

SCDMH All Hazards Disaster Response Plan



August, 2006

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH Office of the Medical Director

M E M O R A N D U M

TO: DMH Administration Division Directors, Community Mental Health Center Directors, Hospital Directors

FROM: Ed Spencer, M.Ed., MSW
Manager, Emergency Preparedness Planning and Response

SUBJECT: State Mental Health Disaster Recovery Plan: An All Hazards Approach

DATE: June 1, 2006

Enclosed are important additions to the DMH Disaster Response Plan including the national Operating Conditions (OPCON) structure, specifics regarding the preparation of DMH response teams (Away Teams) and community recovery strategies. This material has been developed in conjunction with changes within the Emergency Response Plan of the SC Emergency Management Division. Orientation and Training on will be provided to center and hospital Disaster Coordinators in January 18, 2006

Please call me at (803) 898-8579 with questions and comments.

ES: sjn

Enclosure

**DISASTER ACTION GUIDE TO BE
COMPLETED FOR EACH COUNTY AND
INCLUDED IN EACH MHC/HOSPITAL PLAN**

IN THE EVENT A DISASTER IS PREDICTED OR HAS OCCURRED IN YOUR AREA, TAKE THE FOLLOWING IMMEDIATE ACTION:

1. NOTIFY YOUR CENTER/HOSPITAL DIRECTOR OR THE PERSON ACTING IN THAT CAPACITY:

NAME: _____

OFFICE PHONE: _____

HOME PHONE: _____

2. NOTIFY THE OFFICE OF PUBLIC SAFETY AT THE DEPARTMENT OF MENTAL HEALTH:

EMERGENCY NOTICE: (803) 935-5499

24 HOUR DISPATCHER NUMBER: (803) 935-5478 or 935-5470

GIVE THE NAME, LOCATION, DIRECTIONS AND PHONE NUMBER OF THE MENTAL HEALTH CONTACT PERSON IN THE AREA.

3. SEND A MHC STAFF MEMBER TO THE COUNTY EMERGENCY OPERATIONS CENTER LOCATED AT:

ADDRESS: _____

DIRECTIONS: _____

NAME OF COUNTY EMERGENCY PREPAREDNESS DIRECTOR:

PHONE NUMBER DURING REGULAR WORKING HOURS: ()

PHONE NUMBER 24 HOURS A DAY: ()

4. IMPLEMENT YOUR CENTER or HOSPITAL DISASTER PLAN.

5. MAINTAIN CONTACT WITH THE DEPARTMENT OF MENTAL HEALTH OFFICE OF PUBLIC SAFETY AT LEAST EVERY TWO HOURS UNTIL ADVISED OTHERWISE.

**STATE ACTION GUIDE
TO BE COMPLETED FOR EACH COUNTY AND
INCLUDED IN EACH MHC/HOSPITAL PLAN**

1. COUNTY: _____

2. LOCAL MENTAL HEALTH CENTER/CLINIC CONTACT PERSON:

NAME: _____

HOME ADDRESS: _____

HOME PHONE: _____

DIRECTIONS TO THE HOME FROM COLUMBIA: _____

OFFICE ADDRESS: _____

OFFICE PHONE: _____

DIRECTIONS TO THE OFFICE FROM COLUMBIA: _____

3. COUNTY EMERGENCY PREPAREDNESS OFFICE CONTACT PERSON:

NAME: _____

EMERGENCY OPERATIONS CENTER ADDRESS: _____

EMERGENCY OPERATIONS CENTER PHONE NUMBER: _____

DIRECTIONS TO THE COUNTY EMERGENCY OPERATIONS CENTER FROM

COLUMBIA: _____

ACKNOWLEDGMENTS


The South Carolina Department of Mental Health is indebted to Peggie Shealy, Ph.D., (Ret.) and Fred L. Sons, Director of Public Safety (Ret.) who pioneered disaster preparedness planning and response from the mental health perspective in South Carolina and nationally. Their leadership in educating staff about the role of public mental health agencies in disasters and their coordination of the Department's response to the Tornadoes of 1984 resulted in a cadre of staff knowledgeable about mental health disaster services. Their legacy proved invaluable in organizing the Department's response to Hurricane Hugo in September, 1989.

The Department of Mental Health also acknowledges the outstanding contributions of its employees who responded to Hurricane Hugo, either by going into the affected areas or by working double shifts or covering additional services back home. These employees were magnificent.

Their analysis of the Department's response during the Hugo Retrospective Conference in October and November, 1990, which was funded by the Federal Emergency Management Agency and the National Institute of Mental Health, provided the information that was needed to make the original plan possible. The work of the Statewide Disaster Preparedness Committee in providing critiques of drafts of the original plan was invaluable.

A very special Thank You goes to Nancy Carter, retired. Her commitment to faithfully reflect the information and recommendations made by staff is commendable.

Through the work of Emergency Services Branch of the Center for Mental Health Services in Rockville, Maryland and the Federal Emergency Management Agency, the Department of Mental Health has had the privilege of learning from other States' experiences with disaster mental health services since our experience with Hurricane Hugo. The ever growing knowledge base from these experiences has contributed significantly to this revision of the plan. We thank them for their consistent help and support.



Alison Y. Evans,
Chairperson Mental Health Commission



John J. Connery, M.A.,
Interim State Director

June 1, 2006

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SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH OFFICE OF DISASTER MANAGEMENT SERVICES SC DMH DISASTER RECOVERY PLAN STATEMENT OF EXECUTION

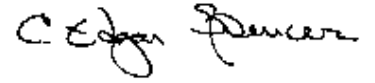


The purpose of the South Carolina DMH Disaster Recovery Plan is to provide a framework for the delivery of coordinated assistance to local

mental health centers and hospitals. This plan provides processes and procedures to utilize crisis counseling and other disaster related services in time natural disaster or act of terrorism.



Interim Director



C. Edgar Spencer
DMH Disaster Response Manager
Office of the Medical Director

BASIC PLAN

SOUTH CAROLINA DMH DISASTER RECOVERY PLAN

1. INTRODUCTION:

A. General. The policy of the State of South Carolina is to be prepared for any emergency or disaster. South Carolina State Regulations 58-1 and 58-101 require contingency plans and implementing procedures for all major hazards, other natural or manmade disasters, led by the state and coordinated with counties that have a potential of being impacted. The South Carolina Emergency Management Division Plan augmented by this plan, and the Emergency Support Functions (ESFs) Standard Operating Procedures (SOPs), meet the requirements of the stated regulations. It is the goal of the South Carolina Department of Mental Health to establish and maintain close collaboration with Sister agencies including Department of Alcohol and Drug Abuse (DADOAS), Department of Health and Environmental Control, South Carolina Vocational Rehabilitation as the Department of Disabilities and Special Needs.

B. Specific: This plan establishes specific policies and procedures to be followed by the mental health centers and hospitals when responding to the threat of a natural or terrorism related disaster. The SC Emergency Management Division (SC EMD) Plan addresses all forms of disaster operations if South Carolina is impacted by an event.

The SC Emergency Management Division Plan covers the threat, operations and recovery terminology, the utilization of the various disaster plans as the basis for disaster preparedness and planning, evacuation decision timeline, phased evacuation decision factors, and lane reversal/counter flow indicators when indicated.

Each state designated geographic conglomerate section serves as the general operational plan for the conglomerate.

2. PURPOSE:

To prevent or minimize injury to individuals and damage to property or to the environment resulting from a disaster by planning and coordinating the application of DMH, state and local crisis counseling resources to warning, evacuating, sheltering and recovery activities for South Carolina citizens and visitors.

3. THREAT OF A NATURAL DISASTER EVENT:

South Carolina is susceptible to all levels of tropical cyclones, from tropical depressions to severe category 5 hurricanes. These tropical cyclones produce three major hazards: the storm surge, high winds, and rainfall-induced flooding.

