Meeting Community Behavioral Health Surge Capacity Requirements with Psychologically-Informed Emergency Preparedness & Response in All-Hazards Disaster Situations: Concepts and Strategies

Mark L. Dembert, M.D., M.P.H., FACPM*

Summary: In many cases, community planning and preparation for disasters and emergencies will fail in key areas because it is wrongly assumed that official plans will be unilaterally and automatically accepted, understood, and acted upon by all. Such planning and preparedness does not take into account the many forces of human psychology, especially when it involves individual fears, harm, responses, and survival. Officials and planners may not put themselves in the shoes of community individuals and write from empathy and understanding in all aspects. Moreover, emergency planning and preparedness is often a one-size-fits-all approach. Principles of human psychology in daily life show us that behaviors of acceptance and action, on individual and collective levels, are much more shaped by numerous intangible factors than by official demand.

This paper describes in considerable detail how extensively principles of individual, group, organizational, and occupational psychology affect all aspects of emergency preparedness and response through all phases of the disaster cycle (*psychologically-informed emergency preparedness and response, or PIEPR*). It shows how medical-surgical and behavioral health planning, including surge capacity planning, are both different yet actually more similar and interdependent. Further development of *behavioral health surge capacity planning, or BHSCP—immediate and delayed*—is explored in detail and identifies numerous concepts and strategies for communities to use that will lead to success. It is important for communities to identify local behavioral health or psychology professionals who can assist planners and others by applying and tailoring these concepts and strategies to local attributes and needs.

This paper is written in a straightforward manner in such a way that anyone with responsibilities and interests in these two areas—government officials and staff, emergency planners, public health and community behavioral health departments staff, public safety and first response personnel, business and industry safety and risk management personnel, community leaders—can find areas of specific interest.

***Strategic Public Health Solutions LLC, 4230 Tara Circle, Boothwyn, PA 19061**
www.strategicph.com and SPHSLLC@aol.com

Table of Contents

Introduction

Disastrous acts of nature know no bounds, as was evident in the 1994 Asian tsunami, the 2005 hurricane season in the United States, and now the rising concerns over possible pandemic influenza. These events have brought mental health surge capacity planning into greater public awareness. [The term *behavioral health* encompasses traditional terms of mental health, developmental, and substance abuse disorders and I will be use it preferentially in the rest of this paper.] Behavioral health surge capacity planning (BHSCP) is the worst-case scenario of overall behavioral health emergency preparedness and response planning, which is a subset of general EP&R programs.

The Health Resources and Services Administration (HRSA) benchmark for "mental health" surge capacity requires a system of a spectrum of psychosocial interventions and longer term care for 5,000 adult and pediatric clients and healthcare workers per 1 million population exposed in an incident involving a weapon(s) of mass destruction, or more generally a very devastating all-hazards disaster. However, to accomplish comprehensive and successful planning in the behavioral health realm requires more than a formulaic approach.

I choose the term "psychologically-informed EP&R" (PIEPR) to describe the application of psychological principles (individual, group, organizational, occupational) to the creation and implementation of any EP&R initiative for the four disaster phases (preparedness, response, recovery, mitigation). The goal of using psychology is to enable the optimal collaboration and support by all charged with planning, as well as to gain optimal acceptance and compliance by the public. This happens because the work that planners and the public do on behalf of EP&R is task driven and usually in response to plans and other directives. This work is much different from the private opinions and concerns, personal experiences, emotions, and "world views" of life and society that each person carries within himself or herself. The latter, which is both individual and collective of the whole community, is affected by both resilience and coping strengths as well as by psychological mechanisms of defense. These defense mechanisms are in response to conflict and anxiety, in this case, due to worry and fear that the work being done publicly will not or does not address the private worries and fears for survival. The "disconnect" between these two will only decrease when private individual and collective views are fully addressed with a psychologically-attuned and empathic public planning and work effort. Behavioral health surge capacity planning will succeed then.

The community psyche and morale are affected by many tangible and intangible components and the degree to which they are suppressed or openly dealt with, including: past and recent disasters, the local economy, socioeconomic status variability and population proportions, business and industry, occupations and job stability, culture and ancestry, ethnic and racial diversities, the environment of geography and landscapes, climate, local politics, redevelopment and new development, community resilience, local media and communication venues, transportation industry, overall health of the public, and spiritual diversities. The objective is to first identify which of these are "positive" and which are "negative" factors. Next, subtle and overt creative efforts should be made to ensure that the negative ones (accepted or changed) minimally undermine EP&R efforts and the positive ones (accepted or strengthened) maximally enhance any strategies.

A key challenge in operationalizing EP&R initiatives is to reconcile the following: people (public) in impending and real disaster situations have wants that are based on their needs, while governments and their officials at the same time have needs that are based on their wants. BHSCP, with its psychological perspective, takes into account that unconscious human needs become transformed into conscious wants in times of high anxiety and threats to survival. Government leaders and planners want to do the best things they can to answer those expressed wants, because it makes them feel needed (unconscious) and successful (conscious). I will present ideas in the course of this paper that suggest how this might be accomplished.

My goal in writing this paper is altruistic, to share philosophies, concepts, and approaches that I found to be extremely useful in my behavioral health-public health-EP&R work (see Appendix 1). This information fills in "psychological gaps" that exist in many exemplary and useful national, state, and organizational documents (1-4) on behavioral health planning and response for states and others. Readers of this paper are encouraged to extract and use any of my ideas which are most appropriate for their states or their communities.

Because of the number of ideas and length of this paper, I use double lines as a break into a new section on a new page, and I use dotted lines to separate the numbered ideas within these sections. With the index, readers can pick and choose topics of interest quickly and easily.

==

Concepts

1. Framework

Psychologically-speaking, surge capacity is about a large number of anxious people planning for and then taking care of a much larger number of anxious people. Disasters make everyone anxious at or near the area, because fears of one's death (by horrible means) outside of one's control, are expectable and palpable. Others hearing of and/or seeing this disaster from far away will be similarly anxious, some even more so than those at the affected area. This anxiety will be additionally manifest by: anger towards those who caused it or allowed it to happen; grief for those who were killed or injured (especially if children were involved); aloneness and loneliness if those close to a person by family or business were so killed; fear if one might have been exposed or actually affected by a causative agent; worry if the nearby environment was contaminated and is now inhospitable; suspicion if one could acquire the causative agent through contact with others outside the family home; agitation if one had experienced previous personal or societal traumas and disasters; dread if one does not have access to needed essential services, food, and water for survival; desperation if one does not have shelter from the elements; and pessimism when one realizes that there is no support system because a huge number of fellow citizens are similarly affected. The last situation may be calming for some, because there is the reality that one is "not in this alone."

…………………………………………………………………………..

2. Distinctions

For planning purposes, necessary conceptual and operational distinctions exist between medical-surgical surge capacity and behavioral health surge capacity. It is important to describe these.

First, surge capacity planning is traditionally linked with physical (the body) morbidity; first responder and public safety groups, hospitals and allied facilities, and medical-surgical health care providers across a broad spectrum of capability and specialty are the primary components of local and state emergency and surge capacity plans. BHSCP is nowhere near as visible.

Second, medical and surgical surge capacities care are both one-on-one and one-on-hundreds. Triage is objective out of necessity, and providers are trained to work in emergency and chaotic situations. Interventions and treatments are objective and visible results-oriented, algorithmic, focused, and accomplished with succeeding levels of care. In contrast, behavioral health care is traditionally practiced as one-on-one, fluid, focused on the individual but inclusive of family and related support staff as part of the treatment. Triage and evaluation are objectively based on observed signs and gradations of behavior that may be unpredictable and unanticipated in the office and in the public. However, assessment is also very subjectively based on patient self-reports of history and symptoms, along with the subjective "feel" that a provider has in his proximal interactions with the patient.

Third, the behavior of the medical or surgical patient is usually highly controlled by the medical or surgical treatment and the sheer exercised determination of the providers in surge capacity situations; the behavior of the psychologically-distressed patient is emotional and not so predictably controlled by the exercised sheer determination of the providers, unless dramatic interventions of physical and/or chemical restraints are used.

Fourth, medical and surgical patients in surge mass casualty situations are at best ambulatory with some impairments but are usually stretcher or wheelchair-borne;

psychologically-distressed patients are usually very ambulatory, sometimes chaotically so.

Fifth, control is what medical and surge capacity care providers require; behavioral health care providers have a trained tolerance for and can work within gradations of control up to chaos. This basic distinction is what separates these two health care areas and can put them at odds. This is seen in health care facilities where behavioral health inpatient wards and clinics are often segregated from other clinics and wards. It is dramatically seen with the philosophies and attitudes of individual providers, managed care and health insurance companies, even in the media. No one is stigmatized by medical or surgical diagnoses or care; the opposite is commonly true with behavioral health diagnoses and care.

Sixth, disaster-related medical and surgical morbidity is “in view.” Injuries and illnesses generally manifest within a reasonable time after the event. However, some illnesses, like those related to exposure to airborne particulate matter, fumes and toxins, and viral or bacterial agents, may be sub-clinical and cumulative over time and only manifest weeks or months later. Disaster-related behavioral health disorders may manifest within a reasonable period of time after the event. However, symptoms and signs with life impairments may not likely manifest and be diagnosed until weeks, months, even years later; this is *delayed behavioral health surge*. Because these disorders can be insidious and dormant, diagnostic tests, clinical suspicion, and multimodal therapies—*delayed behavioral health surge capacity*--must remain in place, available, and updated for months or years after the event.

I listed these to show how difficult it may be for all involved in medical-surgical care surge planning to understand and acknowledge the equal legitimacy and importance of BHSCP. Extra effort may have to be scripted and planned by knowledgeable planners and behavioral health providers to educate the former, so that an equal seat is guaranteed at the proverbial planning table. Medical-surgical and behavioral health surge capacity planning rely upon each other.

……………………………………………………………………………………

3. Basic Tenets

I keep the following guiding principles in mind for all situations where I apply PIEPR and where I assist in BHSCP.

