Disaster Mental Health

State of Indiana

Preparedness Assessment

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Prepared for:
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INTRODUCTION

Indiana has addressed a significant range of emergency planning issues, and more remains to be done. Collaboration with the Indiana State Department of Health recognized the Indiana Division of Mental Health and Addiction (IDMHA) to begin assessing and planning for disaster recovery and response. These activities allowed the Indiana Division of Mental Health and Addiction to participate in a pilot program sponsored by the National Association of State Mental Health Program Directors (NASMHPD) to utilize the Mental Health Planning Guidance for All-Hazards Disasters created by Dr. Brian Flynn. This program guidance, when finalized, will permit Indiana to develop a comprehensive disaster plan for local and state providers and systems.

The Indiana State Department of Health appointed representatives from the Indiana Division of Mental Health and Addiction to become a part of the Indiana State Department of Health Bioterrorism Preparedness Advisory Committee. This committee was established in June 2002. It is the responsibility of this committee to assure that policy makers and other elected officials from the state and local level are provided with regular updates regarding preparedness activities. The Indiana State Department of Health proposed assisting the Indiana Division of Mental Health and Addiction in doing a full assessment of the Community Mental Health Centers' capability to respond to bioterrorism, terrorism, outbreak of infectious disease, or other public health emergencies. It was the goal of the Indiana State Department of Health that a technical assistance and training protocol would be developed once the assessment was completed. The results of this assessment will have direct implications for many parts of the state and particularly for local health and mental health systems. In order for state and local communities to be fully prepared for a disaster event, all disaster/emergency preparedness plans must be integrated. Public health and mental health are diverse systems working together in order to make an appropriate response. This report will do much to educate both the public health and mental health systems in areas of preparedness that need to be addressed.

Dr. Brian Flynn, a former Assistant Surgeon General (USPHS, Ret.) and consultant contracted by the Indiana Division of Mental Health and Addiction, developed an assessment instrument. In the United Stated of America, this instrument is the first of its kind used to assess Community Mental Health Centers' readiness to respond to a disaster. Through this Indiana Disaster Mental Health Preparedness Assessment, the Indiana Division of Mental Health and Addiction has identified the strengths and weaknesses of the public mental health system, in responding to natural and human-made disasters, and to terrorism and bioterrorism incidents as well.

Collaboration at the state level is currently under development in order to respond to the emerging needs of a disaster response. However, most county-level plans lack mental health components, and local providers will need training and technical assistance to accomplish those goals. The State of Indiana's current budget freeze presents the greatest obstacle for the implementation of further assessment and training plans. Currently, the State lacks funding for the development and implementation of preparedness training, as well as the funding to hire a disaster response director. This director would coordinate training and plan development in order to aid in technical assistance for/with counties and municipalities. Due to the growing need for state preparedness, the Indiana Division of Mental Health and Addiction has received some funding from the Indiana State Department of Health to complete the Indiana Disaster Mental Health Preparedness Assessment of the public mental health system.

The overarching goal of this project is to assure that the State of Indiana is prepared to provide emergency mental health and substance abuse services in the event of a natural disaster or a terrorist attack. The Indiana Division of Mental Health and Addiction All-Hazards Advisory Group, made up of mental health and addiction providers, consumers, public officials, faith-based organizations, emergency management personnel, and other stakeholders, will provide guidance and facilitate collaboration across a broad spectrum of resources.

The Indiana Division of Mental Health and Addiction is hoping that through this report, State-level staff of the Indiana Family and Social Service Administration, Indiana State Emergency Management Agency, and the Indiana State Department of Health, will be educated about the critical need for crisis counseling following a natural or human-made disaster, terrorism or bioterrorism event. The Indiana Division of Mental Health and Addiction hopes to educate county emergency management officials about the need to coordinate their local/county emergency plans with community providers of mental health, prevention, and addiction programs.

This report will clearly show that the overwhelming need of our substance abuse and mental health service providers is optimization of an All-Hazards plan, description and delegation of roles/responsibilities, and agreements with external entities/agencies to better convene a community disaster response. The All-Hazards model is currently being endorsed by the Center for Mental Health Services for use by state and local Mental Health Authorities.

EXECUTIVE SUMMARY

A comprehensive questionnaire was developed to assess the preparedness of Indiana Community Mental Health Centers (CMHC) to respond to a disaster/emergency event. This questionnaire was internet-based through a program called WebSurveyor, allowing all centers convenient access to the questionnaire. All 30 Indiana CMHCs completed the survey. Findings from the Disaster/Emergency Preparedness Questionnaire communicated several needs that must be met in order for Community Mental Health Centers to adequately provide services for victims effected by a disaster/emergency event. These requirements include the need to (1) optimize mental health disaster plans, (2) clarify the division of responsibilities and roles each worker needs to accomplish, and (3) the ability to develop memoranda of understanding (MOUs) with outside entities/agencies such as volunteer organizations, schools, businesses, local emergency management, etc.

The first of these requirements illustrates the centers' necessity to optimize their plan. All 30 CMHCs stated they have a disaster plan or are in the revision process. Most of these centers do not have the knowledge or expertise to complete a plan that includes all-hazards coverage. Due to the recent terrorism and bioterrorism disasters, more than 73 percent of the centers are currently updating their plans to include this coverage, but voiced concerns about what the development of their plan should contain. As one center stated, "It is very difficult to know how far to go with preparedness."[1] When asked what the centers felt they needed most to optimize their plans, 22 of the 30 centers stated they needed technical assistance/expertise to develop an adequate disaster response.

The second requirement noted by the CMHCs proved consistent throughout the entire questionnaire. Although most centers could list the types of vital tasks performed before, during, and after a disaster, nearly 67 percent could not specify the delegation of responsibility to complete those tasks within their own entity. More than 76 percent of the CMHCs did not have an understanding of the roles/responsibilities of other local, State, and Federal organizations. One center questioned, "What is our role as a CMHC in the process of responding to a community/regional disaster?," while another stated that determining, "who is in charge is the most difficult".[2]

The final vital need expressed evidenced by the CMHCs was the ability to develop MOUs with collaborating entities/agencies in order to better respond to a disaster. More than 71 percent of the centers stated that they are not integrated with local emergency management agencies, while 80 percent stated they have no coordination with businesses or schools in their area. One center stated that "our preparedness is primarily geared toward our own facilities, staff, and clients who may be involved, and not to the community at large".[3] While completing the questionnaire, many centers realized that their plan only includes a basic guideline for disaster response, but does not incorporate the essential agreements needed to coordinate with collaborating entities/agencies and individuals during such times of crisis.

Overall, the greatest needs of these CMHCs are optimization of plans, description and delegation of roles/responsibilities both internally and externally, and agreements with potential collaborating entities/agencies to better convene a community-wide disaster response. With the appropriate training and consultation, these centers will maximize their current plans and provide a superior response to consumers in the event of a disaster.

[1-3]Comments from the Indiana Division of Mental Health and Addiction Disaster/Emergency Preparedness Questionnaire

Disaster/Emergency Preparedness Questionnaire

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Name of Agency:
Adult and Child Mental Health Center, Inc.
BehaviorCorp, Inc.
Center for Behavioral Health
Center for Mental Health, Inc.
Community Mental Health Center, Inc.
Comprehensive Mental Health Services, Inc.
Cummins Mental Health Center, Inc.
Dunn Mental Health Center, Inc.
Edgewater Systems for Balanced Living, Inc.
Four County Counseling Center
Gallahue Mental Health Center
Grant-Blackford Mental Health, Inc.
Hamilton Center, Inc.
Howard Community Hospital Psychiatric Services
LifeSpring, Inc.
Madison Center, Inc.
Midtown Community Mental Health Center
Northeastern Center, Inc.
Oaklawn Psychiatric Center, Inc.
Otis R. Bowen Center for Human Services, Inc.
Park Center, Inc.
Porter-Starke Services, Inc.
Quinco Behavioral Health Systems
Samaritan Center
Southern Hills Counseling Center
Southlake Center for Mental Health, Inc.
Southwestern Indiana Mental Health Center, Inc.
Swanson Center
Tri-City Comprehensive Community Mental Health Center, Inc.
Wabash Valley Hospital, Inc.

PLAN PREPARATION

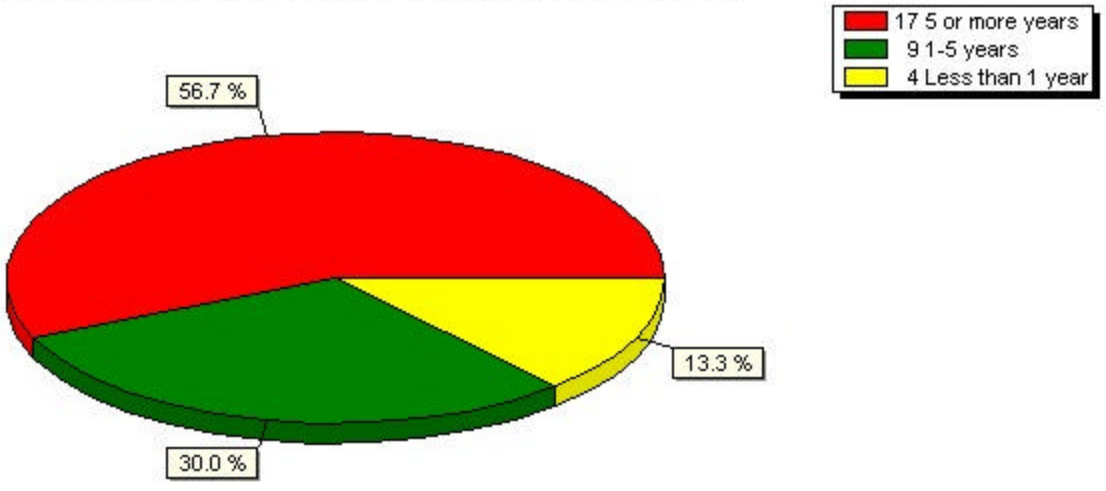
Does your agency cover multiple emergency management jurisdictions (e.g. counties, cities)?

