

Procedures To Reduce Disease Transmission

CDC continually updates its advice on procedures to reduce the spread of influenza, COVID-19, and other diseases. These procedures include making annual flu vaccinations available to employees (and vaccination against specific pandemic strains as vaccines become available) and minimizing potential exposure by promoting good respiratory hygiene and cough etiquette and separating symptomatic clients from other people (CDC, 2021b).

Your program may need to modify procedures in the event of disease pandemic with possible quarantine. Some changes will entail planning and investment:

- Increases in staff telecommuting may require improving your program's communications infrastructure and developing policies that govern working from home.
- Telephone or web-based counseling may require new equipment and testing, ideally before a pandemic. Prior approval from funding sources, such as insurance providers and Medicaid, for substitute forms of counseling may be needed to facilitate reimbursements. Any plans to provide counseling through remote means (e.g., telehealth, telephone) need to specify how clients who don't have telephones, mobile devices, or computers will access the service.
- Staff may need training in appropriate at-home telehealth or web-based counseling. In addition to training on hardware and software, your program should train staff on ethical and professional considerations.
- Any program modifications should be reviewed for their potential impact on patient confidentiality.
- Clients may need assistance in obtaining hot spots. Some clients in your program may not have Internet access, or their Internet access will not be strong enough to allow for a good connection.
- Telehealth or web-based providers must meet local, state, and federal guidelines on security.

Be prepared to incorporate lessons learned from the COVID-19 pandemic and quarantine experiences into program processes and future responses.

Your program can seek guidance from your state disaster behavioral health coordinator on planning for modifications to procedures during a pandemic (see "State Disaster Behavioral Health Coordinator" in Chapter 2). It's a good idea to work with your legal representative to ensure that procedures comply with privacy requirements and to develop documents for new procedures (e.g., client release forms for phone, texting, or Internet counseling).

Test and practice procedures to identify weaknesses in the plan and to prepare staff. Chapter 6 provides information on testing a disaster plan and training staff to use it.

Influenza guidance for the general public and health professionals is available from:
CDC—www.cdc.gov/flu
U.S. Department of Health and Human Services (HHS)—www.hhs.gov/about/agencies/oga/global-health-security/pandemic-influenza/index.html
World Health Organization (WHO)—www.who.int/influenza/en/

COVID-19 guidance for the general public and health professionals is available from:
CDC—www.cdc.gov/coronavirus/2019-ncov/index.html
HHS—www.hhs.gov/coronavirus/index.html
WHO—www.who.int/emergencies/diseases/novel-coronavirus-2019

Vaccines

The disaster planning team can ensure that the program has policies in place to facilitate vaccination of staff and clients for seasonal flu, if medically indicated. In the case of COVID-19, no vaccine existed at the time of the outbreak; however, your program's CEO/executive director or other appointed representative can contact state and local public health departments to learn about the community's policies on distribution for COVID-19 vaccines and to ask to have the program's essential staff included on the priority list. Your program should also ask to be added to email groups to receive updates about vaccine availability and be included on provider conference calls.

A decision on whether to provide residential patients with a pandemic vaccine should be made by senior management in consultation with the local health department. If vaccines are offered, your program will need to implement policies and consent forms to support this practice. If possible, patients' pertinent medical information (e.g., previous vaccinations and responses, allergies, risks, contraindications) should be reviewed before vaccination. Your program may prefer to refer nonresidential clients and staff members to their primary care providers, local clinics, or other sites (e.g., pharmacies) for vaccinations. Consult with guardians and obtain written consent before administering vaccines.

Antiviral Medications

Using prescription antiviral medications is well established as an important strategy for suppressing the spread of a pandemic (Hurt, 2019), and recent research suggests that such a strategy could in the future apply to COVID-19 as well (Benlloch, Cortes, Martinez-Rodriguez, et al., 2020). As of this document's publication date, remdesivir is the only antiviral drug approved by the Food and Drug Administration for the treatment of COVID-19 (National Institutes of Health, 2020). Updates on COVID-19 treatment recommendations are available on the National Institutes of Health's COVID-19 Treatment Guidelines webpage at www.covid19treatmentguidelines.nih.gov/whats-new/.

Priority distribution of antivirals is generally to workers at critical infrastructure organizations—those providing goods or services essential to community health, safety, or well-being. In a pandemic situation, your program's CEO/executive director or appointed representative is advised to talk to contacts at the public health department or local healthcare coalition to clarify whether antivirals from the public stockpile will be made available to the program or whether the program should purchase its own supply. The disaster planning team should also become familiar with the medical, legal, and ethical issues involved in the use and rationing of antivirals.

Your program should consider purchasing an antiviral stockpile, especially if the program has a residential component, serves clients who have compromised immune systems, or serves women and girls; as indicated in Exhibit 5.1, pregnancy has been found to increase risk for severe illness or death from some influenza strains. Antiviral stockpiling can be costly, but manufacturers may make financial assistance available. Coordinate all plans to stockpile medications with state and local emergency pandemic preparedness efforts.

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

Hygiene Policies

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

- Encourage hand hygiene (e.g., frequent washing, use of hand sanitizers, use of disposable gloves) among staff members and clients.
- Reduce spread of virus through respiratory means (e.g., teach coughing etiquette [coughing into your elbow if no other covering option is available], post coughing etiquette instructions).
- Enforce the use of face masks at all times inside the program.
- Stock up on sanitation supplies (e.g., disinfectants, hand sanitizers, facial tissues, face masks).
- Provide preventive education for staff members and clients (e.g., maintaining overall good health, avoiding unnecessary exposure to people who are ill, keeping all suggested immunizations up to date to protect against illness that weakens the ability to fend off a virus).
- Educate staff members and clients on disease symptoms (e.g., elevated temperature, persistent cough, chills, body aches).
- Educate staff members on social distancing procedures (e.g., remaining at least 6 feet apart, eliminating traditional forms of physical interaction such as handshakes).
- Make alterations to housekeeping policies to ensure enhanced cleaning occurs regularly at all facilities (e.g., cleaning doorknobs, door handles, phone receivers, keyboards, and other surfaces), especially if staff members share office space.
- Make alterations to sick leave policies during pandemics to allow staff members who are diagnosed or symptomatic to isolate and who are asymptomatic but who have (or may have) been exposed to the virus to quarantine.
- Make temporary modifications during pandemic conditions to the program's appointment policy to ensure that clients who are contagious aren't penalized for canceling appointments at short notice.
- Eliminate food buffet service from meetings and replace with individually boxed meals. If your program serves food, use disposable plates, cups, and utensils.
- Establish curbside services, if your program owns a pharmacy.

For information on appropriate use of PPE, consult CDC guidelines at www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html.

Exhibit 5.5 explains the difference between quarantine and isolation.

Staffing Policies

The order of succession in the disaster plan may need to be extended (i.e., more backups provided) to ensure that leadership and other essential positions are filled. In addition, your pandemic plan may need to identify multiple layers of staff trained in sanitation duties (e.g., disinfecting surfaces, changing linens, removing trash), because sanitation will be very important during a pandemic.

EXHIBIT 5.5. Quarantine vs. Isolation

Quarantine keeps someone who might have been exposed to the virus away from others.

Quarantine helps prevent spread of disease that can occur before people know they are sick or if they are infected with the virus without having symptoms. People in quarantine should stay home, separate themselves from others, monitor their health, and follow directions from their state or local health department.

Isolation keeps someone who is infected with the virus or exhibiting symptoms of infection away from individuals who are not infected, even at home.

People who are in isolation should stay home until it's safe for them to be around others. In the home, anyone sick or infected should separate themselves from others by staying in a specific "sick room" or area and using a separate bathroom (if available).

Sources: CDC (2020a, 2020b).