A. Storm Surge. The storm surge is a large dome of water often 50 - 1- miles wide that sweeps across the coastline near where a hurricane makes landfall. The surge of high water topped by waves is devastating. The stronger the hurricane, the higher the surge will be. Along the immediate coast, storm surge is the greatest threat to life and property.

B. Winds. Hurricane winds can destroy building, mobile homes, and other property. Debris, such as signs, roofing material, siding, and other items become missiles in a hurricane. The winds are the greatest cause of property damage inland off the coast. In addition, hurricanes often produce numerous tornadoes, which add to the storm's destructive power. These tornadoes most often occur in rain bands well away from the center of the storm.

C. Rainfall-induced Flooding. Widespread torrential rains, often in excess of 6 inches, can produce deadly and destructive floods. Long after the winds have subsided, hurricanes can generate immense amounts of rain. In 1999, Hurricane Floyd produced high rainfall totals that resulted in devastating floods in South and North Carolina.

4. HURRICANE EVACUATION STUDY TERMINOLOGY:

A. General. The South Carolina Hurricane Evacuation Study (HES) prepared by the U.S. Army Corp of Engineers (COE) includes analyses of technical data concerning hurricane hazards, vulnerability of the populations, public response to evacuation advisories, timing of evacuations, and sheltering needs for various hurricane threat situations. These analyses, all or in part, had significant impact on the South Carolina Hurricane Plan. The major analyses are: hazards, vulnerability, behavioral, shelter, and transportation analysis. The COE managed the project with input and coordination from federal, state, and local agencies. The HES provides tools for use by emergency managers in preparing for and initiating hurricane evacuation operations. The key components are the hurricane evacuation zones and estimated evacuation clearance times. Both components are further addressed in the Basic Plan and the respective Conglomerate Annexes Introduction Section.

B. Hazards Analysis. The hazards analysis determines the timing and magnitude of wind and storm surge hazards that can be expected from hurricanes of various categories, tracks, and forward speeds. The Sea, Lake, and Overland Surges from Hurricanes (SLOSH) numerical models were used by the National Hurricane Center to compute surge heights. The South Carolina coast is included in three SLOSH basins: Wilmington, Charleston, and Savannah. The COE based hazards from freshwater flooding on the Federal Emergency Management Agency's (FEMA's) Flood Insurance Rate Maps.

C. Vulnerability Analysis. Using the results of the hazards analysis, the vulnerability analysis identifies those areas, populations, and facilities that are vulnerable to specific hazards under a variety of hurricane threats. Inundation maps were produced and evacuation scenarios were developed. The evacuation scenarios are based on the category of storm. For each scenario evacuation zones were delineated. Population data were used to determine the vulnerable population within each evacuation zone. In areas of potential inundation, critical facilities were identified, such as nursing home and hospitals.

D. Evacuation Zones. These are areas in coastal counties vulnerable to storm surge inundation and rainfall-induced flooding. A product of the Hurricane Evacuation Study, the zones meet the following objectives: be describable over radio/TV media to public; be based upon easily identifiable roadway or natural features for boundary identification; relate to storm surge limits based on the most recent SLOSH models; allow coastal county residents to determine if their home is in a storm surge vulnerable evacuation area; be useable for the HES transportation modeling; and be related to census/traffic analysis zone boundaries for population and dwelling unit tabulations and calculation of vulnerable populations. The zones are depicted and described in the respective Conglomerate Annexes' Introduction Section.

E. Behavioral Analysis. This analysis determined the expected response of the population threatened by various hurricane events in terms of the percentage expected to evacuate, probable destinations of evacuees, public shelter use, and use of available vehicles. The methodology employed to develop the behavioral data relied on: discussions concerning expected behavioral response with emergency management staff in each county, review of past behavioral studies as a part of various hurricane planning efforts conducted by COE and FEMA, behavioral research by Hazards Management Group for the region, and behavioral data collected for the 1996 Hurricanes Bertha and Fran responses in Horry County. Even with these resources, the COE used a great deal of assumptions and judgment in developing the needed parameters.

F. Shelter Analysis. The shelter analysis presents an inventory of pre-designated public shelter facilities, capacities of the shelters, vulnerability of shelters to storm surge, flooding, and shelter demand for each county. Shelter inventories were furnished by emergency management offices in each county and by the local American Red Cross Chapter. The COE estimated the shelter demands from behavioral analysis data.

G. Transportation Analysis. The principal purpose of the transportation analysis was to determine the time required to evacuate the threatened population (clearance times) under a variety of hurricane situations and to evaluate traffic control measures that could improve the flow of evacuating traffic. Transportation computer modeling techniques developed to simulate hurricane evacuation traffic patterns were used to conduct this analysis. To provide a better estimate of where these people will go, the behavioral studies included work to estimate what portion of the evacuees will go to other inland counties or seek safe haven in other states.

1. Estimated Evacuation Clearance Times. A HES tool describing the time required to clear the roadway of all vehicles evacuating in response to a hurricane situation. Clearance time is one of two major considerations involved in issuing an evacuation order or advisory. The other time is the arrival of sustained tropical storm winds. The clearance times were developed by storm scenario and by behavioral characteristic for each conglomerate.

Clearance time begins when the first evacuating vehicle enters the road network and ends when the last evacuating vehicle reaches an assumed point of safety. Clearance time includes the time required by evacuees to enter the road network (referred to as mobilization time) and the time spent by evacuees traveling along the road network due to traffic congestion (referred to as queuing delay time). Clearance time does not relate to the time any one vehicle spends traveling on the road network and does not include time needed for local officials to assemble and make a decision.

Several hundred clearance time runs were done based on differing intensity of hurricanes, evacuation area assumptions, rapidity of evacuees' response, and differing tourist seasons. Clearance times generally fall below 24 hours for most of the scenarios. However, due to the limited road network and large numbers of tourists and permanent residents who would have to evacuate in the northern conglomerate, times could potentially exceed 30 hours for a Category 4-5 hurricane, high tourist occupancy scenario.

Pursuant to the plan South Carolina Department of Public Transportation on file with the South Carolina Office of Emergency Preparedness, (803-737-8500), one or more conglomerates' evacuation traffic does nothing to an adjacent conglomerates' clearance time situation. The clearance evacuation time used when one or more conglomerates evacuate is the longest time for each conglomerate based upon their own individual clearance time and track/forward speed of the storm relative to their area location. In addition, traffic produced by inland county mobile home evacuees does little to impact congestion levels on inland evacuation routes. Inland traffic assignments reflect the tendency for inland mobile home residents to evacuate with the county.

The clearance time calculated for each scenario (category of storm) was based on three criteria: evacuation zone participation rates, population response rate, and level of tourist occupancy.

2. Evacuation Zone Participation Rates. Participation rates assumed by zones within a county, and for each scenario, are part of the clearance time model. Key factors behind the participation assumptions are as follows:

- a. Zones to be evacuated for storm surge were assumed to have 100% participation rate. Even though in actuality these rates will be lower, as a matter of public safety the clearance times calculated in this study should allow those who are vulnerable to storm surge the opportunity to evacuate whether they choose to or not.
- b. All mobile home residents in conglomerate counties are assumed to evacuate.
- c. A portion of the theoretically non-vulnerable population was also assumed to evacuate in the modeling. This percentage could be higher than what was used particularly for more intense hurricanes (1% - 15%), but will be balanced out with the less than 100% of surge residents who will participate in an actual event.

3. Response Rate. A critical behavioral aspect considered for the transportation analysis was the rapidity of evacuation response of the evacuating population. Behavioral data from past hurricane evacuations shows that mobilization and actual departures of the evacuating population can occur over a period of many hours or over a very brief time. In the Hurricane Bertha and Fran evacuation, evacuees loaded the road network over a long period due to the meteorology and path of the storm. In Hurricane Floyd, traffic loaded the road network very quickly.

4. Tourist Profile. The tourist population varies throughout the hurricane season. The clearance times were estimated for a low and high tourist population. The high tourist population is based on 90% occupancy of tourist units and the low tourist population is based on 30%.