Response	Count	Percent
Yes	26	86.7%
No	4	13.3%
Unsure	0	0.0%

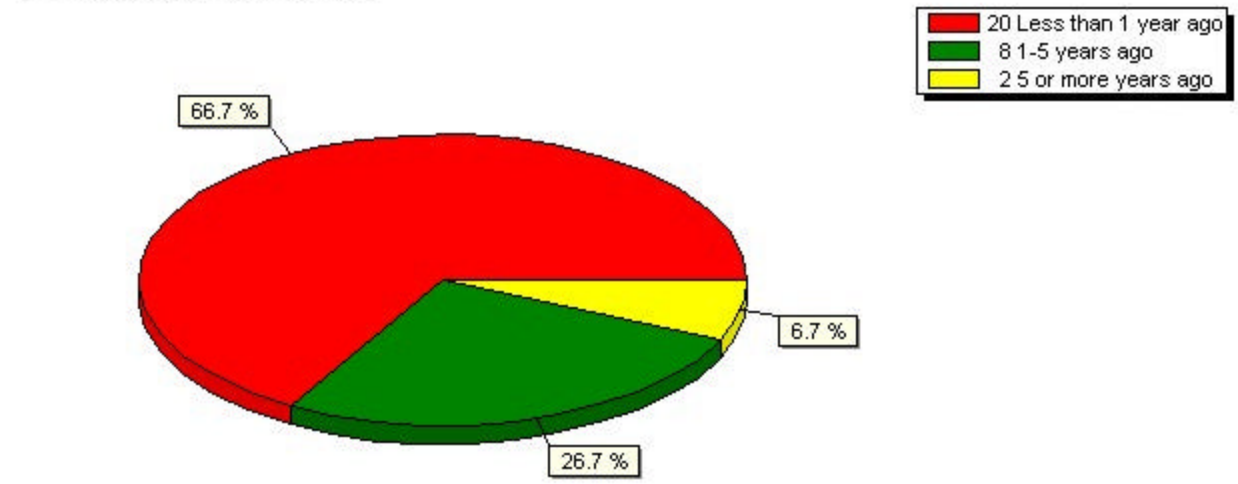
How would you describe your service area?

Response	Count	Percent
Rural	8	26.7%
Urban	2	6.7%
Suburban	0	0.0%
Industrial	0	0.0%
Mixed	20	66.7%

How long has your disaster/emergency preparedness plan been in existence?



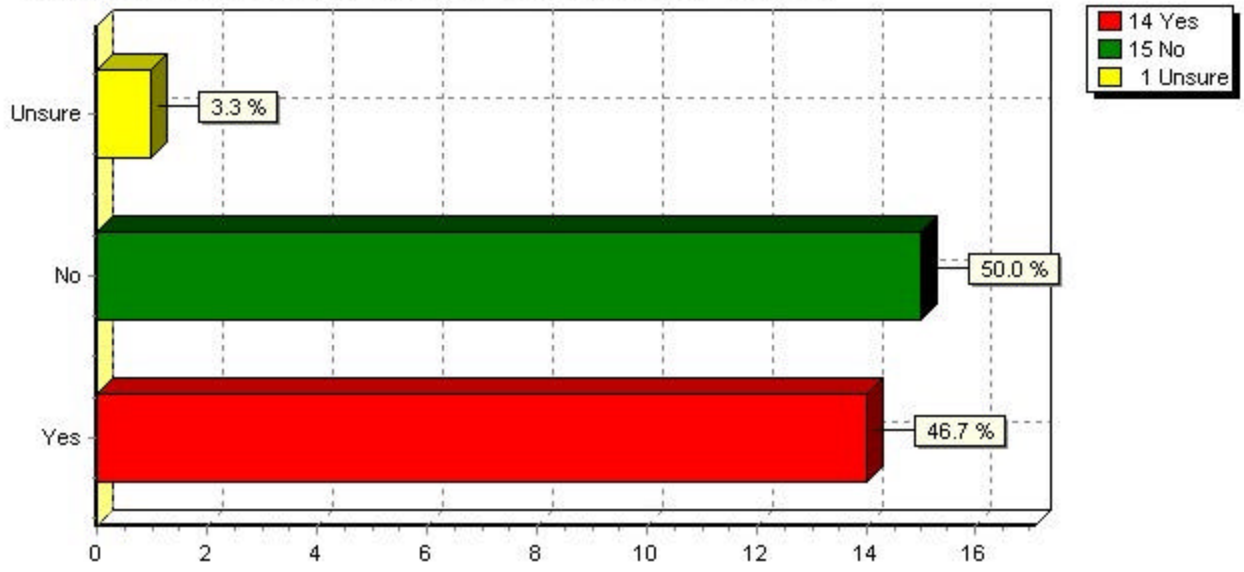
When was the plan last modified?



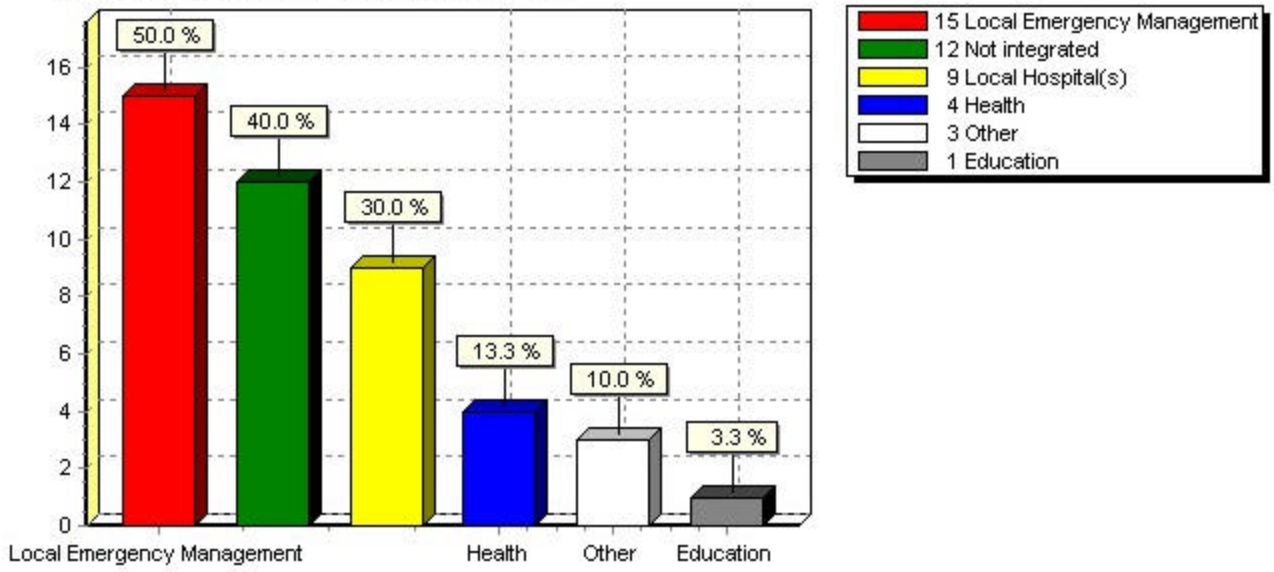
Are you currently in the process of revising / updating the plan?

Response	Count	Percent
Yes	22	73.3%
No	8	26.7%
Unsure	0	0.0%

Have you ever activated the plan in the event of a disaster or emergency?



Is the plan integrated with other plans such as:



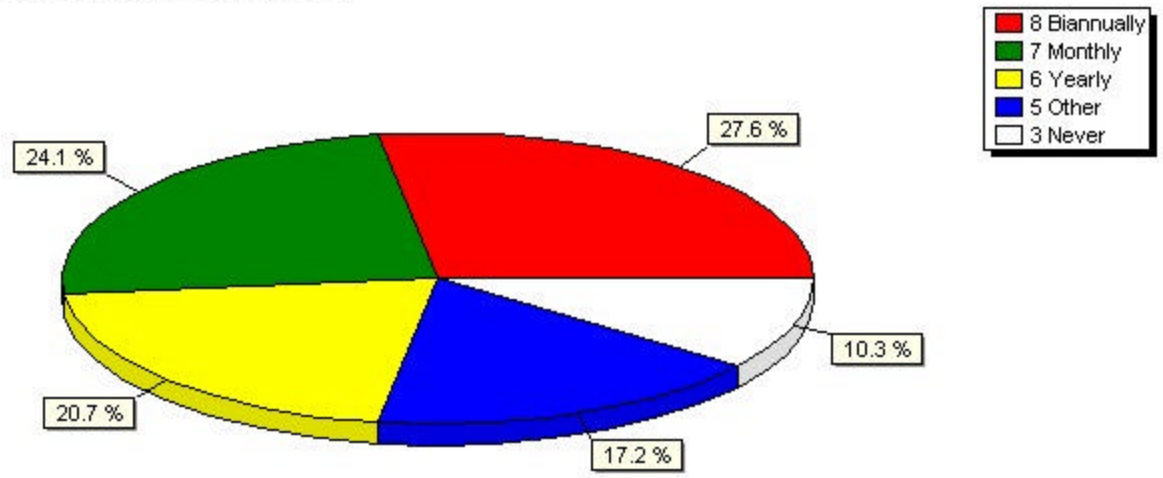
What types of disasters / emergencies do you feel pose the greatest risk to your service area?

Response	Count	Percent
Natural (e.g. flood, tornado, earthquake, fire)	28	93.3%
Man-made (e.g. bomb, terrorism)	5	16.7%

Is your disaster / emergency plan based upon:

Response	Count	Percent
The All-Hazards Model	15	53.6%
Other Model(s)	13	46.4%

Do you run disaster/emergency drills:



When was the last time you practiced your plan?