Your program's pandemic plan can provide direction for rapidly identifying staff members who become symptomatic and for making staff substitutions so that those identified workers can quarantine or isolate. If staff levels become critically low, the program may need to hire qualified staff members from a staffing agency, or it may need to refer or transfer clients. Review CDC guidelines if your program faces a staffing shortage despite mitigation strategies. Exhibit 5.6 presents a symptom-based strategy published by CDC for determining when healthcare professionals with COVID-19 can return to work after being isolated or quarantined.

If contagion is a concern, other programs may not want to treat guest clients from your program, even if mutual aid agreements exist. The disaster planning team should know the agreements' terms and develop in advance an approach to resolving this issue. Local hospitals also may be overwhelmed with ill patients and find it difficult to dispense methadone to referred OTP patients or to treat patients needing medically supervised withdrawal. The disaster planning team needs to consider these scenarios. Your program's CEO/executive director or appointed representative should clarify assumptions with the behavioral health service programs with which your program has mutual aid agreements, with staffing agencies, and with hospital representatives.

The disaster planning team should identify alternative ways to serve clients if your program reduces its operations or closes and if other programs are not immediately available to serve your clients. For example, an OTP may provide patients who qualify with take-home doses for an extended duration. Exhibits 4.4 and 4.5 in Chapter 4 provide 2020 guidance from SAMHSA on extended take-home provisions.

Staff Attitudes and Support

Your program needs to assess staff competencies and attitudes to ensure that all employees are prepared and **feel** prepared for the duties they will be expected to perform under pandemic conditions. Workers who lack confidence in their abilities may need more training in their designated disaster roles and education about how their contributions make a difference. In addition, your program needs to encourage staff members to develop pandemic-specific emergency plans for their own households.

EXHIBIT 5.6. Guidelines for Determining When Healthcare Personnel With COVID-19 Can Return to Work

Who this is for:

Occupational health programs and public health officials making decisions about return to work for healthcare personnel with confirmed infection by SARS-CoV-2 (the coronavirus strain that causes COVID-19) or who have suspected SARS-CoV-2 infection (i.e., developed symptoms of COVID-19) but were never tested for SARS-CoV-2.

Personnel with mild to moderate illness who are not severely immunocompromised:

- At least 10 days have passed since symptoms first appeared.
- At least 24 hours have passed since last fever without the use of fever-reducing medications.
- Symptoms (e.g., cough, shortness of breath) have improved.

Note: Personnel who are not severely immunocompromised and were asymptomatic throughout their infection may return to work when at least 10 days have passed since the date of their first positive viral diagnostic test.

Personnel with severe to critical illness or who are severely immunocompromised:

- At least 10 days and up to 20 days have passed since symptoms first appeared.
- At least 24 hours have passed since last fever without the use of fever-reducing medications.
- Symptoms (e.g., cough, shortness of breath) have improved.
- Consultation with infection control experts has been considered.

Note: Personnel who are severely immunocompromised but who were asymptomatic throughout their infection may return to work when at least 10 days and up to 20 days have passed since the date of their first positive viral diagnostic test. Personnel who are severely immunocompromised could remain infectious more than 20 days after symptom onset. Consultation with an infectious disease specialist is recommended.

Because many individuals will have prolonged viral shedding, the utility of waiting for a negative viral diagnostic test before returning to work is limited.

Be aware that state or local health department guidelines may be stricter than the CDC's.

Source: CDC (2021c).

Exhibit 5.7 provides a framework to support ongoing recovery that has been adapted for COVID-19 by the U.S. Department of Veterans Affairs' National Center for Posttraumatic Stress Disorder (PTSD).

EXHIBIT 5.7. A Framework To Support Ongoing Recovery: Five Essential Elements

Research has identified five essential elements to improve ongoing recovery from a disaster after the initial response. These elements—Cover, Calm, Connect, Competence, and Confidence—have been captured in the Stress First Aid (SFA) peer support model. Behavioral health service programs can use these elements to organize ongoing support for their employees. The sample questions, statements, and actions below have been modified from the SFA model to apply to the COVID-19 pandemic. Programs can choose those elements that best fit the conditions employees are working under, changing them to suit the situation and style of interacting.

Cover

- **Questions**—"How has the pandemic affected your sense of safety? What can we do to help you feel safer?"
- **Statements**—"We are committed to our employees' health and well-being. Here is what we're doing to keep you safe."
- **Actions**—Give your best understanding of timelines and any variables.

Calm

- **Questions**—"How are you doing? What changes have you experienced regarding sleep, feelings of being on edge, or ability to stay calm? If you're having trouble staying calm, is there anything we can do to help?"
- **Statements**—"There are no set rules for working through something like this. Be patient with yourself."
- **Actions**—Allow employees to speak frankly about the event, their reactions, and their concerns. Discuss the importance of taking the time for self-care. More information about self-care is included in the article "Managing Stress Associated with the COVID-19 Virus Outbreak" available at www.ptsd.va.gov/covid/COVID19ManagingStress032020.pdf.

Connect

- **Questions**—"Has there been an impact on how you talk with each other, work morale, or connecting with family and friends? Is there someone you feel comfortable talking with about this? Has anyone you know done or said something that really helped? Do you feel the need for practical support right now?"
- **Statements**—"We'll make it through this together. We value you and the work you do. Be sensitive to those around you. Talk when you need to; listen when you can."
- **Actions**—Encourage employees to consider staying in touch with coworkers via email, text, or videoconferencing, both to continue collaborating on projects if that is part of their work and to be sources of support and connection.

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EXHIBIT 5.7. A Framework To Support Ongoing Recovery: Five Essential Elements, *cont.*

Competence

- **Questions**—"Do you have any concerns about being able to handle what's going on in your life, deal with your stress reactions, or do your work? What are some things that you have done to cope that have been helpful in the past or have been helpful recently? What else could we do that would help?"
- **Statements**—"If you've found a coping strategy that works for you, consider sharing it with your coworkers. Here are resources to help you through (e.g., a workplace peer or supervisor, health department hotlines, a chaplain, an employee assistance program counselor)."
- **Actions**—Offer the resources available at your organization. Encourage use of these resources.

Confidence

- **Questions**—"Have you noticed any change in your confidence in your ability to do your job the same way as before the outbreak or your confidence in leadership? Are you feeling guilty or wish you could do something differently? Does the outbreak hold special meaning or connect with other experiences in any way? What else could help?"
- **Statements**—"Try to take things one day at a time. The situation is unprecedented and ever-changing, and we're all doing the best we can under challenging circumstances. Remember to be patient with yourself and others. Don't let the worst elements of the situation overshadow your belief in yourself or your commitment to what you do. Help is there whenever you need it."
- **Actions**—Check in regularly. Share optimistic news. Increase positive encouragement, reinforcement, and gratitude for employees' contributions.

Source: National Center for PTSD (2020).

Planning Assumptions for a Pandemic Disease

Planning assumptions should be based on available data and information from public health authorities regarding both influenza and COVID-19. These assumptions form the basis for planning decisions. Exhibit 5.8 provides examples of planning assumptions.

Drafting and Activating a Pandemic Plan

The pandemic appendix should state:

- Who determines when to activate the plan because of pandemic conditions.
- What information to use to make the decision to activate the plan.
- Which modified policies and procedures to implement.

The appendix should describe actions to take if essential services cannot be provided because of staff shortages, quarantines/isolations, facility closures, or other pandemic-related events. It should also describe the conditions under which the plan will be deactivated and staff will return to normal duties.

