AHCCCS
Arizona Health Care Cost Containment System

2023 DISASTER BEHAVIORAL HEALTH FRAMEWORK

BEST PRACTICE CONSIDERATIONS FOR ADVANCING ARIZONA'S FUTURE DISASTER BEHAVIORAL HEALTH PREPAREDNESS, RESPONSE, AND RECOVERY

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INTRODUCTION

Overview

The Arizona Health Care Cost Containment System (AHCCCS) built this Disaster Behavioral Health Framework to outline key concepts and best practices for enhancing preparedness, response, and recovery.

To develop this document, AHCCCS began with a thorough assessment of the current situation through focus group discussions and advisory group interviews. The aim was to map existing disaster behavioral health capabilities, explore how they integrate within emergency management structures, and identify areas that could be strengthened. AHCCCS also reviewed national guidance and examples from other states to ensure that the latest research and best practices informed the framework.

An effective behavioral health response to a disaster requires a dual commitment: aiding Arizona's residents in holistic recovery and ensuring that its frontline heroes are equipped with the emotional and psychological tools they need. Arizona has strong emergency response structures and dedicated behavioral health partners that can be brought together to meet these needs. This framework can be a blueprint for both AHCCCS and local communities to lead more formal planning and actionable next steps toward strengthening these linkages and capabilities.

This framework was funded by the Bipartisan Safer Communities Act (BSCA) (P.L. 117-159) for the Community Mental Health Services Block Grant.

Purpose

This framework provides an evidence-informed approach to disaster behavioral health preparedness, response, and recovery. It is a blueprint to help communities integrate emergency management and disaster behavioral health resources, while also serving as a scaffold for AHCCCS's future efforts to support disaster behavioral health initiatives across the state.

Scope

This framework conveys best practices for designing a system to coordinate disaster behavioral health preparedness, prevention, response, and recovery, concepts for disasters that affect the state and its local communities.

AUDIENCE FOR THIS FRAMEWORK[1]

This framework addresses governmental, non-governmental, and private sector agencies and organizations that would be involved in disaster behavioral health planning at the state and local level in Arizona.

[1] Arizona Department of Emergency and Military Affairs, Arizona Division of Emergency Management. State of Arizona Emergency Response and Recovery Plan. 2013. ESF #8 -174

RELATIONSHIP TO OTHER PLANS

This framework is a standalone document that does not supersede any existing disaster behavioral health considerations in state or local plans.

ARIZONA'S SYSTEM OF DISASTER BEHAVIORAL HEALTH CARE

Disaster Behavioral Health

Behavioral health describes the continuum of an individual's emotional, cognitive, and relational well-being and is a key factor in the ways that people act when confronted with crisis. Disasters have a significant impact on behavioral health—affecting the overall behavioral health of the community and responders—more severely affecting people already experiencing behavioral health challenges and complicating access to resources. Hence, behavioral health is an integral component of the public health and medical emergency management system (EMS) and should be fully integrated into preparedness, response, and recovery activities.[2]

Disaster behavioral health is distinguished from other forms of behavioral health in that it is focused specifically on the psychological impact of disasters. Disaster behavioral health is the provision of mental health, substance abuse, and stress management services to disaster survivors and responders. It addresses the psychological, emotional, cognitive, developmental, and social impacts that disasters, emergencies, or large scale incidents have on survivors and first responders during the response and recovery processes. Disaster behavioral health aims to provide services and activities including public information, education, basic psychological support such as psychological first aid (PFA), The goals of disaster behavioral health are to relieve stress, reinforce healthy coping strategies, mitigate future disaster behavioral health problems, and promote individual and community resilience.[3]

Role of Arizona Department of Health Services

The Arizona Department of Health Services (ADHS) plays a pivotal role in Emergency Support Function 8 (ESF 8)—Public Health and Medical—within the Health and Human Services Agency. Within ESF 8, ADHS takes the lead as the primary agency, with numerous support agencies such as:

- Arizona Commission for the Deaf and Hard-of-Hearing (ACDHH)
- Arizona Department of Agriculture (AZDA)
- Arizona Department of Emergency and Military Affairs (DEMA)
- Arizona Department of Environmental Quality (ADEQ)
- Arizona Department of Public Safety (AZDPS)
- Arizona Department of Transportation (ADOT)
- Arizona Department of Water Resources (ADWR)
- Arizona Health Care Cost Containment System (AHCCCS)
- Arizona Humane Society (AZHS) AZ Pharmacy Alliance (AzPA)

[2] Administration for Strategic Preparedness and Response. Disaster Behavioral Health. Available at: https://aspr.hhs.gov/behavioral-health/Pages/default.aspx.
[3] Ibid. ASPR. Disaster Behavioral Health. https://aspr.hhs.gov/behavioral-health/Pages/default.aspx

- Arizona Veterinary Medical Association (AZVMA)
- Arizona Voluntary Organizations Active in Disaster (AZ VOAD)
- American Red Cross (ARC)
- Citizens Corps Program - Medical Reserve Corps (MRC)
- Mental Health Association of Arizona (MHAAZ)
- United Blood Services (UBS)

ESF 8 facilitates federal assistance to reinforce local, county, tribal, and state resources during disasters, emergencies, or incidents that have potential public health, medical, behavioral, or human service implications, including situations of international significance. It also augments capacities for public health and medical services, including patient care, behavioral health care, and support for individuals with disabilities and special needs. This augmentation involves health care professionals, pharmaceutical distribution, medical supplies, and technical support. The aim is to mitigate short-term and long-term health threats and to safeguard responder well-being. ESF 8 disseminates public health information for protective actions, oversees fatality management, and supports smooth transitions to recovery, allowing the community to regain self-sufficiency.

One of the primary roles for ADHS under ESF 8 is behavioral health coordination. During an emergency, ADHS is responsible for requesting appropriate ESF 8 organizations to activate and deploy health and medical personnel (including behavioral health support), equipment, and supplies in response to requests for state public health and medical assistance via the state emergency operations center (EOC).

Role of Arizona Healthcare Cost Containment System

Background

AHCCCS is Arizona's Medicaid program, a federal health care program jointly funded by the federal and state governments for individuals and families who qualify based on income level. AHCCCS contracts with community-based organizations known as Regional Behavioral Health Agreements (RBHAs) to administer behavioral health services throughout the state.

Medicaid (Title XIX/XXI) funds are distributed by AHCCCS to provide covered behavioral health services utilizing a managed care model. AHCCCS policy and contracts create a framework for Arizona's Behavioral Health System, while Managed Care Organizations (MCOs), determine how this can be best operationalized in their region. The MCOs contract with an array of service providers to deliver a range of behavioral health services, including prevention programs for adults and children, a continuum of services for adults facing substance use and general mental health disorders, adults designated with a serious mental illness, and children designated with a serious emotional disturbance. The state is divided into three geographical service areas (GSAs) served by 15 MCOs.

As Arizona's Medicaid and Mental Health Authority, AHCCCS is responsible for administering and distributing funds to support the statewide crisis system. In order to address the unique needs of an effective crisis system, Arizona utilizes three MCOs, referred to as AHCCCS Complete Care, Regional Behavioral Health Agreements (ACC-RBHAs), that are responsible for maintaining the crisis provider network within their respective geographic service areas. This differs from other components of Arizona's behavioral health system as funding is allocated to the ACC-RBHA plans in order to cover crisis services for any individual, regardless of enrollment in an AHCCCS plan. In the event of a community emergency requiring crisis system activation, the ACC-RBHA plan responsible for that region would coordinate any needs specific to crisis system response, with AHCCCS providing support and oversight to the ACC-RBHA plan as needed.

To ensure parity during disaster behavioral health response, it is AHCCCS' role to include any appropriate requirements related to disaster behavioral health in contracts and policies, as well as to ensure funding is appropriately allocated to prepare for disaster behavioral health needs and to support community response in the aftermath of an emergency. Examples may include mandating additional training for crisis providers on topics such as emergency preparedness and response, monitoring data to anticipate overall trends and potential gaps, and considering whether capitation rates should be used to determine funding for ACC-RBHA plans in anticipation of disaster behavioral health needs.

Should additional support be requested from the ACC-RBHA plan in responding to an emergency, AHCCCS remains available to coordinate with other state agencies as well as the Governor's Office to ensure the needs of the community are met. In some instances, AHCCCS may be able to offer flexibility in both policy and funding to meet the needs of a community that has experienced an emergency on a discretionary basis.

For more information about AHCCCS policy and operations, see the AHCCCS Medical Policy Manual web page. Specific crisis care coordination requirements can be found in AMPM 590-Behavioral Health Crisis Services and Care Coordination.

Arizona's Crisis System Funding

Arizona's Crisis Continuum is built based on a braided funding model, utilizing funding from grant, state, federal, and county sources. This funding model ensures the crisis provider network can be funded similarly to a firehouse, where staff is available to meet the needs of the community experiencing an emergency 24 hours a day, 7 days a week, 365 days a year whether or not a need arises. Flexibility in encounter rates becomes crucial in these moments, ensuring that providers can sustainably offer their services without financial constraints, especially when traditional billing avenues for certain response efforts might be unfeasible. The use of multiple funding sources ensures that the needs of the community can be met regardless of insurance coverage or eligibility.

Grants

The Division of Grants and Innovation (DGI) pursues, implements, and oversees all grants administered by AHCCCS and is responsible for advancing AHCCCS' clinical and quality strategies for the Integrated System of Care (ISOC), the Arizona crisis system, and the AHCCCS Housing Program.

DGI manages day-to-day federal grant activities, including research and writing, implementation and contract management, and oversight and monitoring. The DGI ISOC team is responsible for the oversight of all child and adult behavioral health service provision across all contracted MCOs. The DGI crisis team coordinates activities related to grant implementation, Medicaid and Non-Medicaid-related support for child/adolescent/adult initiatives, and advancements throughout the crisis continuum in Arizona.

The DGI Housing Program is responsible for the oversight of the AHCCCS Housing Administrator, and the Serious Mental Illness (SMI) housing programs operated by the ACC-RBHAs. The ISOC, Crisis, and Housing teams work closely with identified stakeholders, MCOs, and other state entities to ensure contracts, activities, initiatives, and member needs are met through strategic planning and operational oversight.

A list of current AHCCCS administered grant funding and descriptions of allowable activities can be viewed by following the AHCCCS Current Grants website.[4]

AHCCCS Emergency Public Information Dissemination

Under A.R.S. § 41-5202 and the Americans with Disabilities Act of 1990, AHCCCS has a process for communicating with its members during a declared state of emergency. AHCCCS has protocols in place to communicate with local, state, county, city, and tribal personnel, and additional protocols for notifications to members when they could be threatened by a state of emergency. It is AHCCCS' priority that all members receive effective communication regardless of language of origin or ability.

Public Awareness Campaigns for Disaster Behavioral Health Resiliency

AHCCCS can share public information through the Communications Department within the Office of the Director. In the event of an emergency impacting the community, information including how to access resources can be distributed via social media, email, and other means. Contact AHCCCS to request assistance distributing public information in the event of an emergency.

[4] Arizona Health Care Cost Containment System. Current Grants. Available at: https://azahcccs.gov/Resources/Grants/.

Role of County Departments of Public Health/Disaster Behavioral Health

County departments of public health collaborate with disaster behavioral health providers, social service agencies, trained volunteers, and both state and federal government entities. Their joint mission is to support access to disaster behavioral health services for community members during crises. They disseminate vital information and resources to the public and guide individuals experiencing the effects of trauma to the right resources and support. Health agencies also are responsible for taking steps to ensure the health and safety of first responders coordinating with partners to provide access to necessary behavioral health services.

Role and Capabilities of Tribes and Tribal Health Programs

Arizona is home to 22 federally recognized tribes.[5] As legally recognized sovereign governments, federally recognized tribes have government-to-government relationships with federal, state, and local governments. The federal Indian Health Service (IHS) is the principal federal health care provider to Native Americans. IHS provides health care and disease prevention services through a network of hospitals, clinics, and health stations. Health services are provided at facilities that the IHS, tribes, or tribal organization manage under contract or compact with the IHS, and urban Indigenous health programs.

The IHS Division of Behavioral Health (DBH) is the primary source of national advocacy, policy development, management, and administration of disaster behavioral health, alcohol and substance abuse, and family violence prevention programs for American Indian/Alaska Native (AI/AN) people. Working in partnership with tribes, Tribal organizations, and urban Native American health organizations, DBH coordinates national efforts to share knowledge and build capacity through the development and implementation of evidence-, practice-, and culture-based activities in American Indian/Alaskan Native areas.[6] For tribal community members, a comprehensive system ensures accessibility to disaster behavioral health services, including:

- **IHS**: The IHS is a division of the U.S. Department of Health and Human Services that provides health services to American Indians and Alaska Natives. Many tribal communities in Arizona have IHS clinics or health centers that offer disaster behavioral health services.
- **American Indian Health Facilities**: IHS facilities, tribally operated 638 health programs, and Urban Indian Health Programs (ITUs) may be referred to as American Indian Health Facilities. They provide general health care services for eligible American Indians and Alaskan Native AHCCCS members, particularly AHCCCS members enrolled in the AHCCCS American Indian Health Program.
- **AHCCCS American Indian Health Program**: Native Americans and Alaska Natives enrolled in AHCCCS or KidsCare may choose to receive their coverage through the

[5] The University of Arizona. Federally Recognized Native Nations in Arizona. Available at: https://statemuseum.arizona.edu/native-nations-arizona.
[6] Indian Health Service. Division Behavioral Health. Available at: https://www.ihs.gov/dbh/.

AHCCCS American Indian Health Program (AIHP) or one of the AHCCCS-contracted managed health plans, known as AHCCCS Complete Care (ACC) plans.

- **TRBHAs:** Tribal Regional Behavioral Health Authorities have an intergovernmental agreement (IGA) with AHCCCS administration, the primary purpose of which is to coordinate the delivery of comprehensive mental health services to all eligible people that the administration has assigned to the tribal entity. Tribal governments, through an agreement with the state, may operate a TRBHA to provide behavioral health services to Native American members.[7] Individuals not enrolled in a TRBHA plan can often access behavioral health services through their MCOs. The five TRBHAs in the state are as follows:
  - Colorado River Indian Tribes[8]
  - Gila River
  - Navajo
  - Pascua Yaqui
  - White Mountain Apache AHCCCS and the tribe's partnership via IGAs.

Each IGA can be accessed at: https://www.azahcccs.gov/Resources/OversightOfHealthPlans/SolicitationsAndContracts/TRBHA.html.

- **Telehealth Services:** With advancements in technology, telehealth can provide remote disaster behavioral health services to individuals in geographically isolated areas. Tribal communities may collaborate with health care providers to establish these services.
- **Grants and Funding:** Federal and state grants are available to enhance disaster behavioral health services in tribal communities. Tribes can pursue these opportunities to expand and improve services.
- **Referrals:** Primary care providers, school counselors, or community leaders are essential in identifying individuals who need disaster behavioral health services and referring them to appropriate providers.
- **State and National Resources**: Organizations like the National Indian Health Board (NIHB) and the Substance Abuse and Mental Health Services Administration (SAMHSA) offer resources and support for tribal communities seeking disaster behavioral health services.

The Arizona Department of Emergency and Military Affairs (DEMA) has a Tribal Liaison who supports all aspects of Emergency Management in collaboration with Tribal nations. ADHS and AHCCCS also have Tribal Liaisons who coordinate with DEMA when necessary. During face-to-face meetings, the Tribal Liaison and appropriate department personnel speak with Tribal leaders, Tribal cultural preservation officers, and Tribal emergency managers to consult on

[7] Arizona Health Care Cost Containment System. Integrated Services Unit. Available at: https://www.azahcccs.gov/PlansProviders/Downloads/HealthPlans/FeeForService/ISA-Overview.pdf.

[8] The IGA with the Colorado River Indian Tribes (CRIT) is for state funded crisis services only and does not include Title XIX services. CRIT continues to receive Title XIX services through the Contractor.

department land use activities and learn about the emergency management program and any potential needs. The objective of these engagements is to frequently share information and promote regular outreach by discussing current and future land use activities, agreements that support future consultation, grant opportunities, emergency management training and exercise opportunities, and the Arizona Mutual Aid Compact (AZMAC).

The desired outcome from regular engagement is to ensure that DEMA has a leader-to-leader relationship with Tribal leaders and emergency managers are connected with their peers within DEMA so that timely assistance and coordination can be provided during a natural disaster or emergency.

Role of Not-for-Profit and Community Partners

Nonprofit and community partners play integral roles in disaster response and recovery. Several of these agencies are outlined below along with their responsibilities during disasters.

Medical Reserve Corps

The Medical Reserve Corps (MRC) is a community-based, civilian, volunteer program that helps build the public health infrastructure in urban and rural communities nationwide.[9] Each MRC unit is organized and trained to address a range of challenges from public health education to disaster response.

The MRC was established to provide a pathway to recruit, train, and activate medical and public health care professionals and other volunteers who can respond to community health needs during disasters and other public health emergencies.[10]

Examples of activities that MRC volunteers participate in, and support include:

- Emergency preparedness and response trainings and exercises,
- Emergency shelter operations and medical care,
- Disaster medical and disaster behavioral health support, and
- And other related medical services.

American Red Cross

The American Red Cross (ARC) is a congressionally chartered humanitarian organization led by volunteers that provides relief to disaster survivors and helps people prevent, prepare for, and respond to emergencies.

- ARC has a memorandum of understanding (MOU) with the American Psychological Association (APA), American Psychiatric Association, National Association of Social Workers, American Counseling Association, American Association of Marriage and

[9] National Association of County and City Health Officials, Medical Reserve Corps. Celebrating the 20th Anniversary of the Medical Reserve Corps. September 21, 2022. Available at: https://www.naccho.org/blog/articles/celebrating-the-20th-anniversary-of-the-medical-reserve-corps#:~:text=Founded%20in%202002%2C%20the%20Peoria%20County%20MRC,a%20mix%20of%20urban%20and%20rural%20communities.

[10] Administration for Strategic Preparedness & Response. The Medical Reserve Corps. Available at: https://aspr.hhs.gov/MRC/Pages/index.aspx.

Family Therapists, and other organizations to engage members of major professional mental health associations for service as ARC disaster mental health volunteers.
- In concert with government partners and other health care providers, ARC provides services at shelters, service centers, bulk distribution routes, aid stations, and temporary evacuation points.
- Local jurisdictions are encouraged to partner with the local chapter(s) of the ARC in their area prior to and during disasters.

ARC has two chapters in Arizona:

- **Central and Northern Arizona Chapter: Serves Maricopa, Gila, and Pinal counties, as well as Luke Air Force Base., Apache, Coconino, Mohave, Navajo, and Yavapai counties.** Contact and location details can be found under APPENDIX B – LIST OF CONTACTS.
- **Southern Arizona Chapter: Serves a population of** more than **1.4 million across Pima, Santa Cruz, Cochise, Yuma, La Paz, Graham, and Greenlee counties.** Contact and location details can be found under APPENDIX B – LIST OF CONTACTS.

Arizona Voluntary Organizations Active in Disaster

Arizona Voluntary Organizations Active in Disaster (AZ VOAD) is a statewide not-for-profit, nonpartisan, membership-based organization that builds resiliency in Arizona communities. It is a forum for organizations to share knowledge and resources throughout the disaster cycle to help survivors.

- The AZ VOAD is composed of more than 57 organizations with the mission to provide disaster-related services. The network includes faith-based, community-based, and other not-for-profit and governmental organizations.
- To fulfill this mission, AZ VOAD provides effective services to organizations responding to people affected by disaster through outreach, advocacy, and the application of its values and core principles of the "4Cs—cooperation, communication, coordination, and collaboration."
- AZ VOAD is an affiliate of National Voluntary Organizations Active in Disaster (NVOAD). National VOAD, an association of organizations that mitigate and alleviate the impact of disasters, provides a forum promoting cooperation, communication, coordination, and collaboration; and fosters more effective delivery of services to communities affected by disaster.

AZ VOAD operates the Community Organizations Active in Disaster (COADs) at the local level. COADs are coalitions of local organizations that collaborate during the preparedness, response, and recovery phases of a disaster to streamline the coordination of services.[11] A list of the COADs active within AZ VOAD can be found here.

[11] Arizona Voluntary Organizations Active in Disaster. Arizona COADS. Available at: https://www.azvoad.org/coads/.

SITUATIONAL OVERVIEW

Overview

Disasters can have varying effects on behavioral health, creating a spectrum of outcomes. Some individuals may experience temporary distress but eventually find resilience and even personal growth.[12] Others may develop new incidence disorders, including post-traumatic stress disorder (PTSD), generalized anxiety disorder, acute stress disorder, major depression, panic disorder, and substance use disorder (SUD).[13, 14]

Disasters also are associated with a range of impairments, including the ability to function at work, at home, in the community, and at school. For people with pre-existing behavioral health conditions such as SMI, serious emotional disturbance (SED) and early serious mental illness including first episode psychosis (ESMI/FEP), disasters can exacerbate difficulties, and some individuals may lose access to critical medications, routine counseling, and other stabilizing supports and processes. Furthermore, rates of domestic violence, SUD, and child abuse may increase post-disaster.[15]

The overall evidence suggests that the rate of psychiatric/behavioral disorders in a population following a disaster average between 30−40 percent.[16] These effects can persist for years and decades after the event and are associated with increased health care costs and utilization. An important study reported that PTSD tends to affect 5−30 percent of people who experience disasters, up to 25 percent display a recovery response, and another 15 percent exhibit a delayed stress response. Approximately 35−65 percent of people who experience a disaster return to their normal routine shortly after the event, and resilience is a common response.[17]

Risk factors for behavioral health impacts are broad and include age, type of incident, exposure to traumatic stressors, and loss. Children, parents, and people who directly suffer traumatic loss are at a significantly higher risk for long-term depression. Certain minority populations may face increased discrimination and stigmatization or be the target of harassment and violence in the wake of a disaster, as was the case after the 9/11 terrorist attacks, which was followed by a wave of Islamophobia. Others with direct or indirect prolonged exposure to the traumatic

[12] Maine Emergency Management Agency. Maine CDC Disaster Behavioral Health Response Plan. Available at: https://www.maine.gov/dhhs/mecdc/public-health-systems/phep/documents/mainecdcallhazdbh.docx.
[13] Bonanno GA, Brewin CR, Kaniasty K, La Greca AM. 2010) Weighing the Costs of Disasters: Consequences, Risks, and Resilience in Individuals, Families, and Communities. *Psychological Science in the Public Interest*. 2010;11(1):1−49.
[14] Galea S, Nandi A, Vlhov D. The Epidemiology of Post-Traumatic Stress Disorder after a Disaster. *Epidemiologic Reviews*. 2005;27:78−xc91.
[15] Norris, F. "Disasters and domestic violence: Prevalence and impact of domestic violence in the wake of disasters." *United States Department of Veterans Affairs* (2006).
[16] Galea S, Nandi A, Vlhov D. The Epidemiology of Post-Traumatic Stress Disorder After a Disaster. *Epidemiologic Reviews*. 2005;27:78−91.
[17] Bonanno GA, Brewin CR, Kaniasty K, La Greca AM. Weighing the Costs of Disasters: Consequences, Risks, and Resilience in Individuals, Families, and Communities. *Psychological Science in the Public Interest*. 2010;11(1):1−49

effects of a disaster, such as first responders, emergency personnel, and volunteers, also are at risk of detrimental impacts.[18]

Successful disaster behavioral health interventions will depend on jurisdictional capabilities. Communities can deploy several strategies before an incident in conjunction with efforts to improve resiliency. Planning guidance for disaster behavioral health often outlines a range of acute psychological interventions. Specific disaster behavioral health response strategies following acts of terrorism or mass violence include:

- Using a mental health triage, screening, and assessment model[19]
- Providing disaster crisis intervention (DCI)
- Providing PFA
- Publicizing enhanced coping techniques via social media, risk communication, and other messaging
- Developing social support systems pre- and post-event to support personal and population-level efforts to continue routine daily activities
- Accessing existing open-source available treatments (e.g., internet-based, telehealth) for specific subpopulations at risk for depression and PTSD
- Promoting SAMHSA and Federal Emergency Management Agency (FEMA) crisis counseling programs, including specialized crisis counseling interventions by paraprofessionals and professionals
- Offering immediate crisis intervention by disaster behavioral health professionals (BHPs) across a range of modalities
- Conducting brief disaster behavioral health support by health care workers and providers
- Publicizing telehealth capacities such as the National Disaster Distress Helpline
- Implementing acute, evidence-based interventions
- Disseminating resiliency toolkits designed for specific populations such as health care workers

Arizona Profile

Demographics

General population

In 2020, Arizona had a population of 7.17 million people with a median age of 37.9 and a median household income of $61,529. In 2019–2020, the population of Arizona grew from 7.05 million, a 1.76 percent increase, and its median household income grew from $58,945 to $61,529, a 4.38 percent increase. The five largest ethnic groups in Arizona are non-Hispanic

[18] Negele A, Kaufhold J, Kallenbach L, Leuzinger-Bohleber M. Childhood Trauma and Its Relation to Chronic Depression in Adulthood. *Depress Res Treat*. 2015;2015:650804. doi: 10.1155/2015/650804.
[19] Pynoos R, Schreiber M, Steinberg A, Pffefferbaum B. Children and Terrorism. In B. Sadock, V. Sadock, and P. Ruiz (eds.). *Kaplan and Sadock's Comprehensive Textbook of Psychiatry* (pp. 3551-3563). 8th ed. Vol 2. New York: NY; Lippincott Williams and Wilkins.