SECTION I: OVERVIEW

A. INTRODUCTION: ALL HAZARDS RECOVERY PLAN

Federal legislation requires that states provide crisis counseling to survivors of natural and terrorism disasters. In most cases, this responsibility rests with DMH and local community mental health centers.

Disasters are unplanned and involve a host of unexpected elements. Disasters often result in feelings of fear, anger, stress, anxiety, depression and many other emotional reactions. These are normal responses to overwhelming stress from coping with an abnormal situation created by a disaster. In recent years, mental health professionals have been called upon to address such emotional reactions in these situations, hence the mental health role in disaster response and recovery.

Knowledge about the emotional effects of disasters and the emotional effects of trauma and post traumatic stress reactions have joined as a multi-agency and multi-disciplinary field of endeavor. Consequently, the role of the public mental health system now encompasses traumatic community events such as terrorism, violence, loss of life from fire, auto, bus or industrial accidents, etc. Community based crisis response teams are developed to respond to these local events. These teams often include trained staff from emergency medical services, fire and law enforcement agencies, the community clergy and public and private mental health practitioner as well as collaboration with DHEC, DDSN,

SCVR and DADOAS. The South Carolina Department of Mental Health and several of its community mental health centers and facilities are members of the South Carolina Crisis Response Team Consortium. The goal of the statewide Consortium is to encourage the development of local crisis response teams; providing training in debriefing skills to individual members and to assist communities experiencing a traumatic event to heal from that experience. The South Carolina Department of Mental Health Disaster Plan now includes planning for a mental health response to community incidents as well as responding to regional and national major disasters.

The purpose of disaster planning is two-fold: First to specify the role, responsibility and relationship of the agency to federal, state and local entities who have overall responsibility for disaster planning, response and recovery; second, to specify roles, responsibilities and relationships internally in the agency in responding to disasters.

The plan that follows consists of an explanation of statutory authority for Emergency Preparedness Planning and Response. It then details the organizational structure of the Department of Mental Health in responding internally and in collaboration with the SC Emergency Management Division. In appropriate sections, it also outlines the role and responsibility of community mental health centers and hospitals in responding to local disasters and traumatic events.

B. STATUTORY AUTHORITY

The Robert T. Stafford Disaster Relief and Emergency Assistance Act and Miscellaneous Directives of P. L. 100-707 establishes the requirements that SC Emergency Management Division plan for providing mental health crisis counseling services in manmade or natural disaster response and recovery. Section 416 of this act specifically addresses the mental health function. The law states:

The President is authorized to provide professional counseling services, including financial assistance to state and local agencies or private mental health organizations to provide such services or training of disaster workers, to victims of major disasters in order to relieve mental health problems caused or aggravated by such major disaster or its aftermath.

South Carolina state statutes have also been established in order to address state, county and municipal responsibility during a disaster situation through all phases of response and recovery. (Refer to acts 25-1-420, 25-1-430 and 25-1-450, S.C. Code of Laws, at Appendix B).

The State Director of the Department of Mental Health also established in April, 1990, a policy directive which defines the responsibility of the Department of Mental Health regarding disaster preparedness planning and response. (Refer to Directive 783-90 in Appendix B).

C. ORGANIZATIONAL STRUCTURE AND OVERVIEW OF RESPONSIBILITIES:

1. The Commission of the South Carolina Department of Mental Health is responsible for establishing policy which governs the administrative actions of the State Director. In turn, the State Director has delegated operational responsibility for disaster preparedness planning, training and implementation to the Office of the Medical Director. The clinical management role is further delegated to Director, Division of Special Projects, and Office of the Medical Director.

2. Operational principles and responsibilities of this clinical manager are as follows:

1. Chair a Disaster Preparedness Planning Committee which is responsible for the continued development of a state wide mental health disaster response plan.
2. Activate the plan, when necessary, with the approval of the State Director or his designee.
3. Transfer administrative responsibility for the Mental Health Emergency Operations Center (MHEOC) to the DMH Disaster Response Team Leaders, who will coordinate the specific deployment of Department of Mental Health staff and resources to respond when the scope of the disaster exceeds the capacity of local community mental health centers or Department of Mental Health hospitals to manage locally. The team leaders will report directly to the State Director until the MHEOC is deactivated. The Disaster Manager remains an active team member until this occurs.
4. Consult with MHCs and hospitals about planning and management of their response to local disasters.
5. Identify and coordinate disaster related training for DMH disaster response staff.
6. Encourage and monitor MHC and hospital all hazards disaster plan development.
7. In the event of a major disaster, all offices, divisions, community mental health centers and hospitals in unaffected areas are expected to reduce their day-to-day operations to the minimum necessary to maintain the health, safety and basic needs and services of people served by the Department of Mental Health. All available resources are to be directed toward the response phase until on-going and long term services can be established, generally no longer than six to eight weeks. In the event of a local disaster, the same principle applies to the local community mental health center or hospital. Local community mental health centers are expected to respond to local disasters proactively by visiting the area to assess needs and assigning mental health staff to work with survivors, without waiting to be invited by another authority. It must also be assumed that survivors and responders need debriefing and crisis counseling.

D. RESPONSIBILITIES OF DMH OFFICES AND DIVISIONS

1. Office of the State Director:

The State Director and/or Deputy Director supervises all disaster coordination activities including the following:

A. Office of Public and Legislative Affairs I (Reference I):

1. Coordinate all media relations including involvement with print and visual media materials.
2. Develop and maintain a library of brochures and educational materials for public dissemination.
3. Provide liaison to volunteer services external to DMH including the Mental Health Association, American Red Cross, faith community, Volunteer Organizations Assisting in Disasters, etc. and coordinate DMH volunteer responses.

B. Office of Public Safety (Reference II):

1. Serve as a Departmental team member to the S.C. Emergency Management Division disaster activities.
2. Supervise and help staff with needs assessment and resource acquisition.
3. Provide on-site security for DMH staff in the disaster area.
4. Provide logistical planning and support in transporting personnel, deploying supplies, medication and assorted equipment.
5. Serve as the primary liaison with state and county Emergency Operations Centers where needed.

C. Office of General Counsel (Reference III):

Provide legal consultation, advice and assistance when unusual circumstances arise.

D. Office of the Medical Director and Division of Community Care Services (Reference IV) "General":

1. Coordinate the Department's overall clinical response to the disaster, including activation of the DMH Disaster Response Team and local EOC process.
2. Identify and orient clinical staff as needed to respond to the disaster.
3. Supervise all grants earmarked for crisis counseling and trauma services.
4. Supervise the implementation and maintenance of disaster related crisis counseling programs.

Office of the Medical Director/Division of Community Care Services/Joint Emergency Operations Center (Reference IV) "Specific":

1. Provide clinical staff for the needs assessment and response phases.
2. Coordinate the formation and deployment of crisis counseling "Away Teams".
3. Coordinate coverage for Disaster Application Centers, local Emergency Operations Centers, Shelters and other sites as may be needed in the affected area.
4. Coordinate 24 hour phone coverage of the DMH Emergency Operations Center.
5. Provide support and staff for clinical coordination activities.
6. Provide medical equipment and medications through the pharmacies.
7. Plan for the evacuation of patients from DMH hospitals in a disaster area to hospitals in non-affected areas.

8. Plan for receiving inpatients from hospitals in affected areas.
9. Plan for receipt of nursing home or non-critical medical patients from community facilities.
10. Supervise a mandatory debriefing process and procedure for DMH employees and volunteers who are responders in the field.

Division of Community Care Services (Reference IV):

1. Assist the Community Office of the Medical Director and Division of Community Care Services in the selection and deployment of crisis counseling teams.
2. Ensure that people with psychiatric disabilities are educated about how to personally prepare for a disaster, how to access disaster related services and the plan for restoring community mental health services in the event of a disaster.
3. Develop a peer counseling program in which consumers can provide crisis counseling services to consumers impacted by the event.