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

EXHIBIT 5.8. Examples of Pandemic Planning Assumptions

Issue	Assumptions
Time Factors	The time interval between an alert issued for pandemic influenza and its arrival in the community may be short or long (ranging from days to months). The pandemic may last as long as 18 months and occur in several waves, with mortality and morbidity increasing and decreasing sporadically. Waves of severe disease may last 1 to 4 months.
Prevention and Treatment of the Influenza	A vaccine may not be available for many months after an influenza pandemic begins, and supplies of it may be limited. Antivirals may not treat or protect against the pandemic influenza virus strain. Even if effective, antiviral medications may be in limited supply, and their distribution may occur in phases. Infection control strategies and social (physical) distancing strategies (e.g., postponing public gatherings such as support group meetings, substituting telehealth [either 2-way audio/video or telephone only] for in-person sessions) can be used to slow the spread of disease. Isolation of persons who are symptomatic or who test positive will be required. Quarantine of asymptomatic people exposed to symptomatic persons or persons who test positive may be implemented.
Clients and Staff Members	Individuals who are immunocompromised and/or have chronic medical conditions are potentially more vulnerable to disease severity. Twenty to fifty percent absenteeism for staff, clients, vendors, and services within the community may occur. Absenteeism will be the result of staff members and clients becoming ill, staying home to care for children or family members, or refusing to go to the facility for fear of contracting the virus. Every person who becomes ill is likely to miss at least a few days and possibly many weeks of work. Staff members and clients (including residential patients) may develop symptoms while on program premises. Staff members may be asked to perform tasks that are not in their job descriptions to provide coverage for essential services; they may be transferred to other duties or facilities where coverage is needed; or they may be assigned to work extended or additional shifts. In a severe pandemic, essential staff members may be drafted into the care of the sick, and residential facilities may be commandeered to create pandemic wards separate from the main hospitals. In a severe pandemic, fear and anxiety levels will increase.

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EXHIBIT 5.8. Examples of Pandemic Planning Assumptions, *cont.*

Issue	Assumptions
Services	Services will be stressed but will remain functional. Telecommuting practices may be implemented for support services (e.g., administrative functions). Critical functions carried out by contractors, consultants, and vendors may be erratic. The program may be unable to rely on mutual aid resources to support its response efforts. Staff may accrue an unbudgeted amount of overtime or use higher-than-normal amounts of leave and sick time.

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

The decision to activate the pandemic plan must be made carefully. Your program must weigh the hardships imposed by reducing or modifying services to clients against the risks of infection. The pandemic appendix should detail how your program will notify staff members, clients, and the public of changes in service provision and procedures, including closings and alternative options for seeking assistance. This notification plan can be similar to those used for other types of emergencies; online and social media notifications have increasingly becoming an effective method of communication.

You can write boilerplate text for notification messages in advance and include it in the pandemic appendix. Examples of standard messaging include:

- Informing staff members and clients of pandemic conditions and of the pandemic appendix's activation.
- Counteracting rumors and misinformation by providing staff members with accurate infection control information on such topics as the efficacy of face masks, hand hygiene (e.g., handwashing technique, hand sanitizer use), and social (physical) distancing.
- Providing information and suggestions on how to relieve anxiety (e.g., deep breathing, relaxation techniques, hydration, online mental health resources).
- Providing staff members with a confidential resource (e.g., an employee assistance program) that can help them with pandemic-related challenges.
- Providing staff members with a mental health support hotline number.
- Providing referral to bereavement counseling and other social supports.
- Providing notification that the pandemic appendix of the disaster plan is no longer in effect, at the end stage of a pandemic situation.

Establishing a social media relationship with clients and the community before a disaster will help ensure that they can trust your program to dispense accurate and reliable information in an emergency. Familiarize yourself with the predominant social media platforms used in your community (e.g., Facebook, Twitter, Instagram, Snapchat, Nextdoor), to maximize the effect of your messages (Frank, 2019).

Chapter 6—Completing, Testing, Activating, and Deactivating the Disaster Plan

IN THIS CHAPTER

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

Worksheets (see Appendix B)

- B1 Checklist for the Written Disaster Plan
- B18 Disaster Plan Training and Testing Log

As discussed in Chapter 1, a behavioral health service program's disaster planning team drafts the sections of a written disaster plan based on information gathered from a risk assessment document. The team then recommends implementation options to management (following the processes outlined in Chapters 2 and 3). This chapter explains the steps involved in completing, testing, activating, and deactivating the plan.

Assemble the Plan

When all sections of the disaster plan are completed, they can be assembled into one document. **Worksheet B1** (in Appendix B) provides a checklist of all items to include in the plan. Insert the following elements at the front of the document:

- **Cover page**—This page includes the title, date, and facility covered by the plan.
- **Signature page**—This page includes signatures of the program's executive director and other senior managers (e.g., the chair of the program's board of directors) who affirm that the program's leadership approves and endorses the plan. Management can sign off on sections as they are completed or at one time on the entire document.
- **Title page**—This page includes placeholders to record the date of changes and revisions to show that the plan is being kept current and to indicate that the document is the current version.
- **Record of changes**—This record indicates changes to the plan and the dates they were made.
- **Record of distribution**—This page indicates who has received a copy and where other copies are stored (e.g., in the facility go kit).
- **Table of contents**—This list of the sections in the plan helps users find information quickly.

Distribute the Plan

Once management approves the plan, the disaster planning team should distribute it to all relevant parties. Staff members assigned responsibilities under the plan can receive the full document or the sections relevant to their duties. The disaster planning team can develop a management-approved summary to provide to other staff members, have IT place the plan on the desktops of all staff computers, or place the plan on the organization's intranet or on a shared drive. The team can also provide copies of the summary or the full plan, as appropriate, to the state behavioral health service agency and to other organizations with which the program has developed relationships for disaster response (e.g., local departments of health and social services, local emergency managers, the local chapter of the American Red Cross).

Train and Test: Disaster Exercises

In an actual disaster, no one has time to consult a disaster plan. The process of training and testing staff members familiarizes them with procedures so that they can respond efficiently when a disaster occurs, using the written plan as a reference.

Disaster exercises can help staff members build the skills and team relationships they will need when executing a disaster plan. These activities also identify problems or gaps in the plan that should be addressed, as well as actions that can mitigate risk. These drills and exercises may involve staff from—and take place within—a single facility, encompass multiple facilities of one organization, and/or involve unaffiliated programs that are geographically close.

The Federal Emergency Management Agency's (FEMA) Emergency Management Institute offers courses in all aspects of disaster response with an emphasis on different organizations collaborating in all-hazards emergencies; a list of topics is available at https://training.fema.gov/emi.aspx. Local chapters of the American Red Cross also provide disaster training information at www.redcross.org/take-a-class/disaster-training. All members of your disaster planning team should complete appropriate training. Your program may consider providing staff with compensated time for training conducted outside regular working hours and other incentives to enhance disaster readiness skills. **Worksheet B18** (in Appendix B) can be used to log training and testing activities.

The U.S. Department of Homeland Security's (DHS) Homeland Security Exercise and Evaluation Program (HSEEP) offers a tool for developing training exercises and establishing and evaluating the exercise goals. You can scale this tool up or down for exercises of all sizes and types, and you can modify it based on your program's needs; it's available at www.fema.gov/emergency-managers/national-preparedness/exercises/hseep. HSEEP also lays out an Exercise Cycle, presented in Exhibit 6.1, that involves four stages of disaster preparedness training.

FEMA's Preparedness Toolkit (available at https://preptoolkit.fema.gov/web/hseep-resources) includes templates for documents that your program can use at each stage of the Exercise Cycle. An introduction to the HSEEP structure for exercises can be found in a free online course at https://emilms.fema.gov/is_0120c/curriculum/1.html.

Disaster exercises fall into two categories: discussion-based exercises and operations-based exercises. Each exercise your program conducts should build on previous training and testing (DHS, 2020).

EXHIBIT 6.1. HSEEP Exercise Cycle of the Four Stages of Preparedness Training

Source: DHS (2020).