White (54.1%), White/Hispanic (19.6%), other Hispanic (6.62%), multiracial Hispanic (4.35%), and Black/African American (4.26%).[20]

Among Arizona's households, 26.7 percent reported speaking a language other than English at home. These data do not consider the potential multilingual nature of households, but only the primary self-reported language spoken by all members of the household.[21]

The most populous area in Arizona is Maricopa County, which includes Phoenix. For data by county, see Table 1.

Table 1. Population in Arizona by County, 2022

County	Population
Maricopa County	4,551,524
Pima County	1,057,597
Pinal County	464,154
Yavapai County	246,191
Mohave County	220,816
Yuma County	207,842
Coconino County	144,060
Cochise County	125,663
Navajo County	108,650
Apache County	65,432
Gila County	53,922
Santa Cruz County	48,759
Graham County	38,779
La Paz County	16,506
Greenlee County	9,302

United States Census Bureau. B01001 SEX BY AGE, 2021 American Community Survey 5-Year Estimates. U.S. Census Bureau, American Community Survey Office. Web. 8 December 2022. http://www.census.gov/.

Access and Functional Needs

The Americans with Disabilities Act (ADA) of 1990 ensures that people with physical or mental disabilities have the right to full participation in all aspects of society. Meeting the needs of people who experience access and functional needs during disaster requires a whole community approach. Communities should engage the full capacity of the private and nonprofit sectors, including businesses, faith-based and disability organizations, and the public, as well as local, tribal, state, territorial, and federal governmental partners.[22] A community's goal should be to return individuals to their pre-disaster level of independence as quickly as possible.

[20] Data USA. Arizona Profile. Available at: https://datausa.io/profile/geo/arizona.
[21] Arizona Department of Emergency and Military Affairs. Hazard Mitigation Planning. Available at: https://dema.az.gov/emergency-management/preparedness/planning-branch/hazard-mitigation-planning.
[22] Arizona Department of Emergency and Military Affairs. The Arizona State Emergency Response and Recovery Plan. November 19, 2018. Available at. https://dema.az.gov/sites/default/files/publications/EM-PLN_SERRP.pdf.

People with access and functional needs are disproportionately affected by disasters and may experience severe and less forgiving consequences without essential support. The margin of resiliency in emergencies is smaller and the impact is higher. Exacerbating this issue, many disaster response systems and plans are designed for people who can walk, run, see, drive, read, hear, speak, and quickly respond to alerts and instructions. Jurisdictions should ensure their planning efforts are inclusive of people with access and functional needs—both by incorporating access and functional needs (AFN)-specific considerations and engaging people with AFN and their support networks in the planning process.[23]

Individuals with AFN include people who have/are:

- Blindness or low vision
- Chronic conditions
- Deaf, deafblind, or hard of hearing
- Infants and children
- Injuries
- Limited English proficiency or are non-English speakers
- Living in institutionalized settings
- Limited mobility
- Older adults
- Physical, intellectual, cognitive, developmental, and mental health-related disabilities
- People experiencing poverty or low socioeconomic status
- Temporary disabilities
- Transportation disadvantaged

Table 2 outlines the percentages of Arizonans experiencing access and functional needs.

Table 2. Estimated Access and Functional Needs Demographics in Arizona, 2021 Census[24]

Disability Type by Age	Percent with a Disability
With a hearing difficulty	4.2%
• Population younger than 18 years old	0.8%
• Population younger than 5 years old	0.8%
• Population 5−17 years old	0.8%
• Population 18−64 years old	2.2%
• Population 18−34 years old	1.0%
• Population 35−64 years old	3.0%

[23] Ibid.
[24] Arizona Department of Emergency and Military Affairs. Estimated Access & Functional Needs Demographics State of Arizona 2021. Available at: https://dema.az.gov/resources/estimated-access-functional-needs-demographics-state-arizona-2021-census.

Disability Type by Age	Percent with a Disability
• Population 65 years and older	14.4%
– 65–74 years old	9.2%
– 75 years and older	21.9%
With a vision difficulty	2.5%
• Population younger than 18 years old	0.9%
• Population younger than 5 years old	0.8%
• Population 5–17 years old	0.9%
• Population 18–64 years old	2.2%
• Population 18–34 years old	1.6%
• Population 35–64 years old	2.6%
• Population 65 years and older	5.5%
– Population 65–74 years old	4.1%
– Population 75 years and older	7.6%
With a cognitive difficulty	5.4%
Population younger than 18 years old	5.3%
Population 18–64 years old	4.9%
Population 18–34 years old	4.8%
Population 35–64 years old	4.9%
Population 65 years and older	7.5%
– Population 65–74 years old	4.7%
– Population 75 years and older	11.4%
With an ambulatory difficulty	6.8%
Population younger than 18 years old	0.8%
Population 18–64 years old	4.5%
Population 18–34 years old	1.2%
Population 35–64 years old	6.5%
Population 65 years and older	19.5%

Disability Type by Age	Percent with a Disability
– Population 65–74 years old	13.9%
– Population 75 years and older	27.4%
With a self-care challenge	2.4%
Population younger than 18 years old	1.5%
Population 18–64 years old	1.5%
Population 18–34 years old	0.7%
Population 35–64 years old	2.0%
Population 65 years and older	6.1%
– Population 65–74 years old	3.7%
– Population 75 years and older	9.5%
With an independent living challenge	5.5%
Population 18 to 64 years	3.7%
Population 18 to 34 years	2.9%
Population 35 to 64 years	4.2%
Population 65 years and over	11.4%
Population 65 to 74 years	6.5%
Population 75 years and over	18.3%

Geography

Arizona is the sixth largest state in the United States, with a land mass of 114,006 square miles.[25] Arizona is typically considered a desert state, but it has six major terrestrial ecoregions with widely varying geography.

Each of the following six ecoregions cover varying land areas within the state:

- Arizona Mountain Forests ecoregion
- Chihuahuan Desert ecoregion
- Colorado Plateau Shrublands ecoregion
- Mojave Desert ecoregion
- Sierra Madre Occidental Pine-Oak Forests ecoregion
- Sonoran Desert ecoregion

[25] Economic and Business Research Program, 2003

The Arizona mountain forests ecoregion, much of which is known as the Mogollon Rim, is located approximately in the center of the state and runs diagonally from southeast to northwest, including portions of Apache, Coconino, Graham, Gila, Greenlee, Maricopa, Mohave, Navajo, Pinal, and Yavapai Counties. This ecoregion includes numerous small- to medium-sized cities and towns, such as Eagar, Flagstaff, Globe, Pinetop Lakeside, Payson, Prescott, and Sedona. Elevations in this zone range from approximately 4,000 to 13,000 feet, resulting in comparatively cool summers and cold winters. Vegetation in this ecoregion is composed largely of a mix of Scrub Grassland, Mogollon Chaparral Scrubland, Great Basin Conifer Woodland, Rocky Mountain Conifer Forest, and Plains Grassland.[26]

The Chihuahuan Desert ecoregion occupies much of the southeastern portion of Arizona, including portions of Cochise, Gila, Graham, Greenlee, Pima, Pinal, and Santa Cruz Counties. Located in this ecoregion are the small- to medium-sized desert communities of Bisbee, Douglas, Safford, and Sierra Vista. The elevation varies in this zone from approximately 3,000 to 4,500 feet. Because of its generally higher elevations, the Chihuahuan Desert is cooler than its Sonoran Desert counterpart, with dry summers and occasional winter rains.[27]

The Colorado Plateau Shrublands ecoregion covers much of the northern one-third of the state, including portions or all of Apache, Coconino, Mohave, Navajo, and Yavapai Counties. This ecoregion includes numerous small cities and towns, including Holbrook, Page, and Winslow. Elevations in this zone average around 4,000−5,000 feet. Vegetation in this ecoregion is composed mainly of Plains Grassland and Great Basin Desert scrub, as shown in the following map titled Terrestrial Ecoregions of Arizona. Temperatures can vary widely in this zone, with comparatively warm summers and cool winters.[28]

The Mojave Desert ecoregion covers a relatively small portion of northwest Arizona, including portions of Coconino and Mohave Counties. This ecoregion includes the communities of Kingman and Bullhead City, as well as a portion of the lower Grand Canyon. The elevation varies in this ecoregion from 1,500 feet to nearly 4,000 feet on some mountains. Typically, the climate in this ecoregion is very hot and dry during the summer and comparatively warm during the winter.[29]

The Sierra Madre Occidental pine-oak forest ecoregion is scattered throughout southeast Arizona, including small portions of Cochise, Graham, Greenlee, Pima, Pinal, and Santa Cruz Counties. Located within this ecoregion is the Town of Nogales, several portions of the Coronado National Forest, as well as the Chiricahua and Galiuro Wilderness areas. This ecoregion is considered to have mild winters and wet summers, with variation within these regions due to the fluctuation in elevation associated with the forests.[30]

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[26] State of Arizona Department of Emergency and Military Affairs. State of Arizona Hazard Mitigation Plan. 2013.
[27] Ibid.
[28] Ibid.
[29] State of Arizona. State of Arizona Hazard Mitigation Plan. 2013. Available at: https://drought.unl.edu/archive/plans/GeneralHazard/state/AZ_2013.pdf.
[30] Ibid.

The Sonoran Desert ecoregion is an arid environment that covers most of the southwestern one-third of the state, including portions or all of Gila, Graham, La Paz, Maricopa, Mohave, Pima, Pinal, Yavapai, and Yuma Counties. Located within this ecoregion are the major metropolitan areas of Phoenix and Tucson as well as numerous smaller towns and cities such as Florence, Parker, and Yuma. The elevation varies in this zone from approximately sea level to 3,000 feet. Vegetation in this zone consists mainly of Sonoran Desert Scrub. Typically, the climate in this zone is hot and dry in the summer and comparatively warm in the winter.[31]

The primary component of the Arizona Mountain Forests is the Mogollon Rim, a mountainous area that is the major landform defining the northern from the southern portions of the state.

The White Mountains in the central-eastern part of the state is another large mountainous area. A series of mountain islands rests in the southeastern corner of the state, including the Graham Mountains. Each of these areas has relatively dense vegetation, ranging from high grasslands to Ponderosa Pine forests.

Arizona also contains a number of rivers, the largest of which is the Colorado, which runs year-round and defines most of the western border of the state. The Colorado River also created the Grand Canyon, which acts as a major barrier to movement in the northwestern portion of the state. Other large rivers, most of which are controlled via dams and run only occasionally, include the Agua Fria, Gila, Salt, and the Verde Rivers.[32]

Climate

Arizona's geography results in an extreme climate in comparison with other states, which varies significantly across different locations. The state's extreme climate is a major contributor to natural hazards in Arizona, including floods, drought, and wildfires. Average annual temperatures are in the mid-70s in the Sonoran Desert ecoregion located in the lower half of the state, including cities such as Phoenix, Tucson, and Yuma.

Conversely, annual average temperatures are much lower at higher elevations in the Arizona Mountain Forests, Chihuahuan Desert, and Sierra Madre Occidental Pine-Oak Forests ecoregions. Average annual temperatures for communities in the Colorado Plateau Shrublands ecoregion fall between these two extremes. Summer temperatures may exceed 120˚ F in the Sonoran Desert ecoregion. Even relatively high elevations in the Arizona Mountain Forests, such as Flagstaff, may reach high temperatures of 100˚ F during the summer and well below freezing (32˚ F) in the winter. For example, Flagstaff has dropped to –23˚ F, and Phoenix winter temperatures have been known to drop into the teens.

These extreme temperatures are at least partly the result of Arizona's relatively dry climate. This arid environment is itself a function of several factors, including Arizona's separation from nearby major water bodies (i.e., Pacific Ocean, Gulf of California, and Gulf of Mexico),

[31] Ibid.
[32] Ibid.

intervening mountainous regions (i.e., Sierra Nevada Mountains), and relatively low elevations across two-thirds of the state.[33]

Economy

In 2022, the State of Arizona had a population of 7,326,692, having grown an annualized 0.8 percent over five years, ranking it 17th out of all 50 U.S. states by growth rate. Arizona's gross state product (GSP) in 2022 reached $341.8 billion, with growth of 2.5 percent over the five years of 2017−2022.

Businesses in Arizona employed 4,365,728 people in 2022, with average annual employment growth over the past five years of 1.9 percent. The top sectors by total employment are real estate, rental and leasing, manufacturing, health care, and social assistance. The unemployment rate across the state in 2022 was 3.4 percent.[34]

Threats and Hazards in Arizona

Arizona is renowned for its diverse landscapes and climates, which present a unique array of natural hazards. The state's geographical location and topographical features expose it to a variety of environmental challenges.[35]

This framework recognizes the 15 hazards identified in the State of Arizona Hazard Mitigation Plan:

- Dam failure
- Drought
- Earthquake
- Extreme heat
- Fissure
- Flooding
- Hazardous materials incidents
- Infectious disease
- Landslide
- Levee failure
- Severe wind
- Subsidence
- Terrorism
- Wildfire
- Winter storm

[33] Ibid.
[34] IBIS World. Arizona Economic Overview. Available at: https://www.ibisworld.com/united-states/economic-profiles/arizona/#:~:text=In%202022%2C%20Arizona's%20GDP%20reached,of%20all%2050%20US%20states.
[35] State of Arizona. State of Arizona Hazard Mitigation Plan. 2013. Available at: https://drought.unl.edu/archive/plans/GeneralHazard/state/AZ_2013.pdf.

It is important to note that no single threat or hazard exists in isolation. An earthquake, for instance, can lead to landslides, fires, and hazardous material spills.

Climate Change

Based on the growing body of research, it has become increasingly clear that the world's climate is changing. Though the scope and severity of climate change are difficult to predict, emergency managers should consider the implications of these hazards during mitigation planning. The projected challenges climate change poses—more intense storms, frequent heavy precipitation, rising temperatures and heat waves, increased drought and wildfire risk, and extreme flooding—could significantly increase the frequency and magnitude of emergencies and disasters facing Arizona communities.[36] The need to identify hazards and risks with the potential to cause future disasters, including those that may be intensified because of climate change, is an essential part of emergency management's mission to reduce physical and economic loss and promote lifesaving measures. Proper acknowledgement and adequate accounting for climate change and resultant challenges will greatly assist emergency management in fulfilling this mission in the future, according to "Climate Change, an Aggravating Factor for Arizona's Natural Hazards," in the State of Arizona Hazard Mitigation Plan's appendices. Appreciating the difficulty in predicting the effects of climate change, we realize this issue warrants further consideration.

Behavioral Health Consequences

The behavioral health consequences of disasters and public health emergencies can vary depending on many factors, such as type of incident, level of exposure, individual characteristics, and community factors. It is common for people who survive a disaster to experience transitory distress that resolves over time without the need for disaster behavioral health services.[37] A smaller portion of people may develop new clinical disorders or experience the exacerbation of pre-existing disorders because of their experiences during the disaster. Disaster behavioral health consequences manifest in the areas of distress responses, behavioral changes, and psychiatric illness (see Figure 1).[38]

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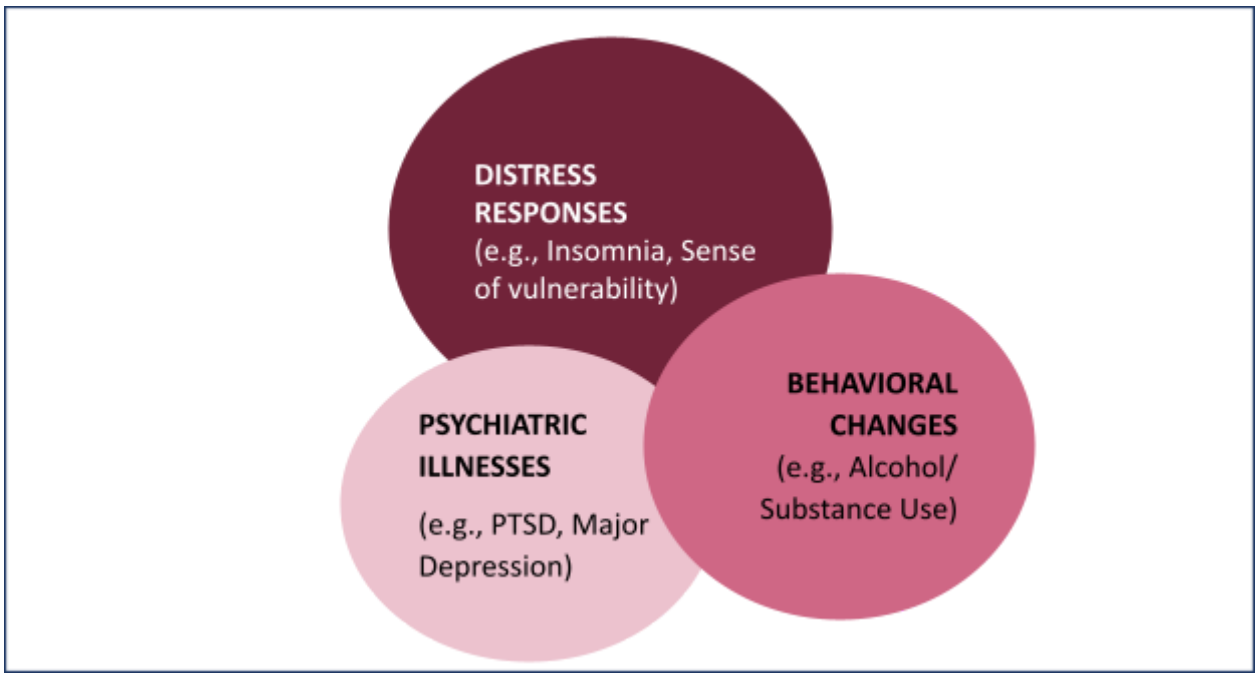
[36] FEMA 2011

[37] California Department of Public Health. California Disaster Behavioral Health Plan (DBH Consequences, page 48). Available at: https://www.cdph.ca.gov/Programs/EPO/CDPH%20document%20Library/EOM%20documents/California%20Disaster%20Behavioral%20Health%20Plan.pdf. Accessed October 15, 2023.
U.S. Department of Health and Human Services. California Disaster Behavioral Health Plan. Available at: https://asprtracie.hhs.gov/technical-resources/resource/9621/california-disaster-behavioral-health-plan. Accessed October 15, 2023.

[38] Stith Butler A, Panzer AM, Goldfrank LR (eds). *Preparing for the Psychological Consequences of Terrorism: A Public Health Strategy*. Institute of Medicine, Committee on Responding to the Psychological Consequences of Terrorism. Washington (DC): National Academies Press (U.S.); 2003.

Figure 1. Distress Responses, Behavioral Changes, and Psychiatric Illnesses



In addition to the range of stress responses described above, the National Center for PTSD has identified numerous factors that may contribute to the development of serious or lasting psychological reactions following disasters or mass violence, such as major depression, generalized anxiety, or PTSD.[39] These comorbidities can include the severity of exposure (especially injury, threat to life, and extreme loss), post-event stress and adversity, and inadequate psychosocial support. Some populations face disproportionate vulnerability to behavioral health impacts from disaster, including women, members of a minority group, people experiencing poverty or low socioeconomic status, individuals with prior exposure to trauma, and people who have previously experienced mental disorders. Community-level factors that can cause additional risk include displacement and low social cohesion.

The National Center for PTSD identified protective factors at the individual, social, and community levels that can promote adaptive responses following disasters. Examples include the ability to reframe the situation in a more positive or helpful light, the willingness to seek support from others when needed, the ability to use distraction as appropriate to reduce distress, the use of positive religious/spiritual guidance, the capacity to adapt flexible coping strategies, and the ability to find meaning in the situation based on individual personal values. Social support has also been shown to be a key factor in facilitating well-being and limiting

[39]US Department of Veterans Affairs. Risk and Resilience Factors After Disaster and Mass Violence. Available at: https://www.ptsd.va.gov/professional/treat/type/disaster_risk_resilience.asp.

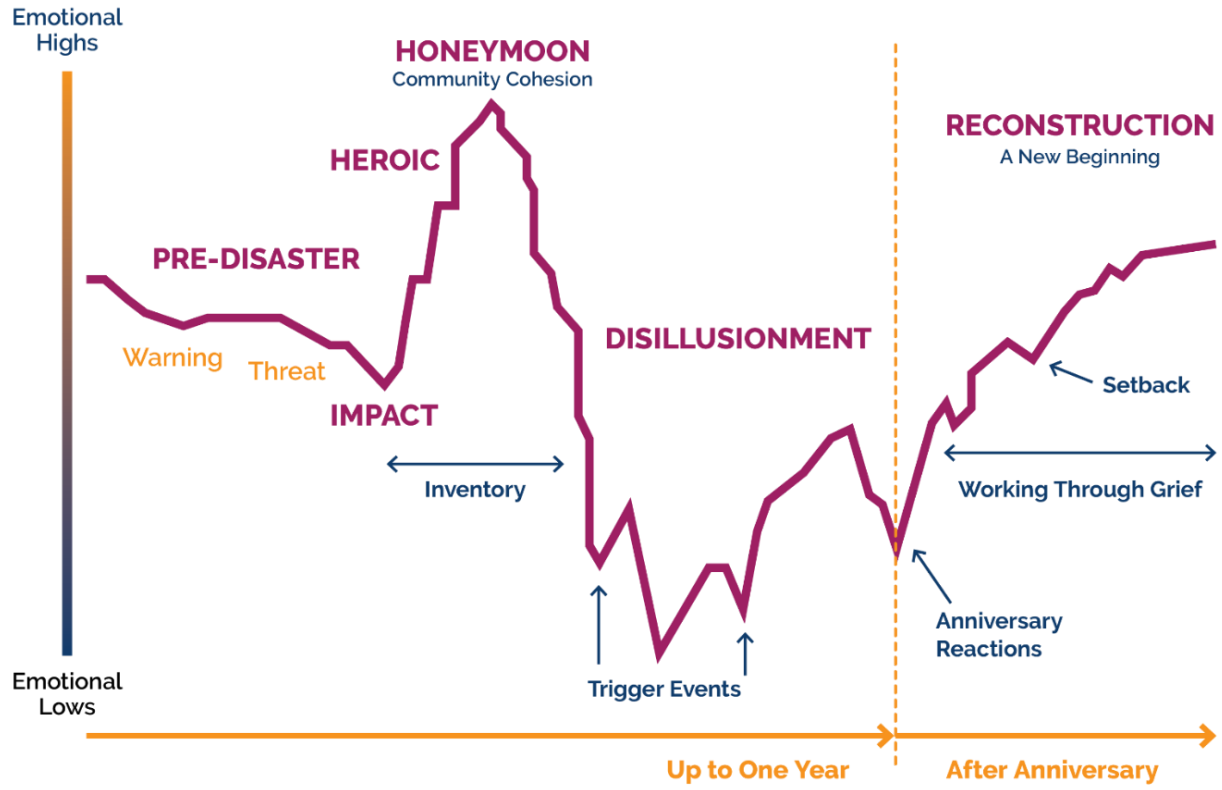
psychological distress. Disaster behavioral health interventions such as PFA and skills for psychological recovery (SPR) can foster many of these adaptive skills as well.[40, 41]

Many researchers suggest assessing for pre-existing event-related and post-event risk factors as well as existing individual and community strengths, resources, and abilities. This helps communities tailor response interventions in a way that is best suited to support the natural coping abilities and protective factors of individuals and communities impacted by disasters.

Another foundational concept for disaster behavioral health response is understanding the stages of reactions communities can experience following a disaster. Figure 2 was originally developed by Zunin/Meyers and cited in the U.S. Department of Health and Human Services "*Training manual for mental health and human service workers in major disasters*".[42] It shows the stages of disaster reactions in communities over time, including reactions seen during pre-disaster, impact, heroic, honeymoon, disillusionment, and reconstruction stages.[43]

[40] The National Child Traumatic Stress Network. About SPR. Available at: https://www.nctsn.org/treatments-and-practices/psychological-first-aid-and-skills-for-psychological-recovery/about-spr.
[41] The National Child Traumatic Stress Network. About PFA. Available at: https://www.nctsn.org/treatments-and-practices/psychological-first-aid-and-skills-for-psychological-recovery/about-pfa.
[42] Substance Abuse and Mental Health Services Administration. Training Manual for Mental Health and Human Service Workers in Major Disasters. U.S. Department of Health and Human Services Publication 90-538. Available for download at: https://www.hsdl.org/?view&did=4017.
[43] Routledge. Interactive Cases: Hudson. Available at: https://www.routledgesw.com/interactive-casabdes/hudson/assess/mapping-a-social-problem.