Basic Tenet #1: The above medical-surgical versus behavioral health distinctions are always present. But I can work around them at the general planning table when I remind others that:

> *Wherever goes the body, goes the mind…..in a patient and in a provider.*
> *This is true in life and in death.*

Basic Tenet #2: Behavioral health surge capacity planning is based on the psychology of, and targeted for, individuals up to whole communities. Public behavioral health agencies are the mainstays of BHSCP. Everyone—providers, patients, the public at large—is considered affected and vulnerable to the expectable stress of an unnatural situation. Similarly, public health disaster planning is for individuals up to entire communities. Public health department staff are used to working in controlled situations as well as in chaotic mass situations. Their care uses drugs and supplies, but organizational and epidemiological thinking is key to their success where there is often no distinction among patients, providers, and the public at large when exposed to a causative agent. These are two public agencies with similar missions in the broadest scope. Thus:

> *Behavioral health surge capacity planning must also be closely allied with public health surge capacity planning as much as possible.*

Basic Tenet #3: If the nature and leadership of a jurisdiction is already conducive to its agencies working closely together, a concerted attempt should be made by the public behavioral health and public health agencies to truly partner for the purpose of behavioral health EP&R and BHSCP. Both directors and select staff must meet earnestly, collaborate closely, and work synergistically. Thus:

> *Mutual interest and evidence of inter-agency collaboration between the two directors must be very visible to staff in both agencies.*

Basic Tenet #4: Behavioral health surge capacity planning should not begin during the response phase of a disaster or during the short-term or immediate recovery phases after a disaster. It must begin during the mitigation phase or the preparedness phase, or at earliest, during the late or long-term phase of recovery. It most effectively begins when the public health and public behavioral health agencies first meet. Thus:

> *Behavioral health surge capacity planning, as part of overall behavioral health EP&R, continues 365/24/7, through all and any stages in the "cycle" of a disaster.*

Basic Tenet #5: Organization, guidance, and leadership for all community EP&R initiatives must first start at the top and then flow down. National plans are adapted and incorporated into state plans, led by key state agencies and departments and select officials. Jurisdictions are tasked with creating, organizing, training, and maintaining local plans. One person is selected to accomplish this, with a myriad of supporting and coordinated agencies. While leadership and responsibility is "top-down" at this level, one person cannot come up with all the concepts and strategies for local implementation. Neither can directors of these agencies and departments. Often the best ideas, concepts, and strategies come from below, even far below, from all levels of employees and staff and volunteers. This must be considered. Thus:

> *Effective and successful local emergency planning is both a top-down and bottom-up–or grassroots leadership (5)—phenomenon*

Basic Tenet #6: Thomas Friedman (6) describes the modern world as being "flat" in terms of the new technological and horizontal interconnectedness of people and businesses that blurs traditional distinguishing and isolating boundaries of geography, culture, and economy. Media coverage of government responses to natural disasters in recent years have shown our collective humanistic sides but have also shown our biases about geography, culture, and socioeconomic status. The latter have unfortunately blinded disaster planning efforts. Thus:

> *Effective BHSCP and overall community EP&R acknowledge that communities are flat for the same reasons that the world is flat. This considers everyone's needs as equally important, thought out, and taken into account during the times before, during, and after disasters..*

Basic Tenet #7: One person or one agency cannot accomplish BHSCP. It is a community and government challenge, thus requiring many people and many agencies linked to work very well together and to rely upon each other, over space and time. Thus:

BHSCP will succeed only as well as the degree of well thought out and dedicated networking (7) of people and agencies is accomplished.

Basic Tenet #8: General community EP&R, behavioral health EP&R, and BHSCP must fully delve into all phases of the disaster cycle. This underscores the need for broad psychological perspectives and for behavioral health providers to consider consultative and participatory roles outside the traditional office, ward, or academic settings. Thus:

Effective community EP&R and BHSCP must include psychologically-informed EP&R concepts, strategies, and resources..

Basic Tenet #9: Recent natural disaster and terrorism events have demonstrated both the abilities and the inadequacies of technological and interpersonal communications. The goal of effective EP&R communications planning and implementation is first based on effective people-to-people communications, whether it is 1:1, 1:1,000, or 1:1,000,000, in meeting rooms, in emergency operations centers, in the public, and in print and other media. Without this, the most advanced technological communications will fail the overall mission. Thus:

Psychologically-informed EP&R must fully explore, assess, and advise on all EP&R communications.

Basic Tenent #10: Psychologically-informed medical and public health risk communication is the most important BHSCP resource and yet likely the most neglected resource at the community level. If this is done “right,” then all phases of community disaster planning will be successfully implemented when the time comes for action. Thus:

One hundred well thought out spoken words coupled with the audiovisual image of the most psychologically-attuned speaker will shape the community planning and response to a disaster far more than 100 types of fact sheets, booklets, and articles.

……………………………………………………………………………………..

4. The Psychology and Symbolism of Disasters

I view a disaster as a uniquely individual phenomenon in the context of a group phenomenon; this gives a wider application in BHSCP. *I define a disaster as: an unexpected event that occurs in one’s own life [substitute group, organization, community, city, region, state, etc.]—as both outwardly lived and inwardly experienced—of such significance as to change one’s [any group’s, etc.] life and to leave one with both haunting and emotionally charged memories and with some extra degree of wariness about the future (8).*

A disaster is usually thought of as short-lived for minutes to days. However, for many individuals, chronic conditions such as poverty, medical illness, psychiatric illness, loss of benefits and pension from a company bankruptcy or downsizing, divorce, death of a spouse or a child, rape or torture, living in areas with industrially polluted earth and ground or drinking waters, or high stress job burnout can be considered disasters, as well. EP&R initiatives are shaped by the nature of the disaster and by the fact that individuals and groups experience traumatic events of whatever length in very personal and cumulative ways.

A primary goal in disaster EP&R is maintaining and restoring communality. People, their activities, the land on which they live, and what they build and do on that land comprise a community. In contrast, *communality*—a term described by Professor Kai Erikson in his sociological studies of the Buffalo Creek, WV and other disasters (9,10)—is different. It is the nature of the localized network of human interrelationships: the interpersonal underpinnings of a neighborhood, a region, a farm district or business district, a county, etc. Reliance upon and responsibility for persons in a collective sense—of present, past, and future; of physical proximity and neighborhood familiarity; of shared cultural and ethnic strengths—is the communality that is especially disrupted and even obliterated in a large natural or accidental disaster.

The sum of psychological damage from a large-scale disaster on top of a preexisting local disaster (a group of military veterans with combat-related posttraumatic stress disorder, a cluster of sudden violent deaths among members of a high school, the primary industry in a small town suddenly closed, a multidisciplinary HIV-AIDS Clinic in a medically-underserved area closed, etc.) is far greater than the parts and can grievously rupture communality.

A major motor vehicle accident with much loss of life that occurs in a town, and a jet airliner crash with complete loss of lives that occurs outside a major city, are similar in that a net of tragedy is cast over community and communality. In the former incident, it is a relatively circumscribed net of both. In the latter (especially if it was an international flight), many small nets of tragedy reach over families and friends and businesses and institutions and communities worldwide. They further reach over the airlines company itself (labeled as "the cause") and even into the international collective feelings of grief, anger, and retribution if gross negligence or a terrorist cause is suspected. It is not that the emotional brushfires are that much greater in a larger disaster than smaller disaster; the intensity remains the same but they can burn worldwide.

The psychological and sociological ramifications of a disaster which strikes a community can be very subtle, destructive, and long-lasting far beyond any expectable period of time (for rebuilding homes and lives and businesses, providing medical and psychological care, and implementing new disaster response plans and programs).

Leaders and planners must have a workable conceptual grasp for distinguishing the nature of the disaster. One approach is to categorize it as: natural disaster: accidental (technological, transportation, etc.) disaster; disaster caused by intent to harm others, with a corollary of weapons of mass destruction use; business or industry workplace disaster; disaster which directly or indirectly hurts children and adolescents; and a public health disaster. The nature of the disaster has significant psychological implications for individuals, for the communality affected, and for interventions.

Natural Disasters such as a tornado, firestorm, drought, flood, or an earthquake bring up issues of loss and fate and luck. There can be a turning-inward and soul searching for why it happened. Because it is a natural disaster, some will implicate nature's whims or God's punishment, others will say it is bad luck, and others will say ruefully that such disasters have happened here before but were never expected to occur again. Family members often endure the disaster together, and there is an expectation that most or all victims' remains will be recovered for burial [the 2004 Asian tsunami and 2005 Hurricane Katrina are examples of very tragic exceptions]. There is a sense of an enduring future, based upon rebuilding or relocating. Memorial sites can be erected as healing rituals that later can be visited by many. As a corollary, intense blame may be fixed on an individual or a group such as a meteorology service, earthquake or tsunami warning system, a town's civil defense warning system, or a state or federal government emergency management or engineering agency if these do not forewarn and prepare the community sufficiently in the citizens' eyes.

Accidental Disasters often cause a sudden and devastating loss of life and property. Survivor guilt can be intense. An effort to affix blame as to the cause of the accident is expectable, intense, and litigious. Any suspicions of terrorism or intent to cause harm can fuel outrage at company and governmental officials in charge. Suspicions of error in judgment, negligence, or design defect likewise are combustible sources of rage. A large number of victims─their remains and personal effects─may not be recoverable if the incident occurred in a marine or aviation disaster, for example; the grief of survivors and relatives is greatly compounded when there is not even the smallest body piece to formally bury or personal effects to keep as a remembrance. Recovered remains and personal effects may be kept by authorities for long periods of time, angering relatives, until identification can be made and their use in a possible criminal investigation is over. Especially in a transportation accident, there may not be a strong and wide communality from which surviving members or next-of-kin can gain support, as victims may have been brought together by chance from many parts of the world. Grassroots efforts to make international organizations of "Parents and friends of the [airlines and flight number]" have been successful in providing a sense of international communality and support here. An erected memorial near the disaster site can also have great importance for victims' relatives and others who have traveled from faraway places to see it.