Discussion-Based Exercises

Discussion-based exercises are seminars, workshops, and tabletop exercises. These exercises help staff members understand and explore your program's disaster plan and the policies, procedures, and agreements that are part of it.

Training through seminars can begin while your team is developing the program's disaster plan. Seminars can be structured as small-group meetings or as lectures, led by a presenter or facilitator. People leading the seminar could be members of your disaster planning team, senior program leadership, or outside subject matter experts. Training seminars communicate to the staff a common framework for disaster planning and response.

Workshops involve increased participation by your program's staff. The structure should be small groups or large groups with focused breakout sessions. Workshops should be discussion oriented. The disaster response plan should be in draft form so that staff members can provide input to help finalize the plan. Workshops continue the process of familiarizing staff with the plan and build consensus and support for it.

A tabletop exercise provides initial training to key staff members who are responsible for executing the disaster plan. A simulated, facilitated tabletop exercise held with program leaders and staff can prepare an organization before an event occurs. Tabletop exercises examine current preparations related to specific events, help define roles, uncover challenges or issues, and identify needs or gaps that should be addressed (DHS, 2020). In a small-group setting, an experienced facilitator presents a scenario, and participants talk through possible responses. New developments in the scenario are presented during the exercise so that participants reconsider previous decisions and plan their next actions. Participants share ideas and discuss options for responding to the hypothetical situation, without the pressures that occur in a real or simulated event. The discussion-based exercise familiarizes

participants with their roles and responsibilities and reveals issues that require revision or additional planning. These exercises also enable local organizations to network and share ideas on improving disaster readiness.

Exhibit 6.2 provides an overview of a tabletop exercise on Ebola response, and Exhibit 6.3 summarizes tabletop exercises involving opioid treatment programs (OTPs) in King County, WA. Exhibit 6.4 provides an example of the useful networking that can occur at a tabletop exercise.

Operations-Based Exercises

Operations-based exercises include drills, functional exercises, and full-scale exercises. These exercises validate plans, policies, procedures, and agreements; clarify roles and responsibilities; and identify resource gaps.

OTP Clinic Director on the Utility of Disaster Planning

"So, you know, again knock on wood, we really haven't had any major disasters. That's good of course, but then it also doesn't give people an opportunity in real time to have to use their processes to make sure, 'Okay, this works. This doesn't work.' Sometimes, they could be challenging if you only have something that kind of stays on paper and you never really have to implement it. I mean, which we also see with emergency, whether it's 9/11, whether it's Hurricane Katrina, you know, it doesn't matter. It's like we deal with it at the moment. We go . . . 'What the hell, we weren't prepared or we could have done A,B,C, and D better.' And then as time goes on, it's not in our face anymore, and we're moving on to new things. . . . You know the more you drill, the more it's natural."

—Elliott, Benoit, Matusow, & Rosenblum (2017, p. 158).

EXHIBIT 6.2. Tabletop Exercises for Employees

We recently held an Ebola Virus Preparedness and Response tabletop exercise and provided staff a situation manual covering the exercise overview, scenario description, and objectives. Participants identified strategies and plans for client isolation and transfer while developing plans to protect other clients and staff. Continuity of operations was a primary concern, with the need to continue service delivery with reduced staff.

The team identified that during an outbreak we should assist the greater community with associated mental stress responses, which need to be coordinated with local, state, and federal organizations. Ways and means of improving communication internally and externally were identified. Discussion was held regarding the provisions needed to provide safety and sanitation, including the possibility of operating as a point of distribution for medications or vaccinations. Recommendations were recorded so that updates could be made to agency policies, procedures, and our emergency preparedness manual. Benefits included interdepartmental discussion and collaboration on how the agency would respond to a potential viral outbreak and discussion on the benefits of coordinating efforts with the regional healthcare coalition.

Source: Debbie Fitzgerald, Ed.S., LPC, NCC, personal communication, September 2020.

EXHIBIT 6.3. Tabletop Exercise for OTPs (1.5 hours)

Element	Description
Participating Organizations	City of Seattle Office of Emergency Management Drug Enforcement Administration (DEA) Evergreen Treatment Services King County Healthcare Coalition Public Health—Seattle and King County Therapeutic Health Services University of California, Los Angeles Veterans Administration (Washington State Department of Veterans Affairs) Washington State Board of Pharmacy Washington State Division of Alcohol and Substance Abuse
Exercise Objectives	Determine ability to support timely decisions about operations of OTPs in an emergency Demonstrate ability to coordinate communication and resources among key stakeholders Evaluate process for activating mutual aid agreements among OTPs Discuss protocols and rules of regulatory agencies
Scenario Timeline and Major Events	Friday, May 29, 7:59 a.m.: A very large earthquake occurred, rumbling through the entire Puget Sound region for 2 minutes. Damage is visible in the entire county. All landline and cell phones are jammed. Electricity is out in the neighborhoods of SODO, Capitol Hill, and First Hill. Friday, May 29, 8:45 a.m.: Media report a shallow 6.8 magnitude earthquake occurred in the Black Diamond area and extensive damage in Kent, Auburn, and Renton. The 520 Bridge has collapsed. The Alaskan Way viaduct is closed. Saturday, May 30: Landline and cell phones work sporadically. Text messages are getting through. Limited power returns to SODO region. Evergreen Treatment Services has power but no water. Monday, June 1: President signs a disaster declaration for the area. Monday, July 6: Several moderate aftershocks (2–5 in magnitude) have occurred since May 29.
Lessons Learned	OTPs that have generators will assess what equipment, including alarms and medication storage areas, is powered by their agencies' backup generator. OTPs will advise staff members that they should plan alternate routes to work. OTPs will work on strategies for communicating with staff members, patients, and the general public, including the media, in a disaster. This includes developing communication strategies for contacting patients if power is down and landline and cell phones are jammed and encouraging staff members to have an out-of-area phone contact.

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EXHIBIT 6.3. Tabletop Exercise for OTPs (1.5 hours), *cont.*

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

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

The aim of these drills is to practice a specific function or hone a specific ability. Drills may involve a small group of people (e.g., only those who work with a certain piece of equipment or group of patients) or your entire program (e.g., to practice the disaster communication plan, evacuation, and what to do if utilities fail). Regardless of who participates, drills should have a narrow focus with a quick turnaround on feedback.

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

EXHIBIT 6.4. Networking at a Tabletop Exercise

Various community agencies and organizations participating in a tabletop exercise can exchange useful information that might otherwise not be shared. During the tabletop exercise described in Exhibit 6.3, discussion turned to the use of generators for emergency power. The manager of an emergency responder agency indicated that OTPs might be able to obtain priority fuel assistance for their generators during an outage. The OTP administrators found this information useful because lines at gas stations can be long during an emergency. One administrator who had experienced a communitywide extended power outage after a storm reported that he had had to divert staff members from their treatment functions to the task of finding gas: "I'd load them up with gas cans and send them out to fill them all up, so we'd have fuel for a couple of days."

Source: Podus, Maxwell, & Anglin (n.d.).

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

- Coordination of staff members from two programs providing behavioral health services for the transfer of clients from one facility to another
- Communicating during a severe pandemic with clients who have limited English proficiency
- Notifying families and referral agencies during an emergency evacuation at an adolescent residential treatment program
- Executing a plan for sheltering in place that provides for the unique needs of at-risk populations

Typically, it will be more feasible, cost-effective, and productive for your behavioral health service program to participate in a community-sponsored operations-based exercise than to conduct one on its own. Your disaster planning team, via its working relationship with local emergency planners or healthcare coalitions as described in Chapter 2, can stay apprised of when such exercises are scheduled and find out how to arrange for program staff members to participate.