Response	Count	Percent
Within last 6 months	18	60.0%
Within last year	3	10.0%
Other	4	13.3%
Never	5	16.7%

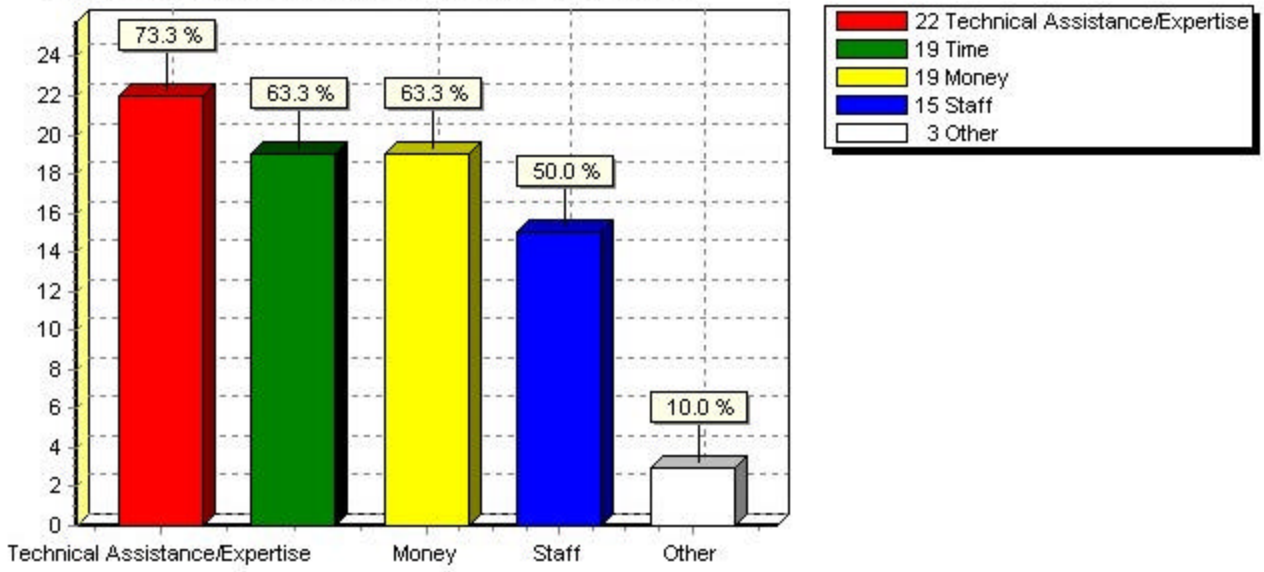
Have you practiced your plan as part of a larger drill involving other agencies and/or organizations?

Response	Count	Percent
Yes	9	30.0%
No	16	53.3%
Unsure	5	16.7%

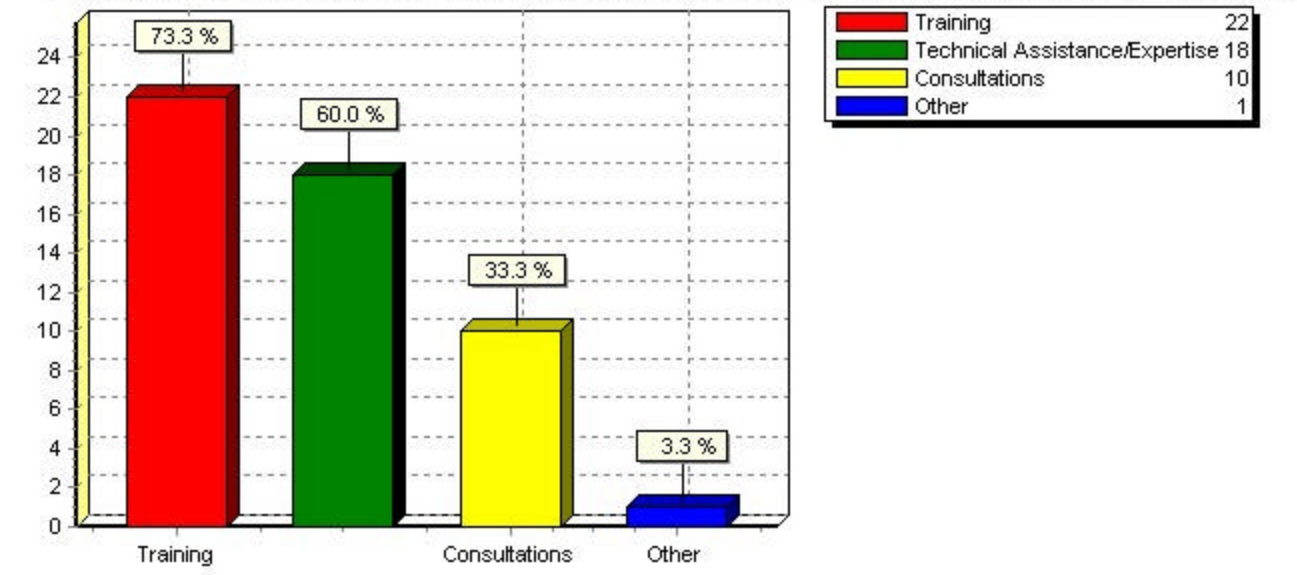
Would you describe the development of the plan to include:

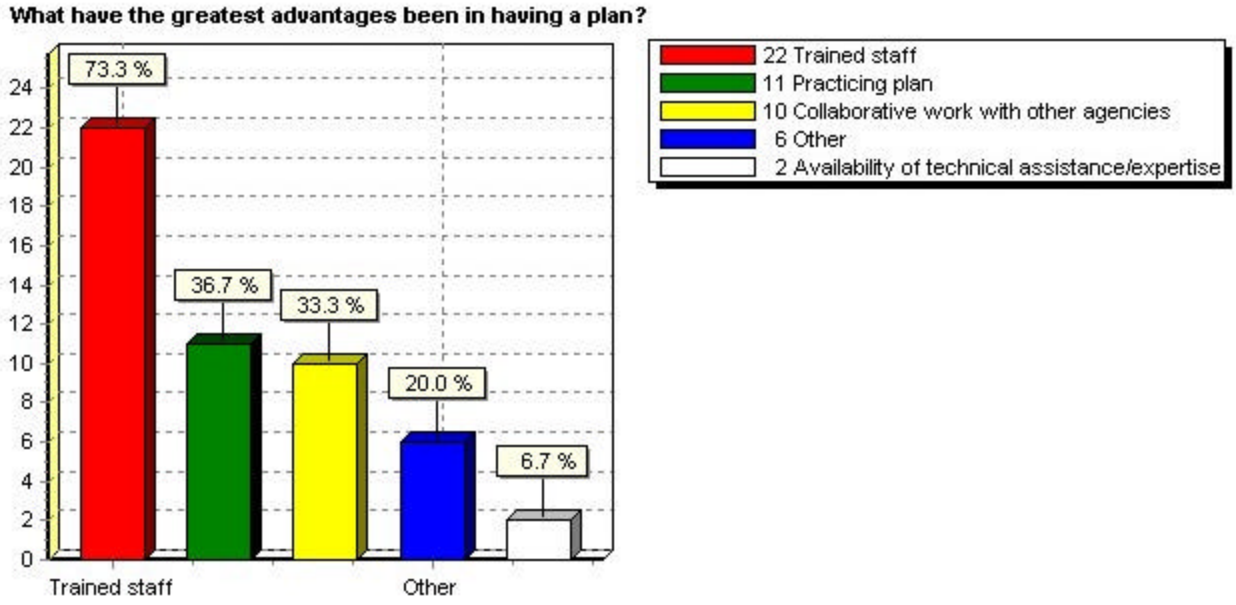
Response	Count	Percent
Health	15	50.0%
Education	7	23.3%
Mental Health (MH) Service Consumers	24	80.0%
Other	8	26.7%

Please list what you believe you need to optimize your plan.



What type(s) of assistance would be most helpful to your agency in maximizing your preparedness for disasters?





Are there other aspects of the planning process that are important to note?

Response	Count	Percent
Yes (if yes please specify in comments field)	11	36.7%
No	8	26.7%
Unsure	11	36.7%

"Comment" responses:

“We are just being included in the 4 county disaster groups through county Indiana Dept. of Environmental Management teams.”
“Making certain that evacuation sites aren't subject to the same pressures (e.g. damaged by the same flood).”
“We are working on a plan - not developed yet.”
“I find staff forget much of the plan we have, so the simpler the better.”
“Consultation and coordination with other community agencies and plans is needed. We are working with the County Mental Health Coordinating Committee to develop a mental health disaster plan.”
“Intra-state coordination is a must. It is also important to coordinate with local Red Cross, which we do. More training is needed for red cross mental health workers just to respond to everyday disasters too (fires).”
“Currently revising plan to integrate better with the local hospital plan and County/City Disaster Plan. Staff seem more comfortable during this stressful time knowing we do have some plan and guidelines in place.”
“Information on evacuation time, standards, & dealing with the unexpected, etc.”
“Commitment to the plan by everyone.”
“Our plan needs to be more detailed in crisis intervention response and better integrated with external agencies.”

"Awareness and documentation of plan is needed."
"A State plan to facilitate & guide local plans is needed, as well as a model for collaboration with other local, state, and national agencies. Finally a model to activate and test local plans in coordination with regional and state plans is needed."