Figure 2. Disaster Reactions in Communities Over Time. (Adapted from GreaterHealthNow)



The behavioral health consequences of disasters, including terrorism and mass casualty incidents, suggests two categories of community needs that Arizona should consider addressing in a disaster behavioral health response:[44]

- Resilience-based psychoeducation and psychosocial interventions to reduce emotional distress and social problems, and
- Referral and treatment for psychiatric and other disaster behavioral health disorders (e.g., SUD).

Relative to the first need, most people exposed to disasters will experience distress for a period but do not develop psychiatric disorders. Disaster behavioral health emphasizes the normalization of reactions that survivors and responders experience. Early psychoeducation and psychosocial interventions are indicated for most survivors and responders to reduce distress, provide emotional support, educate, and normalize emotional responses.[45]

[44] California Department of Public Health. California Disaster Behavioral Health Plan - Community Services a Phased Approach, pages 55-56. Available at: https://www.cdph.ca.gov/Programs/EPO/CDPH%20document%20Library/EOM%20documents/California%20Disaster%20Behavioral%20Health%20Plan.pdf.

[45] North CS, Pfefferbaum B. Mental Health Response to Community Disasters: A Systematic Review. *JAMA*. 2013;310(5):507−518.

The second need relates to the smaller proportion of people who go on to develop or experience a worsened disaster behavioral health disorder. These individuals may need referrals to appropriate clinical services and access to brief or longer-term care. Disaster behavioral health aims to provide a continuum of services and activities—including communication/public information, education, basic psychological support such as PFA, crisis intervention, as well as referrals for clinical services when needed—to promote resiliency and mitigate the progression of adverse reactions into more serious physical and disaster behavioral health conditions.

DISASTER PREPAREDNESS AND PLANNING

Preparedness and Prevention

Arizona and its local communities should consider collaborating to identify actions necessary to prevent negative disaster behavioral health effects resulting from a disaster. This effort might include:

- Engaging historically marginalized populations and people at greater risk of negative disaster behavioral health outcomes in planning efforts,
- Promoting available disaster behavioral health services that are culturally and linguistically appropriate,
- Supporting disaster behavioral health and disaster behavioral health service providers in the community to foster and promote disaster behavioral health resiliency before the incident, and/or
- Working with internal partners to identify training and services needs to support staff stress management and resiliency on an ongoing basis, including disaster fairs or other methods of reaching staff.
- Create a disaster behavioral health advisory committee to meet with and collaborate with a range of organizations and community members. The committee may establish working groups or other committees for specific topics such as planning for schools, historically marginalized or underserved populations, people with access and functional needs including individuals with SMI, SED, and ESMI/FEP, people experiencing homelessness, etc.
- Build an achievable plan for disaster behavioral health operations and services in the region, engaging key stakeholders through the disaster behavioral health advisory committee.
- Review the comprehensive emergency management plans (CEMP) within the region to identify areas where additional written guidance, policies, and procedures may be needed for disaster behavioral health. Supplies or other resources needed to support the disaster behavioral health mission also should be identified. (See also in this framework: Terrorism and Mass Violence Incidents Considerations)
- Review data on populations within the community that may be more susceptible to behavioral health impacts after a disaster.
- Identify response agencies and non-governmental organizations likely to provide disaster behavioral health services in Arizona and review copies of their disaster

plans. Identify opportunities to collaborate, reduce redundancies in the provision of services, and fill gaps where appropriate.

- Provide disaster planning and continuity of operations guidance and support to behavioral health services providers to ensure the continuation of services following an event.
- Develop memoranda of understanding (MOUs) with RHBAs, as well as other public and private organizations that may be able to provide disaster behavioral health services. MOUs should identify agreed-upon roles following disasters or public health emergencies. This process also may help with post-disaster grants and cost recovery efforts.
- Participate in planning disaster exercises with key emergency management, health care providers, public health officials, and community partners in Arizona to practice roles and responsibilities for disaster behavioral health response.
- Review and update this framework.
- Work with relevant human resource departments to discuss employee assistance programs (EAPs) and identify gaps in capacity to support a surge of employees requiring assistance following a disaster.
- Provide disaster resiliency education to responders and government employees on a regular basis before disasters, terrorism, or mass casualty incidents.
- Assist with the provision of other relevant disaster response training such as PFA and SPR for key disaster response staff as well as community partners assisting with the disaster behavioral health response mission.
- Bolster possible disaster behavioral health volunteer response groups, which could include MRC members, community emergency response teams (CERTs), or nonprofit volunteer groups.

Disaster Behavioral Health Representation in the Emergency Operations Center

Based on available resources and the size and scope of the incident, the role of jurisdictions within Arizona in assisting with subsequent disaster behavioral health consequences may include:

- Appointing a Disaster Behavioral Health Unit Leader to oversee the disaster behavioral health coordination within the EOC of jurisdictions within Arizona.
- Integrating the disaster behavioral health response with ESF # 8 - public health and medical response, including identifying priorities and tasks for disaster behavioral health as part of the EOC AP (see also Disaster Behavioral Health Action Planning below).
- Situating a disaster behavioral health representative in the central facility where the incident command is coordinating resources and information among responding entities, such as EOCs, emergency coordination centers (ECCs), and multiagency coordination groups (MAC groups). Regardless of their name, these centers are physical locations where agencies gather to conduct emergency operations, collect–analyze–disseminate information, and coordinate delivery of resources that support emergency response personnel. Several agencies and organizations,

including some non-governmental organizations (NGOs) and other private sector entities maintain such facilities as well. Not all entities have a center that is set up for continuous 24/7/365 operations. These entities often activate their centers when the need arises and, for local governments, are typically located within their public works department, fire department, or city/town hall.

- Assessing previous events to develop a baseline understanding of the short-term and long-term disaster behavioral health impacts on the community. This process includes considering existing behavioral health services infrastructure as well as the effects on residents and response staff.
- Establishing methods of regular communication and status reporting among relevant government agencies, NGOs, public health, and disaster behavioral health community partners involved in the disaster behavioral health response.
- Researching advance behavioral health and spiritual care mutual aid.
- Working with community partners, including the ARC Disaster Mental Health Services, to identify and publicize available disaster behavioral health programs and services for the community throughout the three phases of the disaster behavioral health response (see Response and Recovery: Considerations for a Phased Approach for Disaster Behavioral Health above).
- Gathering disaster behavioral health-related information in advance to promote disaster resilience and recovery services that cater to the needs of marginalized or underserved populations and diverse linguistic/cultural groups.
- Working with internal partners to assess and mitigate the potential short- and long-term effects of the response on employees. It is important to identify resources to support mental health resilience and crisis counseling; EAPs are not typically designed to shoulder the full spectrum of post-disaster support.
- Collecting and maintaining data on the disaster behavioral health impacts and services provided to keep internal and external stakeholders informed.
- Joining any after-action and improvement meetings and/or hosting meetings to obtain feedback from community partners.

Development of Standard Operating Procedures for Disaster Behavioral Health

Developing comprehensive standard operating procedures (SOPs) for disaster behavioral health personnel responding to a disaster is paramount to ensuring effective and coordinated assistance to communities. SOPs serve as a blueprint for responders, outlining the systematic approach to providing disaster behavioral health support in high-stress environments. Such procedures encompass a range of essential actions, including initial assessment protocols, crisis intervention techniques (CIT), referral processes, and ongoing monitoring strategies. As part of the disaster response planning process, the state and the local community should consider the actions that should be taken to support community disaster behavioral health and where along the response timeline they fall.

Formalizing these procedures prior to a disaster can help streamline the administration of disaster behavioral health treatment and promote the continuity of care. Working directly with

community and response partners can help jurisdictions forge connections ahead of disaster and ensure planning efforts reflect the diversity of the community. Suggested SOPs for disaster behavioral health include:

- Deciding how and when to deploy disaster behavioral health leadership into the appropriate EOCs medical and health branch. The integration of disaster behavioral health representatives into EOCs in the region will help ensure the disaster behavioral health strategies outlined in this framework are implemented appropriately.
- Appointing a Disaster Behavioral Health Unit Leader within each EOC to oversee the coordination of disaster behavioral health programming and services for that jurisdiction.
- Integrating the disaster behavioral health response into the public health and medical response (ESF 8), including identifying priorities and tasks for disaster behavioral health as part of the EOC AP (see also Disaster Behavioral Health Action Planning below).
- Assessing the short-term and long-term behavioral health impacts of the disaster on the existing behavioral health care infrastructure as well as the residents of Arizona.
- Establishing methods of regular communication (e.g., video conference calls, in-person meetings, situation reports) and status reporting with all government, community-based, and health care partner organizations involved in the disaster behavioral health response.
- Facilitating behavioral health and spiritual care mutual aid requests.
- Working with community partners, including the ARC Disaster Mental Health Services, to identify and publicize available behavioral health programs and services for the community throughout the three phases of the disaster behavioral health response (see Response and Recovery: Considerations for a Phased Approach for Disaster Behavioral Health above).
- Working with internal partners, including human resource departments within the state, ADHS, EOCs, and/or EOC Personnel Unit Leaders, to assess the potential short-and long-term impacts of the disaster on government employees, and to identify resources to support disaster behavioral health resilience and crisis counseling.
- Collecting and maintaining data on the behavioral health impacts of the disaster in the region, as well as the services provided throughout response and recovery efforts.
- Joining any after-action and improvement meetings and/or hosting meetings to obtain feedback from community partners.
- Consider deploying a leadership-level disaster behavioral health representative to assist with activities encompassed within ESF 6: Mass Care, Housing, and Human Services to help coordinate the deployment of disaster behavioral health staff to disaster shelters.

Identify Disaster Behavioral Health Responders

Identifying and mobilizing disaster behavioral health responders is a crucial aspect of disaster preparedness. These individuals and organizations should possess the training and expertise necessary to address the unique psychological and emotional challenges that emerge during and after disasters. These responders provide a range of services, from immediate crisis intervention to long-term support. The following responders are key players in disaster behavioral health response and their qualifications and reasons for their suitability will be further detailed in this document:

- Disaster behavioral health response teams (DBHRTs)
- Crisis mobile teams (CMTs)
- Behavioral health professionals (BHP)
- Behavioral health technicians (BHT)
- Drug and alcohol counselors
- Faith-based organizations and spiritual care
- ARC
- First responders and government disaster response staff
- Volunteer organization active in disasters

To facilitate statewide and community preparedness, it is essential to compile a list of individuals with their name, role, organization, and contact information.

Training and Education Programs

Providing comprehensive training programs for disaster behavioral health responders, as part of the preparedness and planning phase should be a priority. These educational courses will give staff the expertise they need to effectively handle a range of behavioral health concerns in the aftermath of a disaster and can help the jurisdiction align its actions with the goals set forth in the Three-Phased Approach for Disaster Behavioral Health Response.

Training should encompass PFA, SPR, CIT, trauma-informed care (TIC), and strategies for managing acute stress reactions, ensuring that responders are prepared to provide timely and empathetic support to people in need. A detailed explanation for each of those trainings can be found in the Short-Term Recovery Strategies section of this framework. Sources of training for disaster behavioral health responders can be found in this Framework under Appendix C- Disaster Behavioral Health Training and Resources.

Disaster Behavioral Health Public Awareness and Education

As part of their preparedness efforts, the State of Arizona and the local communities should develop public awareness campaigns that better prepare its citizens for the behavioral health consequences of disasters or other public health emergencies. The State of Arizona and the local communities also should determine how disaster behavioral health-related information will be coordinated following disasters. Behavioral health messaging mediums may include:

- Press releases

- Social media campaigns
- Brochures/flyers
- Billboards
- Television broadcasts
- Radio commercials
- Public service announcements (PSAs)
- Newsletter updates
- Health fair appearances
- Websites

Effective communication strategies should be employed when developing informational content for the public. These efforts might include:

- Ensuring information is grounded in evidence and verifiable data,
- Bearing in mind a target population's level of health literacy and access to the internet, social media, and technology (e.g., computer, mobile phone),
- Translating informational material into commonly spoken languages in the region,
- Ensuring all information is accessible to people with hearing, visual, or other sensory impairments,
- Devising content that is straightforward, concise, easy to comprehend, and free of unnecessary scientific or medical jargon,
- Incorporating the principles of equity, diversity, and inclusion into all messaging materials,
- Adapting content to ensure it is culturally specific (i.e., tailored to the needs of members of particular racial and ethnic groups) and culturally responsive (i.e., actively engaging with and adapting to the cultural backgrounds and identities of communities) manner,[46]
- Promoting specific disaster behavioral health events or services in the region,
- Encouraging positive health behaviors and destigmatizing disaster behavioral health issues, and
- Teaching the importance of self-care, when to seek additional help, and healthy coping mechanisms.

DISASTER RESPONSE

Phased Approach to Disaster Behavioral Health Considerations

When mobilizing behavioral health resources during disaster response and recovery, it is critical to prioritize the level of intervention needed at each phase. Table 3 outlines a phased approach to disaster behavioral health interventions, linked with FEMA's response and recovery phases. This approach can assist the DBH lead in the emergency operations center in informing decision-making and incident action planning. It also connects emergency response and

[46] Children's Bureau and Child Welfare Information Gateway. Embedding Equity Into Disaster Preparedness Efforts in Child Welfare. December 2021. Available at: https://www.childwelfare.gov/pubPDFs/equity_disaster_preparedness.pdf.

recovery phases with actionable information for behavioral health practitioners to prioritize the immediate and long-term behavioral health needs of affected individuals.

A description of a phased approach strategy is described in the California Disaster Behavioral Health Plan – Appendix B: Disaster Behavioral Health Considerations (page 55-58).[47] Important considerations for a phased disaster behavioral health approach in this framework include:

- The behavioral health consequences of mass violence, terrorism, or other disasters in Arizona are likely to extend beyond the individual survivors or disaster workers/responders to their friends and families. Therefore, community-based early intervention systems developed should encompass family members and use familial resources in the recovery to prevent or reduce emotional and disaster behavioral problems in affected spouses/partners, children, and other family members.
- Community-wide information and coping advice, including details tailored to the needs of disaster workers, should be a routine part of any community's disaster response. Information should include useful, relevant advice from credible sources.[48] The receipt of accurate information about the event, the nature of adaptive coping, and available support services can reduce uncertainty and calm survivors.[49]
- Care must be taken in the design of survivor education information because it is possible that certain educational approaches (e.g., the presentation of "shopping lists" of psychological symptoms) may in fact worsen reactions by labeling common reactions negatively and encouraging selective attention to sensations and symptoms following trauma.[50]
- Traditional communications channels and social media approaches should be incorporated into risk communication materials.

As appropriate to the situation and relevant to the varying needs, resources, and priorities, the State of Arizona and the local communities may want to consider and adapt the three-phase approach.[51]

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[47] California Department of Public Health. California Disaster Behavioral Health Plan. Appendix B: Disaster Behavioral Health Considerations, pages 55-58. Available at: https://www.cdph.ca.gov/Programs/EPO/CDPH%20EOCdocdocument%20Library/EOM%20EOCdocuments/California%20Disaster%20Behavioral%20Health%20Plan.pdf.

[48] Rogers MB, Amlt R, Rubin GJ, Wessely S, Krieger K. Mediating the Social and Psychological Impacts of Terrorist Attacks: The Role of Risk Perception and Risk Communication. *Int Rev Psychiatry*. 2007;19(3):279−288.

[49] Vaughan E, Tinker T. Effective Health Risk Communication about Pandemic Influenza for Vulnerable Populations. *Am J Public Health*. 2009;99:Suppl 2:S324-S332.

[50] Wessely S, Bryant RA, Greenberg N, Earnshaw M, Sharpley J, Hughes JH. Does Psychoeducation Help Prevent Post Traumatic Psychological Distress? *Psychiatry*. 2008;71(4):287-302.

[51] California Department of Public Health. California Disaster Behavioral Health Plan. Appendix B-Disaster Behavioral Health Considerations, Community Services: A Phased Approach, pages 56-58.) Available at: https://www.cdph.ca.gov/Programs/EPO/CDPH%20EOCdocument%20Library/EOM%20documents/California%20Disaster%20Behavioral%20Health%20Plan.pdf.

Table 3. Three-Phased Approach for Disaster Behavioral Health Response

FEMA Phases	Disaster Behavioral Health Phase	Primary Goal	Timeline Status	Emotional Stage
Response and Short-Term Recovery	Phase 1	Provide immediate support	First hours and days	Impact Honeymoon
Short-Term and Intermediate-Term Recovery	Phase 2	Improve coping and resilience skills	Days, weeks, months	Disillusionment Reconstruction
Long-Term Recovery	Phase 3	Continuation of care for those affected	One year or more	Disillusionment Reconstruction

Phase 1 (Provide Immediate Support)

Phase 1 support occurs in the early days of the disaster and typically encompasses the pre-disaster, heroic, and honeymoon stages. The goal of disaster behavioral health in Phase 1 is to meet basic needs, calm survivors, and their families, mobilize social support, and reinforce coping skills. Strategies for responders to consider in Phase 1 include:

- Assessing potential behavioral health consequences of disasters and identifying which communities experienced the greatest impact.
- Working proactively with community partners to determine the most efficient and effective methods of disseminating incident-related information to the public. This activity often is performed through the joint information center or public information officers. Special attention should be given to common local languages, access and functional needs, and the unique demographics of the area.
- In Arizona, particular emphasis should be placed on identifying and reaching temporary residents, such as snowbirds and out-of-town visitors, who may be impacted by an incident and then return to their home states. It is also essential to devise discreet and secure methods to communicate and support undocumented individuals who may be hesitant to seek assistance due to fears of identification or deportation. Such efforts ensure that all impacted populations are informed and supported.
- Providing informational materials specific to the incident and/or links to county websites with relevant information from local health departments and community-based partner organizations.

- Adding a link to the SAMHSA National Disaster Distress Helpline[52] and/or local mental health crisis line(s) that jurisdictions plan to use as disaster emotional assistance helplines following incidents in Arizona.
- Providing materials on coping with disaster/responder stress to responders, including contact information for EAPs for government staff and responders.
- Supporting efforts to provide PFA. PFA is typically delivered to affected individuals by disaster BHPs, disaster responders, and others trained in PFA. The purpose of PFA is to assess the immediate concerns and needs of an individual in the aftermath of a disaster.
- Continuing to provide credible and timely information about the disaster, as well as publicizing organizations that provide disaster recovery assistance.

Phase 2 (Improve Coping and Resilience Skills)

Phase 2 support occurs in the days, weeks, and months following an incident and typically encompasses the disillusionment and early reconstruction stages. Here, the focus is typically on offering stress-reduction education, building social support networks, and normalizing acute stress responses. During Phase 2, a clearer picture of survivor/responder disaster behavioral health care needs will begin to emerge. People closer in proximity to disasters or who sustained more severe injuries may require more intense medical and behavioral health treatment. Strategies responders may consider during Phase 2 include:

- Continuing to refine and support the provision of Phase 1 strategies, including proactively updating and modifying public information as the need arises.
- Working with government and community partners to identify resources for shorter-term crisis counseling and disaster behavioral health services.
- Continuing to provide coping, stress management, and burnout prevention training and education to responders.
- Engage SPR groups to conduct needs assessments, problem-solving, social support facilitation, and distress management. These interventions are provided over one to six sessions in a flexible manner tailored to need. Peer specialists and health and community practitioners with varying levels of expertise can provide SPR in a variety of community settings.
- Supporting and/or publicizing virtual or in-person grief groups for people who suffered the loss of family member(s) (including pets) because of the disaster.

Phase 3 (Continue to Provide Care to Those Affected)

Phase 3 support occurs in the months and years after the disaster and addresses the disillusionment and ongoing reconstruction stages. The focus of Phase 3 support is to facilitate the provision of longer-term disaster behavioral health services to individuals who display persistent and moderate-to-severe stress and may require more intensive care. A smaller subset

[52] Substance Abuse and Mental Health Services Administration. Disaster Distress Helpline. Available at: https://www.samhsa.gov/find-help/disaster-distress-helpline. Accessed October 16, 2023.

of mass violence survivors, for example, may develop a new or worsening disaster behavioral health disorder, such as anxiety, depression, PTSD, and SUD.

It should be noted that a relatively small proportion of disaster BHPs are trained in the trauma-informed practices recommended in clinical practice guidelines.[53] Trauma-focused interventions require specialized training and point to the need for capacity-building among the clinical disaster behavioral health workforce. Therefore, responders should work with their county and community partners to identify a list of intermediate and long-term referral resources in the state and the local communities. Strategies responders may consider for Phase 3 include:

- Continuing to refine and support Phase 1 and 2 strategies, including proactively updating and modifying public information as needed,
- Continuing to provide coping information relevant to survivors, responders, and their loved ones; continuing to publicize EAP for employees,
- Working with county and community partners to identify resources for longer-term disaster behavioral health support for disaster survivors, including identifying resources for those who need assistance beyond what jurisdictions within the State of Arizona and the local communities can provide,
- Applying for grant funding to support additional behavioral health services for disaster survivors and other marginalized groups,
- Identifying and providing disaster behavioral health information,
- Supporting or arranging ongoing events to commemorate the anniversary of the attack in the years to come, and
- Continuing to work with the State of Arizona and the local communities to identify resources and other evolving disaster behavioral health needs.

Disaster Behavioral Health Priorities Establishment

A crucial step in the early aftermath of a disaster is the evaluation of immediate needs and the prioritization of operational actions. By focusing on the most essential tasks and diverting resources to residents facing the greatest challenges, disaster behavioral health responders can ensure that critical support reaches the people who need it most, thus contributing to a more effective and targeted response.

Following an emergency, disaster behavioral health responders in affected regions of Arizona should begin assessing the population's disaster behavioral health status as a whole, identifying urgent needs and deploying resources and services accordingly. Disaster behavioral health responders can refer to *Table 4. Needs Assessment* to establish a baseline point to determine where additional assessment may be necessary.

[53] National Center for Disaster Medicine and Public Health. Curriculum Recommendations for Disaster Health Professionals Disaster Behavioral Health, Second Edition. 2020. Available at: https://www.cstsonline.org/assets/media/documents/CSTS_Curriculum_Recommendations_2nd_ed.pdf.

Responders can use a range of tactics to evaluate the needs of the population, such as deploying trained assessment teams into affected areas to gauge the emotional state of residents, using validated screening tools to identify individuals with acute stress reactions, and engaging with community leaders, who may have a keener understanding of the population. In addition, responders may leverage digital tools, such as social media, mobile phones, and computers, to distribute surveys and other self-assessment tools and administer virtual counseling services. Responders should proactively seek out at-risk individuals for assessment, targeting spaces such as temporary shelters, homeless encampments, assisted living facilities, behavioral health treatment and residential facilities and correctional facilities.

Contingent upon the magnitude and extent of the disaster, the State of Arizona and local communities may prioritize the following actions throughout the appropriate phases of response and recovery:

Operational Priorities for Maintaining Existing Disaster Behavioral Health Facilities and Services

- Assess the structural integrity of facilities, safety, and availability of PPE,
- Secure necessary resources and staffing,
- Establish alternative spaces for care,
- Use virtual tools to ensure the continuity of health care services (e.g., telehealth/counseling, online prescription refills, wearable health monitoring devices), and
- Collaborate with local health care providers and agencies to share staff, resources, and best practices.

Operational Priorities for the Community

- Disseminate information on stress management, coping strategies, and available resources.
- Publicize disaster behavioral health-related services and events in the region.
- Mobilize community-based organizations and volunteers to assist with outreach and support efforts.
- Establish centralized spaces for emotional support and group therapy.
- Provide referrals for follow-up services for people who need immediate and long-term trauma-focused treatment.
- Consider establishing a hotline through 2-1-1 or similar services, where individuals can turn for resources that can be quickly mobilized in emergency situations. Planning efforts should outline processes and points of contact for initiating this type of service.