A full-scale exercise (sometimes called a "field exercise") is a comprehensive enactment of a disaster, with people acting out their roles in real time, using actual equipment, and testing multiple emergency functions. A full-scale exercise takes a great deal of planning, is disruptive to normal business operations, and is expensive. Your behavioral health service program is unlikely to conduct this kind of exercise; **however, your staff can benefit from participating in a full-scale exercise organized by local or regional emergency management leaders or healthcare coalitions.** Involving local elected officials in training exercises can be beneficial, because they will be making important decisions during a disaster and allocating funds and engaging state and federal assistance in the wake of a disaster (Craddock et al., 2016).

Although community full-scale exercises can be beneficial, behavioral health service programs do not have a strong record of participating in such efforts. Leaders of your program should actively network with local emergency managers so that program leaders are aware of joint exercises, can testify to the importance of being included in the planning and execution of these exercises, and are invited to be involved.

Evaluation is an integral part of any training exercise, whether a tabletop or a functional exercise. You should make decisions on exercise goals and how to evaluate these goals at the beginning of the process. Effective exercise planning begins with setting these measurable goals. The exercise itself ends with a measurement of success in achieving those goals, which leads to decisions that may include how to improve the current disaster plan, policies, and trainings. The resulting document is referred to as an "After-Action Plan/Improvement Report" and includes improvement goals, objectives, responsible parties, and timelines for making these improvements. FEMA's Preparedness Toolkit has templates you can use to evaluate exercises your program conducts; the toolkit is available at https://preptoolkit.fema.gov/web/hseep-resources/eegs.

Activate the Plan in Disaster

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

1. Activate the program's Incident Command System (a key person is designated Incident Commander to manage response; see "Designate Personnel To Assume Command for Incident Response" in Chapter 2).
2. Decide on objectives and priorities to reduce risk to persons and property, based on the nature of the incident (e.g., if a wildfire is approaching a program, the first priority will be immediate evacuation of the facility and the second priority will be protection of property). The disaster plan's hazard-specific appendixes provide guidance on objectives for response to a specific threat, such as a wildfire.
3. Create an incident action plan. The Safety Officer creates this plan to accomplish the objectives in a specified timeframe. The plan will indicate assignments and the resources that can be used to complete those assignments. An informal draft will work unless the incident response is expected to be large and complex.
4. Follow through on the plan, but be prepared to modify it to address changing circumstances.

Familiarity with disaster procedures helps leaders activate a disaster response at the right time—not too early, not too late, or unnecessarily. Exhibit 6.5 discusses the possible consequences of timing decisions. Two key variables affect the decision: (1) whether the program has received advance notice of the disaster and (2) when the incident occurs (during or after business hours). A hurricane, severe blizzard, or pandemic usually allow for advance notice, whereas an earthquake or hazardous materials spill typically will not.

Disaster incidents that occur when key staff members are off duty may require subordinate staff members to decide when and how to contact their supervisors and what actions to take. Recurrent disaster training for all staff members and a clear order of succession are the best preparation for a sudden disaster that occurs when senior management staff members are not present. Training for management and staff can be offered in short sessions over time and build from basic to more advanced skills, based on roles. This kind of graduated training schedule reduces the disruption of program services.

Deactivate and Revise the Plan

"Deactivation" is the process by which a program ends its state of emergency and resumes normal operations. Examples of deactivation activities include:

- Returning from an alternate facility to the home location after the disaster incident has passed, such as when a mandatory evacuation has ended.
- Contacting outpatient clients to inform them that counseling services have resumed a regular schedule and to reschedule appointments, as needed.
- Encouraging clients to reengage in services by having their assigned counselors contact them by phone, email, or text about additional services or referrals, as needed.
- Arranging for the return of patients on methadone maintenance who have received guest dosing at another facility (and the retrieval of records related to this treatment).
- Completing reconstruction of all or part of a destroyed facility.

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

EXHIBIT 6.5. Effect of Timing Decisions on Staff

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

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

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

Source: Podus et al. (n.d.).

Adequate planning and training for a disaster can expedite the recovery time, although the recovery phase guided by your disaster plan's recovery procedure can last weeks, months, or even longer. Staff should be encouraged to follow the disaster plan's recovery procedures, which can include:

- Contacting insurance representatives.
- Collecting necessary documentation.
- Filing claims.
- Applying for recovery grants and aid.
- Recording recovery expenses.

The *National Disaster Recovery Framework* includes predisaster and postdisaster checklists and planning activities by sector, including the private and nonprofit sectors. You can access these resources at www.fema.gov/sites/default/files/2020-06/national_disaster_recovery_framework_2nd.pdf.

A system should also be in place to allow staff members to record their extended hours of duty during and after the disaster so that they can be compensated and recognized.

Exhibit 6.6 discusses physical recovery steps for your program. Exhibit 6.7 gives an example of wellness steps for staff.

EXHIBIT 6.6. Examples of Recovery Steps

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

Coordinate With the Community in Recovery

A program's involvement with its community's recovery may depend on the extent to which it engaged in predisaster recovery planning and other recovery preparedness, mitigation, and community resilience-building work (see Chapter 2). Community recovery is managed by local governments, in conjunction with nongovernmental partners and stakeholders and with state and federal agencies. Behavioral health service programs are most likely to become involved via the Health and Social Services Core Capability defined by the *National Disaster Recovery Framework* (DHS, 2016).

Support Staff Members, Clients, and the Community After the Disaster

The emotional well-being of staff is an important consideration throughout the disaster recovery phase. Stress management mechanisms (e.g., regular rather than overtime shifts as much as possible, compensatory time for personal recovery needs) can be built into the recovery action plan to reduce psychological burdens for staff.

Staff members should always be referred outside the program for assessment or treatment of personal stress reactions related to the disaster (this does not refer to incident briefings or debriefings that are part of the program's efforts to share information during disaster response and recovery). One option for providing staff support is to contract with a local employee assistance program for these services.

EXHIBIT 6.7. Example of a Wellness Program Focused on Self-Care

It is important to take care of your emotional health before, during, and after a disaster. While wellness programs typically help combat chronic diseases, our wellness program also offers mental health and emotional support. A devastating tornado in our community took a toll on our staff. In response, our organization developed *WellBalance*, a voluntary wellness program that inspires total well-being by creating opportunities, activities, information, and education designed to encourage our employees to improve and maintain their quality of life.

WellBalance allows our employees to participate in preventive screenings, home circuit training, and *Livesmart* walking groups. We offer educational information including coping calendars, emergency family communication plans, and family emergency supply checklists. Disease management and nutrition-focused classes are offered and include mindful eating, *What to Do When You Over Do,* and *Boosting Your Immune System,* along with self-care tips such as *Be Your Best You, Managing Your Stress, Social Nourishment, Dealing with Compassion Fatigue, Understanding Vicarious Trauma,* and *Mindfulness Meditation.*

Employees track participation through our activity tracking program and follow their progress on their individualized dashboard. Participants earn points toward a *WellBalance* financial incentive providing savings on health insurance premiums or a one-time cash reward. The goal of *WellBalance* is to help our employees maintain their psychological and physical health and let our employees know we care about them.

Source: Vicky Mieseler, M.S., BCCP, NP, personal communication, August 2020.

Traumatized mental and substance use disorder treatment professionals should be able to resume their normal duties when they are no longer symptomatic, but such decisions need to be made on an individual basis by the administrator, the clinical supervisor, and the person involved. Professionals who claimed disability benefits will also need permission to return to duty from their primary care provider or therapists.

Clients can benefit from extra support (e.g., educational sessions, pertinent handouts, additional counseling sessions, access to a crisis hotline) to help them maintain recovery following a major event. The program can provide clients with a list of recovery resources that has been updated after the disaster to reflect changes in organizations, locations, and meeting dates and times. The program may also take on other activities to support the mental and substance use disorder recovery communities, such as:

- Arranging for interpretation services at meetings of mutual-help groups.
- Organizing transportation to those meetings.
- Providing space for a meeting at the facility.
- Ensuring that mutual-help groups are available for specific populations, such as those with co-occurring disorders.