PLAN CONTENT / INTEGRATION

Purpose

(Percentages)	Yes	No	N/A
General statement of plan's purpose	86.7%	6.7%	6.7%

General Assumptions and Situation

(Percentages)	Yes	No	N/A
Assumptions (limits of CMHC authority, highest probability scenarios)	60.0%	23.3%	16.7%
Situation (low/high probable impact, vulnerable/special facilities and populations)	44.8%	41.4%	13.8%

General Concept of Operations

(Percentages)	Yes	No	N/A
Overview of approach (what should happen, when, whose direction)	86.7%	6.7%	6.7%
Division of responsibility (state, local, federal)	30.0%	56.7%	13.3%
General sequence of actions before, during, and after event	80.0%	13.3%	6.7%
Who is authorized to request aid in specific situations	66.7%	23.3%	10.0%

Authorities and References

(Percentages)	Yes	No	N/A
Citation of legal authorities and reference documents as appropriate	17.2%	72.4%	10.3%

Organization and Assignment of Responsibilities

(Percentages)	Yes	No	N/A
Listing, by position and organization, of what types of tasks are to be performed (primary/secondary/shared responsibilities)	70.0%	26.7%	3.3%
Documentation of tasks of local MH authority in Federal Emergency Management Agency (FEMA) format: definition of objective, characterization of the situation, general plan of action, delegation of responsibilities, information on resources and administrative support necessary to accomplish tasks, description of treatment responsibilities (internal/external)	20.0%	70.0%	10.0%
Description of local emergency management tasks/context outside local MH authority	23.3%	66.7%	10.0%
Tasks related to other governmental levels and organizations (state, county, city, Red Cross, faith-based organizations, FEMA. Center for Mental Health Services (CMHS). Substance	20.0%	76.7%	3.3%

Abuse and Mental Health Services Administration (SAMHSA), Dept. of Justice (DOJ)			
Description of coordination with other components and local government health depts., substance abuse authority, law enforcement, fire and rescue, agriculture (including extension service and veterinary services), parks and recreation, animal care/control, victims services, social services, education	33.3%	63.3%	3.3%
Description of who is responsible for modifications and updating plan and assuring coordination with other emergency planning elements	66.7%	30.0%	3.3%
Relationship/coordination with appropriate local emergency management with plans described, completed, and insured	25.0%	71.4%	3.6%

Logistics and Legality

(Percentages)	Yes	No	N/A
Arrangements for support needs (food, water, fuel, etc.)	70.0%	23.3%	6.7%
Provision of self support for at least 72 hrs.	43.3%	50.0%	6.7%
Replacement/repair of damaged/destroyed essential equipment	43.3%	50.0%	6.7%
Personnel access to impacted areas (badging, transportation)	46.7%	46.7%	6.7%
Availability, transportation, safeguarding, recording of medications	51.7%	41.4%	6.9%
Proper licensing, informed consent, confidentiality, licensed providers in other jurisdictions, liability, health information management	30.0%	60.0%	10.0%
Existence and scope of mutual aid agreements	23.3%	66.7%	10.0%

Communications

(Percentages)	Yes	No	N/A
Situation assumptions (types of situations likely to occur and the types of communications necessary in such an event)	86.7%	10.0%	3.3%
Methods of communication among local and state MH authority, psychiatric hospitals/facilities, community-based treatment facilities, local emergency management, emergency medical services, hospitals/clinics, shelters; assurance that local MH authority is on notification list from local emergency management and state MH authority	33.3%	53.3%	13.3%
Alternatives in the event of failed communication capacity	50.0%	40.0%	10.0%
Availability of technical assistance/expertise	23.3%	66.7%	10.0%

Public Information (PI)

(Percentages)	Yes	No	N/A
Identification of responsibility	86.7%	10.0%	3.3%
Policies for PI (who can speak on specific subjects and what authority do they hold)	76.7%	16.7%	6.7%
Existence of PI materials (fact sheets, guides, multiple languages, access to services, distribution of materials)	40.0%	53.3%	6.7%

Relationship with local emergency management office and Public Information Office (PIO)	43.3%	50.0%	6.7%
Identified means of disseminating information	43.3%	50.0%	6.7%
Identification of experts/resources outside facility	36.7%	53.3%	10.0%
Pre-event relationships with media	40.0%	50.0%	10.0%

Warning/Mobilization (Internal/External)

(Percentages)	Yes	No	N/A
Internal-Links with local/regional emergency warning activities and agency risk management as appropriate	66.7%	26.7%	6.7%
Internal-Description of methods and procedures for notifying staff, facilities, service providers, and others as appropriate	83.3%	10.0%	6.7%
Internal-Policies and procedures for CMHC offices and facilities (sending staff home, holding staff in place, recall of essential staff, facility's evacuation)	80.0%	13.3%	6.7%
External-Identification of groups with special warning needs [mentally ill (MI) who are deaf]	23.3%	66.7%	10.0%
External-Notification of mental health system (other providers)	23.3%	70.0%	6.7%
External-Notification of private sector mental health resources	13.8%	75.9%	10.3%

Evacuation

(Percentages)	Yes	No	N/A
Plan for evacuation of CMHC offices and facilities	90.0%	3.3%	6.7%
Plan for alternative sites (hot, warm, cold sites as appropriate	73.3%	20.0%	6.7%
Clear linkage with local emergency management evacuation plans and operations	24.1%	69.0%	6.9%
Plan for services at shelters/mass care facilities	26.7%	66.7%	6.7%

Mass Care

(Percentages)	Yes	No	N/A
Documentation of coordination with local emergency management mass care plan	23.3%	66.7%	10.0%
Linkage with Red Cross, special populations facilities, and other volunteer agencies	46.7%	46.7%	6.7%

Health and Medical

(Percentages)	Yes	No	N/A
Documentation of coordination with local emergency management health and medical plan staffing, logistics, costs, and availability of pharmaceuticals	20.0%	70.0%	10.0%
Provision of mental health services/consultation as part of local emergency medical plan	50.0%	43.3%	6.7%
Role identification in areas of services/consultation to primary victims, secondary victims, response and recovery workers, incident command, public information, body identification and recovery, mortuary services, and other local agencies and	36.7%	56.7%	6.7%

departments (health, education, social service)			
Documentation of coordination with Red Cross Mental Health services	23.3%	63.3%	13.3%

Resource Management

(Percentages)	Yes	No	N/A
Documentation of means, organization, and process by which CMHC will find, obtain, allocate, and distribute necessary resources	36.7%	56.7%	6.7%
Personnel	76.7%	16.7%	6.7%
Transportation for staff	50.0%	43.3%	6.7%
Communications equipment	50.0%	43.3%	6.7%
Emergency equipment as necessary	40.0%	43.3%	16.7%
Material necessary for immediate temporary repair	26.7%	60.0%	13.3%
Mass care supplies for CMHC resources	10.0%	80.0%	10.0%
Mutual aid agreement with other counties/jurisdictions	13.3%	80.0%	6.7%
Management of invited/uninvited volunteers offering assistance	10.0%	83.3%	6.7%
Availability of aid from other states and Federal government	3.3%	90.0%	6.7%
Plan for maintaining financial and legal accountability	33.3%	60.0%	6.7%
Resources for needs assessment	23.3%	70.0%	6.7%

All-Hazards Specific Planning Materials (Natural and Accidental)

(Percentages)	Yes	No	N/A
Plan for accommodation of unique aspects of hazards	60.0%	33.3%	6.7%
Identification of the nature of hazard	70.0%	23.3%	6.7%
Identification of the areas of high risk	63.3%	30.0%	6.7%
Flooding (flash and slow rising) and dam failure	37.9%	44.8%	17.2%
Hazardous materials (including chemicals)	63.3%	23.3%	13.3%
Hurricane/Tsunami	13.3%	46.7%	40.0%
Fire	83.3%	10.0%	6.7%
Earthquake	53.3%	36.7%	10.0%
Military chemical agents and munitions	3.3%	73.3%	23.3%
Radiological hazards (medical usage, educational institutions, military, manufacturing companies, transportation of nuclear material)	3.3%	76.7%	20.0%
Nuclear power plant(s)	0.0%	53.3%	46.7%
Nuclear conflict (war)	3.3%	76.7%	20.0%
Snow/Ice	83.3%	10.0%	6.7%
Tornado	86.7%	6.7%	6.7%
Civil unrest/community violence	10.0%	83.3%	6.7%
Agricultural disasters/emergencies	3.3%	83.3%	13.3%
Immigration emergencies	3.3%	80.0%	16.7%
Chemical	33.3%	53.3%	13.3%

Bioterrorism (please note Section V)	23.3%	66.7%	10.0%
Other	4.0%	56.0%	40.0%

TERRORISM

(Percentages)	Yes	No	N/A
Description of the nature of potential hazards (chemical, biological, nuclear/radiological, explosive, cyber, combined)	20.0%	73.3%	6.7%
Potential identification of targets reflective of local and state emergency plan	3.3%	90.0%	6.7%
Understanding of the roles of other local, state, and Federal responsibilities and resources	13.3%	76.7%	10.0%
Knowledge reflection of CMHC plan and integration with local emergency plan with respect to warning, communication, emergency public information, protective actions, mass care, health and medical annex, and resource management	16.7%	76.7%	6.7%
Description of links to health and medical entities for purpose of assisting in screening potential victims for mental disorders and psychogenic symptomatology, functional impairment, substance abuse, etc.	26.7%	66.7%	6.7%
Description of links with local public health structure for surveillance, screening, consultation intervention planning, and risk communication	13.3%	80.0%	6.7%
Description of MH authority role in risk communication planning and response	16.7%	76.7%	6.7%

Local MH Authority Continuity of Operations

(Percentages)	Yes	No	N/A
Overview of goals of Continuity of Operations plan (e.g. to maintain/re-establish vital functions of MH authority during the first 72 hrs. following an event that would seriously compromise or halt normal operations	40.0%	53.3%	6.7%
Documentation of coordination with overall local and state Continuity of Operations plans	13.3%	83.3%	3.3%
Identification of vital functions to be maintained within first 72 hrs.	56.7%	36.7%	6.7%
Identification of vital records/data necessary to function within first 72 hrs.	53.3%	40.0%	6.7%
Description of plans related to human resources (essential staff, staff notification, family support)	73.3%	23.3%	3.3%
Description of alternative locations of essential operations	70.0%	26.7%	3.3%
Description of transportation and staff support	46.7%	46.7%	6.7%
Description of alternate vital records/documents sites (assurance of access to disaster plan, staff rosters, patients' vital medical records if existing sites are destroyed or inaccessible)	36.7%	56.7%	6.7%