Intent-to-Harm Disasters cast shadows of incomprehension, rage, insecurity, and distrust across the fabric of a community that can best be likened to a permanent stain in clothing. Individuals and the community as a whole will have their sense of trust and safety in day-to-day society shaken. This can be a fatal bank robbery, a gang-related stray shooting of a young child, a domestic revenge murder, sniper attack, school shooting, fatal arson or bombing [a public suicide could also be included as an example, as it is violence towards oneself with psychological revenge against others a common motive]. There is a fear this incident could recur again. A strident demand for justice is common. If the perpetrator(s) is never caught, then for many survivors, there is an even greater sense of unremitting distrust, loss, and anger that never goes away. If the perpetrator is caught and justice unfurls, the rage of some survivors or rescue workers remains focused on the defendants. Once the trials are over and sentences meted out, that rage in some individuals has nowhere to go but inward; self-destructive behaviors and even suicide can result, further adding to the numbing and painful sense of loss within the communality.

Weapons of Mass Destruction use a corollary to intent-to-harm disasters. These disasters are unique. They are a form of psychological warfare or threat of the highest degree: they are based on extreme fear of an unknown agent(s) that has no sensory cues of exposure and penetration into the body; the morbidity and mortality come from within (body systems may be affected without external injury); quarantine and isolation emergency laws are imposed because of a fear of high contagiousness; and the diseases or injuries caused can be long-lasting and recurrent within the individual or the community. Significant psychological problems can occur without physical injury or contact exposure. Psychological illness and impairment can be a major source of casualties from the fear and misinterpretation of subjective symptoms, which can lead to outbreaks of exceptional panic or outrage.

Cyberterrorism, including computer and email viruses and worms which invade the privacy and security of one's work, social, and home domains, is a related intent-to-harm disaster which has direct psychological, emotional, and financial implications for its victims.

Workplace Disasters bring issues of causation and liability that may remain indeterminate for long periods of time because of the need for investigations and the conflicting demands placed upon the corporation. This can involve the families of victims, coworkers, senior management and executives (who are inferred to have the workers' best interests at heart), shareholders, governmental regulating agencies, and the public/consumers. Recounting of specific events, catharsis of strong emotional reactions, survivor guilt, redress and justice against the perpetrators or those responsible in the organization are common themes in psychological debriefings, but participating employees may fear their job security and pensions, or possible future claims for disability, would be jeopardized by their open discussion. A suicide or murder on the premises of a work site may make it exceedingly difficult for others to work near or at that specific site.

Disasters Involving Children are intuitively horrible to think about: harm predominantly or solely done to children and adolescents. There are two types of this disaster: an incident directly kills or injures classmates, friends, peers, or family members; or an incident kills and injures parents, guardians, teachers and other adults who play close guiding roles. The causes are those described above. The extent of grieving and suffering among community members is likely higher in the former type. In either type, the aftereffects are devastating for a very long time. Such deaths in either situation cut to the real and existential heart of a family and communality, because their future legacy was to be propagated through their children.

Public Health Disasters are a corollary to all the above disaster types. Preparing and responding to a public health disaster is a now-recognized massive multi-agency, multidisciplinary, and combined local, state, and federal effort. Pandemic influenza, anthrax dissemination and other bioterrorism acts, contamination of municipal and rural water supplies and sources by biological and chemical agents, SARS transmission internationally, and single and multiple-source food-borne illness outbreaks within and across state lines are alarming examples.

Disaster types can occur in combination as well. While actual physical sites of destruction or sickness can be "contained," current events and media capabilities now teach us that even such local events are psychologically harmful state-, country-, continent-, or even world-wide. This must be taken into account in EP&R and BHSCP initiatives.

The psychological symbolism attributed to a specific loss of basic infrastructure services must be considered and planned for separately when there is a loss of (or in combination when there are multiple losses), for example: electrical power in general; light; water for drinking; ice and refrigeration; air conditioning; personal wastes disposal; shelter or housing; and/or ingress and egress from a high rise apartment or "sealed" habitat. As a case in point, the loss of power in general may not bother many people, but the loss of any electrical lighting when caught in a pitch black building or shelter, or home at night, is for many of us the most unsettling scenario of all. Humans are not evolved to see dangers in the dark. Thus, one solution for a community might be to purchase outright with local funds, or have a company donate, a huge number of small sealed or battery-required flashlights for stockpiling and then mass distribution. [Here, candles are not good to distribute, as they have caused too many fires and fatalities in homes of survivors of hurricanes, etc.] In this way, for each possible loss, planning could take into account simple basic or psychologically-attuned solutions which would be of enormous morale benefit to citizens.

In summary, *the psychology and symbolism of a specific disaster type will shape unique behavioral health surges, and planned responses—where much can be done for many with good effort–should be tailored accordingly.*

==

Organizational Strategies

5. Organizational Responsibilities

The triad of community behavioral health, public health, and emergency management must make coordinated BHSCP an important priority. This can be accomplished as a behavioral health subcommittee of a jurisdiction disaster advisory committee or as a committee of a local Metropolitan Medical Response System, or MMRS (described in Appendix 1).

Two co-chairs work best. They will likely be staff from the public behavioral health agency or behavioral health providers in the community who have the interest and accordingly volunteer. The task and the leadership should be accorded official designation, assigned to the appropriate larger EP&R committees, and viewed publicly by government leaders as an extremely critical and visible steward of the community's wellbeing. Public health department representation is necessary. Professional and community support will follow, along with anticipated volunteerism of and dedication from any committee members. [This is no place to give people the impression that it is a "thankless" job!] It stands to reason that active recruitment for committee members will be accompanied by the open implication that this is important and recognized work. Jurisdictional and grant funding for requisite education and training in EP&R and behavioral health EP&R for committee members should be offered.

The public is a valuable asset in emergency planning (11) and in BHSCP and could include, for example, patients, family members of patients, behavioral health services consumer representatives, civic-minded activists with altruistic missions, community service organization leaders, concerned members of advocacy groups, astute fund raisers, and corporate sponsors or donors. Few public behavioral health agencies designated as lead agencies in BHSCP or general behavioral health emergency preparedness and response, will have the personnel, time, and fiscal resources to accomplish all of the tasks. Most, though, will be able to accomplish some basic elements of a plan and rely upon assistance from the above persons as well as the local health department, public safety, etc. to assist them.

In addition, the scope of a state's and specific locality's disaster BHSCP response and recovery components will have an impact on existing programs as well as financial and human resources. These considerations should be incorporated into the planning process. For example, intensive outreach and case finding post-disaster will result in the identification of more individuals in need of assistance, thereby requiring additional funding, personnel, and care sites. Some number of survivors will later develop significant behavioral health problems. Planning should include an assessment of the ability of the state and local behavioral health infrastructure to absorb additional recipients of services, as a start.

It is important that local behavioral health surge capacity plans be maintained and kept "on the horizon." Effective plans are exercised, modified, and updated regularly. They are meaningful, comprehensive in scope, but remain sufficiently basic for all stakeholders to understand and apply.

………………………………..……………………………………………

6. The Psychology of Creating Better EP&R and BHSCP Plans

Writing plans for emergency preparedness and response initiatives is a daunting task and the results show that. When someone is responsible for writing a large document about information that comes from disparate sources and in language and terms that are unfamiliar, more often than not human psychology leads that person to write a document that looks comprehensive in scope, outline, and length and appears very official in a nice binder. With an urgent time deadline and government officials looking over the shoulder, the writer has a choice of whether to make a small terse document or a large all-inclusive one. The latter path is usually chosen, for obvious reasons. Some plans will be highly usable and readable. However, others will be approved that are more problematic than solution-focused; this is discussed below.

Writing emergency plans does not have to be so psychologically daunting. The writer who has been unfairly designated because of the job title only—and not on administrative skills–should also have an assistant officially appointed (part time hire or additional duty from another job) to help who is well-versed in organizing and creating such documents.

Plans are crafted words and thus are works of art and creativity.

Plans in an ancient communal sense are narratives. They should be plainly understandable to all who are gathered to listen to it, or more commonly in modern times, to read them, and they must be accessible to those with sensory challenges. The actual words, sentences, and thread of narrative should read well and smoothly to the eye and should sound well-spoken and well-paced to the ear. [Documents in outline form can sill be read and sound well-crafted.]

Plan review and approval must not be an automatic "given." Lives and livelihoods are at stake. Final jurisdiction accountability after a disaster is determined by what was done in comparison to what should have been done according to emergency plans (including behavioral health ones) from local to national levels. Any errors of omission or commission by vested officials that led to loss of life, property, or income will be greatly magnified by public legal and media scrutiny; this can have profound and detrimental effects on hardworking staff and their morale, even their job security, in responsible agencies.

To prevent this situation, a plan should be reviewed with the basic goals in mind: Is it visually well-organized and navigable, especially in crisis situations? Is it organized with a common sense continuity of information flow during emergency situations? Reviewers should read it out loud to themselves as they proceed. They should make comments and suggested content revisions on a visual as well as auditory basis. This will ensure that final plans are not stilted in formal terms which obfuscate and burden readers with careless repetition. Plans should not be bewildering to readers from involved agencies who wonder how the plan really applies to them or even helps them. Approval should not just be *de facto*. Reviewers should be honest and put themselves in the shoes of the public and other agencies who will use these plans. [It brings back the old adage of the Emperor who had no clothes, yet everyone nodded in acquiescence that he looked just great.] An impending or sudden disaster is not the time to spend puzzling over and deciphering an emergency plan.

It is a given that document review of an emergency plan or even BHSCP will be done by cognizant high level agency staff and committee representatives. However, managers and regular staff also should review any plans and their recommendations should be given equal importance. This is because these emergency plans may be thrust later into the hands of non-managers in scenarios where they are the most senior people available. They must understand and read the plans well enough to initially implement them.