Operational Priorities for First Responders and Government Disaster Responders

- Provide access to low- or no-cost counseling services and stress management training,
- Designate a staff member for each impacted region to advocate for the health and wellbeing of responders in their respective areas and serve as a point of contact for responders' disaster behavioral health needs,

- Establish peer support networks that allow responders to connect with colleagues who can provide understanding, empathy, and assistance in dealing with stress and trauma,

Operational Priorities for Jurisdictions

- Establish a centralized disaster behavioral health coordination center that can facilitate information sharing among stakeholders,
- Identify gaps in service delivery and resource allocation, and rapidly deploy disaster behavioral health crisis teams to affected areas, and
- Ensure that emergency shelters and recovery centers are equipped to address disaster behavioral health needs and provide necessary support to individuals and families

Disaster Behavioral Health Action Planning

The incident command system (ICS) contains the incident action plan (IAP), which sets forth priorities, objectives, and tasks during a disaster. The IAP should outline disaster behavioral health objectives/planned actions, including future objectives/planned actions, and potential challenges/limitations. The jurisdiction's EOP will outline steps for planning within an IAP. This planning should be done as part of EOC operations. Some considerations may include:

Understand the Department's Policy and Direction

The command and general staff must understand the department's policies and priorities to develop appropriate response actions. For example, the jurisdiction may have developed plans to provide specific services during an emergency. This policy should be clearly understood as a component of the jurisdiction's response.

Assess the Situation

Situational awareness is critical to developing effective response actions. The department should have access to established mechanisms and systems within the community (city, county, regional, or state) that can provide and/or verify situational information needed to assess disaster behavioral health impacts and response needs.

Establish Incident Objectives

At the tactical field level, the incident commander (IC), or unified command if multiple agencies are involved, sets the overall objectives for the response. EOCs above the field level (e.g., a EOC for the county disaster behavioral health department or a county EOC that includes county disaster behavioral health department representation) usually have a senior policy group that provides input on objectives that are communicated to the EOC manager or coordinator. Incident objectives always follow the SMART format: specific, measurable, actionable, realistic, and time-bound).

Determine Appropriate Strategies to Achieve the Objectives

Once the objectives have been established, the EOC section chiefs will determine the appropriate strategies and actions to effectuate the response. They will use their findings to create an action plan for each section that clearly identifies responsibilities and duties. Action plans can be developed on a daily or weekly basis, depending on the needs associated with the incident. It is important to track and document objectives and their completion.

Give Tactical Direction and Ensure that It Is Followed

Tactical directions provide operational and response personnel with a concise list of actions to take and identify the resources necessary to complete them.

Provide Necessary Back-Up

When tactical direction is initiated, support may be needed to meet the objectives. This may include revision of the actions taken in the response, the assignment of additional resources (e.g., personnel, supplies and equipment), and/or the revision of objectives.

The Action Plan

FEMA has developed forms (see: APPENDIX H – FEMA ICS ACTION PLANNING FORMS) that can be used in action planning. These forms help direct the response and archive the objectives, strategies, and tactics. They also are used to document the personnel, supplies, and equipment used in response and recovery phases. County disaster behavioral health departments can customize ICS forms in a way that best meets their needs. The completed action plan should be copied and shared with all deployed disaster behavioral health leadership staff so that all team members clearly understand the information most relevant to incident response.

Disaster Behavioral Health Needs Assessment

Crisis Counseling Assistance and Training Program (CCP)

The CCP is a short-term disaster relief grant for states, US territories, and federally recognized tribes. CCP grants are awarded after a presidential disaster declaration. The CCP is designed to provide immediate mental health support, primarily relying on face-to-face contacts with survivors in their communities. The CCP provides these support-centered services to survivors over a specific period of time.[54]

In the event of a disaster, it is vital that precious time isn't spent trying to research or draft resource summaries. As part of the planning process, summarizing resources and capabilities and periodically updating that information becomes paramount to ensure that affected areas can tailor and adjust what they have on hand for an effective response.

To receive CCP funding, the state, territory, or tribe must provide a description of its resources and capabilities, as well as local resources and capabilities, and an explanation of why these

[54] Substance Abuse and Mental Health Administration and FEMA. Crisis Counseling Assistance and Training Program Guidance: CCP Application Toolkit, Version 5.3. April 2023. Available at: https://www.samhsa.gov/sites/default/files/dtac/ccptoolkit/fema-ccp-guidance.pdf.

resources cannot meet existing needs. Following the grant award and throughout the life of the program, grantees are expected to conduct an ongoing needs assessment to justify continued supplemental funding.[55]

Behavioral Health Needs Assessment

A behavioral health needs assessment is conducted immediately after a disaster. The assessment justifies the request for CCP assistance and identifies at-risk populations who will be targeted to receive crisis counseling services. In most disaster situations, children, adolescents, older adults, and people with disabilities or other access and functional needs are considered at-risk populations. The needs assessment may reveal additional groups who are vulnerable to disaster impacts or who have been particularly affected by the disaster.[56]

The needs assessment also provides an opportunity for the state, territory, or tribe to demonstrate the nature and extent of mental health and substance use-related needs resulting from a disaster and how those needs surpass local resources and capabilities.[57]

The data for the needs assessment will usually rely on input from the affected locality as to damage, casualties, injuries, and populations exposed. Formal sources for needs assessment might include:

- Analysis of damage assessments
- Registrants for services from FEMA or the CCP

Additional data sources could involve:

- Special use surveys
- Assessment tools

The needs assessment might also draw on the corroborative data including:

- Anecdotal evidence from crisis counselors
- Feedback from other disaster relief providers

These sources may be especially important to meet changing needs in communities affected by disaster. [58]

According to SAMHSA, a needs assessment:

- Determines the need for crisis counseling, mental health and/or substance misuse treatment, public education, and information dissemination.
- Assesses risk factors and reactions in relation to:
    - Safety
    - Level of exposure to the traumatic event

[55] Ibid
[56] Ibid
[57] Ibid
[58] Ibid

  - Prior trauma, physical or behavioral health concerns
  - Presence of severe reactions
  - Current functioning
  - Alcohol and drug use and misuse

- Identifies at-risk groups
  - Is neutral and value-free judgment when assessing the needs of each specific sector of the community, cultural group, or other at-risk population post-disaster.
- Emphasizes techniques that facilitate grouping and mobilizing people to work together.
  - Fosters collective activities
  - Facilitates leadership development
- Is an ongoing process and should be updated as needed throughout the response to the disaster.
- Identifies the community's role in influencing and affecting the general well-being of the population.
- Involves residents in the entire process.
- Looks at quantitative data, including demographic records, official statistics, and the damage assessment report provided by the locality or in the case of a presidentially declared disaster, may include information from the FEMA Preliminary Damage Assessment as well as qualitative data from individual social indicators and contacts with the community. These often take the form of:
  - Observations
  - Community surveys and group forums
  - Key informant interviews
  - Community impressions
  - A behavioral census
- While some assessments use only one or the other type of data, a combined technique known as a convergent analysis can be used and is likely to be more comprehensive of the larger picture.
- Informs the outreach strategy of the disaster response (refer to Outreach Strategy Development).

SAMHSA provides a template that can be used to estimate disaster behavioral health needs (*Table 4. Needs Assessment*). Please note that this model is included in this framework as a helpful example to support the state and the local community's efforts to assess the post-disaster behavioral health needs in their region. Though many survivors will fit into more than one loss category, they should be counted only once on the needs assessment.

Table 4. Needs Assessment

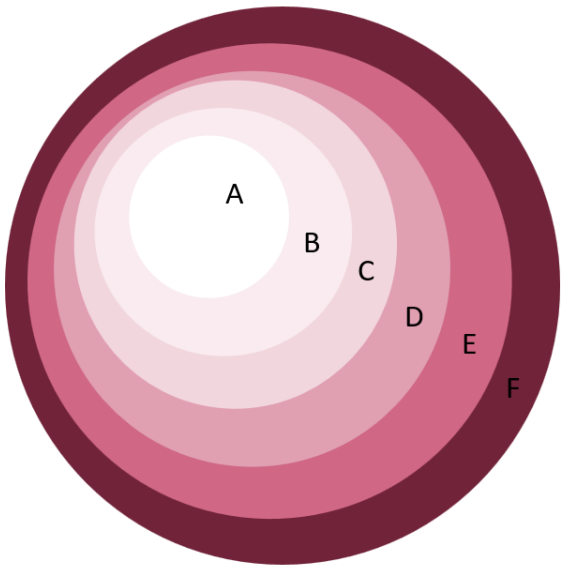
Loss Category	Number of Individuals	Average Number of people per household (ANH)	Range Estimate	Number of Persons per Loss Category
Type of Loss	Number	Multiply by ANH	At Risk Multiplier	Number of Persons Targeted per Loss Category
Missing or Dead		2.62		
Hospitalized		2.62		
Non-hospitalized Injured		2.62		
Homes Destroyed		2.62		
Homes – Major Damage		2.62		
Homes – Minor Damage		2.62		
Displaced		2.62		
Evacuees				
Disaster Workers				
Children				
Elderly				
People with Prior Behavioral Health Illness				
Racial and Ethnic Minority Groups				
Non-English-Speaking Groups				
LGBTQ Population				
People Experiencing Homelessness (PEH)				
People with Disabilities or Access and Functional Needs				

Population Exposure Model (PEM)

The CCP uses a PEM to help identify and prioritize groups who could benefit from crisis counseling services and other behavioral health outreach efforts during disasters as seen in the figure below.[59]

More information about the federal CCP grants program and its requirements can be found on the SAMHSA website.[60]

Figure 3. Population Exposure Model



A	Injured survivors, bereaved family members
B	Survivors with high exposure to disaster trauma, or evacuated from disaster zones
C	Bereaved extended family and friends, first responders
D	People who lost homes, jobs, and possessions; people with preexisting trauma exposure or behavioral health problems; at-risk groups; and other disaster responders
E	Affected people from the larger community
F	All needs that can be addressed with a CCP grant

The population exposure model in Figure 3 shows a ripple effect, illustrating how the impacts of a disaster expand to broader segments of the community. The injured and bereaved individuals represented in sphere "A" have the highest level of exposure to the disaster and are most likely to benefit from services that are delivered face-to-face and are more intensive. Those represented in each subsequent ring have a lesser degree or intensity of exposure. Those in ring "E" have experienced little to no direct exposure to the disaster and, thus, may be targeted for the less intensive services, such as public education and information.

Outreach Strategy Development

The development of outreach strategies in the wake of disasters stems from the knowledge that most people do not see themselves as in need of behavioral health or crisis intervention services even when they are experiencing distress symptoms after a traumatic event. The

[59] Ibid
[60] Substance Abuse and Mental Health Services Administration. Crisis Counseling Assistance and Training Program (CCP) Toolkit. Available at: https://www.samhsa.gov/dtac/ccp-toolkit. Accessed October 16, 2023.

development of an outreach strategy is based on the behavioral health needs assessment and should be adjusted throughout the response.

FEMA defines a whole community response as the inclusion of individuals and families (including those with access and functional needs), businesses, faith-based and community organizations, non-profit groups, schools and academia, media outlets, and all levels of government including state, local, tribal, territorial, and federal partners. It is important to note that effective community engagement needs to include external partners as they may be the only way to reach certain populations. Engaging the whole community can also increase overall awareness and personal preparedness, and subsequently increase individual and overall resilience of a community. An informed and comprehensive community-based response is warranted to protect the health of the affected population.

SAMHSA provides an Outreach Strategy Template that can be adapted to meet the needs of the jurisdictions' disaster response.

Engaging the Target Community

Outreach to the public is essential to ensure that needs are accurately identified and addressed. Part of this process includes identifying relevant demographic information, such as the percentage of community members that identify with a particular faith, to understand and prioritize engagement with specific community organizations. Though outreach to the entire population of a jurisdiction is an unrealistic goal, outreach to key groups and creating avenues for feedback can be invaluable in the planning process. Outreach to the public should include, at a minimum, various cultural and religious denominations throughout the community, Tribal Nations, urban, suburban, and rural communities, access and functional needs communities, communities where English is not the primary language, and other underrepresented groups. These groups can be reached through representative organizations, social media, community-based organizations, local religious groups, and other parties that traditionally interact with them. Cultivating relationships with these groups not only recognizes them as vital stakeholders, but also positions them as crucial partners during responses. Their members can act as cultural intermediaries and valuable resources when collaborating with varied populations.

Though outreach is common to people who live in the community year-round, many jurisdictions have a large temporary resident population, such as academic institutions, tourist sites, people with second homes in the vicinity, etc. These people are harder to reach, but it is important to attempt to engage them in outreach as well, as addressing the needs of temporary residents during a response can become a complex process. Outreach may require more non-traditional methods, such as advertising at travel hubs, commercial advertisements, and working with tourism venues, for example.

Connecting with this range of stakeholder groups during planning and preparation allows not only for the inclusion of their unique needs into the framework, but also provides a crucial

opportunity to develop relationships with these constituencies. This work can be accomplished through a variety of pathways including:

- Social media or other online methods,
- Door-to-door public education within a community,
- Community hubs such as community centers, libraries, municipal buildings, etc.,
- Working with municipal leaders to help distribute information. This could be accomplished by working with groups such as the Arizona Association of Counties,
- Working with other governmental agencies that may bring these groups together (emergency management office, social services, health department, etc.), and
- Leveraging existing outreach training that may be occurring. For example, childcare facilities are licensed by the ADHS–Bureau of Child Care Licensing. They provide mandatory and optional training modules through their learning management system (LMS) on various topics including emergency evacuation.

Engaging the Disaster Behavioral Health Community

Though the disaster behavioral health community will play an essential role in any disaster response, disaster behavioral health providers vary in their disaster related training and experience. Many providers may have no training in disaster behavioral health. As opposed to traditional behavioral health services, which are often designed to diagnose, treat, and monitor behavioral health issues, disaster behavioral health relies on a strength-based model which focuses on restoring functioning and encourages survivors to access their support systems and preexisting coping skills and strategies. Therefore, the identification of training needs and provision of such training pre-disaster will build local capacity and broaden the pool of disaster behavioral health providers as well as increase the efficacy of their work with those impacted by disasters post-event. Disaster behavioral health providers should be targeted through their representative professional associations, state regulatory or licensing bodies, and other professional groups. Many of these groups already conduct outreach and training to those they represent and could serve as a key resource in reaching a variety of providers throughout the state.

Engaging the Response Community

The response community is broad and far reaching in any state. Outreach to law enforcement agencies (federal, state, regional, local, tribal, etc.) including peace officers and others, career and volunteer fire departments and EMS agencies, as well as public safety answering points (PSAPs) can be accomplished through state regulatory bodies that coordinate their certification and/or licensure, state and regional representative organizations for these groups, and local institutions that conduct initial, refresher, and continuing education trainings for this audience. Disaster behavioral health training within the response community will vary widely. However, all responders can benefit from training that promotes their own well-being and resilience, as well as training in supporting the disaster behavioral health of those they serve, including PFA.

The response community also will be able to provide valuable information about their communities. Issues such as vulnerable populations, unique challenges within certain

communities, and other information that could assist with overall engagement and outreach can help drive outreach methods.

Engaging the Education Community

The inclusion of schools (including K-12 as well as colleges, universities, and trade schools) is essential, as these institutions often serve a range of populations and have resources to assist with outreach and education. They also often employ in-house health and disaster behavioral health staff and have referral resources for short- and long-term disaster behavioral health treatment. At the same time, students, as well as faculty and staff, are likely to feel the effects of any disaster in their community; preparing schools to manage a response will serve to minimize educational disruption. Much like with behavioral health providers, education professionals are rarely trained in disaster behavioral health, so providing such skills during the preparedness phase will be important. Trauma reactions and other disaster behavioral health reactions can be highly disruptive to classroom learning, and if not properly addressed, to overall child development. Thus, providing PFA training for teachers and other school staff who interact with children post-disaster will provide an additional tier of monitoring and support.

Engaging the Marginalized Community

When planning and implementing a disaster behavioral health response initiative for people affected by a terrorist attack, the ICT, BHPs, and other responders should consider the needs of marginalized groups. These individuals may include people who are experiencing the following challenges:

- **Individuals with Limited Mobility:** This group can experience heightened anxiety and distress, given their physical limitations in a crisis. They may fear being left behind during evacuations or being unable to access shelters or safe spaces. They need specialized assistance, ensuring they can move safely, as well as psychological support tailored to their unique fears and concerns. Minimizing disruption to ongoing support services and treatments for this group is vital, as continuity can alleviate some of their anxieties.
- **Individuals with Cognitive Impairments:** People living with cognitive impairments may struggle to comprehend the gravity of the situation or follow emergency procedures. Tailored communications, patience, and repeated instructions are essential to ensuring their understanding and safety. It also is important to provide emotional and psychological support that aligns with their cognitive levels. Ensuring minimal disruption to their established support and treatment services is crucial, providing a semblance of routine and stability during uncertain times.
- **SMI diagnosis**: Individuals living with an SMI diagnosis might experience heightened anxiety, paranoia, or depression during challenging situations. A calming environment, routine check-ins, and ensuring access to medications and specialized therapeutic interventions are critical.
- **Children experiencing SED:** These children might act out, retreat emotionally, or show heightened distress. Consistency, a safe environment, and therapeutic

interventions tailored to their age and emotional state can help. Support for their caregivers is equally essential.

- **First episode psychosis (FEP):** Early interventions are crucial for people experiencing FEP. Regular therapeutic sessions, a non-judgmental environment, and access to immediate medical interventions can make a significant difference. Ensuring that they are not isolated and have consistent support is vital.
- **Individuals with Limited English Proficiency:** Language barriers can exacerbate feelings of isolation and confusion during a disaster. It's critical to have interpreters or multilingual professionals available and provide materials in multiple languages to ensure comprehension and alleviate anxiety.
- **Individuals with Limited Access to Transportation**: The stress of being unable to evacuate or access essential services can compound disaster-induced trauma. Provisions for transportation and ensuring access to safe spaces are key, alongside counseling to address their heightened vulnerabilities.
- **Individuals who are Blind or with low vision:** Visual impairments can escalate fears of the unknown during disasters. Guided assistance, auditory information sources, and tactile tools are vital, along with disaster behavioral health support that addresses their unique experiences and anxieties.
- **Individuals who are Deaf or Hard of Hearing:** The lack of auditory information can be disorienting and distressing. Sign language interpreters, visual alerts, and written communication are essential. Providing trauma counseling that's sensitive to their experiences is crucial.
- **Children, adolescents, and young adults (ages 18-25):** This age group is in a transitional phase, experiencing changes in identity, peer groups, and responsibilities. Clear communication that acknowledges their growing autonomy, combined with resources tailored to their age group, such as peer support and age-appropriate therapeutic interventions, can be beneficial. Recognizing their need for independence while providing a safety net is a delicate but essential balance.
- **Individuals who are Pregnant:** Pregnant individuals may have heightened concerns about their own safety and their unborn child's well-being. Besides the physical necessities, they may need specialized counseling that addresses pregnancy-specific anxieties.
- **Tribal Population:** Native communities often have unique cultural and spiritual practices that play roles in coping. Respecting these practices and integrating tribal leaders or healers into the disaster behavioral health response can enhance community trust and improve outcomes.
- **LGBTQIA+ Community**: Members of the LGBTQIA+ community may face additional layers of stress, including stigmatization, discrimination, or family estrangement. Disaster behavioral health initiatives should be inclusive, affirming, and sensitive to the unique experiences of LGBTQIA+ individuals.
- **Rural Communities:** Rural populations may face isolation, limited access to services, and infrastructure challenges. Interventions need to consider the geographic spread,

limited resources, and often tight-knit nature of these communities, promoting community-led support initiatives and ensuring outreach to remote areas.

- **Individuals Experiencing Homelessness:** This population often lacks immediate access to resources, information, and safe shelters. Trust is a critical factor when communicating with these individuals because of the stigmatization and marginalization they often face. Meeting their basic needs first—such as food, shelter, and warmth—can pave the way for effective communication.
- **Veterans and Active-duty Service Members**: Many veterans and active-duty personnel have faced intense situations or have PTSD. Recognizing their past experiences and ensuring they have access to resources that understand military culture is crucial. Regular check-ins, peer support, and specialized trauma informed care can significantly benefit this group.

Disaster Behavioral Health Response Locations Identification

Congregate Settings

Congregate settings during an emergency or disaster may include disaster shelters, FACs/family reunification centers (FRCs), local assistance centers, DRCs, and other settings where a group of affected people are brought together to receive designated services. Though different settings have some differing needs, the basic principles for delivering disaster behavioral health services remain the same.

The environment of any congregate setting can affect the overall well-being of everyone involved; therefore, a key disaster behavioral health responsibility is to ensure that the setting itself promotes healing and recovery to the extent possible. This includes taking steps to ensure that the environment feels safe and calm, that policies and procedures are clear and easy to understand, that services and resources are easy to access, and taking any other measures necessary to minimize unnecessary sources of stress or tension.

Key considerations in planning for disaster behavioral health services in congregate settings include:

- Applying a trauma-informed approach whenever possible, particularly with respect to where services are provided and privacy.
- Integrating disaster behavioral health into the organizational and command structure of the setting.
- Identifying appropriate spaces for disaster behavioral health services.
- Identifying flexible staffing resources as congregate settings often mobilize, consolidate, and demobilize over the course of a disaster.
- Identifying pathways to request additional supplies, staff, and resources as needed.
- Planning for the provision of disaster behavioral health services in congregate settings for everyone involved—both the people receiving services and the people providing those services.

- Planning for demobilization and follow-up; individuals and staff should be aware of what resources are available to them once the congregate site is closed.
- Planning for the maintenance of documentation and records as required by the jurisdiction, regulatory entity, and/or setting leadership.

Services for Survivors

The needs of people affected by the disaster will vary by individual and may, or may not, present themselves in typical ways. These needs may also be compounded by pre-existing behavioral health disorders, disruptions in their daily routines and access to their daily needs (i.e., medications, school materials, etc.,) and the stressors associated with the congregate setting itself, among others. Additional considerations include:

- Public education material on the behavioral health impacts of disasters, positive coping skills, and available resources.
- Available space for disaster behavioral health screening and follow-up.
- Signage about the availability of disaster behavioral health services. This should be done in a way that ensures everyone knows that disaster behavioral health support is available but allows people to access this support discreetly. Many survivors will be reluctant to walk up to a table that advertises that it is offering disaster behavioral health services, even if they are seeking such services. Additionally, offering the option for individuals to remain anonymous when calling crisis lines or DTAC lines can further encourage participation among those hesitant about sharing personal details or being identified.

Staff

The disaster behavioral health needs of staff working in congregate settings rarely are addressed until the emergency is over. This model results in the compounding effects of the response instead of addressing those needs at regular intervals to address issues before they become more serious. Jurisdictions can avert this problem by planning for regular contact between the disaster behavioral health providers and the rest of the staff. This process may include:

- Disaster behavioral health staff participating in daily briefings, shift change reports, and other staff meetings to maintain situational awareness and develop rapport with staff.
- Disaster behavioral health staff providing briefings on the potential for disaster behavioral health impacts, what staff should be alert to in themselves and in others, and actions that individuals can take to help themselves as well as how to reach out to for help.
- Disaster behavioral health staff circulating regularly throughout the congregate setting looking for signs of stress amongst the staff, conducting brief check-ins, and
- Offering more intensive support as necessary. Any interventions beyond brief check-ins should be done in a private space and with the recognition that often staff will want to return to their positions as quickly as possible to complete their mission.

Disaster Shelters

Shelters can range from ad hoc facilities that result from the congregation of people impacted by disasters to facilities that are pre-planned, stocked, prepared, and staffed to accommodate a range of needs. Some disaster shelters may have only a handful of survivors and a few staff, while larger facilities may have hundreds of people, and mega-shelters may operate like small cities. Often, locations that may be used as homeless shelters, "code blue" shelters for cold weather, cooling centers for extreme heat weather,[61] or other non-disaster events are leveraged during a disaster. The operations of a non-disaster shelter and a disaster shelter vary significantly, so careful planning is important.

In addition to the disaster behavioral health issues described elsewhere in this document, key disaster behavioral health considerations for individuals staying in disaster shelters include the stressors associated with relocation, living in a large group setting with strangers, limited access to one's belongings, relying on others for meals and other necessities, and noise and overcrowding, among others. Interventions focused on promoting a calm and comforting atmosphere and helping people access their daily needs are thus particularly important in this setting.

Resources for addressing the disaster behavioral health needs of a shelter include, but are not limited to:

- Mega-Shelter Planning Guide
- Sheltering Handbook: Disaster Services
- Mental Health Interventions in Shelters: Lessons from Hurricane Harvey

Family Assistance Centers/Family Reunification Centers

Many congregate settings post-disaster may be involved in locating deceased and/or missing people, but FACs/FRCs almost always address these situations to some extent. The American Red Cross can help locate loved ones who have been impacted by a disaster, offering an additional resource in these circumstances.[62] ADHS will be involved in field operations, which include FACs to provide expertise and personnel support.

In addition to the disaster behavioral health issues described elsewhere in this document, disaster behavioral health issues in these settings will include addressing extreme levels of loss, grief, uncertainty, and confusion. To the extent possible, these sites should be staffed with experienced disaster behavioral health providers capable of managing mass casualty situations. Each disaster is different, so making specific disaster behavioral health plans for these sites is infeasible. Regardless of the disaster, having an experienced team who can be flexible and adapt

[61] Arizona Department of Health Services. Statewide Cooling Center. Available at: https://www.azdhs.gov/documents/preparedness/epidemiology-disease-control/extreme-weather/heat/statewide-cooling-centers.pdf.