Other Special Planning Concerns

(Percentages)	Yes	No	N/A
Description of MH authorities presence and role in local emergency management structure	40.0%	53.3%	6.7%
Documentation of regional or multi-state planning and coordination	13.3%	76.7%	10.0%
Description of various issues around licensing within the state, out of state providers, scope of practice, etc.	3.3%	86.7%	10.0%
Documentation of plans to prepare and support MH staff during and following deployment under plan (physical, health, special medical needs, family support, psychological)	16.7%	73.3%	10.0%
Documentation of public sector linkage with private MH resources	6.7%	83.3%	10.0%
Documentation of coordination with businesses/corporation and other private sector interests in planning behavioral health response and consequences	6.7%	83.3%	10.0%
Documentation of appropriate planning linkages with institutions of higher learning (academic departments, student health services)	3.3%	83.3%	13.3%
Assurance that all MH authority facilities meet JCAHO or other appropriate standards for disaster/emergency preparedness	60.0%	30.0%	10.0%
Accommodations for people with physical/mental disabilities	63.3%	30.0%	6.7%
Accommodations for the hearing impaired	40.0%	53.3%	6.7%
Accommodations for the visually impaired	26.7%	66.7%	6.7%
Accommodations for non-English speaking people	33.3%	60.0%	6.7%
MH authority role in risk communication	16.7%	73.3%	10.0%
Training and practice	53.3%	36.7%	10.0%
Coordination of research	10.0%	80.0%	10.0%
Data collection/evaluation	30.0%	60.0%	10.0%

Standard Operating Procedures (SOP) and Checklists

(Percentages)	Yes	No	N/A
Applicable SOPs	76.7%	20.0%	3.3%
Contains applicable checklists (emergency contact numbers, lists of facilities)	73.3%	23.3%	3.3%

Glossary of Terms

(Percentages)	Yes	No	N/A
Local and state specific terms	20.0%	73.3%	6.7%
Emergency management terms	20.0%	73.3%	6.7%
Public health terms	13.3%	80.0%	6.7%
Mental health terms	36.7%	56.7%	6.7%

BIOTERRORISM

Do you see biological agro-terrorism (i.e. infecting livestock with disease) as risk in your service area?

Response	Count	Percent
Yes	7	23.3%
No	14	46.7%
Unsure	9	30.0%

In the event of biological agro-terrorism, do you see a role for your agency (i.e. organizations that need to be involved, necessities to fulfill your role)?

Response	Count	Percent
Yes (If yes, please describe in comment field)	12	40.0%
No	6	20.0%
Unsure	12	40.0%

"Comment" responses:

As a part of the county preparedness plan.
The role would be two-fold: First, due to the functioning level of some of our severely mentally ill (SMI) clients, a number of clients will need to be addressed when any terrorist event occurs. Second, our role could be providing mass psycho-education to the community.
Mental Health Services and support
Possibly could be involved as in other accidents/disasters.
Provide mental health support
Yes, linked through to local Red Cross authorities as part of local emergency management
Support resources to first responders and victims
With connection to our local hospital, we would likely provide support to the hospital as well as assist with follow-up care and support to responders.
Probable management of the psychological consequences in the community
Disaster counseling
The traumas come with psychological problems and our organization is more equipped to handle these kinds of problems in the community.
Might be slight risk in surrounding counties
Half of our designated service area is rural and is possibly a target. This could generate potential hysteria that CMHC staff may need to assist in defusing in coordination with other community agencies.

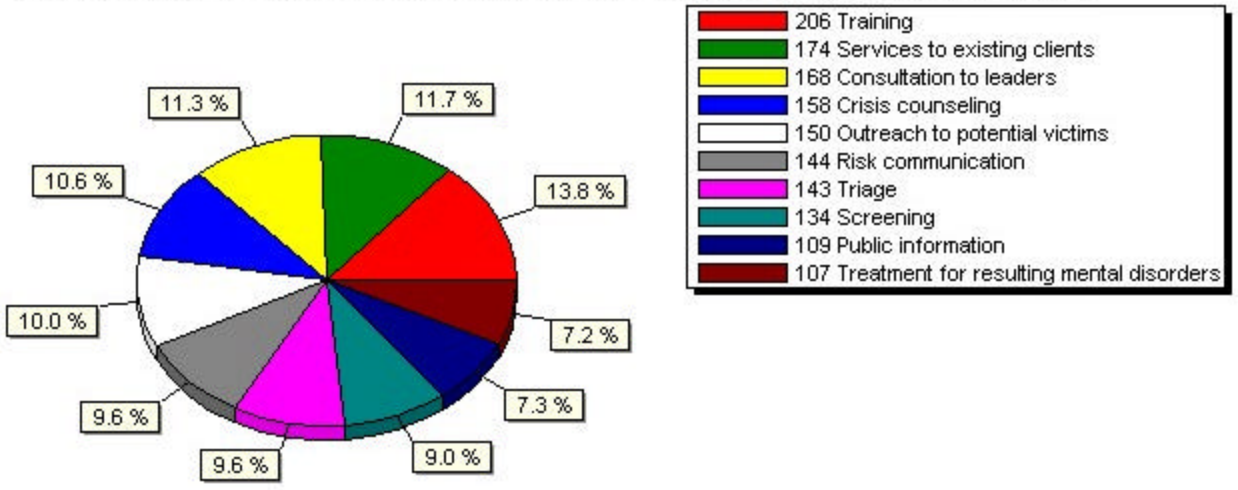
Have any employees expressed interest/concern about your agency's preparedness for a bioterrorist event?

Response	Count	Percent
Yes	16	53.3%
No	13	43.3%
Unsure	1	3.3%

Have any employees received specialized training in this area?

Response	Count	Percent
Yes	9	30.0%
No	17	56.7%
Unsure	4	13.3%

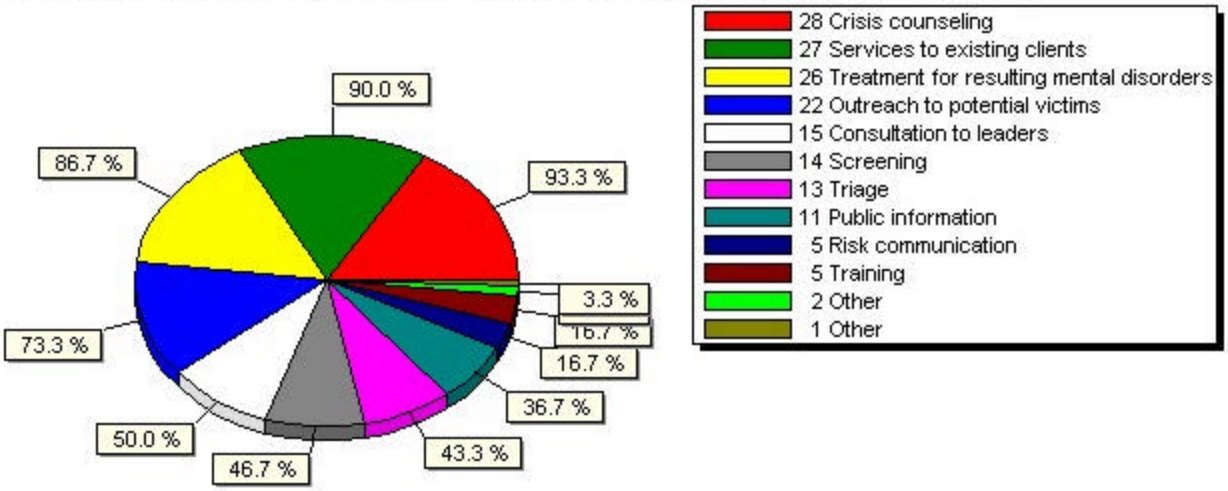
Please prioritize the needs of your agency to become better prepared for a bioterrorist response.



Has your local public health authority received additional funding to prepare for a bioterrorist event?

Response	Count	Percent
Yes	4	13.3%
No	10	33.3%
Unsure	16	53.3%

If fully prepared, what roles would you envision your agency fulfilling in a bioterrorist incident?



"Other" responses:

“Crisis Debriefing Process”
“Debriefing of first responders; children”
“Support resources to first responders and victims”
“Support (CISD) to Emergency services workers”