Crafters of emergency plans are due "official" acknowledgement and appreciation, because creating such plans, again, is an art as well as a science.

…………………………………………………………………………………

7. Haddon's Matrix as an Exceptional EP&R Planning and Analysis Tool

A written EP&R plan is only as good as the framework upon which overall planning is organized. A good plan reflects substance as well as style, and it should be cognitively attuned to the minds of planning personnel in general and accordingly organized. Thinking about a plan requires a logical and intuitive mental framework to create and enact it.

William Haddon, Jr., M.D., M.P.H. pioneered new visions with which to examine, describe, and prevent the occurrence of motor vehicle-related accidents and fatalities as well as other injurious situations in the community (12-14). His work, best embodied in the matrix he created, is truly unique because it: is straightforward to understand; makes good sense; is readily applied to a spectrum of public, occupational, and environmental health problems; and is applicable to all levels of prevention.

Basically, Haddon's Matrix consists of a combination of possible factors involved in an injuries or fatalities event from whatever single cause or incident (e.g., bioterrorism event, hurricane, airplane crash) or repetitive causes (e.g., highway motor vehicle accidents, pedestrian fatalities, bicycle injuries) on the horizontal axis of the matrix, and the time surrounding such an event(s), e.g., pre-incident, incident, post-incident, final results, on the vertical axis. The horizontal axis categories can be few, such as person, environment, and vehicle, but in the best application, these few categories are broken down into various subcategories of interests, all along the horizontal axis. Within each cell of the matrix, all possible variables or defining characteristics can be listed per cell number, as represented below. Then, preventive strategies for each item within a cell, for each cell, can be considered for inclusion in an overall plan that is similarly organized.

Haddon Matrix Example for Hurricane EP&R Planning

FACTORS

PHASES	**People**	**Houses**	**Environment**	**Climate**	**Infra-Structure**	**etc….**
Pre-Hurricane	**1**	**5**	**9**	**13**	**17**	
Hurricane	**2**	**6**	**10**	**14**	**18**	
Post-Hurricane	**3**	**7**	**11**	**15**	**19**	
Results	**4**	**8**	**12**	**16**	**20**	

In addition to the problem or disaster itself, Haddon's Matrix has been applied expertly to the exploration and delineation of various behavioral health interventions for a specific disaster (15), most notably its recent application to pandemic influenza (16).

Psychologically-speaking, the use of Haddon's Matrix makes the EP&R planning process a far less daunting one. In fact, it would likely elicit maximal collaboration with others, as it stimulates the excitement of creative and innovative thinking.

……………………………………………………………………………………..

8. Schools as an Integral Part of PIEPR and BHSCP

The involvement of schools in all aspects of overall emergency preparedness and response in the community must be choreographed extremely well. It makes intuitive sense that this must be done right. Our children are our future collectively and individually, so their safety is top on everyone's minds.

With an impending or sudden disaster during the school day, the first parental response is to first remove students from school. The reasons can be psychologically expectable, based on fact or impressions, for example: if the student were to suffer any harm, it must happen within the protective and caring arms of the family; the school can not minister to all the physical and emotional needs of a student in fear and separated from family; the school is old and would not survive a major disaster; the school is structurally new but still impersonal enough that the student would be in fear; the school is viewed as unconcerned for its students because of negative interactions with school staff; if the student is not picked up now, then it is possible that he or she may be isolated there for a long period of time; the student needs medicines which are only stocked at home; the student will not have food, bedding, changes of clothes, or toiletries at the school; or the student will get a communicable disease because of possible overcrowding and less than optimal available hygiene facilities in a disaster.

Some schools, on the other hand, may be very protective of their students and believe that they can well take care of them safely until the time when parents are asked to come and get children. There may be great reluctance, even legal prohibitions, for schools to release students on their own cognizance when the environment is threatening or damage has occurred. Some students may consider their schools much safer than their home environments and thus be very reluctant or resistant to leaving.

Any disagreements among parents, school officials, and students at a time of impending or real disaster will quickly flash, especially when police and fire departments, local government and school administration officials, the media, and other parents are drawn into the fray. This is a worst case scenario, usually caused by lack of previously orchestrated communication and understood policies about emergency plans, between parents and schools.

This is unfortunate, as schools can be invaluable resources for community disaster planning for all disaster stages. Schools are often pressed into use as emergency shelters and thus considered a very safe place to be in a disaster. Many school personnel are often personally familiar with, and trusted by, members of their community. Schools are in the position to assist in providing many disaster-related services, such as an accessible meeting place for support groups or dispensing site after a disaster. Because of students' inherent familiarity with teachers, nurses, and counselors, they may be much more amenable to receive individual and group support, advice, psychoeducation, and counseling from these staff after a disaster and in an outreach program, than going to behavioral health providers elsewhere.

Schools and school administrations should have disaster plans in place. It is critical, then, that schools be consulted and brought into collaborative partnerships during the entire community planning process. Their plans, along with those of other institutions in the community, should be shared at planning meetings. Formal ways of educating parents and students must be thought out and creatively tailored for the different communities and cultures they serve. At the same time, all school personnel must be educated fully about these plans and how they are carried out during times of great distress among parents, children, and personnel themselves. Any disaster planning regarding the welfare of students must be done now and done well. A disaster is not the time to find out what should have been done for them.

==

Behavioral Health Providers in BHSCP

9. Roles and Responsibilities

Think in broad brush strokes when defining "behavioral health providers" and BHSCP care. Depending upon the size of the community, examples include: psychologists, psychiatrists and other physicians with significant interests in counseling and psychology, social workers, counselors, psychiatric nurses and nurse practitioners, art therapists, massage therapists, psychiatric physician assistants, psychoanalytically-trained educators/sociologists/anthropologists, clergy and faith-based counselors, teachers with special interest in counseling and psychology, and military enlisted behavioral health and religious affairs members.

Behavioral health care providers can be used in many roles regarding disaster BHSCP that are beyond the traditional provision of primary care in office, hospital, clinic, or academic settings. These roles are also integral to psychologically-informed emergency preparedness and response. Community emergency medical and health care planners must use creative matching of a provider's knowledge, skills, and interests with a spectrum of assignments. These can be categorized by Provision of Care, Advisor/Consultant, Membership in Groups, and Other Services.

<u>Provision of Behavioral Health Care in the form of:</u>

Continued primary care in one's own practice.

Continued primary care by filling in (as part of a previously designated pool for such occasions) for another provider who is ill, emergently deployed elsewhere, or filling another local role (below).

Emergency care, triage, and counseling at shelters, schools, mass antibiotic or vaccination dispensing sites, hospital emergency rooms, mass decontamination stations and facilities, other designated mass gathering sites, and on-scene at disaster sites when indicated.

Emergency care as part of a deployable behavioral health or combined medical/surgical/behavioral health team.

Critical incident stress debriefing or disaster response team for public (schools, public safety and emergency response personnel), private, or organizations and agencies such as the American Red Cross, Disaster Psychiatry Outreach, or local Medical Reserve Corps unit.

Organizer, provider, and leader of therapy and non-therapy groups alike in the community (see section 16).

<u>Advisor/Consultant to:</u>

Local health department director for issues engendering behavioral health consequences, e.g., forced evacuation and relocation of citizens, quarantine, isolation, or shelter in place.

Local health department director on the care and overall cultural attunement to and psychological needs of specific ethnic populations in the community.

Local jurisdictional emergency operations center (EOC) staff.

Jurisdictional leaders (mayors, county administrators, city managers), emergency managers, and public affairs officials for creating psychologically-attuned information, education, and risk communication messages for the media and for the population, for short term and long term needs.

Jurisdictional leaders running controversial and challenging meetings.

Media officials on public communication issues, specific articles and features, and traumatic stress exposure for on-scene reporters and journalists.

Chamber of Commerce, businesses, and specific industries for psychologically-informed emergency preparedness, response, and recovery plans and actions.

Local behavioral health advocacy groups (National Mental Healthy Association, local Mental Health Association, National Alliance for the Mentally Ill, etc.) and their emergency or contingency plans for staff, patients, and families.

Faith-based organizations.

Military groups (especially if the provider is active duty, veteran, retired, or reserve status) and local Veteran Affairs Medical Center.

Hot line center for media, agencies, and health care facilities.

Membership on:

Jurisdictional or regional Metropolitan Medical Response System (MMRS), as part of behavioral health and other relevant sub-committees.

Teams and committees assigned to create and maintain emergency plans for an entire community, local public behavioral health care agencies, health department, hospitals, long term residential facilities, schools, etc.

Disaster committee of local or state professional behavioral health care association or society, local hospitals, etc.

Civic action preparedness and rebuilding committees and teams.

Other Services:

Lecturer on disaster psychology, behavioral health preparedness and response, and related issues to local health care (BH and non-BH) groups, academic departments, community groups, businesses and industries, etc.

Research team or grant writer for agency or academia investigating behavioral health clinical, services provision, and other community responses or indicators, before, during, and after a disaster.

Writer of disaster behavioral health care-related manuals, research papers, refereed and non-refereed articles, position papers, literature reviews, media articles, book chapters, and books.

Producer of videos and media documentaries on psychological aspects and community preparedness and response to disasters.

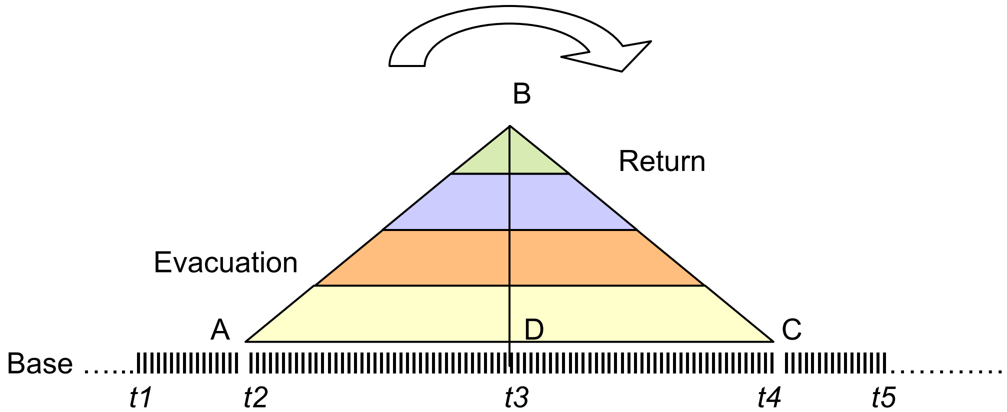
Jurisdictional spokesperson to the media, if the provider has preexisting good risk communication and public speaking skills.