Finally, through its participation in the community's coordinated disaster recovery, your program should stay alert to the needs of the local community after the disaster. You may be able to offer targeted assistance, for example, partnering with other agencies to offer screening, brief intervention, and referral to treatment (SBIRT) services for mental, substance use, or co-occurring disorders. SBIRT assessments can be offered on quarterly or yearly anniversaries of the disaster or as requested.

Your program may want to be especially proactive about offering SBIRT services to community members directly affected by the disaster or involved in response efforts (e.g., first responders, shelter staff, members of the media who reported on the disaster).

Continually Revise and Update the Disaster Plan

The development, planning, and testing cycles of any good disaster plan are ongoing. Review, evaluate, and update the plan after every test and every activation—and after any significant change to your program's services or facilities.

Several factors may affect how often and when your program updates its disaster response plan (FEMA, 2018a):

- **Change in leadership**—New leaders will have input into the disaster response plan and may want to change procedures based on their experience. New leadership will entail updating orders of succession and delegations of authority.
- **Program reorganization**—If your program reorganizes or becomes part of a larger healthcare organization, essential functions and the processes that support them may need to be updated. The disaster response plan will need to be updated to reflect those changes.
- **Results of disaster exercises or real-world events and incidents**—Disaster exercises and actual disasters can point out lapses in planning, gaps in resources, and areas for improvement. Your disaster response plan should be updated to reflect lessons learned.

- **Results of evaluations**—Evaluations conducted after exercises can identify areas for improvement, which may require changes to plans.
- **Mandated requirements**—Changes in local, state, or federal statutory requirements that affect behavioral health service programs may make it necessary to revise plans.

This cycle is continual, requiring resources and commitments from leadership and the whole staff. However, the benefits of disaster preparedness and planning for behavioral health service programs, clients, and staff cannot be underestimated. The effort that goes into continual disaster planning can save lives and lessen the long-term impact of disaster on the people and the community that your program serves.

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

Appendix A—Bibliography

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Appendix B—Worksheets

Worksheet B1 Checklist for the Written Disaster Plan

Name_____Date _____

Instructions: Use with **Chapter 1, Rationale and Process for Planning,** and **Chapter 6, Completing, Testing, Activating, and Deactivating the Plan.** List the dates that each component of the disaster plan was drafted and compiled into one resource or updated.

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

continued on next page

Worksheet B1 Checklist for the Written Disaster Plan (page 2)

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

Worksheet B2 Checklist for Disaster Planning

Name_____ Date _____

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

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

Worksheet B3 Checklist of State and Community Representatives and Groups

Name_____ Date _____

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

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

Worksheet B4 Checklist of Disaster Planning Discussion Topics

Name_____ Date _____

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

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

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

continued on next page

Worksheet B4 Checklist of Disaster Planning Discussion Topics (page 2)

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

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

Worksheet B5 Sheltering-in-Place Checklist

Name_____ Date _____

Instructions: Use with **Chapter 2, Disaster Planning and Preparation.** In the left column, indicate when the preparation listed in the right column has been addressed or updated.

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

Worksheet B6 Incident Command System Positions

Name_____ Date _____

Instructions: Use with **Chapter 2, Disaster Planning and Preparation.** Complete at least the top table. For each position, list the primary staff member and one or more backups. Worksheet B11 can be used to create a roster for the Incident Command System (ICS) positions.

Position	Primary	Backup	Backup	Backup
Incident Commander				
Liaison Officer				
Safety Officer				
Public Information Officer				
Administrator or Director				

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

Worksheet B7 Requirements for Alternate Facilities

Name_____ Date _____

Instructions: Use with **Chapter 2, Disaster Planning and Preparation.** In the left column, list your behavioral health service program's essential functions (from Worksheet B10). In the middle columns, estimate the number of people involved in each essential function at any one time, and list facility requirements to accommodate that number of people. Then, make a copy of this partly completed worksheet for every alternate facility being evaluated. On each copy, write the prospective alternate facility's name and contact information and indicate whether it meets the requirements. Use the data collected to compare prospective alternate facilities and to consider how to meet requirements that an alternate facility cannot provide.

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

Worksheet B8 Alternate Facility Arrangements by Disaster Scenario

Name_____Date _____

Instructions: Use with **Chapter 2, Disaster Planning and Preparation.** For each disaster scenario, list the alternate facilities that have been arranged. Add any notes (e.g., whether prearrangements have been confirmed, costs for use, distance from facility, whether some staff members will work from home). If your program has multiple sites, a separate sheet should be completed for each noting the specific alternate arrangements. Memorandums of agreement (MOAs) and/or prearrangements are recommended for external sites not owned by your program.

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

Worksheet B9 Checklist for Relocation Planning

Name_____ Date _____

Instructions: Use with **Chapter 2, Disaster Planning and Preparation.** Indicate by date when each planning step has been addressed or updated.

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

Worksheet B10 Identify Essential Functions and Staff Positions

Name_____ Date _____

Instructions: Use with **Chapter 3, Continuity Planning.** Complete a copy of both parts of this worksheet for each department. For the upper part, list all functions that the department performs. For the lower part, in the left column, list the department's essential functions in priority order as determined in the upper part. In the right column, identify the staff position(s) necessary to perform the function.

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

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

Worksheet B11 Essential Staff Roster

Name_____ Date _____

Instructions: Use with **Chapter 3, Continuity Planning.** Complete a copy of this worksheet for each essential staff position identified in Worksheet B10. Record contact information for the primary staff member and backups who can perform the essential staff position's duties.

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

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

Worksheet B12 Checklist for Continuity Planning

Name_____ Date _____

Instructions: Use with **Chapter 3, Continuity Planning.** Indicate by date when each planning question has been addressed or updated.

ALL PROGRAM TYPES

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

continued on next page

Worksheet B12 Checklist for Continuity Planning (page 2)

OUTPATIENT TREATMENT PROGRAMS

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

RESIDENTIAL TREATMENT PROGRAMS

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

continued on next page

Worksheet B12 Checklist for Continuity Planning (page 3)

MEDICAL DETOXIFICATION

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

OPIOID TREATMENT PROGRAMS (Note: See also Chapter 4, Management of Prescription Medications.)

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

continued on next page

Worksheet B12 Checklist for Continuity Planning (page 4)

PRIMARY PREVENTION SERVICES (Note: Primary Prevention Will Not Be an Essential Service in a Disaster.)

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

Worksheet B13 Checklist for Maintaining Communications With Essential Groups

Name_____ Date _____

Instructions: Use with **Chapter 3, Continuity Planning.** For each essential group listed in the left column, place an X to indicate the means by which communications will be maintained during an emergency.

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

continued on next page

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

Worksheet B13 Checklist for Maintaining Communications With Essential Groups (page 2)

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

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

Worksheet B14 Checklist of Records and Databases To Ensure Interoperable Communications

Name_____ Date _____

Instructions: Use with **Chapter 3, Continuity Planning.** For each category of record or database listed in the left column, place an X to indicate the options for retrieving or entering data. Also indicate the staff members who have authority to retrieve or enter data and whether they will have access to the passwords or authentication procedures for accessing the record.

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

Worksheet B15 Checklist for Protecting Records and Databases

Name_____ Date _____

Instructions: Use with **Chapter 3, Continuity Planning.** For each category of record or database listed in the left column, provide the information requested in the other columns. Use this information to determine the steps to ensure protection of vital records and databases.

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

Worksheet B16 Checklist for Managing Human Capital

Name_____ Date _____

Instructions: Use with **Chapter 3, Continuity Planning.** Indicate by date when each staff policy has been addressed or updated.