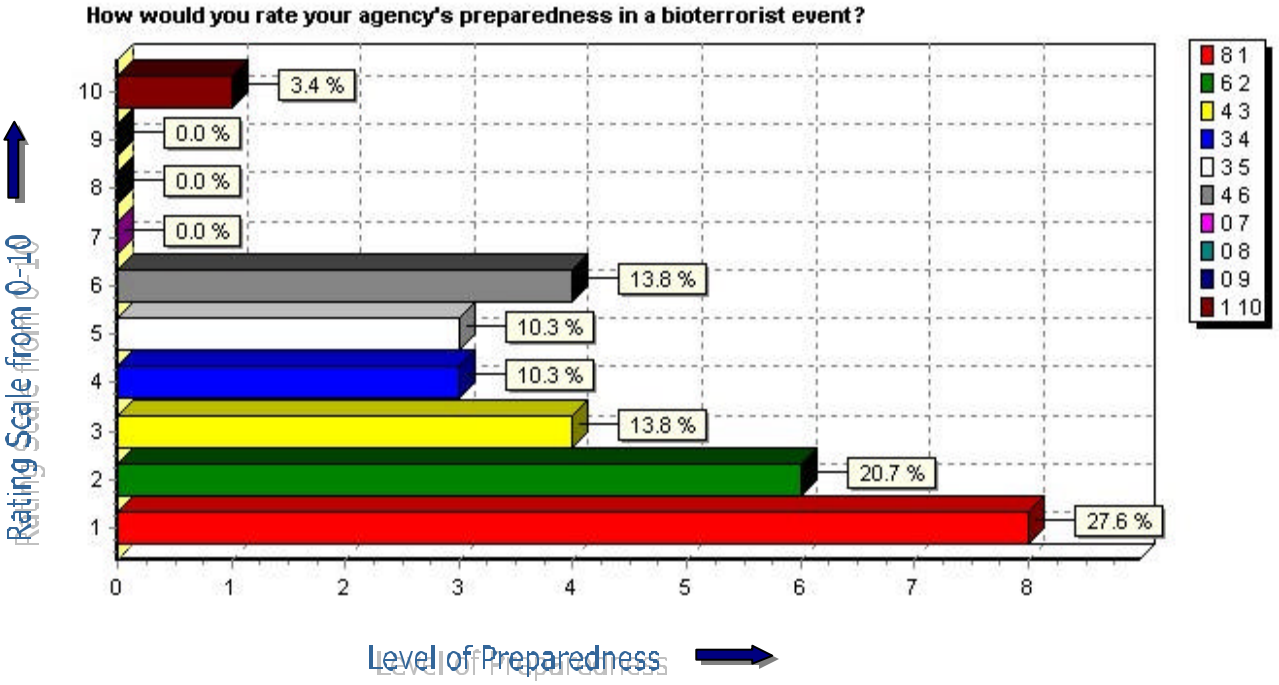
Are there other comments/concerns/suggestions/plans you would like to share with respect to your agency's preparedness for a bioterrorist event?

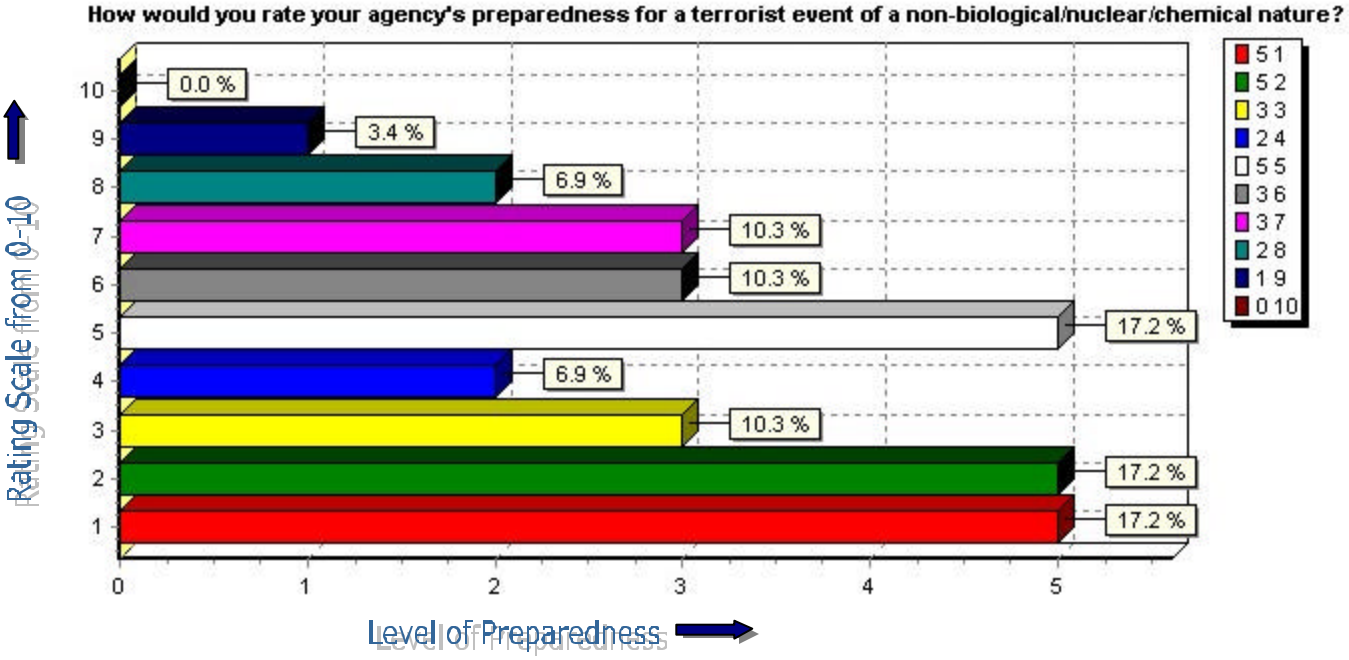
Response	Count	Percent
Yes (If yes, please indicate response)	13	43.3%
No	15	50.0%
Unsure	2	6.7%

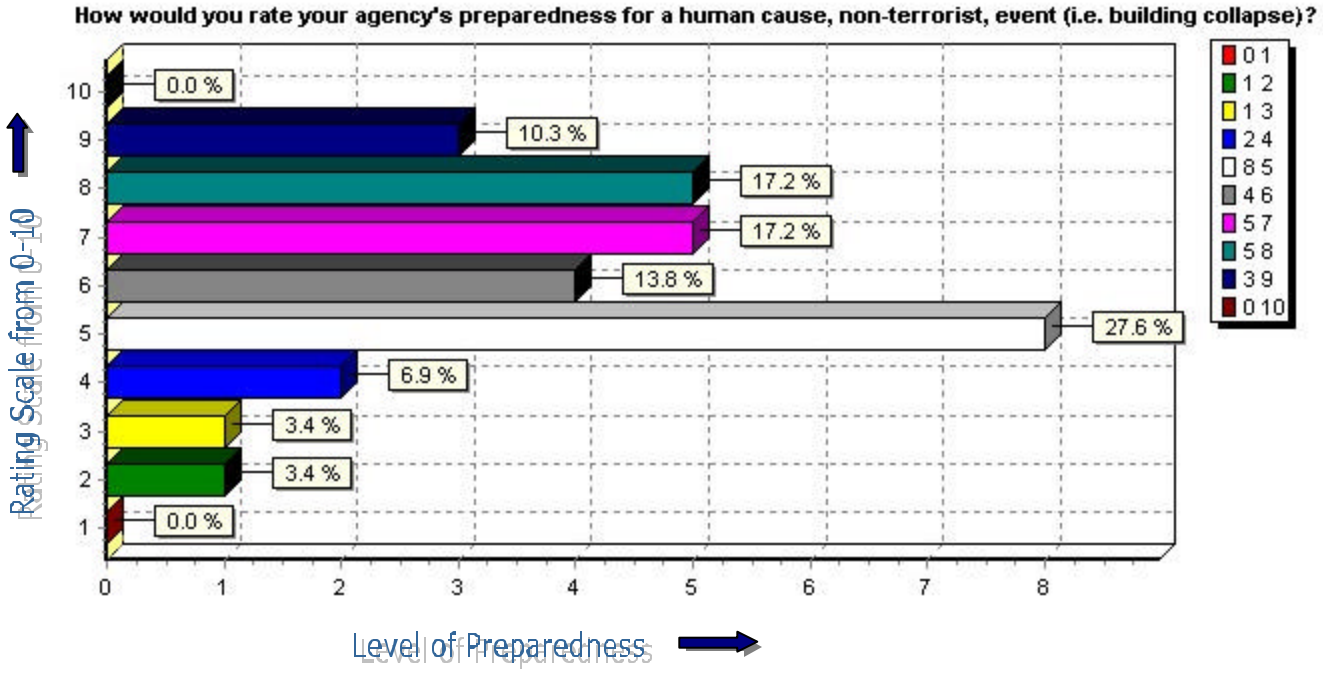
"Comment" responses:

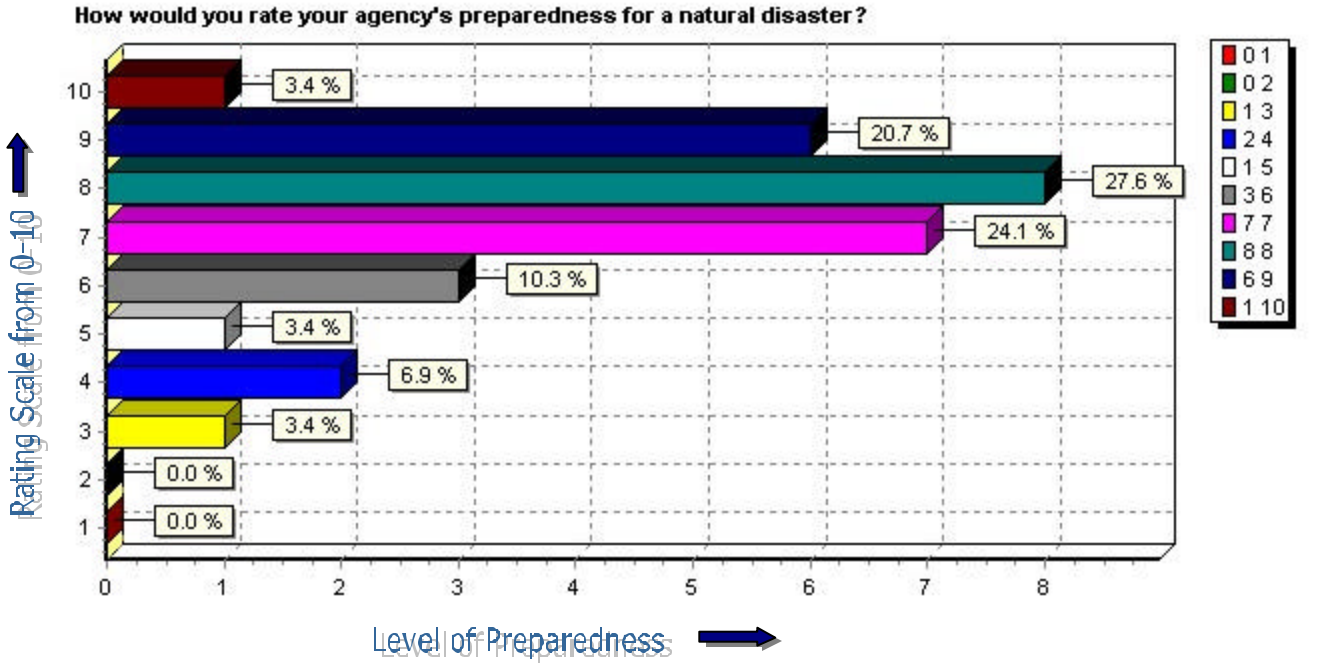
“Mental health is now being seen as having a role and we want to be able to meet the need as best we can.”
“Our Community Hospital is presently training all staff in this area.”
“We need a lot of help.”
“Some good relationships with other involved entities; one of our staff is "clinical director" for county critical incident debriefing team.”
“A lot of this questionnaire was related to our plan. Our community has met and has some ideas, but no plan yet.”
“It is very difficult to know how far to go with preparedness.”
“Equipment is needed.”
“As we stated a year ago, we need training.”
“Some YES answers in regards to the plan currently in place reflect anticipated changes with current revision. As an agency, we recently acknowledged we need a more specific and comprehensive plan.”
“I would like info on protection downwind from high-risk sites.”
“Plan needs much more detail and needs to be coordinated with county plans (which is also not detailed in terms of MH response).”
“We view bioterrorism to be highly unlikely in this vicinity but would be quite willing to receive expert input on the matter.”
“Lessons learned from 9/11 that are relevant.”