Depending upon the nature and characteristics of the local community, behavioral health providers should be actively recruited to these roles by a jurisdictional leader or emergency manager, a medical emergency planner, a public health department director, an executive of the local public behavioral health care agency, or other health care leaders.

==

10. Psychological Pyramid of Evacuation

Imagine a pyramid with mirror image ascending and descending steps. The ascending side is the evolution and implementation of evacuation for a specific disaster. The descending side represents the evolution and implementation of the post-evacuation return process. In an ideal world, citizens psychologically suppress fears of the disaster with the belief that evacuation, if needed, will be accomplished smoothly because local government has planned and made sure of that. They similarly believe that the return to intact residences and properties will be accomplished smoothly, as well. Thus, the psychological pyramid of evacuation (my term) is:



Point A→ Evacuation → Point B→ (time spent at Point B)→ Return→ Point C

But the reality of the 2004 and 2005 hurricane seasons showed U.S. citizens that it just does not happen quite like that and it could happen again. Evacuees from Point A come back to Point C changed, because of actual loss of property or life or income or communality, to start life over again. [Geographically it may be "back" at Point A, but in all other facets, it is not now what life used to be at Point A.]

The evacuation process flows upward A–B, over horizontal time *t2→t3.* The return process flows downward B–C, over time *t3→t4*. The vertical layers within the pyramid represent expectable psychological and physical changes in the collective community at different points in time; the vertical line B–D (into the Base) demarcates evacuation events and time (A–B–D) from return events and time (B–C–D).

My concern is the fabric and strength of the community (the Base), how it exists and functions on the time continuum *t1→t5*. But I want to focus now on the time of preparedness *t1→t2,* before (A–D) and the disaster occurs.

The Base from *t1→t2* is the present community shaped by history and events including: a sense of self-worth and confidence, accomplishments, failures, disasters and traumas, politics, economics, education, religion, jobs, citizens' lives, ancestors and immigrants, cultures, races and ethnicities, and views. The Base contains all the institutions in the community, but in the broadest sense, it is the primary infrastructure and direct representation of the community government and how well or how poorly it works. Thus, in preparation for disasters, it provides either calculated strong support or wobbly uncertainty for the eventual pyramid above it. *Whatever is accomplished t1→ t2 in the Base will determine how the Base endures from t2→ t5.*

Government leaders and emergency planners have to make a choice: pragmatically and openly planning and strengthening the Base for everyone's needs; or planning what is most expeditious and heady in goals and public relations but short on accomplishment. The consequences of the latter are what filled viewers' television screens the two years previous.

If the former path is chosen, then open networking, altruistic collaboration, joint dedication, and mutual respect among parties could work through divisive and impeding issues. Painful "lessons learned" from past events could become "lessons gained," put into place now. Enough government mortar and bricks are provided to make the Base strong enough to weather any real or figurative "storm."

People move, but they don't evacuate. Lives, family lineages, hard-earned and treasured possessions, communality, relationships to the environment, a shared collective psyche, and hopes, all embodied in people, are what evacuate. The evacuation and hopeful return of each citizen must be taken into consideration for planning purposes. Government officials and community leaders involved with evacuation planning and implementation must first ask of themselves, "What if I were in that particular citizen's shoes? What would I then want everyone to know about me and my needs for evacuation?" Keeping that in mind at all times, a sort of informational empathy, is what makes for a successful design and a strong base for each succeeding layer of the psychological pyramid of evacuation and return. Whether the process and outcome of evacuation and return is anticipated and weathered, or unanticipated and tragic, empathic planning will be remembered and valued.

………………………………………………………………………………………

11. Animals and Disasters

The collective community psyche is very closely attached to pets, business animals, and wild animals. As goes the welfare of the community's animals, so goes the community. This is especially true if a community's economic livelihood depends greatly upon animals.

However, in disaster planning meetings for communities, considerations of pets and business animals (animals used to conduct a business or animals, animals raised and bred for the joy of it, animals raised as eventual food sources), and animals integral to the beauty of natural resources are often afterthoughts with lip service paid but insufficient action taken. This is understandable at an unconscious level. Most people do not want to be responsible for ensuring the death of a pet or a working animal, or they will face financial ruin and inability to provide for a family if they lose their animal-for-food business, or they will lose their very personal connection to nature. All of these are troubling thoughts, so human nature and psychological defenses being what they are, the most painful thoughts are often suppressed and not discussed. But they need to be in this situation. Magical thinking here—"my pet's evacuation and sheltering will be dealt with later by someone who will take charge and care of everything"—is illusory and extremely counterproductive.

Pet owners may not want to evacuate an area when required, even in the face of possible death, if they cannot stay with their animals, bring them to a people shelter, or bring them to a fixed or mobile emergency animal shelter with provisions for basic care. Owners of certain animals raised for joy, and owners of certain business animals like small zoos or small pet stores, could have difficult decisions to make about evacuation or sheltering in place, without access to their animals.

From a local government planning effort, it is not purely the choice of the animal owner to make painful decisions in times of impending emergencies. Instead, it is first the choice and responsibility of emergency planners to address this issue, with a scope based on the particular attributes of each community. They should direct working groups to convene pet and animal committees, to support that work and its recommendations. Membership should be drawn from: veterinarians and veterinary technicians, pet store owners, jurisdiction animal control officers, crop farmers with working animals, zoo staff, horse owners, other large animal owners, 4-H members, avid teen-ager pet owners, local animal humane society, cattle and hog farmers, local PETA (People for the Ethical Treatment of Animals) members who may know of successful animal disaster programs elsewhere, behavioral health providers who are avid pet or animal lovers and can apply psychological perspectives here, environmental health staff from local health departments, and local Bureau of Game and Wildlife Fisheries or National Park Service.

As templates, there may be government or state veterinary society animal disaster plans already in place and available through the internet. After local plans are written and endorsed, and after they are publicized for the community, then it becomes a choice for citizens to take individual action before a disaster strikes.

==

12. Disaster-Specific Behaviors of Masses

The nature of the disaster is a crucial factor here. If the causative agent is contagious from person to person and especially if it causes a fatal illness, expectable paranoia, self and family isolation, work absenteeism, and reliance upon external sources such as television, radio, telephone, and the internet will be likely. These same external sources will be main conduits of important information about the disaster: continuing evidence of contagiousness; trends of illness and death; guidance about shelter in place, isolation, and quarantine; when, why, where and how to get preventive medicines and immunizations or actual treatments; and status reports of the community infrastructure and necessary services. Planners will have to use innovative approaches to get the above news and medical information to individuals or even large subgroups of the community who have no access to television or the internet especially. Loss of electrical power complicates the situation; ways to link up people with others and "the outside" have to be thought through as part of planning.

If the nature of the disaster and the causative agent or agents cause illness and death (but not through people-to-people transmission), then large numbers will likely come forward. The good part is that in this way, news and information can spread (even with likely rumor and misinterpretation), irrespective of loss of electrical power for the print and broadcast media. There does need to be a dedicated information and education campaign to explain the lack of contagiousness, despite nearby people showing signs and symptoms of illness, and to differentially direct large numbers of people with illness versus those without illness, to points of dispensing sites, mass town hall meetings, and transportation venues, to name a few.

The third situation is when there is large fear of, or direct evidence of, environmental contamination in neighborhoods, business areas, planned points of dispensing, mass health care gathering areas, mass transit lines, and others. The psychological ramifications of "contaminated" air (unseen, untouched, but inhaled), versus contaminated surfaces (unseen but touched) like structures, ground, and walkways, versus contaminated water (unseen but ingested or touched) have to all be differentially considered and planned for, when shaping information and guidelines for the public during and after a real event.

It is expectable that people will seek and demand refuge in places which, in their eyes and for whatever psychological reasons, will afford the best chances of protection and survival. They will clamor for refuge to reduce distress and to increase coping (to feel protected from disease agents or toxins, to feel safe in general, to not be alone, to be near food and water and shelter, to get public information, to be near medical personnel) and obtain preventive immunizations or drugs. The following is not an exhaustive list but rather demonstrates a need to "think out of the refuge box:"

Houses of worship
Schools
Police and fire stations
National Guard armories
Hospitals and clinics
Psychiatric hospitals and clinics
Health Departments
Community Service Boards and Community Mental Health Centers

Private health care providers' offices
Military bases and medical facilities, including Veterans Affairs
Shopping malls
Transportation hubs and terminals for rail, flight, shipping
Ships
Restaurants
Pharmacies
Shelters
Underground subway stations
Point of Dispensing Sites
Government buildings
Business office buildings
Business or industry storage facilties
Sports facilities (indoors)
Private vehicles, boats, planes (anticipation of leaving)

This PIEPR aspect has to be taken into account for BHSCP and consideration for staffing for group interventions/crowd anxiety management. Each shelter or place of refuge will have its own psychological symbolism that connotes collective community and individual views, based on past history (up until the disaster). It is conceivable that this symbolism will shape: the willingness of owners, managers, or landlords to plan for and open these up as mass gathering places; the sense of communality and working together among jurisdictional leaders, organizations, and commerce and industry; the actual numbers of evacuees who go to places contraindicated by good sense or logic in a particular situation; the order and calm of evacuations; and the compliance with government and health department directives and advisories.

……………………………………………………………………………….