E. Division of Children, Adolescents and Their Families (Reference V):

1. Coordinate the presence of children's mental health workers on crisis counseling teams.
2. Provide consultation and training to children's mental health workers about disaster trauma, trauma resolution and assisting families, teachers and other caregivers to help their children work through the disaster experience.

F. Services for Persons with Mental Illness and Deafness (Reference VI):

1. Coordinate the availability of American Sign Language interpreters and counselors for deaf persons to serve on crisis counseling teams.
2. Ensure the availability of stress de-briefing services for deaf responders and stress reduction services for the general public who are deaf.

G. Office of Financial Services (Reference VIII):

1. Provide a system to document all costs including equipment, supplies and regular and overtime hours of personnel involved.
2. Facilitate emergency purchases and contracts.
3. In coordination with the Office of Information Technology Services, procure communications and other equipment as many are needed.
4. Provide food, supplies and equipment to support crisis counseling teams and local MHC and hospital recovery operations.
5. Provide engineering services to assess the damage to office buildings and effect sufficient repairs to make sites operable.
6. Provide priority printing services to insure the availability of public information.

H. Division of Human Resource Services (Reference IX)

1. Issue identification tags for volunteers working under DMH supervision.
2. Expedite approval process for hiring new crisis counselors.
3. Establish policies and procedures governing unusual personnel actions which may require staff to respond to emergencies.
4. Secure trauma counseling and debriefing services for the DMH Disaster Response Team members and DMH employee responders through a contract.

I. Division of Education, Training, Research and Evaluation (Reference X):

1. Under the Office of Continuing Education and Staff Development:

1. Develop and deliver a curriculum to train DMH clinical staff in debriefing and crisis counseling techniques appropriate for survivors of trauma and disasters.
 2. Develop and deliver a curriculum to train senior mental health staff in disaster mental health team management and supervision.
 3. Provide training and orientation of DMH response teams prior to their assignment during disaster response.
2. Provide clinical staff for the needs assessment phase.
 3. Provide staff to assist the Division of Community Care Services in carrying out their responsibilities.
 4. Provide maintenance personnel to assist with debris removal, delivery, setup, operation and maintenance of equipment (e.g., generators, chain saws, etc.).
 5. Supply and maintain vehicles.
 6. Complete property damage assessments and coordinate appropriate insurance claims and determine needs beyond insurance coverage.
 7. Collect data regarding disaster impact on personal and property losses.
 8. Supervise the development of the Immediate Services Grant for crisis counseling services.
 9. Supervise the development of the Regular Services Grant for crisis counseling services.

J. Division of Information Technology Services (Reference XI):

1. Organize and report data collected from crisis counselors in the course of their providing services to disaster survivors to support data information requirements for grant applications and the documentation of grant supported services.
2. Coordinate the procurement and issuing of communications equipment and services.

E. PLANNING AND PREPAREDNESS SECTION OVERVIEW

The Planning and Preparedness Phase includes the time period before a disaster. Activities include the development of plans and participation in local, regional or statewide training exercises. Disaster plans need to include the role of the hospital or center as a survivor and as a responder. Plans need to address internal lines of authority and action. Joint plans and collaboration with the local County Emergency Preparedness authority are also needed at the community mental health center level. This phase also includes provision of appropriate training for staff and at least an annual update or revision of plans and a comprehensive review of the plan with all staff.

F. ALERT AND MOBILIZATION SECTION OVERVIEW

The Alert and Mobilization Phase includes the time period immediately preceding a forecasted disaster and/or the impact phase of the disaster. Activities include activating the plan, notifying the system to go on Alert, forming the state level coordinating team, setting up the Mental Health Emergency Operations Center and reassigning staff in preparation for the event. Early training and deployment of staff to shelters, EOCs, etc., the development of stand-by staff and crisis counseling teams and taking inventory of supplies and equipment, all take place during this phase. This section outlines areas of responsibility for the pre-disaster warning period and the initial response activities and broadly describes procedures which will be followed.

G. RESPONSE SECTION OVERVIEW:

This section focuses on the manner in which disaster mental health services are provided from impact until the recovery phase begins. During this period, which generally lasts no more than six to eight weeks, resources from within the mental health system are dedicated to the affected areas until the crisis is resolved or federally supported crisis counselors are hired to take over the longer term services needed by survivors. Assistance in restoring community mental health center operations and stationing staff at congregate sites in the community where survivors are likely to be are the two primary goals. Working in concert with local mental health staff, FEMA and other response personnel, outreach to the public and center clients is conducted; individuals and families are counseled; responders are debriefed; and people in need of longer term crisis counseling services are identified.

H. RECOVERY SECTION OVERVIEW

This section addresses the provision of crisis counseling services to survivors for a nine month period. These services are provided by full-time

temporary staff, usually indigenous workers with trained and experienced clinical supervisors. These services are provided through outreach and in community settings where survivors live and work.

SECTION II: PLANNING AND PREPAREDNESS

The following guidelines should be viewed in the context of the overall Department of Mental Health All Hazards Disaster Plan. The major sections that follow this can serve as a guide to community mental health centers and inpatient hospitals as to what should be addressed. Community mental health centers and hospitals are strongly encouraged to plan from the level of "small" community incidents such as random violence or chemical spills to major catastrophic events like earthquakes and hurricanes. Centers and hospitals are also encouraged to participate through their individual staff activities and other related response organizations.

A. PLANNING GUIDELINES FOR STATE OFFICES AND DIVISIONS:

Each office and division shall develop a written plan that specifies how the assigned responsibilities will be carried out. These plans will be reviewed and updated annually.

B. PLANNING GUIDELINES FOR MENTAL HEALTH CENTERS

1. The Internal Disaster Plan:

1. Each community mental health center shall have a disaster plan that is area wide in its focus and addresses disaster preparedness planning and response on a county by county basis and meets the standards for their Accreditation Authority.
2. The community mental health center shall address the following elements:
 - 1). Planning and preparedness activities.
 - 2). Alert and mobilization of plans, staff and activities.
 - 3). Response plans and organized activities.
 - 4). Recovery plans and activities.
3. Plans will list specific primary staff contacts and telephone/fax numbers by which those staff members may be reached. Back up staff members, who may be contacted if primary staff are absent when activation of the plan occurs, will also be listed. These staff listings should be separated into Clinical Staff and Administrative/Support Staff lists for ease of use.
4. Plans will address how staff members' personal and family needs will be met before and after the event.
5. Plans will address how the MHC relates to and works with the local and/or state Disaster Response Teams. The SCDMH Teams will also identify necessary linkages to other affected agencies and service providers/groups and ensure that these linkages are initiated and maintained as necessary.
6. Plans will address how center consumers will be educated about disaster preparedness, sheltering, obtaining disaster related services and where to report to reconnect with the mental health system after a disaster. The plan should specify actions the center will take to ensure that consumers in its residential programs are safely sheltered prior to impact when there is warning and post impact if there is no warning or their normal residence is not habitable.
7. When consumers are served by contract providers, the plan should address how disaster preparedness planning, education and assistance will be addressed by the provider and monitored by the center.
8. Plans will accommodate consumers with special needs, ensuring their proper care both pre- and post-disaster. These consumer groups should include, but are not limited to: consumers who have visual or hearing impairments, children and adolescents, the elderly, and consumers who are a part of the SCDMH TLC (Toward Local Care) programs.
9. Plans will address the interface between the County Emergency Operations Centers and the local Mental Health Centers before, during and after a disaster.
10. Plans will provide a framework for ensuring that adequate staffing exists to continue the day to day operations of each affected Mental Health Center. This will be especially important when designated staff members from those Centers are called to the field to provide crisis counseling, damage assessments, or other needed services during or after a disaster.
11. Community Mental Health Centers will review and update their internal Disaster Plans at least once a year, involving all staff in this process. Any necessary forms, assessment tools, or other items that need to be added to the Plan will be addressed at these annual reviews.

2. County Disaster Plans

1. Community mental health centers will negotiate an interface with each county Emergency Preparedness Office as to how the two agencies will work together during any phase of a disaster event.
2. The county plan will specify the center's involvement in local, regional or state wide training events.
3. The center and county will develop a document to ensure specific local arrangements.