The following bar graphs are based on a 10-point scale; 0 representing least prepared for a disaster event, 10 representing most prepared.






How would you rate your agency's preparedness for a human cause, non-terrorist, event (i.e. building collapse)?
Rating Scale from 0-10
Level of Preparedness
0.0 %
10.3 %
17.2 %
17.2 %
13.8 %
27.6 %
6.9 %
3.4 %
3.4 %
0.0 %
0 1
1 2
1 3
2 4
8 5
4 6
5 7
5 8
3 9
0 10


How would you rate your agency's preparedness for a natural disaster?
Rating Scale from 0-10
Level of Preparedness
3.4 %
20.7 %
27.6 %
24.1 %
10.3 %
3.4 %
6.9 %
3.4 %
0.0 %
0.0 %
0 1
0 2
1 3
2 4
1 5
3 6
7 7
8 8
6 9
1 10

Please provide any additional information you think would be important and helpful in reference to disaster/emergency preparedness.

"Coordination of the IDEM, Red Cross and local groups is a major issue. Who is in CHARGE is the most difficult. Also which training would be of the most use for us?"
"Basically, the self-evident question: Exactly (or generally) what is our role as a CMHC in the scheme/process of responding to a community/regional disaster?"
"Behavioral Health Services is a division of our Community Hospital. Currently, we are using the existing plan for the hospital."
"Our preparedness is primarily geared toward our own facilities, staff and clients who may be involved, and not to the community at large."
"Just as already cited, one of our staff is the clinical director for the county critical incident debriefing team."
"A template on how other communities organize these efforts would be useful."
"The focus of the current plan is on internal operations with no linkage to the plans for external community agencies."
"I am very willing to help design a region-wide plan and coordinate with area services."
"We are currently working with other agencies within our county to develop a plan. We are weaving this into our revised Center plan and also keeping it consistent with the local hospital's disaster plan."
"Information on adequate protection downwind from a major terrorism event involving a nuclear plant, an international port, or a large city."

RESULTS

A comprehensive questionnaire was developed to assess the preparedness of Indiana Community Mental Health Centers (CMHC) to respond to a disaster/emergency event. This questionnaire was internet-based through a program called WebSurveyor, allowing all centers convenient access to the questionnaire. All 30 CMHCs completed the survey. Findings from the Disaster/Emergency Preparedness Questionnaire communicate several needs that must be met in order for Community Mental Health Centers to adequately provide services for victims effected by a disaster/emergency event. The results from the assessment are listed below.

I: Plan Preparation

All thirty community mental health centers (CMHC) identified having an existing plan in place with 73 percent of the centers currently in the process of revising their plans. More than 40 percent of centers had enough plan preparation to allow them to activate their plan during and after a previous disaster. The problem those centers encountered during activation was the lack of integration with other entities and the inability to collaborate effectively. Over 50 percent of the centers have not yet officially activated their plan and have not pursued interprofessional collaboration.

Fifty percent of centers stated they use the All-Hazards planning model; however, evidence shows that most centers have not yet identified a specific planning guidance to incorporate their plan. The majority of CMHCs identified natural disasters as their greatest risk, while urban centers stated human-made disasters pose the greater risk within their service area.

Most CMHCs feel that in order to have an effective disaster mental health preparedness plan, the centers are in need of technical assistance/expertise, training, and money. Centers need these services to develop a fully functional disaster plan; yet, money is a necessity to gain those resources. Because of the time and money involved in creating an effective plan, these centers are looking for a plan that is "simpler" and "better integrated with external agencies"[4] (i.e. Red Cross, local emergency management agencies). By having the resources needed for plan optimization, CMHCs could properly train their staff to respond to disasters by using a crisis counseling model versus the models staff currently use for severely mentally ill (SMI) consumers. Technical assistance/expertise could be used to walk centers through the planning process, enabling them to have direct integration with the State All-Hazards Plan. There could also be technical assistance through entities such as the Titan Corporation, a national security corporation specializing in disaster preparedness, to administer table-top exercises that would allow CMHCs to work their plan and strengthen any deficit areas that may currently be present. According to Butler, Panzer, and Goldfrank (2003) in their newly released book *Preparing for the Psychological Consequences of Terrorism*, "there is a critical need for a public health approach to the psychological consequences resulting from terrorism. The psychological health of the nation is critical to sustaining the nation's capabilities, values, and infrastructure" (p. 5)[5]. In order for CMHCs to have such an effective response to victims, expert assistance must be provided for plan optimization through a comprehensive statewide collaboration of all mental health providers.

II: Plan Content

All 30 CMHCs have taken steps toward developing an emergency/disaster plan that meets the needs of the communities served. One of the greatest deficiencies found through the assessment is the centers' inability to include a comprehensive approach to the plan layout as

[4] Comments from the Indiana Division of Mental Health and Addiction Disaster/Emergency Questionnaire

[5] Butler, A.S., Panzer, A.M., & Goldfrank, L.R. (Eds.). (2003*). Preparing for the psychological consequences of terrorism: A public health strategy.* Washington D.C.: The National Academies Press.

well as in-depth documentation of plan content. The majority of the CMHCs have situation assumptions as well as accurately identified worst case scenarios included in their emergency/disaster plans; however, more in depth situational planning that identifies high risk areas and building vulnerability is not present. Most centers stated that they are logistically ready for a disaster response, but more in depth provisions such as 72 hour self support and replacements for damaged equipment have not been made. When further follow-up was made with CMHCs, it was reported that these provisions are not left out intentionally or unknowingly, but instead have not been included due to lack of funding to provide pre-event, logistical precautions. The same was reported in the area of communications, showing that nearly 87 percent of centers listed a need for proper emergency/disaster communications, but again were unable to fund such provisions. Sixty-seven percent of centers also listed that even if they were provided available funding they do not have the technical assistance needed to provide these communications.

Public information education has been identified as a much needed resource by all the centers, but only 40 percent of the centers have existing material to distribute before, during, and after a disaster. Dr. Brian Flynn (2003) stated, in his *Promoting Psychosocial Resilience in the Face of Terrorism* briefing for the U.S. House of Representatives, that public information must be presented "in ways that calm and reassure the public while maximizing the potential that people will behave in ways that promote safety and security" (para. 12)[6]. By providing medically accurate public information in times of disaster, CMHCs will help alleviate the fear and anxiety the general public may experience; however, more that 50 percent of the centers do not contain this material or have known access to these available resources. Once the centers do gain access to this material, identified ways of dissemination are also needed.

Internally, CMHCs have been proficient in providing warning and mobilization information for their staff and internal provider network. More than 80 percent of the centers include procedural descriptions for emergency warning activities and staff notification at the time of a disaster. The deficit shows through external communication and notification such as identification of groups with special warning needs such as the hearing impaired. Over 90 percent have evacuation plans and/or alternative working sites, but again, clear linkage with collaborating entities/agencies is lacking. For nearly 67 percent of the centers, the Red Cross is the only outside entity that has had any inter-organizational collaboration, and that is only evident in areas of mass care. Even documentation of health and medical care is absent, especially with the aforementioned role identification problems. Overall, most centers have taken great strides in plan development, but there is a definite, recognizable gap that begins with the lack of collaboration and integration with outside entities/agencies.

III: Plan Integration

One of the greatest resulting needs evidenced through the assessment is the lack of coordination with external entities/agencies. Although nearly 87 percent of centers have a good understanding of their plan overview (i.e. what should happen, when, and under whose direction), the clarification of roles and responsibilities becomes blurred outside of each center's overall direction. Because plan content serves as a basic guide that does not distinguish specific roles of each staff, workers feel insecure about their responsibilities, thus, adding to the chaos of the disaster. By developing a Mental Health and Addiction All-Hazards Advisory Group functioning at the state level, Indiana's CMHCs will be able to have the guidance desired and needed to designate responsibilities and establish best practices during any disaster.