13. Who are the Mass Numbers?

In the priority-setting process, both research and practice experience point to exposure as a prime predictor of the development of psychological sequelae. DeWolfe's Population Exposure Model (17) provides an excellent planning tool and schematic for conceptualizing the degree of psychological morbidity that populations within a community could suffer and thus need commensurate services. He describes a series of concentric circles, a ripple effect, with those most "exposed" occupying the innermost circle A and those least exposed occupying the outermost circle. The following template should be tailored and expanded upon depending upon the makeup of the community.

A	Seriously injured victims • bereaved family members
B	Victims with high exposure to trauma • victims evacuated from the disaster zone
C	Bereaved extended family members and friends • rescue and recovery workers with prolonged exposure • medical examiner's office staff • service providers directly involved with death notification and bereaved families
D	People who lost homes, jobs, pets, valued possessions • mental health providers • clergy, chaplains, spiritual leaders • emergency health care providers • school personnel involved with survivors, families of victims • media personnel
E	Government officials • groups that identify with target victim group • businesses with financial impacts
F	Community-at-large

However, keep in mind that exposure is not just shaped by occupation, socioeconomic status, health, etc. It is also based upon governmental strengths or weaknesses, such as completeness of emergency plans, integrity of the transportation system in case of outreach health care needs or required evacuation, infrastructure of public utilities, roads, and barriers to flooding or other natural disasters.

While it is generally agreed that all who experience a disaster are somehow impacted by it, there are groups who, even if not at greater risk, warrant specialized approaches and services. These include children, vulnerable populations (e.g., children with impairing developmental or behavioral health disorders, the frail or disabled elderly, adults with significant and limiting behavioral health and medical disorders, homeless persons, adults and children with sensory impairment disorders, communities and individuals previously exposed to disaster or traumatic events, those at low socioeconomic or poverty levels of living), ethnic and immigrant populations, and many others.

An excellent summary of the empirical research, including a discussion of risk and status factors, can be found at

www.ncptsd.org/facts/disasters/fs_range.html

===

The Big Picture of BHSCP Resources and Interventions

In the case of BHSCP, it is not necessarily the numbers of available behavioral health providers, listed above, that determines the success of planning. It is the wise and strategic use of these resources, even when the extent of behavioral health surge is appalling. Important work has shown the imperative need to match evidence-based interventions depending upon the vulnerabilities and the traumatic exposures to different populations in the community (18,19). There should also be a match among the provider, his or her skills, the ranking or priority of the roles needed to be accomplished (again, see above), and a final assignment or placement in a position where one provider can influence, shape, educate, or calm many over the short term and long term.

Using PIEPR again, planners and providers must put themselves in the shoes of citizens. Thought must be given to the ways in that particular community that citizens would be able to be in contact with the provider (media venue, internet, telephone, radio, printed page, face to face), which of course will depend upon utilities, infrastructure, and so forth. It is not just a question of whether people will try to listen, read, or engage psychological assistance; they must be given the opportunity to do so through frequent and repeated messages.

There can understandably be a significant lag time between the decision to implement post-disaster behavioral health services and their actual implementation. However, in Virginia, the success of the Community Resilience Project was significantly predicated upon the quick and timely grant applications made to FEMA, which resulted in hiring many behavioral health care professionals to provide surge capacity services for almost three years after the 9/11 Pentagon attack. The points of contact/websites for applying for such grants should be kept readily available to behavioral health agencies.

BHSCP can be augmented in creative ways within a community. Medical Reserve Corps units with behavioral health components are important. State and local behavioral health professional societies can create disaster committees and volunteer teams, and they can assist in the initiatives to train large numbers of citizens in psychological first aid delivery. Memoranda of understanding can be created between local community behavioral health agencies and military or Veteran Affairs behavioral health departments. Finally, disaster behavioral health education and training initiatives for individual providers could be created by state or local public health, behavioral health, or emergency management agencies and thus increase the overall pool of resources for all four phases of disaster planning and response. Psychological first aid training (20) should be incorporated into these efforts.

Public education, public health, and collaborative media involvement following an event is critical. In the case of large natural disasters, for instance, the media proclivity to up the psychological ante by announcing likely widespread outbreaks of communicable infectious diseases must be directly countered and explained by public health officials when there is, in fact, little risk of such outbreaks (21). Many victims will require little or nothing more than information that reassures, provides anticipatory guidance, and provides meaningful advice about what they can do to reduce/manage disaster-related stress. Consistency in these messages is critical.

Behavioral health experts in psychologically-informed risk communication and public speaking should be used by media conduits and municipalities' communications directors in crafting messages and advising spokespersons on the best messages and formats/venues to use, specific for the type and psychological symbolism of specific disasters and loss of essential services.

14. Psychologically-Attuned Risk Communicators as a Primary BHSCP Resource

Think out of the disaster box for a minute. Think instead about the election of public officials. Think for whom you decided to vote and why. Was it the platform of philosophies and promises? The political party affiliation? Preexisting experience in politics…..family pedigree…..religion…..race…..and more?

Or were the facial features constantly attuned with the words spoken and the emotional gravity of the topic? How was the voice paced and modulated? What did the eyes and the eyebrows say by their continual movement? Did the axis of the head tilt and nod and rotate in accordance with the words and the emotions? How did the lips shape and move accordingly?

Is it the words, is it the biographical facts, or is it the component image of the person that so strongly resonates within you? It really is the last one that makes you listen so intently and believably that the individual experience endures far past the actual media or live appearance. It is really this last one which shapes your final vote for a leader.

Now go back to BHSCP. The same experience applies to a government or jurisdictional spokesperson for all phases of disaster planning and response. As a corollary, how many times have you wished that your favorite television news anchor—the one you listen to and trust for your personal understanding of the impact of daily events on your life—could assume other guiding roles in your life, in terms of personal or community emergency or disaster? Your favorite news anchor and your favorite political leader are psychologically-attuned with you.

Spokespersons for disaster planning and response (all four stages of the disaster cycle) should be selected and further groomed and trained for a community, based on the same principles. The title of public affairs/information/relations officer should not guarantee the actual spokesperson role for disaster planning and response. Community focus groups should be enlisted to help select the appropriate person (actually, persons, because one spokesperson cannot be on duty 24/7) by test screenings, etc. Select psychologically-attuned spokespersons, and the rest of BHSCP will be much easier.

……………………………………………………………………………………

15. Psychologically-Informed Risk Communication Venues as Key BHSCP Resources

There are multitudes of disaster preparedness fact sheets, articles, guidebooks, flash cards, door hangers, and posters, among other products, that are available in different languages. However, each community needs to consider how to maximize the effect and attunement for these products, for each representative subpopulation. "One size does not fit all."

Culture and ethnic appropriateness must be factored into selection of materials, in terms of: literacy, photographs, printed images; advice versus guidance versus demand; ability to reassure through printed material; hierarchy and respect for family members and community leaders; color combinations in products and prints; acceptability and understanding of icons; and type and size and individual handling of products.

Elder-attuned and child-attuned aspects such as print and product size, amount of information per page, use of visual images and icons versus cartoons versus printed material are further considerations.

Signs (for point of dispensing sites, hospitals, shelters, etc.) are another matter. Their readability and effectiveness are influenced by such factors as: language, culture and ethnic attunement; size of sign and its print; health literacy; function (guidance, demand, movement, directions, information, location of rest rooms, etc.) and cultural attunement with this; placement and repetition at differential optimal heights for readability during times of chaos and crowds; and ability to reassure. The same considerations should be made for public health and environmental health flyers, posters, etc. to be posted throughout a community and its businesses.

Television and radio media venues require special consideration, not just in the ways described above. Television is an audiovisual experience, but it needs to take into account that hearing impaired individuals may not appreciate warning tones for emergency messages, so messages need to be repeated often and in very visible format. Those with visual impairments who can still see to a degree need to have messages delivered that are not crowded into small print with a lot of information on one screen, but rather in large print and slowly or not moving across the screen.

Radio broadcasts can be available to homes with no power but battery operated radios. What is important here is that announcements and messages need to be formulated and organized and broadcast in such a way that: there is constant repetition; and broadcasts are strategically scheduled to coincide with family routines day and night. These need to be culturally and language-attuned, child and elder-attuned, and created in such a way that the message and the psychological attunement of the broadcasters are optimized.

……………………………………………………………………………………

16. Support, Education, and Therapy Groups for Surge Numbers

My colleague Ed Simmer and I published a comprehensive book chapter entitled “When trauma affects a community: Group interventions and support after a disaster” in 2000 (22). A portion of it is slightly abstracted here, as the subject is extremely instructive on considering the spectrum of groups that can be used after a disaster as part of behavioral health surge capacity.

Whereas crisis stress debriefing interventions have been traditionally used after a disaster especially for emergency response workers and traumatized survivors, support groups are usually begun many days or weeks after a disaster and are primarily organized for traumatized survivors and other members of the affected community. Emergency response workers whose lives outside of the direct practice of their skills have also been affected can participate in such support groups as well.

Support groups provide key behavioral health interventions and stabilization for traumatized individuals and communities after a disaster. They work well because they instill hope, universality of suffering, information, altruism, positive group cohesiveness, and positive existential factors. Post-disaster support groups also foster a sense of normalization (the reactions members are experiencing are considered to be expectable reactions to an abnormal or unexpected event) and a sharing of resources.

Wee (23) provides an excellent comparison of basic types of support groups. The first type consists of the standard support groups, which provide psychological education with emotional support as the primary function over many weeks or months. The phases of the standard support group, compared to those of critical incident stress debriefing, are as follows: "recovery goals," "remembrance," "cognitive mastery," "mourning," "stress management," "teaching/resources," and "follow-up." Groups of the second type are referred to as "topic groups." These are organized around recovery topics (e.g., completion of paperwork for damage and insurance claims; advice on how to pick a building contractor or architect) and may meet once or twice and allow for group interaction, support, and networking. Groups of the third type are called "event groups." These groups bring large groups of disaster survivors together for a single occasion or event to address an entire community's needs (e.g., an anniversary commemorative event).