4. Community mental health centers will review and update their county plan at least annually with representatives from the local county Emergency Preparedness Office.

C. PLANNING GUIDELINES FOR DMH INPATIENT HOSPITALS

1. Inpatient programs will have disaster plans which meet the requirements of their accrediting bodies.
2. Plans will list specific primary staff contacts and telephone/fax numbers by which those staff members may be reached. Back up staff members, who may be contacted if primary staff are absent when activation of the plan occurs, will also be listed. These staff listings should be separated into

Clinical Staff and Administrative/Support Staff lists for ease of use.

3. Plans will address how the Inpatient Program relates to and works with the local and/or state Disaster Response Teams. The SCDMH Teams will also identify necessary linkages to other affected agencies and service providers/groups and ensure that these linkages are initiated and maintained as necessary.
4. Inpatient programs will have plans for housing evacuees from other inpatient and community programs on an emergency basis.
5. Plans will provide a framework for ensuring that adequate staffing exists to continue the day to day operations of each affected inpatient program or hospital. This will be especially important when designated staff members from those hospitals are called to the field to provide crisis counseling, damage assessments, or other needed services during or after a disaster.
6. Inpatient hospitals will review and update their internal Disaster Plans at least once a year, involving all staff in this process. Any necessary forms, assessment tools, or other items that need to be added to the Plan will be addressed at these annual reviews.
7. The Division of Community Care Services shall be responsible for coordinating the development of disaster plans with the Emergency Preparedness Offices in Richland and Anderson counties on behalf of the hospitals located in those two counties.

SECTION III: ALERT AND MOBILIZATION

A. GUIDELINES FOR ACTIVATING THE PLAN: Decision Tree

The following are general guidelines. In all instances, the magnitude of the disaster shall take precedence over the size of the area affected in governing the Department's response. **Local mental health agencies are expected to be proactive in assessing whether they need to respond to a local incident and in advising the Department of Mental Health that outside assistance is needed to ensure the availability of recovery activities and services.**

1. Community Incidents/Emergency Situations:

In situations where small groups of individuals are affected by a traumatic event or where one county or service area is affected, it is the responsibility of the community mental health center/inpatient facility to activate its plan. When the plan is activated, the DMH Disaster Response office is to be notified immediately. In these situations, casualties and property losses are minimal and response is generally within the capability of the local mental health. Should outside assistance or special expertise be needed, the Department of Mental Health through SCEMD GSF-8 will secure that on behalf of the local center. CMHCs and inpatient hospitals need to develop a capacity to work with local community based Crisis Response Teams at this level of event.

In the event of a Center Specific loss or tragic event which impacts the entire Center, The Office of the Medical Director, Division of Emergency Prepared Response at the request of the affected organization, shall ensure the operations of the Center are covered by clinical and administrative staff and shall provide post traumatic stress debriefings as requested.

2. Small Scale Disasters:

When one or two service areas, four or fewer counties, one hospital or a portion of a hospital is affected by a disaster, this would qualify as a small scale disaster. A Presidential Declaration may or may not exist. The responsibility for alert, response and recovery remains with the local

area though DMH assistance may be needed. State level assistance would be available for needs assessment, deployment of outside assistance and other necessary supports. CMHCs and Inpatient hospitals are responsible for activating their plans and for notifying the DMH Disaster Response Office of their status and needs. Local CMHC staff should immediately be deployed to county EOCs to monitor the impact and keep local and state staff advised of developing issues.

3. Large Scale Disasters:

Three or more service areas or more than four counties affected by a disaster or a Presidential Declaration constitutes a large scale disaster. DMH, CMHCs and Inpatient hospitals, DHEC, DDSN, SCVR, DADOAS, will automatically activate their respective plans. Immediate contact should be made with the DMH Disaster Response Manager, if at all possible. The DMH will also exercise its judgment to immediately deploy a needs assessment team(s), if preliminary reports indicate the scope and magnitude is significant. The needs assessment will form the basis for determining the resource and support needs of the affected mental health system and geographical area.

B. DMH Influenza Pandemic Plan

In the event that the President, Office of Homeland Security and/or the Center for Disease Control implement emergency plans to address an influenza pandemic, the South Carolina Department of Mental Health in conjunction with the Department of Health and Environmental Control (DHEC) will implement plans to address the threat to our clients, staff and their families.

In concert with the South Carolina Pandemic Plan (SCPP) at DHEC, SCDMH will prioritize the distribution of vaccines and anti-viral in the following manner.

1. All personnel providing direct care services to those hospitalized in DMH Facilities, including Nursing Homes, will be offered the inoculations in the first phase of implementation including the Office of Public Safety. The staff of those residential Care Facilities housing clients, Towards Local Care of SCDMH will be offered the vaccine.
2. In the event of an avian influenza event, the areas impacted will, with the permission of the Governor, Close the Community Mental Health Centers in the impacted areas. Center Staff selected by the Center Director, will assist in local facilities designated by DHEC to ensure clients have access to needed mental health services.
3. Key SCDMH staff including the State Director of Mental Health, the Medical Director, the Director of the Division of Community Care Services, the Director of Emergency Preparedness, and selected members of the Disaster Coordinators Director of the Division of Financial Services, Director of Information Technology and key staff; Director of Communications, Director of Human Resource Management and skeleton staff, and volunteer administrative assistants will receive the vaccine.
4. SCDMH will follow the State plan and take every precaution to provide prevention programs, containment strategies and crisis support to those affected by the pandemic.

C. PROCEDURES FOR ACTIVATING THE PLAN:

1. Notification: The State Director, Deputy Director, Division head, and staff that are in an acting role in these positions including the DMH Disaster Response Manager are authorized to activate the State Mental Health Disaster Plan.

If anyone other than the Director activates the plan, the Director must be notified immediately after the event and the Chairperson of the Mental Health Commission is to be notified thereafter.

Members of the management team are to be notified through phone, e-mail and/or fax that the plan is being activated and are to notify their staff, centers, hospitals, offices and units.

2. Preliminary Actions:

1. The DMH Disaster Response Manager is to establish a Mental Health Emergency Operations Center (EOC) immediately and publicize the phone and fax numbers. The DMH Disaster Response Team (DRTeam) will staff the DMH EOC.
2. The Office of Public Safety is to staff the SC Emergency Operations Center on a 24 hour basis until advised otherwise.
3. The DMH Disaster Response Team is to formulate instructions to the field.

D. ESTABLISHMENT OF A MENTAL HEALTH EMERGENCY OPERATIONS CENTER (MH EOC):

The DMH Disaster Response Manager is responsible for establishing and supervising the MHEOC. In turn, each CMHC/hospital should address

the need for the establishment of a local MHEOC. If desired, local service areas can develop mutual aid agreements with regard to supporting the implementation of local disaster plans. The DMH EOC will be staffed 24 hours a day for as long as necessary and serve as the point of contact between state level coordination and local needs, including assembling information about resource needs.

E. ACTIONS OF THE DMH DISASTER RESPONSE TEAM (DRTeam):

The DMH Disaster Response Team shall convene with the activation of the State Mental Health Disaster Plan or at the discretion of the State Director or his designee(s) depending upon the magnitude of the disaster. It shall remain operational until the recovery phase begins. The Disaster Response Team will meet daily to review the status of the response, emerging needs and requirements, assign tasks and areas of responsibility and debrief groups returning from the field assignments.

F. ESTABLISHMENT OF NEEDS ASSESSMENT TEAMS:

Needs assessment teams shall evaluate the magnitude of the disaster with regard to casualties and damage incurred by the disaster, the status and needs of the CMHC/hospital director, the capacity of staff from the affected area to respond and the needs of community leaders and the general public in the affected area.