[62] American Red Cross. Reconnecting Families. Available at: https://www.redcross.org/about-us/our-work/international-services/reconnecting-families.html#:~:text=Restoring%20Family%20Links%20provides%20free,to%20respond%20to%20your%20request.

to the evolving needs in the site will be key. Disaster behavioral health support for providers themselves in these settings is crucial. Deployment and shift lengths should be kept short, and jurisdictions should consider having a designated disaster behavioral health responder whose role it is to support the team.

Addressing the behavioral health needs of those impacted at FACs/FRCs should also take into consideration that these sites don't typically operate 24/7. If behavioral health services are needed immediately and FACs/FRCs are closed, crisis lines, mobile team response, and walk-in crisis stabilization facilities are always available. It may be necessary to develop a plan for making services available to survivors in other ways. If behavioral health services are needed immediately and FAC/FRCs are closed, crisis line/MT/walk-in CSU facilities are always available. Similarly, because these sites are open for a limited time following an event, jurisdictions should establish a clear plan for referrals and pathways for survivors to access services (including community resilience centers [CRCs]).

Disaster Recovery Centers

DRCs are set up post-disaster in federally declared emergencies. During disasters that do not meet that threshold, state and/or local jurisdictions often set up similar centers called local assistance centers, disaster assistance service centers, or a related term. These centers are structurally and conceptually similar; the lead agency, participating agencies, and services being offered may differ. Their purpose is to help people affected by disasters with the identification of services and resources available to them during the recovery phase.

Federal, state, and local agencies, community-based organizations, and nonprofit groups typically have stations set up where they can meet disaster survivors and discuss what resources are available, assist with any applications, and offer other support as needed.

One key disaster behavioral health consideration is that survivors may be asked to tell their story multiple times to multiple agencies, which may heighten their distress as they relive the traumatic events surrounding the disaster. In such cases, agencies should consider streamlining and standardizing processes, such as creating a unified form that enables victims to apply for various forms of assistance simultaneously, reducing the need for them to recount their experiences multiple times.

A second key consideration is the level of distress associated with the secondary stressors being dealt with by survivors at these sites, such as the loss of a driver's license or other forms of identification. DBH services can involve circulating among the different stations in a DRC to support survivors as they complete each task, as well as having a station where individuals can learn more about available disaster behavioral health services in the community.

Crisis Hotlines

Arizona has a robust behavioral health crisis services network available to any Arizona resident regardless of health insurance coverage.[63] Services include:

- 24/7/365 crisis telephone lines operated by trained crisis specialists.
- Peer operated warm lines to provide additional support and resources.
- 24/7 mobile teams staffed by behavioral health professionals who travel to the individual experiencing a crisis and provide assessment, stabilization, and may triage the individual to a higher level of care, as appropriate, and
- Facility-based centers that offer crisis stabilization and observation, including access to Medication Assisted Treatment.

If someone is experiencing a behavioral health crisis, they can call one of these national or local crisis lines. The contact numbers and information can be found in APPENDIX B – LIST OF CONTACTS:

- Arizona Statewide Crisis Hotline: The statewide crisis hotline is managed by Solari, the sole statewide crisis phone vendor chosen to operate the state's 24/7/365 behavioral health crisis line. Solari encompasses both behavioral health paraprofessionals (BHPPs) and BHPs. Trained peer support specialists are available 24/7 to support the warm line, 602-347-1100 (Central Arizona),[64]
- National 24-hour crisis hotlines, and
- Suicide and crisis hotlines by county and Tribal Nation.

Though hotlines are often well-equipped to deal with more common crises experienced by the public, they may need additional resources to respond to disasters. It's important to establish disaster-specific scripts and ensure staff are trained in disaster behavioral health. The demand for services may also outpace typical capacity. Call centers often have contracts for surge situations; but the contracting agency may or may not have training and/or experience with disaster behavioral health. Training requirements in surge contracts and pre-disaster coordination with providers can help mitigate these issues.

Disaster Behavioral Health Responders Staffing

Arizona and local jurisdictions should identify disaster behavioral health responders to adequately address directly and indirectly affected persons as per the Disaster Behavioral Health Needs Assessment.

Disaster Behavioral Health Response Teams

Coordination of resources is a key consideration for an effective disaster behavioral health response. Jurisdictions within Arizona should consider identifying Disaster Behavioral Health Response Teams (DBHRTs), building on existing resources and capabilities. DBHRTs are

[63] Arizona Health Care Cost Containment System. Crisis Hotline. Available at: https://www.azahcccs.gov/BehavioralHealth/crisis.html.
[64] Solari Crisis Response Network, Warm Line. https://crisis.solari-inc.org/get-help/warm-line/

specialized units uniquely positioned to address disaster-related behavioral health crises. Trained and equipped to offer critical support, they assist individuals undergoing acute emotional and psychological distress stemming from disasters. Their multifaceted role ensures that affected individuals receive immediate psychological assistance and that community's benefit from resilience-building efforts.

These teams aren't just first responders; they comprise seasoned professionals skilled in disaster behavioral health. Their expertise transcends traditional disaster behavioral health support, encompassing specialized interventions tailored to the unique challenges disasters present to behavioral well-being. DBHRTs are adept at:

- Rapid Assessments: Swiftly gauging the disaster behavioral health needs of disaster-stricken communities and individuals.
- Specialized Triage Techniques: Efficiently identifying and prioritizing severe cases.
- Psychological First Aid: Offering instant emotional support to those most affected.
- Crisis Counseling: Delivering counseling tailored to disaster-specific traumas.
- Referrals: Linking individuals to further specialized disaster behavioral health services.
- Community Resilience-Building: Spearheading efforts to bolster disaster behavioral health resilience community-wide.

Within the overarching emergency response structure, DBHRTs are integral assets dedicated to preserving the disaster behavioral health and resilience of disaster survivors. They seamlessly weave into the larger response framework, addressing the psychological implications of disasters often overshadowed in emergency responses.

Additionally, DBHRTs act as liaisons for any disaster behavioral health crisis, anticipated or not. This involves pinpointing key community stakeholders for a united response. Emphasis on team composition ensures they mirror the communities they serve, drawing from a diverse pool of disciplines and backgrounds. This inclusivity promotes collaboration among disaster behavioral health clinicians, law enforcement, community elders, and advocates, culminating in a cohesive response during crises. An established annual review process further ensures the relevance and efficacy of their strategies.

Instituting BHRTs in the State of Arizona and the local communities would substantially elevate the state's capacity to navigate the disaster behavioral health challenges unique to disasters. Their presence would ensure compassionate, targeted responses that not only address immediate needs but also foster longer-term community resilience.

Disaster Behavioral Health Response Teams Activation

Activating the DBHRT is a flexible process best guided by the unique needs and circumstances of each disaster. While specific guidelines can be beneficial, they should be adapted as required to ensure an effective response. Activation can be considered under the following circumstances, but should not be limited to them:

- The decision to activate the DBHRT should be based on a comprehensive assessment of the disaster's impact. Considering factors such as the scale of the disaster, the potential for severe psychological impact, and the number of affected individuals.
- Activation may come from various sources, including local authorities, incident command, or disaster behavioral health experts. Recommendations to activate the BHRT can be made based on an evaluation of the emotional and psychological needs of disaster survivors, or previous similar emergency disasters that can offer best practices.

Roles and Responsibilities

The roles and responsibilities of the DBHRT members can vary based on the unique circumstances of each disaster. These roles may include:

- Team Leader: A seasoned disaster BHP can provide leadership for the DBHRT. Their role could involve coordinating team activities, liaising with incident command, and ensuring the team's flexibility to respond to changing dynamics.
- Crisis Counselors: DBHRT members can consist of licensed disaster BHPs, social workers, or trained crisis counselors who offer immediate emotional support and crisis intervention. Their specific roles should adapt to the evolving needs of the affected population.
- Assessment and Triage: In disaster situations, assessment and triage are critical. DBHRT members can assess the psychological needs of survivors and adapt their interventions accordingly.
- Psychoeducation and Support: DBHRT can provide psychoeducation to help survivors understand common emotional reactions to disasters and encourage self-help and resilience-building strategies.

Qualifications and Training

DBHRT members should ideally have qualifications and training in disaster behavioral health response; however, flexibility in considering other relevant qualifications and experience is important to ensure a diverse and adaptable team.

- Consider members with disaster behavioral health certification post-licensure, but also recognize the value of those with relevant crisis intervention and community support experience.
- Encourage ongoing training in crisis intervention, cultural competency, and disaster response, while also valuing practical experience and adaptability.

Coordination Strategies with Various Entities

Collaboration among various entities, such as disaster behavioral health providers, law enforcement, justice systems, local agencies, and public health, is essential for creating integrated and sustainable services. To ensure effective cooperation and integration of services, consider the following recommendations:

- DBHRT should consider maintaining open lines of communication with the Incident Command and EOC to align with the broader disaster response strategy.
- Engage with local community organizations, non-profits, and disaster behavioral health services to access resources, share information, and provide comprehensive support.
- Designate liaison officers within each agency who are specifically tasked with fostering interagency collaboration. These officers can serve as a direct point of contact for communication and coordination.
- Offer interdisciplinary training sessions where disaster behavioral health, law enforcement, justice systems, local agencies and public health agencies are educated on each agency's roles, responsibilities, and expertise. This can foster mutual understanding and respect.
- Establish routine meetings where stakeholders can discuss ongoing issues, review progress, share resources, and brainstorm solutions. This will ensure everyone is on the same page and can adjust approaches as needed.
- Implement integrated information systems that allow agencies to share relevant data while respecting privacy laws. Having a shared database can improve service delivery and ensure that individuals don't fall through the cracks.

Collaboration with various entities is key to providing effective disaster behavioral health support during and after a disaster.

Crisis Mobile Team (CMT)

Arizona's CMTs are available statewide and are composed of BHP/BHT level staff, with a designated BHP available 24/7 telephonically, and/or via telehealth when applicable. Whenever CMTs are dispatched on a call, the BHP plays a pivotal role in guiding each interaction with consumers. CMTs travel to the individual experiencing a crisis and provide assessment, stabilization, and, if needed, triage the individual to a higher level of care.[65]

Acknowledging that the current scope of practice of those teams is focused on responding to individual crises, the scope of practice may require expansion to proficiently respond to disaster behavioral health needs of disaster survivors. Consequently, a clear protocol should be established to dispatch these specialized teams, delineating the circumstances and mechanisms for dispatch during community traumas. This protocol should detail collaboration frameworks with Public Safety Answering Points (PSAPs) and crisis lines in each county within Arizona, ensuring streamlined and coordinated responses.

It is important to note that CMTs' current scope may not be fully equipped to manage disaster behavioral health responses, both in terms of the resources and funding available. The crisis team should be considered as a supplemental support to the DBHRTs described in the previous section. Jurisdictions can also build upon existing CMT infrastructure to stand up DBHRTs.

[65] AHCCCS. National Recognition for Arizona's Crisis System. https://www.azahcccs.gov/BehavioralHealth/ArizonaCrisisSystem.html

Dispatch Procedure

In the event of a disaster behavioral health emergency where a CMT is needed, the State of Arizona and the local communities can use its CMT dispatch protocol, initially designed for individual crises, to support the DBHRT as needed.

Using this protocol, individuals can reach out to the AZ Crisis Line, a service operational 24/7, by dialing 844-534-4673 (HOPE). All calls to this crisis line, particularly those from first responders, are given utmost priority, swiftly triaged to assess the severity of the situation, and, if a caller is unable to be stabilized by phone a CMT can be activated to address the unfolding crisis.[66]

To ensure an efficient response, CMT resources are strategically concentrated in areas that experience a high volume of calls. Furthermore, the crisis line maintains a dedicated channel to 9-1-1 Public Safety Answering Points (PSAPs), facilitating the diversion of calls with a crisis nexus to appropriate channels, thereby alleviating the burden on 9-1-1 services for calls that do not necessitate a first responder.[67]

Upon activation, the CMT aims to adhere to response time guidelines, which requires the ACC-RBHAs to maintain a monthly average arrival time below 60 minutes for urban regions (Pima and Maricopa Counties) and 90 minutes for rural areas (everywhere else). As such, some response times may be far above 90 minutes, especially in remote areas or during a crisis that impacts transportation (e.g., if there were a crisis in Supai at the bottom of the Grand Canyon). It is important to note that during periods of high demand, there may be delays in response times if all CMTs are engaged.[68]

Training

Specialized Disaster Behavioral Training: Training programs suggested by Arizona Complete Health - Complete Care Plan (AzCH-CCP), such as Crisis System Overview, Resiliency 101, Resiliency: 5 Skills, Mental Health First Aid (MHFA), and CIT Training, can be highly valuable in preparing the teams for disaster settings[69]. These courses cover essential topics such as crisis management, resiliency building, MHFA, and specialized CIT tailored to disaster scenarios. This training helps ensure that team members are well-prepared to address the psychological and emotional needs that emerge during and after disasters. Training should encompass PFA, TIC, and crisis counseling techniques tailored for disaster settings.[70]

Behavioral Health Professionals (BHP)

ADHS defines a BHP as “an individual who is qualified according to a health care institution’s policies and procedures to provide behavioral health services at or for the health care

[66] Arizona Complete Care Plan - Crisis Protocol: Cochise County
[67] Arizona Complete Care Plan - Crisis Protocol: Cochise County
[68] Arizona Complete Care Plan - Crisis Protocol: Cochise County
[69] Arizona Complete Care Plan - Crisis Protocol: Cochise County
[70] Arizona Complete Care Plan - Crisis Protocol: Cochise County

institution that would require a license under A.R.S. Title 32, Chapter 33".[71] Notably, professionals at lower levels are mandated to always practice under their direct supervision.

Behavioral Healthcare Professionals are licensed experts such as psychologists, social workers, and counselors, who possess specialized skills in delivering behavioral health services. These professionals hold state licensure, demonstrating their adherence to rigorous standards, and hold advanced degrees in psychology, counseling, or social work, backed by relevant clinical experience. Their comprehensive training and expertise empower BHPs to excel in various capacities, encompassing crisis intervention, psychological assessments, counseling, and therapy. Furthermore, they exhibit proficiency in efficiently coordinating care and making referrals to those requiring assistance, both during and in the aftermath of disasters.

Behavioral Health Technicians (BHT)

ADHS defines a BHT as "an individual who is not a BHP who provides behavioral health services at or for a health care institution that would require a license under A.R.S. Title 32, Chapter 33".[72] Importantly, BHT's operate under the guidance and supervision of a licensed BHP.

BHT's are integral to the support network of licensed behavioral health experts during disaster response efforts. Typically, they may possess either a bachelor's degree or relevant certification in their field. Within the disaster response context, they fulfill a vital supportive role, contributing to activities such as crisis intervention, psychoeducation, and the provision of fundamental counseling services. It's essential to emphasize that their responsibilities are carried out under the close supervision and guidance of licensed professionals. This collaborative approach enhances the overall capability to offer essential assistance during the challenging circumstances of disasters.

Behavioral Health Paraprofessionals (BHPP)

ADHS defines a BHPPs as "individuals who are not a BHP and who provide behavioral health services: at or for a health care institution that would require a license under A.R.S. Title 32, Chapter 33".[73] While working under the supervision of licensed BHPs, BHPP's assume a supportive role, complementing the work of licensed professionals. Although they do not hold the title of a licensed BHP, they possess capabilities that include participating in crisis intervention, providing immediate emotional support, offering psychoeducation, facilitating discussions, and basic counseling services under supervision. Qualifications encompass a commitment to supervision, educational qualifications like relevant certifications, specific training, adherence to ethical standards, continuous professional development, cultural competency, and effective communication skills. In summary, these individuals form an integral

[71] Division of Public Health Services, Licensing Services Healthcare Institution Licensing (n.d.). Behavioral Health 101 [Slide show pg.21]. azdhs.org.
[72] Division of Public Health Services, Licensing Services Healthcare Institution Licensing (n.d.). Behavioral Health 101 [Slide show pg.22]. azdhs.org
[73] Division of Public Health Services, Licensing Services Healthcare Institution Licensing (n.d.). Behavioral Health 101 [Slide show pg.23]. azdhs.org

part of the behavioral health support team, delivering essential services under supervision to promote the well-being of clients in health care settings.

Peer Recovery Support Specialist

ADHS defines a Peer Recovery support specialist as "an individual who is a BHT or a BHPP who has progressed in their own recovery from alcohol or other drug abuse or behavioral health disorder and is willing to self-identify as a peer and work to assist other individuals with chemical dependency or a behavioral health disorder. Because of their life experience, such persons have expertise that professional training cannot replicate".[74]

Having navigated their own paths to recovery, they possess unique insights into the complexities of addiction and behavioral health issues, which enables them to connect with and support individuals in a profoundly meaningful way.

Peer Recovery Support Specialists play a vital role in fostering community connections within the context of disaster behavioral health. Their unique lived experiences empower them to establish deeply empathetic bonds with disaster survivors. Their expertise, rooted in personal encounters, goes beyond what formal training can offer. Having navigated their own paths to recovery, they possess profound insights into the intricate facets of addiction and behavioral health issues, enabling them to connect with disaster-affected individuals on a profound and relatable level. To emphasize the importance of lived experience in crisis services and align with national best practices, mobile teams are required by contract to maintain a staffing ratio of 25% peers.

Drug and Alcohol Counselors

Drug and Alcohol Counselors can bring a specialized skill set to disaster response situations, focusing on addressing substance use and addiction issues within disaster-affected communities. These counselors hold state licensure or certification in addiction counseling, which ensures their proficiency in dealing with complex substance use disorders, even in the challenging circumstances posed by disasters.

Incorporating Drug and Alcohol Counselors into the emergency response framework enhances the capacity to address substance use issues effectively in disaster contexts. Their specialized roles encompass assessment and identification, where they are adept at recognizing signs of addiction and assessing the unique needs of those affected. Additionally, they provide crucial counseling and support services tailored to disaster survivors dealing with substance use challenges, helping individuals manage cravings, cope with withdrawal symptoms, and develop strategies for maintaining recovery during a crisis. They also facilitate referrals to specialized addiction treatment services when necessary and play a vital role in educating disaster-affected populations about the risks associated with substance use during and after disasters. This

[74] Division of Public Health Services, Licensing Services Healthcare Institution Licensing (n.d.). Behavioral Health 101 [Slide show pg.24]. azdhs.org

integrated approach ensures that individuals grappling with substance use disorders receive comprehensive support, addressing immediate needs and promoting long-term recovery and resilience within disaster-affected populations.

Faith-Based Organizations and Spiritual Care

Faith-based organizations, representing diverse religious and spiritual groups in the State of Arizona and the local communities, assume a crucial role in delivering clinical pastoral care within disaster settings. In the aftermath of disasters, both emergency responders and affected individuals may seek their expertise in spiritual and emotional support. These organizations bring a team of qualified spiritual leaders and trained volunteers capable of providing counseling, pastoral care, and invaluable community support. Drawing upon their extensive training and deep spiritual insight, they offer profound solace and contribute significantly to the emotional recovery process during and after disasters. Noteworthy training resources include programs like the Dignity Health Arizona Clinical Pastoral Education program[75], which equip these clinical caregivers with the specialized skills and clinical knowledge necessary to effectively serve the community during times of crisis.

American Red Cross

For more information on the role of ARC, refer to Role of Not-for-Profit and Community Partners section.

Volunteer Organizations

Arizona Voluntary Organizations Active in Disaster (AZ VOAD)

AZ VOAD is a vital alliance of volunteer organizations committed to disaster response. AZ VOAD provides assistance to individuals affected by disasters through proactive outreach, advocacy, and the application of guiding values and core principles.[76] This collaboration consists of more than 57 participating organizations, each contributing unique qualifications and capabilities tailored to their specific areas of expertise. Together, these organizations offer a wide array of services, including specialized support for disaster behavioral health, community outreach and education, volunteer mobilization, all integrated into the broader disaster response framework. For a more comprehensive list check AZ VOAD membership list.[77]

AZ-ESAR-VHP

The Arizona Emergency System for the AZ-ESAR-VHP is a secure, Web-based system used to register, qualify, and credential Arizona health care professionals, including those with disaster behavioral health backgrounds, before a major public health or medical emergency. From this

[75] Dignity Health. Spiritual Care. Available at: https://www.dignityhealth.org/arizona/locations/stjosephs/patients-and-visitors/for-patients/spiritual-care.
[76] Arizona Voluntary Organizations Active In Disaster. Available at: https://www.azvoad.org/about-us/.
[77] AZ VOAD. 2022 Arizona VOAD Membership List. Available at: https://www.azvoad.org/wp-content/uploads/2022/03/2022-AZ-VOAD-Membership-List.pdf.

site registrants may also elect to join local MRC units and other community volunteer response teams.

The advanced registration of volunteer health professionals enables ADHS, local health departments and emergency management to rapidly identify and mobilize health care volunteers. Moreover, the system enables hospitals and other medical entities to meet crisis and surge capacity needs and ensure the continuance of critical health care services.

AZ-ESAR-VHP is administered by ADHS/BPHEP and provided through Intermedix EM Systems (CORES Responder Management System).

Medical Reserve Corps (MRC)

Refer to the Role of Not-for-Profit and Community Partners for more information about the role of MRCs.

Community Emergency Response Teams (CERTs)

CERTs play a critical role in bolstering disaster response efforts. These community-based volunteer groups receive specialized training through collaboration with Arizona's emergency management agencies. This training equips CERT members with essential skills and knowledge to provide immediate support, including PFA and basic triage, while awaiting the arrival of professional responders.

Arizona's unique geographical and environmental factors, such as wildfires, monsoons, and extreme heat, pose specific challenges to disaster response. CERT teams in Arizona are sensitized to these regional factors and are well-prepared to address disaster behavioral health needs in the aftermath of such events.

CERT teams operate within local communities, positioning them as the first line of response during disasters. Their proximity allows for rapid deployment and immediate assistance to affected individuals. Their focus on disaster behavioral health is particularly crucial in a state where extreme weather events and natural disasters can trigger emotional and psychological distress. They are adept at providing PFA, a fundamental intervention that stabilizes individuals in crisis, mitigates emotional distress, and fosters psychological resilience. This early support is invaluable in preventing further psychological deterioration.

Neighborhood Emergency Response Teams (NERTs)

NERT teams complement the broader disaster response framework by focusing on neighborhood-specific disaster preparedness and community empowerment. While similar in their volunteer-based approach to disaster readiness, NERT differs from the CERT program by relying on neighborhood-level self-sufficiency during and after disasters. NERT teams, operating at the grassroots level, prioritize factors like local hazards, communication among neighbors, and collaboration within the community.

Incorporating NERT teams into the disaster response framework enhances the resilience of communities by initiating disaster preparedness efforts at the neighborhood level. These teams, in collaboration with local emergency management agencies, can foster disaster behavioral health preparedness. They achieve this through community engagement initiatives, raising awareness about the importance of psychological well-being during disasters, and ensuring neighbors are equipped with PFA training to provide immediate emotional support when needed. Additionally, NERT teams can play a pivotal role in resource coordination and allocation, facilitating access to disaster behavioral health services and support for disaster survivors within their neighborhoods.

NERT teams contribute to disaster behavioral health capabilities by virtue of their intimate knowledge of neighborhood dynamics, allowing for a better understanding of potential disaster behavioral health challenges specific to the community. Typically trained in PFA, NERT members can provide immediate support to neighbors experiencing emotional distress, promoting emotional stability and resilience within the community. The sense of community cohesion fostered by NERT can provide essential emotional support and create a sense of belonging during disasters. By coordinating local resources for psychological support, NERT teams ensure that disaster behavioral health needs are met at the grassroots level, enhancing overall disaster resilience and recovery within Arizona's neighborhoods.

Public Communications

A disaster behavioral health emergency can lead to a range of psychological reactions, including anxiety, depression, and PTSD. In response to these needs, Arizona has a suite of publicly available services tailored to provide support, resources, and guidance to individuals and communities affected by these emergencies.

Types of Public Communications

- **SAMHSA National Disaster Distress Helpline**

  The Disaster Distress Helpline (DDH) is the first national hotline dedicated to providing year-round disaster crisis counseling. This toll-free, multilingual, crisis support service is available 24/7 to all residents in the U.S. and its territories who are experiencing emotional distress related to natural or human-caused disasters.[78]

  - Call or text 1-800-985-5990

- **National Substance Use and Disorder (SUD) Issues Referral and Treatment Hotline**

  - Phone: 1-800-662-HELP (4357)

- **Solari Inc**

[78] Substance Abuse and Mental Health Services Administration. Disaster Distress Helpline. Available at://www.samhsa.gov/find-help/disaster-distress-helpline.