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

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Worksheet B16 Checklist for Managing Human Capital (page 2)

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

Worksheet B17 Checklist for Management of Prescribed Medications

Name_____ Date _____

Instructions: Use with **Chapter 4, Management of Prescription Medications.** Indicate by date when each planning step has been addressed or updated.

Date(s) Addressed/ Updated	Planning Steps—All Programs
	Clients have been advised on how to obtain prescription replacements and refills under various disaster scenarios.
	The program has provided naloxone prescriptions or naloxone kits to all patients who might need them.
	Clients have been educated on what to carry with them when evacuating or seeking services at an alternate facility so that they can obtain prescription replacement, refills, or methadone dosing.
	The program has communicated with the public health department for information on the public stockpile of medications.
	The topic of medication maintenance for clients has been addressed with local disaster planning committees.
	Plans are in place for transfer and tracking of patients receiving medications to an alternate location or to another clinic that will be able to provide guest dosing or other prescription medications.
	Other:
Date(s) Addressed/ Updated	**Planning Steps—Opioid Treatment Programs**
	Patient medical records (including dose levels and take-home privileges) are stored and regularly updated at a secure location (e.g., an offsite server).
	The opioid treatment program (OTP) is ready to quickly and securely transfer patient records and the supporting software to an alternate facility.
	The OTP is ready to submit exception requests to the Substance Abuse and Mental Health Services Administration (SAMHSA) and the State Opioid Treatment Authority (SOTA) (as authorized).
	The option of providing patients with smart ID cards has been considered. If smart ID cards are used, other OTPs have been identified that have the equipment to read the cards and that can accept guest patients in an emergency. A backup method for transferring medical data has been established, in case patients lose their smart ID cards.
	The program has discussed with its SOTA the capabilities of its central database and has determined the procedures for accessing patient records in emergencies. Issues covered include: • How patient information will be accessed when records at the program are destroyed or inaccessible. • How information on guest patients from other OTPs will be accessed. • How the OTP's patient records will be accessed by other OTPs providing guest dosing. • Whether patient releases and other permissions will be required to access patient records. • Whether dosage information from guest patients will be relied on before verification of that information from the guest patients' home OTPs.
	The program is aware of the current status of state-run healthcare communications systems through which dosing information can be securely transferred.

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Worksheet B17 Checklist for Management of Prescribed Medications (page 2)

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

Worksheet B18 Disaster Plan Training and Testing Log

Name_____ Date _____

Instructions: Use with **Chapter 6, Completing, Testing, Activating, and Deactivating the Disaster Plan.** List each training and testing activity in the left column and details about that activity in the other columns.

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

Appendix C—Abbreviations and Acronyms

ASPR	Office of the Assistant Secretary for Preparedness and Response
CCC	Citizen Corps Council
CCP	Crisis Counseling Assistance and Training Program
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
COOP	continuity of operations
COVID-19	novel coronavirus disease 2019
CSAT	Center for Substance Abuse Treatment
DATA	Drug Addiction Treatment Act of 2000
DCMP	Disaster Case Management Program
DEA	U.S. Drug Enforcement Administration
DHS	U.S. Department of Homeland Security
DPT	Division of Pharmacologic Therapies
DTAC	Disaster Technical Assistance Center
EHR	electronic health record
EMAC	Emergency Management Assistance Compact
EMI	Emergency Management Institute
ESAR-VHP	Emergency System for Advance Registration of Volunteer Health Professionals
ESF	Emergency Support Function
FCC	Federal Communications Commission
FEMA	Federal Emergency Management Agency
GETS	Government Emergency Telecommunications Service
HHS	U.S. Department of Health and Human Services
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HSEEP	Homeland Security Exercise and Evaluation Program
ICS	Incident Command System
KAP	Knowledge Application Program
MARC	Multi-Agency Resource Center
MMT	methadone maintenance treatment
MOA	memorandum of agreement

MOU	memorandum of understanding
MRC	Medical Reserve Corps
NCD	National Council on Disability
NDRF	National Disaster Recovery Framework
NEF	National Essential Function
NIMS	National Incident Management System
ONC	Office of the National Coordinator for Health Information Technology
OTP	opioid treatment program
OUD	opioid use disorder
PAD	psychiatric advance directive
POD	point of distribution
PPAEMA	Protecting Patient Access to Emergency Medications Act
PPE	personal protective equipment
PTSD	posttraumatic stress disorder
QSOA	qualified service organization agreement
SAMHSA	Substance Abuse and Mental Health Services Administration
SARS-CoV-2	severe acute respiratory syndrome coronavirus 2
SBA	Small Business Administration
SBIRT	screening, brief intervention, and referral to treatment
SFA	Stress First Aid
SMA	State Methadone Authority
SOTA	State Opioid Treatment Authority
SUD	substance use disorder
TAP	Technical Assistance Publication
THIRA	Threat and Hazard Identification and Risk Assessment
TSP	Telecommunication Service Priority
VOAD	Voluntary Organizations Active in Disaster
WATrac	Washington System for Tracking Resources, Alerts, and Communication
WHO	World Health Organization
WPS	Wireless Priority Service

Appendix D—Disaster Planning Web Resources

Resources From the Substance Abuse and Mental Health Services Administration

Behavioral Health Treatment Services Locator—https://findtreatment.samhsa.gov

Cultural and Population Sensitivity in Disaster Behavioral Health Programs (*The Dialogue*)—www.samhsa.gov/sites/default/files/dtac/dialoguevol14i3and4compliant-508c.pdf

Disaster Apps, Tools, and Technology (*The Dialogue*)—www.samhsa.gov/sites/default/files/dtac/samhsa-dtac-dialogue15-030719.pdf

Disaster Behavioral Health Information Series Resource Collections (focuses on a specific population, disaster type, and other topic pertinent to disaster behavioral health preparedness, response, and recovery)—www.samhsa.gov/dtac/dbhis-collections

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

FAQs: Provision of methadone and buprenorphine for the treatment of opioid use disorder in the COVID-19 emergency—www.samhsa.gov/sites/default/files/faqs-for-oud-prescribing-and-dispensing.pdf

Federal Guidelines for Opioid Treatment Programs, March 2015—https://store.samhsa.gov/product/Federal-Guidelines-for-Opioid-Treatment-Programs/PEP15-FEDGUIDEOTP

Medication-Assisted Treatment webpage—www.samhsa.gov/medication-assisted-treatment

Submit an Opioid Treatment Exception Request (for the administration and management of opioid treatment)—www.samhsa.gov/medication-assisted-treatment/otp-resources/submit-exception-request

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

Screening, Brief Intervention, and Referral to Treatment (SBIRT) webpage, SAMHSA—www.samhsa.gov/sbirt/about

State Opioid Treatment Authorities Directory—https://dpt2.samhsa.gov/regulations/smalist.aspx

At-Risk Populations and Disaster

Health Information Translations, Quality Health Education Resources for Diverse Populations, Disaster Preparedness webpage, Ohio State University Medical Center, Mount Carmel Health System, Ohio Health, and Nationwide Children's Hospital—https://healthinfotranslations.org/topic/disaster_preparedness/26123/

National Council on Disability—https://ncd.gov/

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

New York Disaster Mental Health Responder (quarterly newsletter for the disaster mental health community from the State University of New York's Institute for Disaster Mental Health)—www.newpaltz.edu/idmh/resources-/newsletters.html

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

Tips for People With Disabilities and Medical Concerns, Independent Living Resource Center of San Francisco—http://www.ilrcsf.org/wp-content/uploads/2012/08/Medical.pdf

Coalitions & Communities

Disaster Behavioral Health Coalition Guidance, Office of the Assistant Secretary for Preparedness and Response (ASPR)—www.phe.gov/Preparedness/planning/abc/Documents/dbh_coalition_guidance.pdf