1. Community Incidents/Emergency Situations:

CMHC's and hospitals shall plan for and conduct a needs assessment. The assessment should address the needs of survivors, their families, bystanders or witnesses, first responders and the community at large. It should also address service delivery in concert with existing community based Crisis Response Teams. Debriefing and crisis counseling services should be available for people directly impacted and public education provided to the community. CMHCs should move pro-actively in these events and not wait to be called.

2. Small Scale Disasters:

CMHC's and hospitals should activate their plans. An assessment of the scope and magnitude of the event and the number of people affected directly and indirectly should be carried out as quickly as possible. Local mental health staff should begin crisis counseling and debriefing services immediately. The CMHC should call the DMH Disaster Response Manager as soon as the plan is activated and keep the Disaster Response Manager advised of the needs. If additional assistance is needed, DMH will activate its plan to provide it.

3. Large Scale Disasters:

DMH will automatically activate its plan and send need assessment teams when large scale disasters are predicted or occur without warning. **These teams will link with the CMHC at the County EOC unless other arrangements are made beforehand.** State needs assessment staff will work with local mental health staff to determine the full impact of the event and needs resulting from it. The DMH Disaster Response Team will coordinate the deployment of state needs assessment teams and request Public Safety Officers to accompany teams. **If necessary, state team members may remain in the affected area until a response may be organized.**

G. NEEDS ASSESSMENT CHECKLIST:

A check list will be sent with state level needs assessment teams and is recommended for use by local teams when smaller scale disasters occur. Completed needs assessment checklists will be reviewed by the DMH Disaster Response Team to formulate its response.

H. CONDUCTING THE NEEDS ASSESSMENT:

1. Needs assessment will include damage assessment of MHC/hospital physical plants and office sites, the status and needs of DMH staff affected by the disaster and their capacity to respond, estimate of casualties and the amount and kind of assistance needed.
2. In large scale or Presidential Declared disasters, DMH needs assessment teams will consist of at least one public safety officer and one or two clinicians in conjunction with a CMHC/facility employee from the affected area. **One member of the State team may be required to stay at the County EOC as a primary contact person until a full response is organized, but no more than 24 hours.**
3. Need Assessment Teams Shall:
 1. **Establish contact with the local CMHC through the County EOC Office and the County EOC Director** and in collaborating with partner agencies and private providers at the hospital site in the event an inpatient hospital is affected.
 2. Contact the State MHEOC on arrival and as frequently as deemed necessary thereafter in large scale disasters and contact the Public Safety Office in emergency situations and small scale disasters.

3. Utilize the prepared checklist with the greatest accuracy and detail possible. (Appendix A , part 1 & 2).

4. Orientation, Training and Instructions:

Orientation and instructions will be provided by the DMH Disaster Response Team. The scope and nature of the event, potential problems that may be encountered and requirements for establishing contact in the affected counties and maintaining contact with the MHEOC will be outlined.

I. ESTABLISHMENT OF CRISIS COUNSELING TEAMS:

1. The DMH Disaster Response Team, with the assistance of the Division of Behavioral Healthcare Services, shall develop a mechanism for unaffected CMHC's and hospitals to provide a list of staff who are on standby or available to report for immediate deployment to affected areas.

2. Rosters and schedules shall be maintained by the DMH EOC regarding crisis counseling teams on standby and in the field documenting:

1. Their names;
2. The name of the sending CMHC/hospital;
3. Their professional discipline or affiliation;
4. Their clinical specialty (e.g., psychosocial rehabilitation, addictions, children and their families, crisis stabilization, deaf services, elderly, etc.);
5. Their field assignment location;
6. Their Team Leader;
7. Their rotation dates into and out of the field;
8. Their expected date of return to regular duty follow their crisis counseling rotation;
9. Their availability for subsequent rotations;
10. Their debriefing plan and schedule.

J. ALTERNATE PLAN FOR DMH DISASTER COORDINATION:

1. In the event that the DMH Administrative Building in Columbia is incapacitated due to a disaster, the alternate DMH Coordination site will be Patrick B. Harris Psychiatric Hospital in Belton, South Carolina.

2. In this situation, the Director of Harris Hospital shall have the same authority as the State Director of Mental Health and his staff until the State Director of Mental Health or a member of his line of succession can resume his or her responsibilities.

3. Unaffected CMHCs and hospitals shall coordinate their deployment of personnel and assistance under the supervision of Harris Hospital.

SECTION IV: THE RESPONSE PHASE

A. ACTIONS OF THE COORDINATING TEAM:

The DMH Disaster Response Team (DRTeam) will meet daily in this phase of the disaster to ensure a steady flow of information, staff, supplies and equipment to affected areas. The focus of coordination will be problem identification and resolution with responsibilities assigned to members or their staff as needed and required.

B. NEEDS ASSESSMENT:

1. Responsibility for needs assessment will shift to the DMH EOC with support from the Office of Information Technology Services, Office of Medical Director and the Division of Community Care Services

2. The DMH Disaster Response Team will:

1. Receive and collate data from the crisis counseling teams in the field.
2. Ensure that FEMA/State briefings are attended daily at the Disaster Field Office to obtain updated damage assessment information and

report data from DMH activities.

3. Coordinate data collection from FEMA, American Red Cross, SC Emergency Management Division officials, etc.
4. Prepare the Immediate Services and Regular Services grant applications in a Presidential Declared disaster.

C. RESPONSE COORDINATION:

1. Crisis counseling team leaders will generally be employees with previous disaster response experience and hold program management or middle management roles in community mental health centers or hospitals.
2. Centers and hospitals will provide a list of staff recommended as crisis counseling team leaders.
3. Team leaders will be trained by the DMH Disaster Response Team with support from the Division of Education, Training, Research and Evaluation when such training becomes available or prior to going into the field in a disaster situation.

D. STRUCTURAL RELATIONSHIPS:

1. Team leaders are responsible to the DMH Disaster Response Team in carrying out their overall mission.
2. Team leaders, while responsible to the DMH Disaster Response Team for their overall mission, report to the supervision of the local CMHC/hospital director or his/her designee on site.
3. The Disaster Response Team, in consultation with the Director of the Division of Community Care Services and the affected Executive Director of the CMHC/hospital or his/her designee, will advise the team leaders about where and to whom to report at the disaster site.
4. Team members, regardless of the office, division, CMHC or hospital, will report to the Team Leader for day to day direct supervision while in the field.
5. Team Leaders have the authority and responsibility to return team members to their home base if, in the judgment of the Team Leaders, the team members is unable to carry out the necessary tasks for any reason.
6. Team Leaders have the authority and responsibility to advise the Disaster Response Team if they believe a Center Director is impaired. The Disaster Response Team will consult with the Director of Community Care Services about the matter. The Director of the Division of Community Care Services or his/her designee will supervise or manage any action that may be required.

E. TEAM DEVELOPMENT AND OPERATION:

Teams are made up of clinical and support staff from CMHCs and hospitals in unaffected areas of the state. Their purpose is to provide debriefing and crisis counseling services to responders, community leaders and the general public who are experiencing emotional stress and trauma that follow a disaster experience.

1. Team Functions:

1. Teams provide crisis counseling, debriefing, and support to survivors when the disaster exceeds the CMHC's or hospital's capacity to respond effectively. Teams may provide operational assistance to DMH and DAODAS, Department of Disabilities and Special Needs (DDSN), Vocational Rehabilitation(VR), DHEC Social Work programs and supplemental assistance to Disaster Application Centers, Emergency Operations Centers, shelters, feeding and relief sites, American Red Cross, FEMA personnel and other agencies responding to the disaster.
2. Teams provide crisis counseling services to the survivors which include active listening, supportive counseling, problem definition and solving, information, education, referral, active or concrete assistance, advocacy, and reassurance.
3. Teams take note of survivors whose response, needs and history make them especially vulnerable to the stress of the event and subsequent mental health problems. More frequent and intense support are to be provided to these individuals.
4. Team members will engage in non-traditional services and interventions at unusual sites. For example, teams may accompany FEMA or National Guard Units in outreach activities; serve food at feeding sites; help in the relocation of people; supplement staffing of shelters by staying in them at night, operate child care centers at Disaster Application Centers; remove debris, etc.
5. Team members are responsible for documenting their contacts daily (see contact for, Appendix A.)
6. Team leaders are responsible for summarizing contact data and reporting it daily to the DMH Disaster Response Team. Division of Education, Training, Research and Evaluation

2. Team Structure:

1. Team leaders may organize their members into smaller teams for purposes of carrying out specific functions like debriefing responders; outreach; shelter and congregate site services, etc.
2. Team leaders may assign supervision responsibility to individual team members for other team members.
3. While team members may represent several CMHCs and/or hospital, DAODAS, DDSN, VR, DHEC Social Work, they are under the direct supervision of the Team Leader and the Leader's designee(s) while in the field.
4. Though Team Leaders and members may come from different CMHC's for hospitals, members of each team go into the area together and complete their rotation together and come out together.