Solari Inc. is the Crisis Response Network in Arizona that offers crisis line related services which are operational 24/7.[79]

- Phone: 1-844-534-HOPE (4673)
- Text: 4HOPE (44673)
- Chat: **Chat with a Crisis Specialist**

- **Crisis Text Line**

A dedicated text line to provide immediate assistance to those feeling overwhelmed. It caters to individuals seeking crisis counseling and support. The Crisis Text Line provides free, 24-hour support for those in crisis.

- Text HOME to 741-741 to speak with a trained crisis counselor[80]

- **988 Suicide & Crisis Lifeline**

The 988 Suicide & Crisis Lifeline (formerly known as the National Suicide Prevention Lifeline) offers 24/7 call, text and chat access to trained crisis counselors who can help people experiencing suicidal, substance use, and/or mental health crisis, or any other kind of emotional distress. People can also dial 988 if they are worried about a loved one who may need crisis support.

- Text or call 988: 988
- Chat with the **988 Lifeline Chat**
- Videophone: Select **ASL NOW** at the bottom of the page to connect with a 988 Lifeline counselor

- **SAMHSA's National Helpline**

SAMHSA's National Helpline is a free, confidential, 24/7, 365-day-a-year treatment referral and information service (in English and Spanish) for individuals and families facing mental and/or substance use disorders.

- Phone: 1-800-662-HELP (4357)

- **Arizona Self Help**

Arizona Self Help is a free and easy way to find out if your family may be able to get help from 40 different assistance programs in Arizona.[81]

- Phone: (602) 604-0640
- or by completing a screening on their website: https://www.arizonaselfhelp.org/

[79] Arizona Department of Economic Security. Community Resources. Available at: https://des.az.gov/services/child-and-family/community-resources.
[80] Arizona Department of Economic Security. Community Resources. Available at: https://des.az.gov/services/child-and-family/community-resources.
[81] Arizona Department of Economic Security. Community Resource. Available at: https://des.az.gov/sites/default/files/media/Arizona-Resource-List.pdf?time=1694791098610.

- **2-1-1 Arizona**

2-1-1 Arizona is a hotline and web-based directory of services for a variety of different assistance programs specific to your community.[82]

  - Phone: 2-1-1 or (877) 211-8661

- **Peer-Operated Warm Line**

The Peer Warm line is staffed by trained peers (members with lived experience overcoming mental illness) who provide a friendly voice, support and help to alleviate loneliness and isolation.

  - Warmline in Southern AZ, operated by HOPE, Inc. 1-844-733-9912
  - Warmline Central AZ, operated by Solari Inc., 1- 602-347-1100
  - Warmline Northern AZ, operated by NAZCARE, 1-855-891-2543

- **Tribal Warm Line**

The Tribal warm line is a free and confidential warm line that provides emotional support services to American Indian and Alaska Native callers.

  - Phone: 1-855-728-8630

- **Arizona Department of Veterans' Services**

The Arizona Department of Veterans' Services helps veterans connect with their VA benefits and other organizations and services available to them around the state.[83] (602) 255-3373 https://dvs.az.gov

  - Veterans Crisis Line: 988 (press 1)
  - Be Connected is a support line for Veterans and their family members that can provide resources, support and navigation services. Phone: 1-866-4AZ-VETS (429-8387)

Accessibility of Communication

To ensure the community knows how to access disaster behavioral health resources, Arizona should use a broad variety of accessible communication methods, including:

- Social media posts
- Emergency alerts, warnings, and notifications
- Press conferences
- Town halls
- Digital billboards/message signs
- 988 Suicide and Crisis Lifeline

[82] Arizona Department of Economic Security. Community Resource. Available at: https://des.az.gov/sites/default/files/media/Arizona-Resource-List.pdf?time=1694791098610.
[83] Arizona Department of Economic Security. Community Resource. Available at: https://des.az.gov/sites/default/files/media/Arizona-Resource-List.pdf?time=1694791098610.

- Statewide call centers
- Peer recovery organizations
- Faith-based organizations
- Electronic bed registries
- Warmlines
- Telehealth
- Provider mutual agreements to disseminate

To ensure the disaster behavioral health related information can be understood and utilized by the whole community, the following accessibility considerations need to be built into messaging:

- American Sign Language (ASL)
- Plain, clear, and concise language
- Multiple languages
- 508 Compliance
- Alt text, color contrast, reading order, and headings
- Accessible graphic design and layout considerations

Terrorism and Mass Violence Incidents Considerations

As appropriate, the State of Arizona and the local communities may consider adapting disaster behavioral health planning and response strategies in this Framework for use following incidents of terrorism and mass violence impacting the State of Arizona and the local communities.

The federal Office for Victims of Crime Training & Technical Assistance Center (OVC TTAC) developed a toolkit called OVC's Helping Victims of Mass Violence & Terrorism Toolkit, with resources to assist jurisdictions in developing preparedness, planning, and response initiatives for terrorism and mass violence incidents.[84] Included in this toolkit is the Response and Recovery Framework for Incidents of Mass Violence and Terrorism.[85] The purpose of this resource is to assist communities in establishing an organizational structure for a path to recovery in the immediate and long-term aftermath of an incident of mass violence or terrorism. The framework strategies used will vary based on the scope of the incident, communities impacted, available survivor resources, and government and nonprofit structures and partnerships. It can also be used to centralize and promote efficiency of recovery efforts, define common recovery goals, facilitate grant fund management, and coordinate areas of responsibility and support for recovery efforts. The Response and Recovery Framework

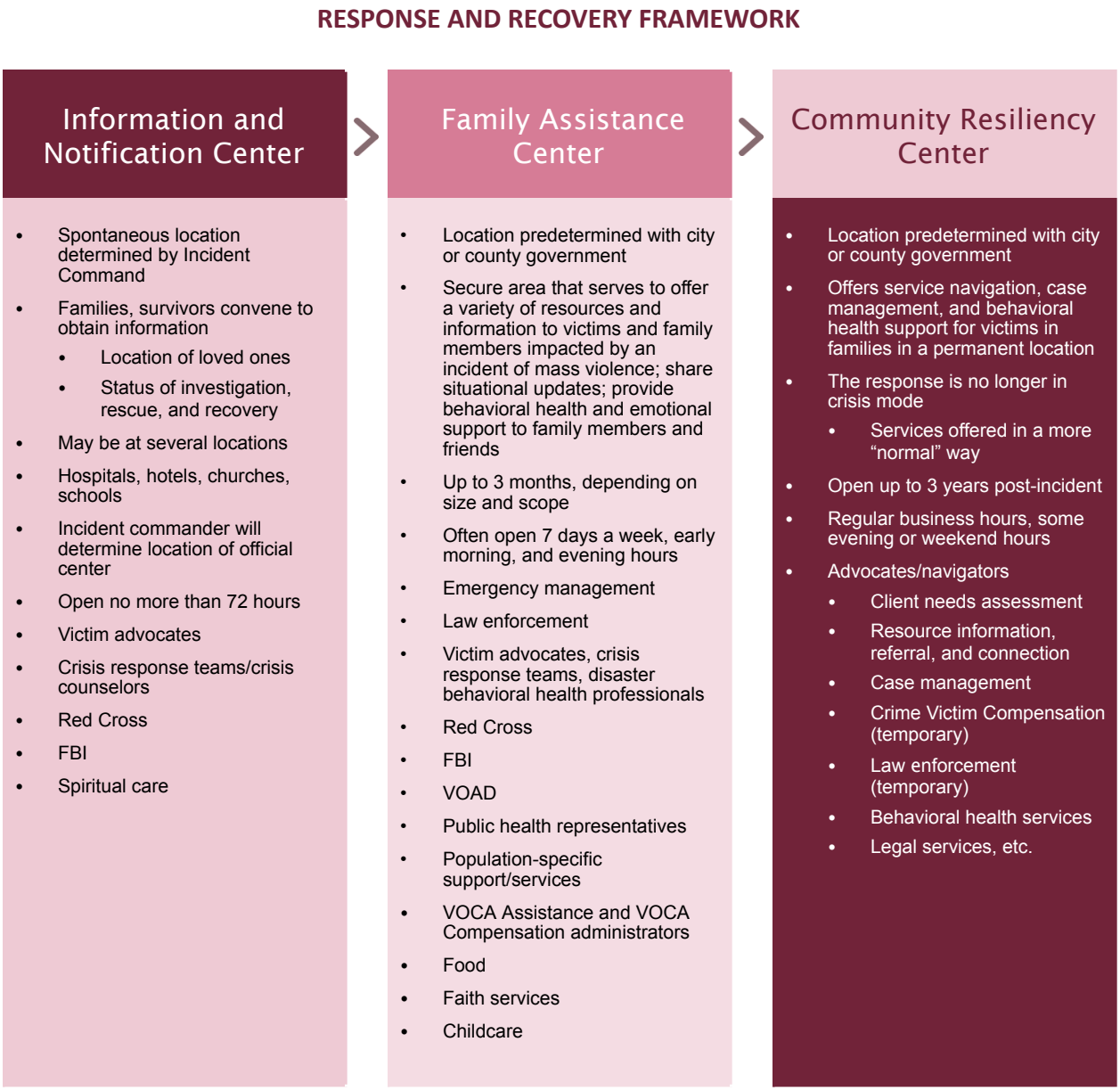
[84] Office for Victims of Crime Training and Technical Assistance Center. OVC's Helping Victims of Mass Violence and Terrorism Toolkit. Available at: https://www.ovcttac.gov/massviolence/?nm=sfa&ns=mvt&nt=hvmv.
[85] Office for Victims of Crime Training and Technical Assistance Center. Response and Recovery Framework for Incidents of Mass Violence and Terrorism. Available at: https://www.ovcttac.gov/downloads/massviolence/Response_and_Recovery_Framework_for_Incidents_of_Mass_Violence_and_Terrorism_508c_021121_JE.pdf.

flowchart in Figure 3 was excerpted from the OVC TTAC document and provides a structure for developing plans for the three parts of the survivor and community response including:

- Information and Notification
- Family Assistance Center
- Community Resiliency Center

The chart also contains suggestions for agencies to include in each area of response that can be adapted as appropriate to meet the needs of the state and the local communities.

Figure 4. Response and Recovery Framework. (Adapted from OVC's Helping Victims of Mass Violence & Terrorism Toolkit)



DISASTER RECOVERY

As appropriate, Arizona jurisdictions should work with partners to identify populations and areas that may be at higher risk for adverse disaster behavioral health impact and determine the best intervention and response strategies for these population groups. The state and the local communities should work with its partners to consider outreach to high-risk groups to provide pre-disaster education and resilience strengthening that may mitigate the acute and long-term psychological consequences of terrorism. Population groups that may be at heightened risk for developing significant stress reactions or enduring disaster behavioral health issues following a disaster are identified in this Framework. (See the above sections: "Arizona Community Profile" and "Preparedness.")

Jurisdictions within Arizona may consider working with community partners to provide information about disaster preparedness, common emotional and psychological responses, and personal resiliency to historically marginalized or underserved groups prior to a terrorism incident, disaster, or other public health emergency. Informational material should address personal, family, and work life disaster planning, common post-disaster stress reactions, and community resources that are available to meet disaster-related needs. These materials should be available in languages that reflect the composition and culture of the community.

Short-term Recovery Strategies

The overall goal of short-term recovery is to promote stabilization that allows individuals, families, and the community to return as quickly as possible to their pre-disaster level of functioning. It is important to recognize that most cognitive, emotional, behavioral, and physical reactions in the early aftermath of a trauma or disaster, while often highly distressing, are not necessarily signs of pathology, and should not initially be treated as such. When individuals and communities have access to support and resources to address their distress and facilitate their transition to normalcy, the need for long-term intervention can often be mitigated.

These resources and support can be provided by utilizing strategies that reduce distress, promote positive coping and (re) establish connections. In a seminal paper that reviewed the evidence-base for early intervention following mass trauma, Hobfoll and colleagues (2007) identified five core principles of early intervention:

Promoting Safety

At a basic level, individuals cannot start to recover until they feel safe; that is, until they are physically safe, and they perceive themselves to be safe. Short-term recovery strategies should communicate accurate and timely information about the ongoing safety situation and realistic reassurance about the extent of the threat. This should also include efforts of rumor control, and the correction of misinformation. Relatedly, people should be protected from overexposure to constant reminders of the event and from messages that emphasize imminent threat rather than themes that promote safety and resilience. This likely includes offering recommendations to monitor and limit media/social media exposure. (Parents should be encouraged to limit and

monitor the media/social media that their children are consuming related to the event as well). All other communications and interventions should be conducted with the goal of helping people return to a baseline level of safety and thus begin their recovery.

Promoting Calm

Some levels of hyperarousal can be considered normal during the exposure to, and immediate aftermath of, a traumatic event. However, prolonged hyperarousal can result in a host of psychological and physical problems that impair functioning and impede recovery, including the ability to make critical decisions. Thus, short-term recovery strategies should include efforts to reduce prolonged overarousal and extreme emotionality and promote calming. Such interventions range from psychoeducation to breathing and relaxation training, stress inoculation and other cognitive strategies. While individual in nature, these strategies can be incorporated into community-based outreach and intervention via psychoeducation. An additional strategy toward the goal of promoting calm is to ensure that all response and recovery environments (physical settings, policies, procedures, and other considerations) include an emphasis on lowering hyperarousal and promoting calm.

Promoting Connectedness

A large body of research points to the central importance of social support to disaster behavioral health recovery following a disaster or traumatic event. Simply put, social support predicts emotional well-being and recovery. Social support and connectedness provide access to crucial information, problem-solving, sharing of experiences and coping strategies, and build community efficacy (described below). Efforts to promote connectedness should include reestablishing natural connections as well as structured interventions to build new connections and provide social support. Short-term interventions should include efforts to target individuals most likely to experience social isolation and prioritize the promotion of connectedness in situations in which natural social support structures have been negatively impacted by evacuations and the destruction of homes and communities.

Reestablishing Self- and Community Efficacy

Disasters and traumatic events often strip individuals, groups, and even whole communities of their sense of efficacy, or the belief that they have the skills and abilities to do what needs to be done to successfully face the challenges that the threat has created. A loss of efficacy, while originating with the disaster itself, can quickly generalize to a more global loss in one's belief in their ability to accomplish goals. Thus, short-term recovery strategies must work to reestablish a sense of competency among individuals, families, and communities to handle the challenges they will face. It is important to note that to be effective, the reestablishment of efficacy must be accompanied by the practical resources necessary to achieve their goals for recovery.

Restoration of Hope

Strong evidence supports the importance of retaining hope in the aftermath of a disaster; this is important because disasters often shatter survivors' worldviews and shorten and disrupt their

visions for the future, which can lead to despair, futility, and resignation. Restoration of hope can be accomplished in part by providing services that return survivors to a sense of normalcy as soon as possible, even if it is a 'new normal'. The provision of basic services, housing/relocation, replacement of household goods, employment, and other services that establish or reestablish predictable routines and structures are interventions that will also serve to restore hope.

Tiered Approach to Recovery

A plan for short-term recovery should promote these principles through a tiered approach to recovery that ensures everyone has access to the level and amount of support and resources that they need. A tiered approach starts with universal interventions that can be useful to everyone, followed by targeted and then intensive interventions for those whose level of distress and impairment warrants focused attention and resources.

Psychoeducation

As described elsewhere in this document, a key strategy for disaster behavioral health is providing psychoeducation universally to responders, survivors, families, and the community at large. This can include information about common reactions, effective coping strategies, and where and how to access available resources and support. Psychoeducational resources should include information for parents that helps them understand and respond effectively to the needs of their children**.** It is important to note here that people who have recently experienced a traumatic event may have a difficult time processing information, so psychoeducational information should be provided in simple language that is made available in multiple formats through multiple channels. Detailed recommendations for communicating psychoeducational information are found elsewhere in this document.

Mental Health First Aid (MHFA)

MHFA is a training program designed to teach individuals how to identify, understand, and respond to signs of mental health illnesses and substance use disorders. Just as traditional first aid provides laypeople with the skills to help someone experiencing a physical crisis, MHFA equips participants with the knowledge and skills to provide initial support to someone who may be developing a mental health or substance use problem or experiencing a crisis. The training offers guidelines for offering assistance, understanding the potential risk factors and warning signs of various mental health challenges, and providing information on professional help and other resources available.[86]

Psychological First Aid (PFA)

PFA is a set of interventions meant to address survivors' practical, physical, and emotional needs. PFA is akin to physical first aid, with parallel goals – to stabilize psychological and behavioral functioning by meeting basic needs, reducing distress, facilitating a return to

[86] Mental Health First Aid. https://www.mentalhealthfirstaid.org/

adaptive functioning, and promoting access to further care. It can be thought of as the emotional equivalent of treating a small wound before it has a chance to develop into a more serious problem. These goals are accomplished through a series of low-intensity brief interventions that can be delivered universally. Numerous PFA models exist; while each has different names and categories for its intervention, all the models share these same broad goals.

PFA is appropriate for children, adolescents, adults, and entire families – anyone who has been exposed to disaster or violence, including first responders and other disaster relief workers. PFA is not a clinical intervention and does not have to be provided by a licensed disaster BHP; rather, as with physical first aid, anyone can be trained to provide PFA. As such, PFA can be utilized as a universal short-term recovery strategy intervention designed to provide widespread initial support to impacted individuals in any setting. Preparedness efforts should include identification of one model followed by offering training in the model as widely as possible in each community.

Crisis Counseling

Crisis counseling refers to brief disaster behavioral health interventions delivered in disaster settings. This strengths-based approach reaches out to provide targeted support to individuals in non-traditional community settings such as shelters, faith-based organizations, and homes. Crisis counseling takes different forms; it can be delivered to individuals or in groups. While it should be tailored to the needs of the situation, the broad goals are to help survivors understand their reactions, enhance their coping, consider their options, make plans, and connect with other needed services. Crisis counseling provides a targeted intervention that is more intensive than PFA; as such, it should be provided by trained professionals or closely supervised paraprofessionals.

Skills for Psychological Recovery (SPR)

As described elsewhere in this document, SPR is an evidence-based set of manualized interventions that include a brief needs assessment, problem-solving, activities scheduling, helpful thinking, social support facilitation, and distress management. SPR can be considered enhanced crisis counseling; while it is not clinical treatment, it offers more intensive disaster behavioral health intervention to those experiencing distress or impaired functioning that is beyond what can be relieved using PFA or crisis counseling interventions. SPR can be provided over one to six sessions in a flexible manner tailored to the needs of individuals or groups. SPR can be provided in a variety of structured office or community settings by licensed disaster BHPs or via telehealth.

Even with the use of these universal and targeted interventions, a smaller proportion of people can be expected to experience ongoing impairments to their functioning and/or to develop, or experience a worsening of, a disaster behavioral illness related to their exposure to the event. Individuals who display persistent and/or moderate-to-severe distress may require professional

disaster behavioral health treatment (e.g., empirically supported treatments or pharmacological interventions) provided by licensed professionals. Clinical treatment as an intensive intervention will be described in the long-term strategies section that follows.

It is important to note that individuals presenting with extreme levels of distress or other features, e.g., suicidality, should be referred for professional care immediately, regardless of time since the event.

Long-Term Recovery Strategies

As previously noted, most people exposed to a disaster can be expected, with the right support and resources, to return to their pre-disaster level of functioning without the need for long-term intervention or clinical treatment. However, there will be individuals, groups, and even whole communities who will have needs that require support that extends into the months and years following the original event. For individuals, the long-term behavioral health consequences of disasters may include PTSD, other anxiety disorders, mood disorders, and substance use disorders. Additionally, there will be a number of long-term concerns, both predictable and unpredictable, that will necessitate a coordinated set of services. This section will cover the provision of clinical behavioral health treatment (an intensive intervention) and the utilization of a CRC, as well as additional key considerations for long-term community recovery.

Screening and Referral

Screening is a 'wide net' process that seeks to identify those who may have specific disaster behavioral health needs and benefit from more comprehensive assessment. Development of a screening protocol can assist community agencies, schools, health care facilities, and CRCs in identifying those most in need of professional behavioral health treatment. Adoption of a screening instrument such as the Trauma Screening Questionnaire (TSQ; Brewin et al., 2002), can be an important part of such a protocol. The TSQ is a 10 yes/no question, self-report instrument that takes just minutes to complete and score; six or more positive responses indicate the need for a more thorough assessment. Similar screenings for other behavioral health problems post-disaster are also available to be incorporated into a protocol. Because a diagnosis of PTSD cannot be made until a minimum of 30 days after the event, screening protocols can begin at or near this time frame. It is important to note here that early symptoms of distress related to the event are, with a few key exceptions, considered normal; symptoms do not equal disorders.

A screening protocol should be accompanied by the development and implementation of a community-wide referral system that connects those at risk of developing a disorder with licensed behavioral health providers trained in evidence-based treatment models for the behavioral health problems most closely associated with disasters. The development of such a referral system should be carefully planned during the preparedness phase, as it will be complex for a number of reasons. First, even under normal circumstances, accessing and navigating the

behavioral health system can be complicated, and in most areas of the country there is a shortage of behavioral health providers relative to the need for their services. Local behavioral health systems frequently function at or beyond capacity on a day-to-day basis and have limited ability to expand or redirect their services after a disaster to meet the surge in demand. Secondly, at present, only a small proportion of BHPs in any community can be expected to have been trained in trauma-informed practices and in the evidence-based models identified in relevant clinical practice guidelines. Thus, the development of a DBH referral system should include:

- A resource map of existing behavioral health providers in the community, their service capacity, and their existing level of training and expertise in disaster behavioral health and evidence-based treatment models and clinical practice guidelines.
- A plan for building capacity within the existing behavioral health system by offering needed training and planning during the preparedness phase.
- A plan for 'just in time' training that can be offered after a disaster to scale up local capacity as necessary.
- A plan for the use of mutual aid programs to meet surge demands as needed.

Clinical Treatment

Numerous practice guidelines exist to support clinicians in identifying and implementing best practices for treatment of the most common disorders resulting from exposure to disasters and other traumatic events. The APA Division 12 (The Society of Clinical Psychology) has created a database of psychological treatments with published evidence of efficacy:

Research-Supported Psychological Treatments | Society of Clinical Psychology (div12.org)

Practice guidelines for the treatment of PTSD have been issued by APA and the National Center for PTSD, among others.

In a review of the relevant practice guidelines, Hamblen et al. concluded that all of the relevant guidelines made strong recommendations for Prolonged Exposure therapy (PE), Cognitive Processing Therapy (CPT), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). The majority of relevant guidelines also gave a strong recommendation to Eye Movement Desensitization and Reprocessing (EMDR).

Community Resilience Center (CRC)

Within a number of weeks to months following a disaster, an FAC or other relevant congregate setting will transition to a CRC which will provide ongoing services and assistance to victims, family members, responders, and community members for months to years. A CRC should serve as a hub for the ongoing provision of resources, services, and referrals, including:

- Information
    - Status of ongoing recovery efforts

  - Ongoing case/investigation briefings
  - Available resources

- Community Engagement and Outreach
  - The CRC can serve as a hub for outreach to impacted groups within the community who may need targeted or specialized resources. Maintaining connections with local community-based organizations focused on these groups can help ensure that individuals are aware of the services and resources available to them. OVC TTAC recommends considering the following list of special populations:
    - Children and youth
    - First responders
    - Tribal communities
    - Elder populations
    - Individuals with functional and access needs
    - Individuals with limited English proficiency
    - LGBTQIA+ population
    - Military veterans
    - Undocumented populations
    - Urban, suburban, and rural communities
    - Culturally diverse communities
    - Other underserved populations

- The CRC can provide the following services and referrals:
  - Victim advocacy and support
  - Case management
  - Legal services
  - Financial guidance
  - Behavioral health treatment

Additional Long-Term Disaster Behavioral Health Considerations

In the weeks, months, and years following a disaster, there are a number of situations that are likely to be points of additional distress for survivors, families, responders, and the community at large. While not all of these situations can be predicted or planned for, arranging for the presence of behavioral health responders for the following should be considered:

- **Memorialization:** Memorial events and activities, including vigils, interfaith/spiritual memorial services, development of public memorial sites, and related events, both planned and spontaneous, can be points of both healing and renewed distress for survivors, families, responders, and the community at large.
- **Reopening:** (schools, businesses, government agencies, businesses, etc.): Reopening marks important milestones in a community's recovery from a disaster. Much like memorial events and activities, reopening can prompt both healing and distress for those impacted by disaster.
- **Anniversaries:** Anniversaries of the event, and of similar events, are likely to evoke a number of reactions among survivors and the broader community.
- **Future disasters:** Survivors of any disaster are often strongly impacted by an occurrence of similar disasters in other communities.

For each of these situations, plans can be made that include publicizing reminders of healthy coping skills, available resources, and opportunities to come together for connection and support. In some cases, reaching out to survivors directly to offer support may also be appropriate.