Healthy, Resilient, and Sustainable Communities After Disasters: Strategies, Opportunities, and Planning for Recovery—www.ncbi.nlm.nih.gov/books/NBK316541/

Communications

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

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

Electronic Health Records

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

Promoting Interoperability Programs, Centers for Medicare and Medicaid Services (CMS)—www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms

Emergency Planning for Staff and Clients

Build a Kit webpage, Federal Emergency Management Agency (FEMA)—www.ready.gov/kit

How to Prepare for Emergencies webpage, American Red Cross—www.redcross.org/get-help/how-to-prepare-for-emergencies.html

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

Ready.gov, Consumer Readiness website, FEMA—www.ready.gov/

Red Cross Mobile Apps—www.redcross.org/get-help/how-to-prepare-for-emergencies/mobile-apps.html

Federal Guidance and Support

Business Readiness webpage, FEMA—www.ready.gov/business

Business Continuity Plan, FEMA—www.ready.gov/business-continuity-plan

Emergency Disaster Relief, Domestic or International, Office of Diversion Control, Drug Enforcement Administration—www.deadiversion.usdoj.gov/disaster_relief.htm

Emergency Preparedness Rule, CMS—www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule

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

Homeland Security Exercise and Evaluation Program, DHS—www.fema.gov/emergency-managers/national-preparedness/exercises/hseep

Independent Study Program, Distance Learning, FEMA (courses on emergency management, continuity of operations, and federal guidance)—https://training.fema.gov/IS/

National Disaster Recovery Framework, FEMA—www.fema.gov/emergency-managers/national-preparedness/frameworks/recovery

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

National Preparedness Goal (2nd ed.), FEMA—www.fema.gov/sites/default/files/2020-06/national_preparedness_goal_2nd_edition.pdf

National Preparedness System, FEMA—www.fema.gov/emergency-managers/national-preparedness/system

National Response Framework (4th ed.), FEMA—www.fema.gov/sites/default/files/2020-04/NRF_FINALApproved_2011028.pdf

Planning Templates, FEMA—www.fema.gov/sites/default/files/2020-10/non-federal-continuity-plan-template_083118.pdf

State Survey Agency Guidance, Emergency Preparedness for Every Emergency, CMS—www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/StateAgencyGuidance

Financial Aid for Programs

Crisis Counseling Assistance and Training Program (CCP), Substance Abuse and Mental Health Services Administration (SAMHSA) and FEMA—https://store.samhsa.gov/product/Crisis-Counseling-Assistance-and-Training-Program-CCP-/sma09-4373

Disaster Loan Assistance webpage, Small Business Administration (SBA)—https://disasterloan.sba.gov/ela/Information/Index

Stafford Act, FEMA—www.fema.gov/disasters/stafford-act

Information for Medical and Health Professionals

Center for Public Health and Disasters, UCLA's Fielding School of Public Health—https://cphd.ph.ucla.edu/publications

Emergency Management Assistance Compact—www.emacweb.org/

Mental Health Intervention in the Event of a Disaster: Field Guide—www.cidrap.umn.edu/sites/default/files/public/php/223/223_guide.pdf

NIDAMED, Clinical Resources, National Institute on Drug Abuse—www.drugabuse.gov/nidamed-medical-health-professionals

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

Sample Qualified Service Organization Agreement—http://www.dbhds.virginia.gov/library/mental%20health%20services/scrn-adol-agreemt-form-SAMPLE.pdf

Pandemic Planning

Influenza (Flu) webpage, CDC—www.cdc.gov/flu/

Introduction to Continuity of Operations Planning for Pandemic Influenzas, Independent Study-520, FEMA—https://training.fema.gov/is/courseoverview.aspx?code=IS-520

Managing Stress Associated With the COVID-19 Virus Outbreak—www.ptsd.va.gov/covid/COVID-19ManagingStress032020.pdf

Planning

2017–2022 Health Care Preparedness and Response Capabilities, ASPR—www.phe.gov/Preparedness/planning/hpp/reports/Documents/2017-2022-healthcare-pr-capablities.pdf

Behavioral Health (listing of resources), ASPR—www.phe.gov/Preparedness/planning/abc/Pages/behavioralhealth.aspx

Prepare for Emergencies webpage, SBA—www.sba.gov/business-guide/manage-your-business/prepare-emergencies

Public Health Emergency Preparedness and Response Capabilities, CDC—www.cdc.gov/cpr/readiness/00_docs/CDC_PreparednesResponseCapabilities_October2018_Final_508.pdf

Public Health Practices, 400+ Practices From 48 States for Emergency Preparedness and Response, Center for Infectious Disease Research and Policy webpage, University of Minnesota—www.cidrap.umn.edu/public-health-practices

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

Precredentialed Volunteer Organizations

Citizen Corps—www.ready.gov/citizen-corps

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

Medical Reserve Corps, HHS—https://mrc.hhs.gov/homepage

Voluntary Organizations

American Red Cross—www.redcross.org/

National Voluntary Organizations Active in Disaster—www.nvoad.org/

Appendix E—Sample Memorandum of Agreement Between Opioid Treatment Programs[6]

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

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

Between the following providers:

_____ (Licensed OTP Provider)

_____ (Licensed OTP Provider)

_____ (Licensed OTP Provider)

_____ (Licensed OTP Provider)

[add more lines as needed]

1. Purpose

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

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

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

2. Description

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

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

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

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

c. Document dispensing and treatment in accordance with county, state, and federal requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Activation and Deactivation

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

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

4. Terms and Termination of MOA

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

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

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

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

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

5. Employees

If the receiving provider requests clinical or administrative staff members from the primary provider, employees of a primary provider shall at all times while providing assistance continue to be employees of the primary provider. Wages, hours, and other terms and conditions of employment of the primary provider shall remain applicable to all of its employees who provide assistance under this MOA. The primary provider shall be solely responsible for payment of its employees' wages, required payroll taxes, and benefits or other compensation. The receiving provider shall not be responsible for paying wages, benefits, taxes, or other compensation to the primary provider's employees.

Each party shall pay workers' compensation benefits to its own injured personnel, if such personnel sustain injuries or are killed while rendering aid under this MOA, in the same manner and on the same terms as if the injury or death were sustained serving its own patients. Nothing in this MOA shall abrogate or waive any party's right to reimbursement or other payment available from any local, state, or Federal Government or abrogate or waive the effect of any waiver, indemnity, or immunity available to a party under local, state, or federal law or other governmental action. To the extent that such reimbursement, payment, waiver, indemnity, or immunity does not apply, then each party shall

remain fully responsible as employer for all taxes, assessments, fees, premiums, wages, withholdings, workers' compensation, and other direct and indirect compensation, benefits, and related obligations with respect to its own employees. Each party shall provide workers' compensation in compliance with the statutory requirements of the State of [name of state].

6. Cost and Method for Reimbursement

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

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

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

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

7. Contract Claims

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

8. Acceptance of Agreement

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

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

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

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

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

Company Name_____
Business Address_____
Phone No._____
Fax No._____
Email Address_____

Afterhours emergency contact information:

Contact Name_____
Phone No._____
Fax No._____
Cell No._____
Email Address_____

Signature of Chief Executive_____
Printed Name_____
Title_____
Date_____

Substance Abuse and Mental Health Services Administration (SAMHSA): TAP 34: Disaster Planning Handbook for Behavioral Health Service Programs. SAMHSA Publication No. PEP2021-02-01-001. Rockville, MD: Substance Abuse and Mental Health Services Administration, Published 2021.

As part of its coursework, Quantum Units Education uses the above-referenced article published by the U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA). HHS and SAMHSA have no affiliation with Quantum Units Education and have not endorsed Quantum Units Education's course or business in any way.

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