3. Team Configuration:

1. Team Leaders will be selected on the basis of their leadership skills, expertise, training and previous disaster experience.
2. The make up of teams will be multi-disciplinary and multi-cultural.
3. The configuration of disciplines and specialties may vary depending on the phase of the response and the specific local needs.

4. Team Call Up Procedure:

1. The initial response will be made by the needs assessment teams which is coordinated by the DMH Disaster Response Team.
2. Assessment teams will report their findings to the DMH Disaster Response Team.
3. The DMH Disaster Response Team, along with the designated staff in the Division of Community Care Services will set in place a process for activating teams and team leaders.
4. All teams will report to the prearranged site for training, briefing, orientation and assignment.
5. Team Leaders shall have the authority to send members home when, in the judgment of the team leader or center director, the member is unable to function in the interest of the whole team or the clients being served.

5. Team Assignment:

1. Teams will be assigned to the CMHC/DAODAS DDSN, VR, DSS Social Work, DHEC or hospital service area affected by the disaster which may be a single or multi-county area.
2. Teams will provide debriefing and crisis counseling services to local MHC/hospital staff, County EOC staff, responders and service providers in the area and to the general public.
3. Teams will conduct outreach services to outlying or rural areas, supplement staffing of shelters and congregate feeding and relief sites, supplement staff at Disaster Application Centers, conduct interventions at schools, work sites, governmental offices, health care institutions, with public safety personnel, survivor/responders, etc.
4. Teams will assist CMHC/DAODAS/VR, DDSN, DSS Social Work, personnel in locating clients and re-establishing services.

6. Team Rotation:

The following are guidelines which may vary depending upon the scope and nature of the disaster and varying needs and stresses as the response effort matures.

1. Team Leaders and members should serve in the field no longer than five (5) full and continuous days on site (inclusive of travel time) in a single rotation. On the final day, the outgoing team leader will brief the incoming team leader.
2. Team Leaders and members shall plan a reasonable amount of time for rest while in the field, but no less than eight (8) continuous hours in each twenty-four (24) hour period.
3. Each team is required to meet at the end of the day or shift and prior to assignment to shelters for the night, to share information, plan for the next day's work and emotionally process the day's activities together.
4. Team members and Leaders are required to leave the disaster area and return home for at least (10) full days before serving a subsequent rotation.
5. Team Leaders and members shall receive the next two (2) full scheduled working days off as Administrative Leave beginning the day after their return to their home and communities. The leave must be taken at this time. It cannot be considered Compensatory Time to be taken at a later date.
6. Debriefing is mandatory for all staff involved in disaster response.

F. SUPPORT SERVICES:

1. Provision for Teams:

The Division of Administrative Services, will the support of Office of Public Safety, is responsible for procuring, coordinating and disseminating supplies, equipment and other resources needed by teams responding to the disaster and MHCs/hospitals affected by disaster.

(See Reference III)

2. Assignment of Vehicles

The Division of Administrative Services shall coordinate the assignment, deployment, servicing and maintenance of vehicles for staff requiring transportation to a disaster site and on-site transportation. (See Reference XII)

3. Facility and Office Building Repair and Debris Removal:

The Division of Administrative Services is responsible for deploying appropriate staff to effect repairs on and remove debris from damaged buildings used by DMH to the extent of making them operable and/or protecting property. (See Reference XII)

4. Medical and Medication Supplies and Equipment

1. The Division of Community Care Services is responsible for maintaining a list of essential medications and medical equipment that will be needed in the event of a disaster. The office of the Medical Director will assist in medication procurement.
2. Medications and equipment should encompass a broad category of acute medical conditions that teams are likely to encounter in their work, including, but not limited to, psychiatric conditions.
3. The Office of Public Safety is responsible for the safe and secure transport of medications and equipment to the disaster site(s)

5. Communications:

Telephone lines and equipment, including cellular or mobile phones, specifically designated for disaster response, will be procured by the Office of Information Technology Services. In the event telephone lines are inadequate or inoperable, that Division will coordinate obtaining alternative means of communication. (See Reference XI)

G. DEBRIEFING PROCEDURES:

Debriefing encompasses the exchange of information for purposes of planning and coordinating services, as well as, the need for all staff involved in the disaster to deal with the emotional effects of the experience. Debriefing is a specific clinical skill and only people trained in a debriefing model will be permitted to carry out this function. **Participation in debriefing is mandatory for all staff involved in disaster work.**

1. Process Debriefing:

1. While in the field, team members will process the day's activities and the plans for the next day with their team leader.
2. While in the field, team leaders will check in daily with the DMH Disaster Response Team to process the day and to report their own and their team's challenges.

2. Post Rotation Debriefing:

1. All employees who carry out field work in the affected area will have at least one debriefing session in their home community before returning for a subsequent rotation.
2. Post rotation debriefing will be documented by a roster of those leading the debriefing and those attending the debriefing.
3. The DMH Disaster Response Team will organize debriefing sessions for responders.
4. Response workers may be debriefed within five to seven days of returning to their home facility or CMHC (these debriefings may occur during the employee's Administrative Leave period).
5. Post Response debriefing will be arranged as needed for each group of response workers.

3. Debriefing for Affected CMHCs/facilities:

1. DMH staff in affected areas (survivors) will be offered the opportunity to debrief daily by response team members.
2. DMH staff in affected areas will be debriefed weekly during the Recovery Phase for up to six (6) weeks.
3. Staff attendance at debriefings will be mandatory.

4. Debriefing for the DMH Disaster Response Team.

Human Resources Services, through the Employee Assistance Program, will maintain a contact with a non-Departmental trauma counseling firm to debrief state level staff.

Plans for debriefing will be established and coordinated prior to disbandment of the DMH Disaster Response Team.

SECTION V: RECOVERY PHASE

The Recovery Phase begins when either the local Community Mental Health Center returns to normal operations and provides long term crisis counseling services to survivors or response teams are replaced by temporary full-time crisis counselors. In a Presidential Declared disaster these counselors will be hired with funds from FEMA and the Center for Mental Health Services. In the event the disaster is not declared, DMH may have to support the hiring of full-time temporary crisis counselors if providing this service to survivors is beyond the existing financial capacity of the affected CMHC or hospital.

A. THE DEPARTMENT OF MENTAL HEALTH DISASTER RESPONSE TEAM (DMH DRTeam):

The DMH DRTeam will be disbanded when the Recovery Phase begins six (6) to eight (8) weeks, post event. The Disaster Response Team will transfer responsibility for service coordination to the Division responsible for managing on-going crisis counseling services. This will most likely be the Office of the Medical Director. The Disaster Response Team will continue to assist that Office with Immediate and Regular Services Grant preparation and implementation as well as The American Red Cross..

B. NEEDS ASSESSMENT:

The needs assessment function will become one of case finding and establishing referral mechanisms between the crisis counseling program and FEMA, Red Cross Salvation Army, DSS, and other entities who will encounter persons at risk.

C. CRISIS COUNSELING SERVICES:

These services will be provided by existing local staff when it is within their capacity to do so. If supplemental staff are needed, the following provisions apply.