Monitoring and Evaluation (M&E)

Establishing an M&E program can provide a comprehensive, data-driven approach to continuous program improvement. A strong M&E program will drive the development of an After-Action Report/Improvement Plan while also helping jurisdictions justify budget needs, personnel needs, and logistical needs for future responses.

The key component of any M&E program is the quantity and quality of data that is collected. Often during a response, data collection is an afterthought. Thus, it is important that items such as data points, collection tools, and procedures are identified and incorporated into protocols and plans in advance. An added challenge is ensuring that data collection supports but does not hinder, slow down, or in any other way negatively impact the ability to respond.

While many jurisdictions may find formal M&E overly complicated and lack the resources to develop it, there are often existing community resources that can be leveraged for this purpose. For example, many universities have staff, graduate students, and others who may be able to assist with the development and analysis. There are some common steps to setting up a behavioral health M&E program that can serve as a guide:

- **Define Objectives and Goals:** Clearly outline the goals and objectives of the program. As a guide to creating clear goals, work to make them SMART.
- **Identify Key Indicators:** Determine the key performance indicators (KPIs) that will help measure progress toward your objectives. These indicators should be directly related to the goals of your plan; they will be the data collected that will be used as benchmarks for measuring progress.
- **Data Collection Methods:** Select data collection methods, quantitative and/or qualitative, that will be used to measure goals and KPIs. Common methods include

surveys, interviews, focus groups, and clinical assessments. Ensure that these methods are appropriate for your target population.

- **Data Collection Tools:** Develop or adapt data collection tools such as questionnaires, interview guides, or assessment scales. Make sure these tools are culturally sensitive and valid for your target population.
- **Data Management System:** Establish a system for collecting, storing, and managing data. This may involve creating a database or using software designed for M&E purposes. Ensure that data are securely stored and accessible only to authorized personnel.
- **Training and Capacity Building:** Train staff and volunteers to use the data collection procedures, as well as the related policies and ethical issues, including the importance of confidentiality. Ensure that all staff and volunteers understand their roles in the process and what is expected of them.
- **Data Analysis:** Analyze the collected data to assess the program's progress and impact. Use statistical analysis if necessary to determine if the program is achieving its intended outcomes.
- **Reporting and Feedback:** Create regular reports that summarize the findings from your M&E activities. Share these reports with key stakeholders. Ensure that the collected data are used to inform the After-Action Report (AAR) process as described elsewhere in this document. Based on the M&E findings and results of the AAR, make necessary adjustments to plans for future responses. This might include modifying interventions, reallocating resources, or changing strategies to improve effectiveness.
- **Documentation:** Maintain thorough documentation of all M&E activities, including data collection protocols, analysis methods, and reports. This documentation will be valuable for accountability and future program development.

Development of Resilience-Building Programs

Programs for building resilience, particularly if they are in place before a disaster occurs, will allow individuals and communities to return more quickly to their baseline level of functioning. Resilience programs can focus on multiple systems, from the community to the individual.[87] At the community level, programs can focus on providing a range of services centered on all aspects of recovery, such as housing/relocation, financial, and legal services. Resilience programs can also provide ways for the community to engage in and support the recovery process, which will build both self- and community efficacy.

At the interpersonal level, resilience programs should promote ways for people to connect with each other, and to give and receive support. As noted elsewhere in this document, social support is strongly linked to disaster behavioral health recovery following a disaster. While much of this will happen naturally for some people, resilience programs should offer pathways, formal

[87] Amy Nitza, 2023.

and informal, for people to receive support, particularly for those who are more likely to be isolated.

At the individual level, resilience programs can offer opportunities for people to learn and practice a range of coping skills related to thoughts, emotions, and behaviors. Coping skills can target each of these areas. In the disaster behavioral health category, this might include physical activities and opportunities for creative expression. Emotion-based strategies might include mindfulness and meditation, deep breathing, guided imagery, and related techniques. Cognitive strategies include stress inoculation and other techniques drawn from cognitive-behavioral theory. SPR, a program described on page seventy of this document, can be offered as part of an overall resilience program to teach skills, and offer support.

Post-Disaster Debrief and Continuous Improvement

Post-disaster debriefs and continuous improvement are vital to identify successes as well as areas for improvement from any response. There are a variety of tools and resources available to conduct and document a debrief. There is no one "right way" to document continuous quality improvement. What is important is to capture all the necessary information, document it, and follow through on improvement items to the extent possible. This section will discuss various ways to accomplish this goal.

The Homeland Security Exercise and Evaluation Program (HSEEP) from FEMA provides a set of fundamental principles for exercises. The HSEEP After-Action Report and Improvement Plan process can be leveraged to accomplish the same outcome whether it's an exercise or real-world response.[88]

There are other templates, formats, and examples available from a variety of sources such as:

- ASPR TRACIE
- Arizona's 2018 National Mass Care Exercise
- Zoonotic-Foodborne Outbreak Investigation Tabletop Exercise
- After Action Review/Improvement Plan: Strategic Planning Toolkit
- Presidential Visit After Action Report

Many jurisdictions use the familiar format of a hotwash, which is an immediate debriefing conducted post-event to capture insights and feedback, and an After-Action Report/Improvement Plan (AAR/IP).

Unfortunately, many hotwashes neglect to include a disaster behavioral health component. Disaster behavioral health should be included not only for input on the disaster behavioral health response, but also to assist those participating in the hotwash as they relive their experiences during the response.

[88] FEMA. Homeland Security Exercise and Evaluation Program. https://www.fema.gov/emergency-managers/national-preparedness/exercises/hseep

There are 5 key components of an AAR/IP regardless of the format, terminology, or process used. These include documenting:

- What was supposed to happen?
- What actually happened?
- What went well?
- What are the areas for improvement?
- What is the improvement plan?

It is important that any hotwash occurs in a no-fault environment. The goal of any AAR/IP process is to identify successes so they can be leveraged for future planning and identify areas for improvement as part of a continuous quality improvement process for an organization. They should not be focused on any individual but rather on positions, processes, and outcomes. The success of any AAR/IP process relies on the support and encouragement of leadership to set the right tone and environment for a positive discussion and support for items identified in the improvement plan.

Discussion of "What was supposed to happen" involves documenting existing plans, procedures, and so forth that pre-identified actions to be taken during and after the response. Most plans, and checklists within those plans, are frameworks based upon planning assumptions, real-world experience, and other factors. It is important to identify what plans, procedures, and documents were used during the response, since real-world events rarely fit perfectly within a plan.

What actually happened involves the solicitation of this information through a variety of means in a no-fault environment. This information could come from sources such as:

- Electronic systems such as Incident Management Software, e-mails, etc.
- Incident documentation such as IAPs, Situation Reports, ICS Forms, GIS products developed during the response, etc.
- Human-source information derived from conducting hotwashes with those involved in the response.
- Depending on the scope and scale of the response, this can be obtained by everyone involved in the response, or representatives of the various agencies involved.
- Open-source information from public documents that were developed by outside parties during the response. This often includes items such as news articles, information shared by those involved in the response, etc.
- Community feedback and experiences gathered through surveys, forums, or direct interactions to understand the impact and effectiveness of the response from a public perspective.

What went well involves capturing the successful aspects of the response. It is important that these are documented so that they can be repeated in future responses. It also validates components of plans that may have only been previously validated by exercises. These aspects should be captured at the process level and not at the individual level. Again, the individual is

not what is being evaluated during the review process but rather the positions, procedures, tools that the individual uses, and training that was provided to the individual.

All responses have areas for improvement. The identification of these items does not reflect on the success or failure of the response, but rather the reality that responses rarely go as planned. These areas for improvement can help improve existing plans, improve future responses, and identify gaps in personnel and/or resources that could be addressed prior to the next response.

The improvement plan not only documents the areas identified for improvement but should also identify the responsible party to lead that improvement effort, the timeline for improvement, and any resources (personnel, budget, policy, procedure, etc.) that would be needed to accomplish that item.

While many entities develop AAR/IPs, long-term follow-up on the Improvement Plan is often lacking. Items in an improvement plan may take a week to implement or may involve a multi-year project. During that time, there may be additional AARs/IPs developed. It is good practice to track these items and ensure that they are completed. It is to be expected that some AAR/IP items cannot feasibly be accomplished for a variety of reasons; all items not achieved should be documented along with the reason(s) they could not be accomplished.

While AAR/IP reviews can often be led by internal entities, it is sometimes beneficial to leverage an outside entity to conduct the review. This provides an objective and neutral review of response, which can be accomplished by using an office within the organization that was not involved in the response, a different governmental agency that was not involved in the response, or an external entity with experience conducting AARs.

As previously discussed, it is important to ensure that an AAR/IP is completed, documented, and followed up on to help strengthen future responses, increase organizational resilience, and better serve the public.

Completing Post-Disaster Community Disaster Behavioral Health Needs Assessments

In order to effectively respond to the behavioral health needs of Arizona residents impacted by a disaster, the state should perform a post-disaster behavioral health needs assessment promptly following the event. The needs assessment, which utilizes a series of metrics related to disaster behavioral health to gather critical data, will help guide the response, ensuring resources are appropriately allocated and that services target populations in order of priority. The needs assessment can serve as a valuable tool for determining the scope of a disaster's impact on the behavioral health of a community, as well as the interventions and resources best suited for that population.

A post-disaster behavioral health needs assessment examines many aspects of a population's health, wellness, and ability to access and make use of vital health-related resources, including, but not limited to:

- **Prevalence of Disaster Behavioral Health Issues**: Includes assessing the overall incidence and prevalence of disaster behavioral health disorders or symptoms in the affected population.
- **Trauma Exposure:** Measures the extent to which individuals have been exposed to traumatic events, and the types of traumas experienced.
- **Symptoms of Psychological Distress:** Involves assessing symptoms of anxiety, depression, PTSD, and other psychological distress.
- **Grief and Loss:** Evaluates the impact of loss, including bereavement, and how it is affecting the disaster behavioral health of individuals.
- **Coping Mechanisms:** Assesses the strategies people are using to cope with the stress and emotional challenges resulting from the disaster.
- **Social Support and Community Resilience:** Reviews the availability of social support networks and community resources that can help individuals cope with disaster behavioral health challenges.
- **Vulnerable or At-Risk Groups:** Identifies specific groups that may be particularly vulnerable to behavioral health issues after a disaster, such as children, elderly, survivors of violence, and those with pre-existing disaster behavioral health conditions.
- **Access to Behavioral Health Services:** Evaluates the availability and accessibility of behavioral health services and resources in the affected areas.
- **Stigma and Barriers to Care:** Examines any social or cultural stigma associated with seeking disaster behavioral health support, as well as logistical or financial barriers to accessing care.
- **Substance Use and Abuse:** Reviews patterns of substance use and abuse as a coping mechanism and assesses the need for addiction support services.
- **Children and Adolescent Behavioral Health:** Specifically addresses the behavioral health needs of children and adolescents who may experience unique challenges post-disaster.
- **Cultural and Linguistic Considerations:** Evaluates how cultural and linguistic diversity may impact disaster behavioral health needs and the provision of services.
- **Long-term Disaster Behavioral Health Impact:** May assess the potential long-term effects on disaster behavioral health and the need for ongoing support and intervention.

Methods of data collection can include surveys, questionnaires, focus groups, forums, direct observations, and key informant interviews. Secondary data, such as demographic information, statistics, and damage assessment reports, may also be evaluated. Jurisdictions within the State of Arizona should choose an approach to conducting a needs assessment that is financially feasible, practical in implementation, and capable of yielding reliable results. In addition to considering each jurisdiction's community profile (see *Arizona Profile*), the state may consider using the PEM and "Needs Assessment Tool" described in this section. It should be noted here that if jurisdictions within Arizona and/or their jurisdictional partners wish to consider applying for federal CCP grants following a federally declared disaster, this information will also be

needed. Applicants seeking to secure CCP funding must include a community needs assessment in their application package to help strengthen their appeal for aid, as well as determine which populations should be prioritized in the response. More information about the federal CCP grants program and its requirements can be found on the SAMHSA website.

CONTINUITY OF OPERATIONS

Arizona has an existing *Continuity of Operations (COOP) Plan* that has identified how Essential Functions (EFs), and services will be prioritized following a disaster. COOP priorities for grant-related disaster behavioral health programs (if any at the time of the disaster) may also be considered as part of Arizona COOP activities.

Incorporation of Lessons Learned

Feedback from a diverse range of disaster behavioral health entities should be included in post-event analyses and reviews. Such input will assist in pinpointing best practices, lessons gleaned, and aspects of this Framework that require enhancement.

In addition to actual events, AARs/IPs are prepared after exercises to identify areas of strength and areas needing improvement. The IP also identifies a plan for implementing recommended actions – including those needed to improve the disaster behavioral health response.

APPENDICES

APPENDIX A – DEFINITION OF TERMS AND ACRONYMS

Definitions and an explanation of acronyms used throughout the Framework.

ACRONYMS	DEFINITIONS
ACC-RBHA	Arizona Health Care Cost Containment System Complete Care - Regional Behavioral Health Agreements
ADHS	Arizona Department of Health Services
ADOA	Arizona Department of Administration
AHCCCS	Arizona Health Care Cost Containment System
APA	American Psychological Association
ARC	American Red Cross
ASL	American Sign Language
AZMAC	Arizona Mutual Aid Compact
AZ VOAD	Arizona Voluntary Organizations Active in Disaster
AzCH-CCP	Arizona Complete Health - Complete Care Plan
AzHAN	Arizona Health Alert Network
AzEIN	Arizona Emergency Information Network
BHP	Behavioral Health Professional
BHPP	Behavioral Health Paraprofessional
BHT	Behavioral Health Technician
BPHEP	Bureau of Public Health Emergency Preparedness
BSCA	Bipartisan Safer Communities Act
CCP	Crisis Counseling Assistance and Training Program
CEMP	Comprehensive Emergency Management Plan
CERC	Crisis Emergency Risk Communication
CERT	Community Emergency Response Team
CIT	Crisis Intervention Techniques
CMT	Crisis Mobile Team
COOP	Continuity of Operations
CPT	Cognitive Processing Therapy
CRC	Community Resilience Center
DCI	Disaster Crisis Intervention
DEMA	Arizona Department of Emergency and Military Affairs
DGI	Division of Grants and Innovation
DRC	Disaster Recovery Center
EAP	Employee Assistance Program
EBS	Emergency Bulletin System
EMAP	Emergency Management Accreditation Program
EMDR	Eye Movement Desensitization and Reprocessing
EOC	Emergency Operations Center

ACRONYMS	DEFINITIONS
ESF	Emergency Support Function
FAC	Family Assistance Center
FEMA	Federal Emergency Management Agency
FEP	First Episode Psychosis
FRC	Family Reunification Center
GSP	Gross State Product
HSEEP	Homeland Security Exercise and Evaluation Program
HSP	Health Services Portal
IAP	Incident Action Plan
IC	Incident Commander
ICP	Incident Coordination Plan
ICS	Incident Command System
IGA	Intergovernmental Agreement
IHS	Indian Health Services
ISOC	Integrated System of Care
JIS	Joint Information System
KPI	Key Performance Indicator
LMS	Learning Management System
M&E	Monitoring and Evaluation
MHFA	Mental Health First Aid
MRC	Medical Reserve Corps
NCTSN	National Child Traumatic Stress Network
NERT	Neighborhood Emergency Response Team
NIHB	National Indian Health Board
NVOAD	National Voluntary Organizations Active in Disaster
OVC TTAC	Office for Victims of Crime Training & Technical Assistance Center
PE	Prolonged Exposure Therapy
PEM	Population Exposure Model
PFA	Psychological First Aid
PIO	Public Information Officer
PTSD	Post-Traumatic Stress Disorder
RSS	Receiving, Shipping, and Storing
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	Serious Emotional Disturbance
SERRP	State Emergency Response and Recovery Plan
SMART	Specific, Measurable, Achievable, Relevant, and Time-bound
SMI	Serious Mental Illness
SPR	Skills for Psychological Recovery
TIC	Trauma-Informed Care

ACRONYMS	DEFINITIONS
TF-CBT	Trauma-Focused Cognitive Behavioral Therapy
TSQ	Trauma Screening Questionnaire

APPENDIX B – LIST OF CONTACTS

KEY CONTACTS	
HEALTH PLANS	
American Indian Health Program	Call: 1-602-417-7100 (For Area Codes: 602, 480, or 623) Call: 1-800-334-5283 (For Area Codes: 928 or 520)
Arizona Complete Health - Complete Care Plan	Call 1-888-788-4408
Banner-University Family Care	Call 1-800-582-8686
Care1st Health Plan	Call 1-866-560-4042
Molina Healthcare	Call 1-800-424-5891
Mercy Care	Call 1-800-624-3879
Health Choice Arizona	Call 1-800-322-8670
UnitedHealthcare Community Plan	Call 1-800-348-4058
DGI CRISIS TEAM	
Provides oversight of Arizona's crisis system, management of crisis-related grant projects, and statewide crisis data. Email: dga.crisis@azahcccs.gov	
AHCCCS CONTACTS	
An updated list of AHCCCS contacts is located on the AHCCCS website.	
DIVISION OF COMMUNITY ADVOCACY AND INTERGOVERNMENTAL RELATIONS (DCAIR)	
The Division of Community Advocacy and Intergovernmental Relations houses all of the functions that interface with members, family members, and other stakeholders. DCAIR is available to provide education, receive feedback, and facilitate and participate in workgroups for specific issues and includes the following offices: ● Office of Individual and Family Affairs (OIFA): Promotes recovery, resiliency, and wellness for individuals with mental health and substance use challenges. Each OIFA team member has lived experience with behavioral health challenges, either from their own experiences of recovery or from directly supporting someone through their recovery. Email: oifa@azahcccs.gov ● Office of Human Rights (OHR): Responsible for providing assistance to AHCCCS members living with Serious Mental Illness. The OHR works within the Medicaid agency to promote the rights of members and ensure access to entitled services under Arizona's Medicaid program. The OHR is directly responsible for ensuring that members who are identified as in need of Special Assistance are promptly identified and formally assigned a designated representative to assist them in participating in treatment planning, discharge planning, the SMI appeal, grievance, and investigation processes. Email: ohrts@azahcccs.gov	
Red Cross Central and Northern Arizona Chapter	

Greater Phoenix (Regional Chapter)
4747 North 22nd Street, Suite 100, Phoenix, AZ 85016
Phone: (602) 336-6660
Flagstaff Office
1750 Railroad Springs Blvd Suite 1, Flagstaff, AZ 86001
Phone: (928) 779-5494
Red Cross Southern Arizona Chapter
3470 E. Universal Way, Tucson, AZ 85756
Phone: (520) 318-6740
Crisis Hotlines
National 24-Hour Crisis Hotlines
Phone ● 988 Suicide & Crisis Lifeline: 988 ● National Substance Use and Disorder Issues Referral and Treatment Hotline: 1-800-662-HELP (4357)
Text ● Send a text to 988 ● Text the word "HOME" to 741741
Chat ● 988 Lifeline Chat
Videophone: Select ASL NOW at the bottom of the page to connect with a 988 Lifeline counselor.
Arizona Statewide Crisis Hotline
● Phone: 1-844-534-HOPE (4673) ● Text: 4HOPE (44673) ● Chat: Chat with a Crisis Specialist
Suicide and Crisis Hotlines by County and Tribal Nation
● Apache County: Arizona Complete Health - Complete Care Plan 1-866-495-6735 ● Cochise County: Arizona Complete Health - Complete Care Plan 1-866-495-6735 ● Coconino County: Care1st 1-877-756-4090 ● Gila County: Mercy Care 1-800-631-1314 ● Graham County: Arizona Complete Health - Complete Care Plan 1-866-495-6735 ● Greenlee County: Arizona Complete Health - Complete Care Plan 1-866-495-6735 ● La Paz County: Arizona Complete Health - Complete Care Plan 1-866-495-6735 ● Navajo County: Care1st 1-877-756-4090 ● Maricopa County: Mercy Care 1-800-631-1314 ● Mohave: Care1st 1-877-756-4090 ● Pima County: Arizona Complete Health - Complete Care Plan 1-866-495-6735

• Pinal County: Mercy Care 1-866-495-6735 • Santa Cruz County: Arizona Complete Health - Complete Care Plan 1-866-495-6735 • Yuma County: Arizona Complete Health - Complete Care Plan 1-866-495-6735 • Yavapai County: Care1st 1-877-756-4090 • Ak-Chin Indian Community: 1-800-259-3449 • Gila River Indian Community: 1-800-259-3449 • Salt River Pima Maricopa Indian Community: 1-855-331-6432 • Tohono O'odham Nation: 1-844-423-8759
Especially for Teens
• Teen Lifeline phone or text: 602-248-TEEN (8336)
Especially for Veterans
• Veterans Crisis Line: 988 (press 1) • Be Connected:1-866-4AZ-VETS (429-8387)

APPENDIX C – STATE OF ARIZONA DISASTER BEHAVIORAL HEALTH PARTNER AGENCIES

STATE OF ARIZONA DISASTER BEHAVIORAL HEALTH PARTNER AGENCIES
Arizona Health Care Containment Cost system (AHCCCS)
Arizona Department of Health Services (ADHS)
Arizona Hospital And Healthcare Association (AzHHA)
Arizona Voluntary Organizations Active in Disaster (AZ VOAD)
Community Behavioral Health Providers
County and State Emergency Management
Arizona Department of Emergency and Military Affairs (DEMA)
Faith-based Organizations
Federal Partners - The Federal Emergency Management Agency (FEMA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) sometimes work with states on disaster behavioral health initiatives.
Local County Health Departments
AHCCCS Complete Care, Regional Behavioral Health Agreements (ACC-RBHAs), and Tribal Regional Behavioral Health Authorities (TRBHAs)
The American Red Cross (ARC) in Arizona
Tribal Nations
Universities and Academic Institutions

APPENDIX D – RESOURCES FOR DISASTER BEHAVIORAL HEALTH

Federal/National Resources

- American Psychological Association (APA) Disaster Resources: Recovering emotionally from disaster (apa.org)
- American Red Cross – Disaster Mental Health program: Disaster Mental Health | American Red Cross
- American Red Cross – Coping with Disasters Resources: Emotional Recovery | Disaster Relief | Red Cross
- ASPR-TRACIE (Healthcare Emergency Preparedness Information Gateway) Disaster Behavioral Health Resources: Disaster Behavioral Health | ASPR TRACIE (hhs.gov)
- SAMHSA Disaster Technical Assistance Center (DTAC): Disaster Technical Assistance Center (DTAC) | SAMHSA
- National Center for Child Traumatic Stress Network (NTCSN): The National Child Traumatic Stress Network | (nctsn.org)
- National Center for PTSD: National Center for PTSD Home (va.gov)
- U.S. Department of Veterans Affairs VA/DoD Clinical Practice Guidelines, Management of Posttraumatic Stress Disorder and Acute Stress Disorder Evidence-Based Practice: Management of Posttraumatic Stress Disorder and Acute Stress Disorder 2023 – VA/DoD Clinical Practice Guidelines
- AZ REACH: https://az-reach.com/
- WRAP-EM Pediatric Surge Playbook: https://wrap-em.org/index.php/jit-resources/pediatric-surge-playbook
- PsySTART: https://www4.psystart.net/ (Part of a comprehensive solution rapid mental health triage system: Provides solutions to link mental health to disaster systems of care in real time, enabling mental health triage and supporting decision-making at the point of care and in developing population-based IAP actions. PsySTART is cloud-based and has a smartphone application).