It must first be determined by cognizant behavioral health providers that there is a need for support groups for a specific community. If so, a broad spectrum of specific populations with unique needs within the community should be considered for separate support groups. These include but are not limited to children, the elderly, ethnic groups, sexual minorities, renters, homeowners, members of various professions and interest groups (e.g., nurses, artists, domestic workers, therapists), gay/lesbian/transgendered individuals, those who lost pets, those with physical disabilities, HIV-AIDS individuals, disaster response and recovery workers, those who lost loved ones, and the chronically mentally ill. Also affecting the need for a support group and the type of group chosen are such issues as the overall short-term and long-term impact of the disaster on the specific community, and the extent and magnitude of damage, death, and injury experience among community members.

Once the need for support groups has been evaluated, and the types of groups and target populations have been selected, the groups' utility and effectiveness can be maximized through attention to a variety of factors. First, the population of the affected community must be looked upon as a composite of many predominant subgroups stratified by age, socioeconomic status, marital status, religion, ethnicity, race, occupation, health, and geography of residential areas, to name some common ones. An effort must be made tomatch planned group leaders with salient characteristics of the likely members of these groups. As a corollary, cultural aspects and practices of these subpopulations must be respected when such groups are planned. For instance, food and drink provided at meetings must not conflict with cultural or religious dietary sanctions followed by the members, and group meetings should not conflict with a religious sabbath or church worship schedules, if at all possible.

Second, depending upon the effects of the disaster and the populations it has affected, group leaders may be more concerned (especially at first) with practical matters: arranging temporary housing, providing basic food for families, immediately starting loan or mortgage applications or insurance assessments of home damage and loss, and/or providing contractor or self-help services for the immediate repairing of homes or of wells or septic systems.

Third, support groups must be held in locations that maximize the transportation assets and abilities of community members. Flooded or damaged highways or local roads, washed-out bridges, debris that block roads, and areas of high damage to homes all influence members' attendance. The emotional attachment to lost or damaged homes may keep many members from making long or arduous trips to a non-centralized group location. If a local building of any type is chosen for group meetings, it should be in a central area. Transportable meeting places, such as trailers or recreation vehicles, may need to be used. Individuals or car dealers who own four-wheel-drive vehicles may be pressed into providing taxi services.

Fourth, the group schedule must take: into account the other urgent needs that community members have in recovering from the disaster. Immediately after the disaster and for several weeks afterward, damaged homes and injured family members take precedence in the psychological and physical priorities of individuals. A weekly group schedule may be too demanding, but an every-other-week schedule may be feasible. The time and day of the week chosen for group meetings are also important factors, which are influenced by the geography, the weather, the integrity of the roads, the availability of child care, the occupations of the local community members, and so forth. Nighttime meetings may inculcate a sense of fear and resistance to attendance when there are poorly lighted or damaged roads. If individuals in the community are able to go back to work, then a balance has to be struck between weekday work schedules and the need for weekend time to regroup and recover mentally, physically, and emotionally with family members.

Fifth, disasters easily conjure up in the minds of the suffering the idea of vulnerability and need for safety. This has to be factored into providing available group locations with nearby parking, as well as very visible protection from crime both outside and inside the meeting area. Such group meetings should be held in areas usually devoid of crime, if at all possible.

Sixth, consideration must be given to providing child care services at the site of group meetings, so that adult members can feel free to express their feelings and concerns in the shared privacy with other adults, without being interrupted by children's situational needs.

As far as the actual mechanics of setting up groups are concerned, many groups seem to work best as open "groups, with community members being able to participate when possible. This works best with support groups dealing with topics such as home repairs and other self-help issues, local governmental issues, resumption of community and utility services, and so forth. Other support groups fare better as closed groups, whose leaders may choose to do a pre-group screening for each individual to ensure compliance with basic rules of privacy and confidentiality and participation, as well as to rule out evidence of severe or impairing mental disorders that indicate a need for immediate treatment.

These latter groups have been used in the aftermath of disasters involving significant loss of life, especially when such disasters have been caused by an accident (e.g., an airliner crash), intent to harm others, or negligence. In these disasters, examples of which are described in more detail in our complete chapter, the emotional reactions (anger, numbness, shock, etc.) are persistent and at times overwhelming; the call for justice may be overarching; and the intense grieving may endure for months and years. All of these factors necessitate an enclosed, safe, trusting, and containing group environment.

The duration of support groups remains flexible in most situations, driven by the unique characteristics and needs of each specific group of individuals; some last a few sessions, some last several months, and some can last years.

Last, group rules are usually minimal; however, depending upon the type of disaster, the open or closed nature of initial membership requirements, and the needs of the participating members, the leader can institute additional rules to maximize the process and thus the benefits of the specific group.

Promoting the group requires consideration of: developing flyers; contacting key persons and organizations in social networks; seeking publicity through newspapers, radio, and television; and promoting referrals from other disaster survivors as well as health care providers.

Basic disaster-specific themes and session-by-session issues are described in detail in our complete chapter. When and how to refer a seriously disturbed group member for urgent or emergent care needs to be considered, as well as what to do if a group member later dies by suicide, illness, or injury. Myers (24) emphasizes that anniversary dates are extremely important to acknowledge and plan for in the group. The group leader must have an understanding of when documentation and reporting are mandatory for issues brought up in group.

Termination strategies need to be thought out ahead of time. Issues to be considered include: preparing the participants; deciding how to continue individual relationships after the group; making referrals to other resources as needed; inducting new support group facilitators; continuing the support group as a self-help group; and providing follow-up to individuals or the group as a whole when funding for the group ceases, such as a federal or local grant for a specific time period of group sessions.

……………………………………………………………………………………..

17. Innovative Outreach

Are there other ways later on in which a community survivor might be able to ventilate or talk confidently with someone who is a good listener and who may also have the knowledge and leverage to quietly steer the survivor to seek help? Hair salon stylists would have women and men clients as captive audiences. So would bartenders. Clergy might; so might video storeowners and employees. Public library staff might be in pivotal positions, especially with many coming there to use computers. Mail carriers see people every day and may be in the best position to note changes in mood or behavior, or even just sociability, in a person who lives on a route. Teachers would be in an excellent position to observe and privately interact with parents at school conferences about their children. Public health departments and clinics are excellent settings, because they are non-stigmatizing or non-threatening in terms of behavioral health problems. Community members will go there for many non-behavioral health evaluations and treatments, programs, or education; trained staff can pick up on behavioral health issues by simple screening questions. Public health clinics are also excellent resources for having behavioral health providers see individuals and groups, again because they are non-stigmatizing settings. This situation is where public health and public behavioral health agencies can collaborate extremely well.

==

Psychologically-Informed Public Health

18. Maternalistic Versus Paternalistic Public Health in Crisis Times

Much consideration should be given to exploring the psychological bases for enhancing the success and compliance of public health initiatives, especially in times of emergency. One approach I developed as a health director was to contrast "paternalistic" versus "maternalistic" public health as related to emergency preparedness and response for specific disasters.

Non-Bioterrorism (chemical, radiation, nuclear, high explosive) type disasters are usually contained and managed with incident command and control structure, less public health and more emergency management/HAZMAT initiatives. The public health role is more paternalistic. There is generally no secondary transmission or contamination of one family member by another, though the environment can be contaminated. Thus, the instinctual protection of the family by the adults is maintained and is reinforced by an "us" versus the outside environment scenario. Directions by health and government leaders to follow guidelines and protocols (medical, occupational-environmental, public health) implies 100% assuredness that all will turn out well. There is relatively little use or necessity of conveyed sympathy or empathy by leaders. Thus *<u>paternalistic</u> public health*—"*Do as I say, and everything will be okay!"*—will generally suffice.

In contrast……….

Bioterrorism-type disasters are not easily contained and managed with established guidelines and protocols, as human motive (especially the intent-to harm) and human behavior by perpetrators are overriding. There can be contagiousness or extreme harm to family members from exposure among family members (where the parent transmits a deadly pathogen and fatal infection to her child, an especially appalling situation that goes against the instinctual grain of adult parents protecting the family). This is complicated further when the environment is contaminated or is a source of continual exposure and harm. No one can convey or imply a 100% guarantee of no harm. Rather, life and survival is a true matter of relative risk with ongoing unwavering care, sympathy and empathy as key requirements. Thus, *<u>maternalistic</u> public health— "There is a real danger out there to you and your family, anything can happen, I will protect and help you in any way through this until it is over."*—implied through psychologically-attuned leaders and spokespersons in health and government is necessary.

Risk communication, intervention and management policies, short and long term planning, must be tailored to the potential or real situation, primarily taking one of the two positions into account. Using one position, e.g., maternalistic public health, does not necessarily preclude using the other one secondarily. Finally, the use of the best psychologically-attuned spokespersons again cannot be overemphasized.

==

Final Comments

There is much literature on the psychological aspects of disasters, community psychological preparedness and responses, and treatments of disaster-related behavioral health disorders. Much is freely downloaded from noteworthy and proven government, private organization, and academic sources, to name a few. There are many online and other training and education venues. Readers are strongly encouraged to keep abreast of developments and information-sharing in their particular interests in this field and to ask continually ask themselves, "I wonder if……?" and "How would this apply to…….?" for their states and communities.

It is important for communities, in terms of this paper, to identify behavioral health or psychology professionals who are interested in the application of individual, group, --and organizational psychology to whole communities; they could serve on advisory and/or planning committees in this capacity.

Entrenched or rigidly held beliefs must be re-examined. I make this point in describing a new paradigm─a "positive" paradigm─for completely changing the traditionally negative paradigm of conceptualizing and operationalizing risk management programs in communities (25).

The timely, informative, thought-provoking, and substantial (in depth and breadth) list of risk communications writings of Peter Sandman and his wife Jody Lanard (www.psandman.com) should only be a click of the computer key away. Their work has been a veritable risk communication bible for me over the years.

Malcolm Gladwell's book The Tipping Point (26) should always be at hand; I know of no other book which promotes creative, innovative, and practical thinking and problem solving in the public health and disaster preparedness fields as well as this has for me.