Sixty-nine percent of CMHCs stated they do not have appropriate policy documentation in regard to situational authority. Due to the overlapping roles of disaster responders, legal records are needed for local and state level guidance to clarify the roles and responsibilities these

[6] Flynn, B. W. Ed.D. (2003, May). *Promoting psychosocial resilience in the face of terrorism*. Briefing conducted for members of the U.S. House of Representatives and their staff, Washington D.C.

responders carryout. Policy development and current policy amendments are presently in process at the state level. The Indiana Mental Health and Addiction All-Hazards Advisory Group will assist in policy development and adoption as well. More than 50 percent of the centers stated that gaining an understanding of the federal and state responsibilities would help with role identification at the local level. As mentioned above, the addition of an Indiana Mental Health and Addiction All-Hazards Advisory Group will alleviate role confusion and will set a precedent to how interprofessional collaboration should take place. Once a state-level understanding of roles and responsibilities has been established, regional and local collaboration can occur more smoothly and successfully.

Over 71 percent of centers stated they do not have a strong working relationship with their local emergency management agency, while 80 percent reported not having mutual aid agreements with other counties/jurisdictions. Coordination with other government level agencies, such as the Red Cross and Federal Emergency Management Agency as well as faith-based organizations, is significantly low with only 20 percent CMHC integration. Through further follow-up, CMHCs reported having an understanding that interprofessional integration is needed, but again, technical assistance and expertise is lacking in order to establish these external working relationships. As previously mentioned, contracted entities such as the Titan Corporation could provide the expertise needed to assist the centers through this integration process. Butler et. al. (2003) mention in their book that, "pre-event, event, and post-event interventions to protect, minimize effects, and respond to consequences will require the joint efforts of the mental health, public health, medical care, and emergency response systems in the United States" (p. 114). The authors go on to say that "the groups and organizations that should be involved in planning to ensure a comprehensive response include, but are not limited to, the following: the American Red Cross, the Department of Veteran Affairs, the Department of Defense (including the National Guard and Reserve), the Department of Education, state emergency management planners, mental health practitioners, workplaces (workplace health programs), schools (including school health programs), faith-based communities, and primary care practitioners" (p. 115). By developing such interprofessional collaboration with the entities (or similar entities) listed above, the overall response to victims of mass disaster will provide a smoother, more effective course of action, while meeting the needs of all those effected.

IV: Terrorism/Bioterrorism

Because of the recent national and international terrorism/bioterrorism disasters, most agencies are currently revising their plans to cover these areas. The problem that has been identified is the fact that the CMHCs do not feel adequately trained to prepare for such an event in their service area. Again, coordination with local and county public health agencies is another aspect lacking in this area. Most CMHCs have realized the role they are being asked to play due to the growing focus on mental health; however, these centers do not feel adequately prepared to fill such a huge role. Sixty percent of centers stated that they have not received specialized training in this area, but nearly all centers envision crisis counseling being a top priority for their workers during such times. Because these centers are primarily focused on the severely mentally ill population, a shift in focus to victims of terrorism causes the workers to take on new roles. Instead of working with the mentally ill, they are being asked to work with the mentally healthy who are experiencing a community crisis. Both Dr. Brian Flynn (2003) and the authors of *Preparing for the Psychological Consequences of Terrorism* (2003), identify training as a much needed resource for mental health workers. Dr. Flynn stated that "we must better train mental health providers and others to better prepare them to work in the field of trauma mental health" (para. 14), while Butler et. al. stated that "training and education emphasizing psychological consequences and methods of response should be provided to professionals within the mental health fields…" (p. 111). By providing this much needed training to disaster responders, CMHCs will be better able to serve victims of tragedy by utilizing the best possible practices available.

FUTURE PLANS

The Indiana Division of Mental Health and Addiction will consult with The Titan Corporation to develop and orchestrate Indiana's mental health disaster plan. Titan has been contracted by the Indiana State Emergency Management Agency and by the Indiana State Department of Health to assist in the development of emergency management All-Hazards Plans for all 92 Indiana counties. Titan will be working with the State Department of Health in the continued development of the State of Indiana's bioterrorism plan. In meetings with Titan officials, it was decided that the Indiana Division of Mental Health and Addiction will continue to work with local mental health providers in the development of their plans, while at the same time working with the county emergency mangers to ensure complete integration with county plans.

The Indiana Division of Mental Health and Addiction will continue to work closely with the Indiana State Emergency Management Agency (SEMA) in the development of the Indiana Division of Mental Health and Addiction All-Hazards Advisory Group. This committee will be formed in response to the overwhelming number of people and agencies wanting to provide crisis counseling services following a disaster. The Indiana Division of Mental Health and Addiction has established a policy in conjunction with SEMA on an endorsement of mental health providers and people who will be allowed to provide crisis counseling services during a presidentially declared disaster. The Indiana Division of Mental Health and Addiction will be exploring the issue of credentialing versus endorsement through the Indiana Division of Mental Health and Addiction All-Hazards Advisory Group. Current policies may need future review by IDMHA according to surfacing issues.

Indiana Division of Mental Health and Addiction All-Hazards Advisory Group

Adequate response and participation in this group is dependent upon extensive planning and communication with all key stakeholders. The Indian Division of Mental Health and Addition All-Hazards Advisory Group, made up of mental health/addiction services providers, consumers, public officials, faith-based organizations, emergency management personnel, and other stakeholders, will provide guidance and facilitate collaboration across a broad spectrum of resources. The group will meet at least monthly to discuss assessment, planning, training, and testing efforts under the direction of the disaster response director. The Indiana Division of Mental Health and Addiction proposes that the All-Hazards Advisory Group will be involved in all stages of development and examination of existing barriers of plan implementation. This group will determine the appropriate response systems and local resources as well as interprofessional cooperation. The Indiana Division of Mental Health and Addiction All-Hazards Advisory Group will also assist in the creation of culturally competent materials and planning efforts.

Goals:

- Complete an assessment of the mental health and addiction providers' ability to respond to a major disaster.
- Educate state-level staff of the Indiana Family and Social Services Administration, Indiana State Emergency Management Agency, and the Indiana State Department of Health about the critical need for crisis counseling following a disaster.
- Educate county emergency management officials on the need to coordinate their local/county emergency plans to respond to the crisis counseling needs of disaster victims.

- Train mental health and addiction services providers about who IDMHA contracts with for crisis counseling programs.

- Coordinate participation of IDMHA mental health and addiction services providers in county mock training drills.

- Establish pre-disaster baseline information on mental health and addiction needs.

- Integrate inter-agency coordination with the emergency disaster response in all phases of planning.

- Identify and train a cadre of mental health responders and crisis counselors.

- Coordinate services and memoranda of understanding (MOUs) with external entities.

- Identify concerns and issues for a mental health/crisis counseling response in Indiana State Mental Health Hospitals.

- Seek State and other funding for continuation of program once federal grant cycle has concluded.

- Create linkages with mental health and addiction services providers not currently under contract with IDMHA.

Objectives and Activities:

- Develop an Indiana Division of Mental Health and Addiction All-Hazards Advisory Group consisting of consumers, providers, State and local emergency management agencies, medical service workers, faith-based organizations, and first-responders, under IDMHA Office of Emergency Management.

- Develop a statewide assessment of mental health and addiction service providers' disaster preparedness by:

    - Developing a system assessment protocol
    - Assessing all CMHCs on their capacity to respond to a major disaster/terrorist attack in their community
    - Assessing all addiction treatment providers who contract with IDMHA on their capacity to respond to a major disaster/terrorist attack in their local community

- Work with all local mental health and addiction treatment providers in developing contacts with local/county emergency planners.

- Develop MOUs and linkages between the American Red Cross, local emergency management agencies and IDMHA treatment providers.

- Carry out training of pre-identified disaster relief staff by:
    - Assisting staff in the identification of their own needs according to their role
    - Provide an orientation to disaster relief operations training
    - Discuss crisis counseling techniques, operations, identification, and interaction with other disaster relief agencies
    - Provide training focused on disaster mental health and addiction services and intervention models

- Discuss and identify special populations and cultural competency issues

- ❑ Convene a statewide crisis counseling conference involving mental health and addiction treatment providers, SEMA personnel, State and local public officials and local emergency management personnel.

- ❑ Provide outreach to faith-based community organizations stressing the importance of the faith community in disaster mental health and addiction services issues.

- ❑ Assist local disaster mental health staff in developing an understanding of the unique features of their local community and citizens when developing a response plan that includes faith communities, large employers, unions, mental health associations, and other groups.

Training Needs and Other Considerations

- ♦ Indiana Division of Mental Health and Addiction will schedule regional training for mental health and addiction providers, public health officials, and local emergency management agencies.

- ♦ Indiana Division of Mental Health and Addiction will complete a statewide training of mental health and addiction providers, public health officials, and local emergency management agencies in response to a bioterrorism, terrorism, human-caused, or natural disaster.

- ♦ Indiana Division of Mental Health and Addiction will conduct a training overview of disaster mental health and crisis counseling to human service workers, medical and para-medical personnel, school administrators, teachers, social services providers, inter-faith groups, and mental health professionals.

- ♦ The Indiana Division of Mental Health and Addiction will establish an infrastructure through written polices and memoranda of understanding in order to manage both local and statewide disaster response personnel. These groups often assist on site following a disaster event. The purpose of the policy is to create a seamless and well-coordinated response for first responders and victims.

- ♦ The Indiana Division of Mental Health and Addiction will develop and disseminate deployable public information and media materials to help relieve public fear and anxiety in order to provide accurate behavioral healthcare information before, during, and following a bioterrorism, terrorism, human-caused or natural disaster. A web site has been developed and will be updated on a regular basis to provide accurate crisis counseling and behavioral health care information.

- ♦ Indiana Division of Mental Health and Addiction will contract with The Titan Corporation to provide technical assistance and expertise to providers in order to properly develop/revise their Disaster Mental Health and Addiction plan, as well as create reliable memoranda of understanding (MOUs).

- ♦ The Titan Corporation will assist Indiana Division of Mental Health and Addiction in the development of the regional and statewide trainings to enable providers to appropriately respond to bioterrorism, terrorism, human-cause, and natural disasters.

- The Titan Corporation will develop an internet-based community planning guidance that will be easily accessible to all providers for maintenance of their disaster mental health and addiction plan.