PTSD Clinical Practice Guidelines

- American Psychology Association: https://www.apa.org/ptsd-guideline

California Resources

- California Association of Marriage and Family Therapists (CAMFT) Crisis Response Education Resources: Crisis Response (camft.org)
- California Disaster Behavioral Response Plan (2020): California Disaster Behavioral Health Plan
- California Public Health and Medical Emergency Operations Manual: FinalEOM712011.pdf (ca.gov)

Community Disaster Behavioral Health Education Resources

- American Red Cross "Coping with Disaster" Materials: https://www.redcross.org/get-help.html
- SAMHSA DTAC: https://www.samhsa.gov/dtac

- NTCSN: https://www.nctsn.org/
- National Center for PTSD: https://www.ptsd.va.gov/
- ASPR TRACIE: https://asprtracie.hhs.gov/dbh-resources
- Professional organizations including CAMFT: https://www.camft.org/Resources/Crisis-Response-Education-and-Resources-Program/Resources-Knowledge-Acquisition

Resources for Hospital Disaster Behavioral Health Response Planning

- HHS ASPR TRACIE Behavioral Health Resource and Guides for Planners: https://aspr.hhs.gov/behavioral-health/Pages/default.aspx
- Planning for Psychiatric Patient Movement During Emergencies and Disasters: https://aspr.hhs.gov/behavioral-health/Pages/Psychiatric-Patient-Movement.aspx
- Disaster Behavioral Health Capacity Assessment Tool: https://aspr.hhs.gov/behavioral-health/documents/dbh-capacity-tool.pdf
- Disaster Behavioral Health Coalition Guidance: https://aspr.hhs.gov/behavioral-health/documents/dbh_coalition_guidance.pdf
- American Indian and Alaskan Native Disaster Preparedness Resource: https://aspr.hhs.gov/behavioral-health/Pages/tribal-preparedness.aspx
- 2016 HHS Disaster Behavioral Health Concept of Operations: https://aspr.hhs.gov/behavioral-health/documents/dbh-conops-2016.pdf
- Los Angeles County Department of Health Services Emergency Medical Services Agency: Family Information Planning Guide for Healthcare Entities: https://asprtracie.hhs.gov/technical-resources/resource/569/family-information-center-planning-guide-for-healthcare-entities

Resources For Meeting the Needs of People with Access and Functional Needs Following Disasters

- HHS ASPR TRACIE Topic Collections -Populations with Access and Functional Needs: https://asprtracie.hhs.gov/technical-resources/62/populations-with-access-and-functional-needs/0
- HHS ASPR TRACIE – Durable Medical Equipment in Disasters: https://files.asprtracie.hhs.gov/documents/aspr-tracie-durable-medical-equipment-in-disasters.pdf
- Substance Abuse and Mental Health Administration (SAMHSA) Disaster Technical Assistance Center - People with Access and Functional Needs: https://www.samhsa.gov/dtac/disaster-planners/special-populations

Resources for Meeting the Needs of LGBTQI+ People During Disasters

- ASPR TRACIE Topic Collection: The LGBTQI+ Community and Disaster Preparedness and Response: https://asprtracie.hhs.gov/technical-resources/160/the-lgbtqi-community-and-disaster-preparedness-and-response/0#general-resources
- ASPR Preparedness and Response: Meeting the Needs of LGBTQI+ Individuals During Disasters and

Emergencies: https://aspr.hhs.gov/at-risk/Pages/Meeting-LGBTQ-Needs-During-Disasters-and-Emergencies.aspx

- Human Rights Campaign - A Cultural Competence Guide for Emergency Responders and Volunteers: https://assets2.hrc.org/files/assets/resources/EmergencyResponders_-_LGBT_Competency.pdf?_ga=2.22735288.2069012471.1529708927-344055508.1529337978
- HHS ASPR TRACIE, Los Angeles County Department of Mental Health – Providing Effective Services to Members of the LGBTQI2-S Community Following Disasters, Public Health Emergencies, and Mass Fatality Events: Providing Effective Services to Members of the LGBTQI2-S Community Following Disasters, Public Health Emergencies and Mass Fatality Events (hhs.gov)

Resources For The Behavioral Health Impacts Of Climate Change

- American Psychological Association (APA) Mental Health and Our Changing Climate – Impacts, Inequities, and Responses (2021): Mental Health and Our Changing Climate: Impacts, Inequities, and Responses (apa.org)
- American Psychological Association (APA) Addressing the Climate Crisis – An Action Plan for Psychologists (2022): Addressing the Climate Crisis: An Action Plan for Psychologists (apa.org)

Disaster Behavioral Health Training and Resources

- SAMHSA DBHIS - Contains resources and toolkits in disaster behavioral health. Resources focus on specific populations, disaster types, or other topics pertinent to disaster behavioral health preparedness, response, and recovery. https://www.atsdr.cdc.gov/stress/resources/pages/017.html
- Center for the Study of Traumatic Stress and the National Center for Disaster Medicine and Public Health – Curriculum Guidance for Disaster Behavioral Health (2020): Curriculum Recommendations for Disaster Health Professionals: Disaster Behavioral Health — Center for the Study of Traumatic Stress (cstsonline.org)
- American Red Cross Psychological First Aid Course – Supporting Yourself and Others During COVID-19 Psychological First Aid Online Course | Red Cross
- Listen, Protect and Connect: Family to Family, Neighbor to Neighbor, Psychological First Aid for the Community Helping Each Other: Listen, Protect and Connect Brochure (ready.gov)
- Listen, Protect and Connect for Children and Parents: PFA Mobile | VA Mobile
- Listen, Protect and Connect: Psychological First Aid for Teachers and Schools: Listen, Protect, Connect - Model & Teach, Psychological First Aid (PFA) for Students and Teachers (ready.gov)
- Psychological First Aid (NCTSN) Psychological First Aid (PFA) Online | The National Child Traumatic Stress Network (nctsn.org)
- Psychological First Aid (NCTSN) Manual: Psychological First Aid (PFA) Field Operations Guide: 2nd Edition | The National Child Traumatic Stress Network (nctsn.org)
- Psychological First Aid Mobile APP: PFA Mobile | VA Mobile

- Skills for Psychological Recovery (SPR): Skills for Psychological Recovery (SPR) Online | The National Child Traumatic Stress Network (nctsn.org)
- Skills for Psychological Recovery (SPR) Manual: Skills for Psychological Recovery: Field Operations Guide - PTSD: National Center for PTSD (va.gov)
- World Health Organization – Problem Management Plus (PM+): Individual Psychological Health for Adults Impaired by Disasters in Communities Exposed to Adversity Manual (similar to SPR and available in 19 languages): https://www.who.int/publications/i/item/WHO-MSD-MER-16.2

Disaster Resiliency Resources for Employees

- HHS ASPR TRACIE Mini Modules to Relieve Stress for Healthcare Workers: https://files.asprtracie.hhs.gov/documents/aspr-tracie-mini-modules-to-relieve-stress-for-healthcare-workers-responding-to-covid-19.pdf
- HHS ASPR TRACIE COVID-19 Health Professional Stress and Resilience: https://files.asprtracie.hhs.gov/documents/aspr-tracie-the-exchange-issue12-final.pdf
- Substance Abuse and Mental Health Administration (SAMHSA) Disaster Technical Assistance Center – Responder Stress Management: https://www.samhsa.gov/dtac/disaster-response-template-toolkit/disaster-responder-stress-management
- U.S. Surgeon General's Framework for Workplace Mental Health and Well Being (2022): https://www.hhs.gov/sites/default/files/workplace-mental-health-well-being.pdf

Resources For Terrorism And Mass Violence Incidents

General Resources	
Resource	Summary
Restoring a Sense of Safety in the Aftermath of a Mass Shooting: Tips for Parents and Professionals – Center for the Study of Traumatic Stress	This document provides tips and resources to relieve stress and create a sense of safety for children after a mass shooting.
First Response to Victims of Crime – Office for Victims of Crime (OVC)	This document is a handbook for law enforcement officers to help better understand and meet the needs of survivors of crime. This document contains general guidelines and tips, as well as individual sections on responding to survivors of particular crimes and to specific populations of survivors.
OVC TTAC Helping Victims of Mass Violence & Terrorism Toolkit	The Toolkit was created for communities to prepare for and respond to survivors of mass violence and terrorism. This toolkit contains resources for: ● Partnerships & Planning

	• Response • Recovery
OVC TTAC Response and Recovery Framework for Incidents of Mass Violence and Terrorism	This document provides points of consideration and examples of a Response and Recovery Framework for the federal, state, and local resources that will work together to help the whole community following an MFI/MCI event.
Responding to Victims of Terrorism and Mass Violence Crimes – OVC	This document supports the important working relationship of OVC and the American Red Cross and provides ARC staff and volunteers with information about crime victims' rights and needs, how to assist survivors of terrorism and mass violence crimes, OVC's services, and types of crime victim assistance and services.
OVC Handbooks for Coping After Terrorism: A Guide for Healing and Recovery	This document offers suggestions to aid survivors' recoveries after an act of terror or mass violence.
Tips for Healthcare Facilities: Assisting Families and Loved Ones after a Mass Casualty Incident – ASPR TRACIE	This tip sheet highlights best practices and issues related to planning for, activating, and operating hospital or health care facility Family Information Centers (FIC)/ Family Support Centers (FSC), in collaboration with Family Reception Centers (FRCs) and FACs. This document provides general considerations for hospital and other community health care response providers during planning, response, and recovery efforts.
Responding to Terrorism Victims: Oklahoma City and Beyond - OVC	This report identifies the special measures needed to protect the rights and meet the needs of survivors of a large-scale terrorist attack involving mass casualties. It demonstrates efforts required to ensure an effective response to survivors' rights and their short- and long-term emotional and psychological needs as an integral part of a comprehensive response to terrorism cases involving mass casualties.
Responding to September 11 Victims: Lessons Learned From the States - OVC	This monograph reflects OVC's frontline perspective and offers lessons for state, federal, and private decision-makers on organizing effective responses to mass criminal victimization.
Planning How to Cope with Commemorations, Special Events, and Timeframes that Activate Trauma Memories	This tip sheet describes the signs and risk factors for managing commemorative events, holidays, and other special timeframes that may bring distressing memories and reactions for a traumatic event.
Tips for Survivors of a Disaster or Other	This tip sheet covers signs and symptoms of traumatization, as well as how to know if you may benefit from more help and guidance on how to manage it.

Traumatic Event: Coping with Retraumatization	
Light Our Way: A Guide for Spiritual Care in Times of Disaster for Disaster Response Volunteers, First Responders and Disaster Planners	The document provides basic concepts of Spiritual Care in disasters including types of Spiritual Care, relationship of Spiritual Care with mental health providers, training, etc.
Mass Shooting Playbook: A Resource for U.S. Mayors and City Managers	This document was developed by the Public Health Advocacy Institute and provides a framework for mayors and elected officials on how to respond to a public mass shooting.

Recommended Readings in Disaster Behavioral Health

- Flynn B, Sherman R. (2017). Integrating Emergency Management and Disaster Behavioral Health: One Picture Through Two Lenses. Massachusetts: Butterworth-Heinemann Publishing.
- Schmidt, RA and Cohen, SL. (2020) Disaster Mental Health Community Planning: A Manual for Trauma-Informed Collaboration (1st ed.). New York: Routledge.
- Stebnicki, MA. (2017). Disaster Mental Health Counseling: Responding to Trauma in a Multicultural Context. New York: Springer Publishing.
- Young B, Ford JD, Ruzek JI, Friedman MJ, & Gusman FD, Disaster Mental Health Services: A Guidebook for Clinicians and Administrators. Washington DC: The National Center for Post-Traumatic Stress Disorder Education and Clinical Laboratory. This guidebook is available at no cost online at https://www.hsdl.org/?view&did=441325

APPENDIX E – DISASTER BEHAVIORAL HEALTH UNIT LEADER JOB ACTION SHEET TEMPLATE

This job action sheet will outline the roles and responsibilities of the Level 1, Level 2, and Level 3 Disaster Behavioral Health responders during the short-term and long-term recovery stages and mitigation stages after an emergency event.

MENTAL HEALTH UNIT LEADER – EOC

Mission:	Provides behavioral health guidance and recommendations to the Operations Section Chief based on response needs and potential triggers of psychological effects (e.g., trauma exposure, perceived risk to staff and family, restrictions on movement[89], resources limitations, and information unavailability). Duties include: ● Organize the Mental Health Team, ● Provide policy guidance and direction to Mental Health Staff working with the community and staff, ● Act as a liaison to the Personnel Unit Leader to monitor staff coping skills, and ● Work with a Liaison Officer to coordinate with mental health community providers for services during and after the incident.

Date:		**Start:**	**End:**
Name of Person Assigned to Position:			
Phone:		**Email:**	
Location:			
Signature:		**Initials:**	

[89] During a large-scale disaster, emergency responders may need to impose movement restrictions on individuals or groups. These response actions affect how people interact physically and verbally with others and include isolation, shelter-in-place, decontamination, quarantine, increased social distances, and evacuation" page E2 Meredith LS, Eiseman DP, Tanielian T, Taylor SL, Basurto-Davila R, Zazzali JL, Diamond D, Cienfuegos B, Shields, S (2010) Prioritizing “Psychological” Consequences for Disaster Preparedness and Response: A Framework for Addressing the Emotional, Behavioral, and Cognitive Effects of Patient Surge in Large-Scale Disasters. Disaster Medicine and Public Health Preparedness, 2010;4:doi:10.1001/dmp.2010.47

What to Take with You to the EOC
Plans ● Arizona Public Health Department Multi-Hazard Emergency Operations Plan/Emergency Operations Manual ● Arizona State Emergency Response and Recovery Plan (SEERP) ● Arizona Emergency Response Plan ● Key Contacts ● Organizational Partners in Arizona who can assist with Disaster Behavioral Health ● American Red Cross Disaster Mental Health Lead ● Arizona Department of Health Services ● Self-Care ● Dress in layers and be prepared for a hot or cold room. ● Bring your tennis shoes. ● Bring water, snacks, pack lunch and/or dinner. ● Bring one item that makes you smile. ● Continue your stress management routine, including telling your "support system" that you are working on a disaster and will need their help.
What to Do when You Arrive at the EOC
● Check in and be sure to sign in/out on the staff roster daily. ● Obtain an ICS 214 "Activity Log form" and maintain it every day to record key decisions and activities. (This form is sometimes done virtually. Ask the Documentation Unit Leader.) ● Check in with the Operations Section Chief and obtain a briefing on the incident. Discuss disaster mental health priorities, expectations, vision, resources, and direction. ● Introduce yourself to key EOC partners including everyone in the Operations Section, Public Information Officer, Safety Officer, and Personnel Unit Leader. ● Determine what EOC and partner organization meetings (including MHOAC partner meetings if appropriate) that you should be attending to maintain situational awareness and information sharing.
Immediate Tasks
● Notify key partners that you have been activated. ● Determine who will be providing Psychological First Aid (PFA) and mental/behavioral health support to EOC staff when needed. It will be you, or you may need to request disaster mental health support from the EOC. ● Meet with the EOC Safety Officer to determine what disaster mental health reminders for staff should be included in the regular safety briefing. ● Determine what "coping with disaster" materials you want to use (or need to create) to address the immediate mental health impacts of the disaster, including "coping with disasters" materials you would like to use for staff and meet with the

Public Information Officer to determine the strategy to distribute "coping with disaster" messaging.

- Meet with the Personnel Unit Leader to determine what disaster mental health "coping materials" may be needed for Arizona Employees, including obtaining a flyer or strategy to refer staff to the EAP in a convenient and non-stigmatizing manner.
- Work with the appropriate EOC Operations Staff, community partner organizations, and MHOAC partners to complete a Community Needs Assessment of the disaster mental health impact on residents of the City of Pasadena, vulnerable population groups including people with access and functional needs, Arizona Staff. Provide this information in EOC briefings.
- Work with the Operations Chief to identify disaster behavioral health objectives, tasks, and problems that need to be added to the Incident Action Plan (IAP).
- Maintain situational awareness of behavioral health impacts throughout the incident.
- Meet with the Operations Section Chief to determine mental health staffing and resource needs. Determine if a mutual aid request needs to be made through the MHOAC program

Ongoing Disaster Mental Health Tasks

Review the Disaster Behavioral Health Framework section: Considerations for a Phased Approach for Disaster Mental Health. Determine what tasks, strategies, and objectives should be used for each phase (Level) of the disaster response. (For ease of use of this checklist, the phased approach levels in the plan have been excerpted here.)

Level 1 (Provide Immediate Support)

Strategies to consider in Level I include:

- Work proactively with community partners to assess potential disaster mental health consequences and identify communities impacted and languages and best strategies to provide disaster mental health information, including virtual and/or in-person community meetings, etc.
- Develop new materials and/or add links to the ADHS website with relevant "coping with disaster" information from county and community-based partner organizations.
- Add a link to the SAMHSA National Disaster Distress Helpline: https://www.samhsa.gov/find-help/disaster-distress-helpline
- Provide "coping with disaster/responder stress" materials to employees, including contact information for the Employee Assistance Program.
- Use the appropriate social media strategies to provide key mental health "coping" messages and links to resources.
- Support efforts to provide Psychological First Aid (PFA) to impacted people and groups including Arizona employees.
- Continue to provide credible and timely information about the disaster and publicizing where people can go to obtain disaster recovery assistance.

Level 2 (Improve Coping and Strength-Based Skills)

Strategies to consider for Level 2 may include:

- Continue to refine and support the provision of Level 1 strategies, including proactively updating and modifying information as the need arises.
- Work with county and community partners to identify resources for crisis counseling and brief mental health services. (Please note that the "brief counseling services" discussed here focus on the psychological impact of the event and the reduction of continuing stress reactions and problems, not "mental illness".)
- Continue to provide "coping", stress management, and "burnout prevention" information (and training if appropriate) relevant to staff, including continuing to publicize the EAP.
- Consider supporting the training for, and provision of, Skills for Psychological Recovery (SPR)[90] groups in Arizona for survivors and responders.
- Consider supporting and/or publicizing virtual or in-person grief groups for those who suffered the loss of family member(s) including pets because of the disaster.
- Assess if more behavioral health resources are needed to address post-disaster mental health needs of the community and staff.

Level 3 (Continue to Provide Care to Those Affected)

Strategies to consider for Level 3 may include:

- Continue to refine and support the provision of Level 1 and 2 strategies, including proactively updating and modifying information as the need arises.
- Continue to provide "coping" information relevant to staff, including continuing to publicize the EAP.
- Work with county and community partners to identify resources for longer-term mental health support for disaster survivors, including identifying resources for employees who need assistance beyond what the EAP program can provide.
- Consider applying for any available grant funding for additional mental health services for disaster survivors and other vulnerable groups.
- Support the identification and provision of mental health "coping" information and support for ongoing events to commemorate the anniversary of the disaster in the years to come.
- Continue to work with county and community partners to identify needs and the resources available.

Closing Tasks

- Complete any meetings, tasks, and documentation needed to close out your function in the EOC.
- Ensure that there is a plan in place for ongoing mental health support for the community and also outgoing EOC staff.
- Notify key partners that your position has concluded in the EOC, as appropriate.

[90] Skills for Psychological Recovery (SPR)

- Turn in all your 214s.
- Brief the Operations Section Chief on any current problems, outstanding issues, and follow-up tasks.
- Ask for an EOC performance evaluation, (ICS 255 Incident Personnel Performance Rating Form), if appropriate.
- Return any equipment and supplies you obtained during the activation.
- Submit comments to the EOC/EOC Manager for discussion and possible inclusion in an after-action report; topics include:
  - Review of pertinent position descriptions and operational checklists,
  - Recommendations for procedure changes,
  - Section accomplishments and issue, and
  - Participate in after-action meetings and debriefings as required.
- Most important:
  - Activate your personal self-care plan including taking time off, talking with your support system, and maintaining your stress management strategies.
  - Be sure to ask for additional mental health assistance or follow up for yourself as needed.

APPENDIX F – LIST OF PARTICIPANTS

The Arizona Health Care Cost Containment System (AHCCCS) engaged Health Management Associates (HMA) and CONSTANT to conduct a statewide assessment of current mental health emergency disaster response preparedness and response activities and plans in Arizona. To fulfill this commitment, the team performed an environmental scan of publicly available plans and convened focus groups with key stakeholders and individuals and families in Arizona.

The assessment and framework would not have been possible without the numerous stakeholders who participated in data collection. These agencies include the Arizona Department of Human Services (ADHS), Arizona Department of Emergency and Military Affairs (DEMA), AHCCCS Complete Care, Regional Behavioral Health Agreements (ACC-RBHAs), Crisis Collaborators, county and state emergency management, individuals and families, Tribal nations, and Public Health Emergency Preparedness (PHEP) Coordinators. Please see the full list of participants below.

Name	Contribution
Adriana Akinwande	Advisory Group
Alana Brunacini	Focus Group
Alexis Baron	Advisory Group
Ana Corcoran	Focus Group
Antonio Hernandez	Advisory Group
Ashley Dickson	Focus Group
Aurora Torrez	Focus Group
Blake Scott	Advisory and Focus Groups
Brian Ornelas	Focus Group
Brianna Barrios	Focus Group
Bruce Koyiyumptewa	Focus Group
Bruce Tucker	Focus Group
Bruce Westberg	Focus Group
Bryan Gest	Advisory Group
Buzz Hickox	Focus Group
Carl Melford	Focus Group

Name	Contribution
Carrie Pastella	Advisory Group
Catherine Barney	Focus Group
Christina Arredondo	Focus Group
Ciera Hensley	Focus Group
Claribel Martinez	Focus Group
Colin Keating	Focus Group
Cynthia Meyers	Advisory and Focus Groups
Dan Landers	Focus Group
Dana Gavin	Focus Group
Dane Binder	Focus Group
Daniel Wilkey	Focus Group
Daren Fry	Advisory and Focus Groups
Dawn Wilson	Focus Group
Dean Wenrich	Focus Group
Debbie Weichert	Focus Group
Edward Gentile	Focus Group
Elizabeth Jimenez	Focus Group
Eric Lee	Advisory and Focus Groups
Fernando Careaga	Advisory Group
Fernando Silvas	Focus Group
Frank O'Halloran	Focus Group
Gabriel Wright	Advisory Group
Gene Cavallo	Focus Group
Gene Holt	Focus Group
Hailey Owen	Focus Group
Hal Nevitt	Advisory and Focus Groups

Name	Contribution
Jenifer Kent	Focus Group
Jessica Willard	Advisory Group
Joseph Hemphill	Focus Group
Julie Cota	Focus Group
Kat Satava	Advisory Group
Kayla Navarro	Focus Group
Kevin Curiel	Focus Group
Kris Carlson	Focus Group
Krysti Hesse	Focus Group
Kym O'Farrell	Advisory and Focus Groups
Laura Santa Cruz	Focus Group
Lori Bachman	Focus Group
Lynn Harlow-Smith	Focus Group
Margie Balfour	Advisory and Focus Groups
Maria Alvarado-Roger	Focus Group
Maria Figueroa	Focus Group
Maria Garvin	Focus Group
Marisela Fisher	Focus Group
Melissa Del-Colle	Focus Group
Melissa Dye	Focus Group
Melissa Register	Focus Group
Michelle Nieuwenhuis	Focus Group
Nancy Neal	Focus Group
Nicole Guzman	Focus Group
Rebecca Robles	Focus Group
Rita Udall	Focus Group

Name	Contribution
Roxanne Pergeson	Focus Group
Ryan Cluff	Focus Group
Sam Torres	Focus Group
Sarah Blanka	Focus Group
Sarah Curiel	Advisory and Focus Groups
Sarah Herndon	Focus Group
Savannah Barajas	Focus Group
Scott Poche	Focus Group
Scott Wright	Advisory and Focus Groups
Tamika Sullivan	Focus Group
Tania Long	Focus Group
Tenasha Hildebrand	Focus Group
Tracie Crater	Focus Group
Tyson Gillespie	Focus Group
Vanessa Seaney	Focus Group
Wendy Dittbrenner	Focus Group
Wendy Tatum	Focus Group

APPENDIX H – FEMA ICS ACTION PLANNING FORMS

FEMA ICS FORMS
• ICS Form 201, Incident Briefing (v3).pdf
• ICS Form 202, Incident Objectives (v3.1).pdf
• ICS Form 203, Organization Assignment List (v3).pdf
• ICS Form 204, Assignment List (v3.1).pdf
• ICS Form 205, Incident Radio Communications Plan (v3.1).pdf
• ICS Form 205A, Communications List (v3).pdf
• ICS Form 206, Medical Plan (v3).pdf
• ICS Form 207, Incident Organization Chart (v3).pdf
• ICS Form 208, Safety Message-Plan (v3.1).pdf
• ICS Form 208HM, Site Safety and Control Plan (v3).pdf
• ICS Form 209, Incident Status Summary (v3).pdf
• ICS Form 210, Resource Status Change (v3).pdf
• ICS Form 211, Incident Check-In List (v3.1).pdf
• ICS Form 213, General Message (v3).pdf
• ICS Form 213RR, Resource Request Message (v3).pdf
• ICS Form 214, Activity Log (v3.1).pdf
• ICS Form 215, Operational Planning Worksheet (v3).pdf
• ICS Form 215A, Incident Action Plan Safety Analysis (v3).pdf
• ICS Form 217A, Communications Resource Availability Worksheet (v3).pdf
• ICS Form 218, Support Vehicle/Equipment Inventory (v3).pdf
• ICS Form 221, Demobilization Check-Out (v3).pdf
• ICS Form 233CG, Incident Open Action Tracker (v3).pdf
• ICS Form 230CG, Daily Meeting Schedule (v3).pdf
• ICS Form 260, Resource Order.pdf

APPENDIX G – AHCCCS CONTRACT AND POLICY DICTIONARY

AHCCCS Contract and Policy Dictionary

APPENDIX H – AHCCCS CRISIS SYSTEM FAQs

AHCCCS Crisis System FAQs

APPENDIX I – 2022 ARIZONA VOAD MEMBERSHIP LIST

To review the Arizona VOAD Membership list check the following link:
https://www.azvoad.org/wp-content/uploads/2022/03/2022-AZ-VOAD-Membership-List.pdf