Dr. Mark Dembert is a public health physician and psychiatrist and is the head of Strategic Public Health Solutions LLC, a joint public health−emergency preparedness−health care consulting firm based in southeastern Pennsylvania. His expertise and focus is using psychology, innovation, and creativity in developing effective strategies and solutions for a wide spectrum of problems and challenges to the public's health, for communities, governments, health care facilities, and businesses. Dr. Dembert had a 27 year Navy active duty career in the public, behavioral, and disaster health fields and a three year, after which he worked in several public health and disaster behavioral health capacities for the Virginia Department of Health.

Resources and References

1. U.S. Department of Health and Human Services. Mental Health All-Hazards Disaster Planning Guidance. DHHS Pub. No. SMA 3829. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2003. Available at www.samhsa.gov.

2. National Mental Health Association. Blueprint for Responding to Public Mental Health Needs in Times of Crisis. Available for purchase from www.nmha.org.

3. U.S. Department of Health and Human Services. Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations. DHHS Pub. No. SMA 3828, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2003.
Available at www.samhsa.gov.

4. Butler AS, Panzer AM, Goldfrank LR, eds. Preparing for the Psychological Consequences of Terrorism. A Public Health Strategy. The National Academies Press, Washington, DC, 2003.

5. Abrashoff DM. It's Your Ship. Management Techniques from the Best Damn Ship in the Navy . Warner Books, New York, 2002.

6. Friedman T. The World is Flat. A Brief History of the Twenty-First Century. Farrar, Strauss and Giroux, New York, 2005.

7. Goldsmith S, Eggers WD. Governing by Network. The New Shape of the Public Sector. The Brookings Institution, Washington, DC, 2004.

8. Dembert ML. When disaster hits a community. Teleconference for National Center for Post-traumatic Stress Disorder, January 6, 2000. Transcript at www.strategicph.com.

9. Erikson K. Everything in Its Path. Simon & Schuster, New York, 1976.

10. Erikson K. A New Species of Trouble. The Human Experience of Modern Disasters. W.W. Norton & Company, New York, 1994.

11. The Public as an Asset, Not a Problem. A Summit on Leadership during Bioterrorism . Conference at the Johns Hopkins Center for Civilian Biodefense Strategies, Baltimore, MD, February 3-4, 2003. Available at www.upmc-biosecurity.org/pages/events/peoplesrole/introduction.html.

12. Haddon W Jr. A logical framework for categorizing highway safety phenomena and activity. The Journal of Trauma 12(3): 193-207, 1972.

13. Haddon W Jr. Advances in the epidemiology of injuries as a basis for public policy. Public Health Reports 95(5): 411-421, 1980.

14. Haddon W Jr. The changing approach to the epidemiology, prevention, and amelioration of trauma: The transition to approaches etiologically rather than descriptively based. American Journal of Public Health 58(8): 1431-1438, 1968.

15. Butler AS, Panzer AM, Goldfrank LR, eds. Preparing for the Psychological Consequences of Terrorism. A Public Health Strategy. The National Academies Press, Washington, DC, 30-31, 2003.

16. Barnett DJ, Balicer RD, Lucey DR, Everly GS, Omer SB, Steinhoff MC, Grotto I. A systematic analytic approach to pandemic influenza preparedness planning. PLoS Medicine 2(12): 1235-1241, 2005.

17. DeWolfe, DJ. (Unpublished manuscript.) Population Exposure Model and text excerpted from Mental Health Interventions Following Major Disasters: A Guide for Administrators, Policy Makers, Planners, and Providers. Rockville, MD: Substance Abuse and Mental Health Services Administration. In U.S. Department of Health and Human Services. Mental Health All-Hazards Disaster Planning Guidance. DHHS Pub. No. SMA 3829. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 12, 37, 2003. Available at www.samhsa.gov.

18. National Institute of Mental Health. Mental Health and Mass Violence: Evidence-Based Early Psychological Intervention for Victims/Survivors of Mass Violence. A Workshop to Reach Consensus on Best Practices. NIH Publication No. 02-5138, U.S. Government Printing Office, Washington, DC, 2002. Available at www.nimh.nih.gov/research/massviolence.pdf.

19. Stein BD, Tanielian TL, Eisenman DP, et al. Emotional and behavioral consequences of bioterrorism: Planning a public response. The Milbank Quarterly, 82 (3), 2004. Available at www.milbank.org/quarterly/8203feat.html.

20. National Child Traumatic Stress Network and National Center for PTSD. Psychological First Aid: Field Operations Guide, September, 2003. Available through www.NCTSN.org and www.NCPTSD.va.gov .

21. Floret N, Viel J-F, Mauny F, Hoen B, Piarroux R. Negligible risk for epidemics after geophysical disasters. Emerging Infectious Diseases 12 (4), 543-548, 2006. Available at www.cdc.gov/eid.

22. Dembert ML, Simmer ED. When trauma affects a community: Group interventions and support after a disaster. In Klein RH, Schermer VL, eds. Group Psychotherapy for Psychological Trauma. The Guilford Press, New York, 239-264, 2000. Available at www.strategicph.com.

23. Wee D. Support Groups in Crisis Counseling Programs: Training Handout (3 vols.). Project REBOUND, Northridge Earthquake Crisis Counseling Assistance and Training, regular Services Program (FEMA 1008-DR-CA), Los Angeles, 1994.

24. Myers D. Disaster Response and Recovery: A Handbook for Mental Health Professionals (DHHS Publication No. SMA 94-3010). U.S. Government Printing Office, Washington, DC, 1994.

25. Dembert ML. "The Four R's:" A positive paradigm shift for risk management. March 2006. Available at www.strategicph.com

26. Gladwell M. The Tipping Point. Little, Brown and Company, Boston, 2000.

APPENDIX 1

Author's Experiences in Disaster EP&R, Behavioral Health EP&R, BHSCP, and Public Health

This paper is a distillation of my professional experiences in 30 years of crisis management in the health care field. Three experiences stand out which truly shaped my views and advice on addressing modern day challenges to the public's health: all three involved work in the interface of public health (PH), behavioral health (BH), and emergency preparedness and response, along with the ultimate challenge of behavioral health surge capacity. They are described here so that readers may get ideas of what might be adapted and work in their states and communities.

Leadership and Guidance from the Top

I was privileged to be selected to chair a state-level Terrorism and Disaster Behavioral Health Advisory Committee in Virginia from its inception in 2003 until the spring of 2005. This committee, well known by the acronym "TADBHAC," was formed by the shared vision and efforts of the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services and the Commissioner of Health, and it was endorsed by the state secretary of health and the governor's office.

TADBHAC had a varying membership of approximately 15 representatives with professional behavioral health backgrounds and representing state level behavioral health, public health, emergency management, and emergency preparedness and response agencies, as well as local community behavioral health agencies, private practice, academia, schools, state professional societies, and emergency services. It stood as a valuable example or template for the partnership of state behavioral health and public health and the ensuing accomplishments in policy recommendations, emergency credentialing recommendations, planning (state emergency plans, behavioral health surge capacity plans), joint exercises, and most notably, education and training in behavioral health and disaster psychology created and then brought to regional gatherings of local BH/PH, social services, American Red Cross, public safety, emergency responders, hospitals, and government officials. The end result of all this was the interagency collaboration at the top trickling down and resulting in similar collaboration and dialogues at local jurisdiction levels throughout the state.

Leadership at the Regional Level

The southeastern region of Virginia, like many other areas in the country, has had a Metropolitan Medical Response System operating for several years. I was a public health/behavioral health member from 2001 to 2005. During this time, I served as a member of the Behavioral Health Subcommittee for the MMRS. This subcommittee membership included representatives from all of the public behavioral health agencies through the southeast region's jurisdictions, as well as invited members from private practice, hospitals, and academia and representing a diversity of professions (psychiatry, psychology, social work, licensed counselors). The biggest accomplishment was the development and final approval of a behavioral health emergency plan template for use among all BH agencies in the region. Concerns, limitations, and requests from different agencies were shared and acted upon where possible. Two major benefits of this subcommittee were face-to-face networking and standard workable communication venues set up for all of the represented agencies. The importance of including behavioral health input for numerous MMRS projects was also accomplished.

Leadership at the Local Jurisdiction Level

As Health Director of the Western Tidewater Health District and Suffolk, VA Health Department from 2003-2005, I chaired an all-hazards and terrorism advisory committee, created by the city manager after September 11, 2001 and fully implemented after Hurricane Isabel deluged and pounded the area in 2003. This committee had its own acronym "BTAC" (for Bioterrorism Advisory Committee) which was easily remembered throughout city government and agencies.

This committee addressed general and specific issues and challenges confronting a city trying to greatly raise its overall preparedness within government, agencies, and the public. A key component of this committee was the special acknowledgement and representation of public behavioral health. The committee membership included, in addition to public health (director, nursing head, emergency planner, Medical Reserve Corps coordinator) and public behavioral health (emergency services coordinator), hospital staff (safety officer, nursing and physician heads of the emergency room, infection control nurse), city emergency services coordinator, city attorney, chief of police, deputy fire commissioner, school administration, and directors of social services and the local American Red Cross chapter. Other community and agency or business leaders were invited to participate on a situational basis. These meetings were held monthly at the large community hospital, and complete minutes were forwarded to the City Manager for review, action, guidance, and support. I presented BTAC recommendations and accomplishments at the bimonthly City Manager's Department Head meetings, so that all city agencies and departments knew about the BTAC, including the special importance of behavioral health EP&R, with visible support from the City Manager.

Numerous working groups were formed under the BTAC, including a behavioral health one. The author and the executive director of the public BH agency led this endeavor and several key community planning components were addressed. The agency's emergency plan was also reviewed by the BTAC at different stages of development to ensure that it dovetailed well with emergency plans for the city and component agencies represented at the BTAC. In almost every project tackled by the BTAC, behavioral health input was incorporated, including the formation of a "super shelter" to include citizens with special needs.