1. The Medical Director will hire, appoint or reassign a qualified staff member as Project Manager to implement and supervise a State supported program of crisis counseling services or a Federally funded Immediate and Regular Services Grant Program.
2. With the support of the Division of Human Resource Services and with the active involvement of CMHC Directors, a process for recruiting, screening, hiring, training and deploying crisis counseling staff will be negotiated.
3. As a general guideline, crisis counselors will be people indigenous to the affected area who are supervised by trained clinical staff.
4. The Recovery Phase will last from six (6) to twelve (12) months depending on the needs.
5. The final 60 days of the project will focus on termination of counselors with their clients and with their jobs. All reasonable efforts will be made to assist crisis counselors in finding permanent positions with the agency or related health and human service agencies.
6. The Focus of Services and Training of Crisis Counselors:
 1. Local crisis counselors will provide primarily home based and community based services; outreach will be an integral and primary means of reaching survivors. The DMH DRTeam will ensure that crisis counselors are trained throughout their tenure. Appropriate training may be delivered by DMH staff or by contract staff with special expertise.
 2. Crisis counselors will be trained to provide debriefing to local groups impacted by the event who served as responders and were also survivors. Crisis counseling training will emphasize the development of cultural and language competence.
 3. Services will be culturally appropriate and focus on active listening, normalization of emotional responses, problem definition and resolution, advocacy, linkage, support, affirmation, support network development or re-establishment, education, information and referral. Training will encompass such topics as cultural competence, active listening skills, basic counseling skills, typical and atypical responses to catastrophic events, issues unique to children and elderly, knowledge of available resources and how to access those, advocacy that supports clients accessing services they are eligible for, active referral and follow up principles, grief counseling principles, anger management, conflict resolution and defusing, education, consultation and training community providers.
 4. Priority populations will be children and their families, persons with deafness, the elderly, and persons with sensory or other disabilities and persons with a serious and persistent mental illness.

7. Within three (3) months after the conclusion of the Recovery Phase, an evaluation will be done of the plans and preparation, alert and mobilization and response and recovery phases to revise, refine and improve the Department's capacity to respond.

REFERENCE I

Office of Public and Legislative Affairs

I. Purpose:

To provide accurate and timely information and guidelines to the public about how to cope with their emotional reactions to a disaster experience; develop and disseminate educational materials for the public, especially children, their families and teachers; respond to requests from the media about the emotional issues associated with a natural or manmade disaster experience.

II. Responsibilities:

A. Develop and disseminate public service announcements and news releases pertinent to the type of disaster and appropriate to the phase of the disaster.

B. Coordinate media relations and support and assist the SC Emergency Management Division Information Officer as resources allow.

C. Develop a library of brochures and educational materials which address a range of possible disasters. Resources are also available on the FEMA site www.usfa.fema.gov.

D. The Department of Mental Health (DMH) makes available to the general public information to help parents and children cope with natural disasters. For example, on the DMH external website, those interested can find coloring books for children who have experienced a tornado or a hurricane. This material is prepared in an easy to read format. Other information is also available on the external site.

On the anniversary of a disaster, DMH Public Affairs can make information available pertaining to the disaster, as well as support the community, schools, and local media in the vicinity of the disaster.

E. The DMH Office of Public Affairs networks with all relevant Public Information Officers (PIO) throughout the state when a disaster occurs, coordinating information as needed. The DMH Public Affairs office maintains a working relationship with the state emergency PIO.

Further, the DMH PIO has taken both the basic PIO class offered by the State Emergency Preparedness Division (EMD) as well as the advanced PIO class offered by FEMA in Emmitsburg, Maryland. In addition, the administrative assistant in DMH Public Affairs has also taken the basic PIO class offered by EMD.

F. DMH Public Affairs makes the public aware of disaster information through various media networks. This includes both print and broadcast. Public Affairs can e-mail in an instant news releases or media advisories to all of the daily papers as well as 35 of the non-daily papers (including some Spanish language) ASL for deaf persons, in the state. Radio and TV stations get faxed material as well as e-mails where requested. At mental health centers throughout the state, the centers' public information person or disaster coordinator may handle media relations. In addition, Public Affairs will make information available on the DMH external website.

G. In the event of a disaster, DMH Public Affairs can disseminate information to the public regarding experts in a particular field who may be of service. For Example, after 9/11, Public Affairs provide internet links to experts in counseling how to cope with loss.

H. DMH Public Affairs maintains an on-going relationship with the principal media representatives in South Carolina, who will call the PIO for information as needed. DMH will work with media to ensure all information regarding disasters will be broadcast in closed captioning.

REFERENCE II

Office of Public Safety

I. Purpose:

To provide for the coordination and delivery of personnel, supplies and equipment to a disaster site; to aid in safety, service delivery, needs assessment, logistical support and communication.

II. Responsibilities:

- A. Participate in a Department of Mental Health Emergency Operations Center (EOC).
 - B. Maintain 24 hour liaison with the State Emergency Operations Center for as long as needed.
 - C. Coordinate obtaining and delivering supplies and equipment needed in the field.
 - D. Participate in the organizing, briefing and deployment needs of assessment teams, ensuring that a Public Safety Officer travels with each team.
 - E. Maintain list of key center staff and their locations to facilitate needs assessment team contact and coordination; maintain director list of CMHCs and County EOCs to facilitate local contact and coordination.
 - F. Maintain master keys to DMH hospital buildings and Central Administration Building.
 - G. Assign Public Safety Officers to each response team sent to affected areas.
 - H. Provide for safe transport and storage of medications and other supplies and equipment.
 - I. Provide security for DMH personnel in affected areas.
 - J. Organize a courier service in support of response teams, supplies and equipment being deployed to the field as needed.
 - K. Assist in the evacuation of inpatient facilities when necessary.
 - L. Maintain a written plan for implementing these activities.**
-

REFERENCE III Office of General Counsel

I. Purpose:

To provide legal guidance to the DMH DRT regarding the legal procedures that may need to be altered to accommodate unusual conditions created by the disaster; assist in negotiating issues of licensure and insurance coverage for out-of-state volunteers; to assist in forms control in ensuring that commitment forms are available to be sent into the field if damage results in the loss of these at a local service site.

II. Responsibilities:

- A. Assist the DMH DRT to ensure that its decisions and actions are within the scope of law and the statutory mandates of the agency.
 - B. Provide phone consultation 24 hours a day during the Response Phase to staff in the field if they encounter legal questions.
 - C. Maintain a current copy of commitment forms which can be used for copying purposes by DMH facilities or other appropriate entities.
 - D. Process questions related to responsibility, liability, licensure and malpractice for out-of-state volunteers who may offer assistance.
 - E. Maintain a written plan for implementing these activities.**
-

REFERENCE IV

Division of Community Care Systems

I. Purpose:

To ensure a coordinated response to survivors, family members and others in the general population who may have special crisis counseling needs following a disaster.

II. Responsibilities:

A. To ensure that the Division of Community Care Services and the community mental health centers and hospitals have current disaster plans that meets the requirements of the State Mental Health Disaster Plan.

B. To educate consumers and their families about disaster preparedness, including shelter options, basic survival information for the first 72 hours, and where to obtain assistance after the disaster.

C. To ensure that specialty staff serving the deaf mentally ill, children, adolescents and their families, the psychiatrically disabled and the elderly have plans to coordinate specialized services for these vulnerable populations.

D. To ensure that staff is available to carry out the organizing, coordinating and supporting functions necessary to respond to a disaster.

E. Maintain a written plan for implementing these activities.

Mental Health Centers

I. Purpose:

To coordinate the involvement of the Division in disaster response and ensure that CMHCs have local disaster plans which meet the requirement of the State-wide DMH Disaster Plan.

II. Responsibilities:

A. To participate in needs assessment and coordinate the development, deployment and rotation of response teams in the field.

B. In coordination with the Office of Public Safety, coordinate scheduling of 24 hour phone coverage at the DHEOC.

C. To implement and supervise Immediate and Regular Services Grant programs.

D. To insure that CMHC's participate in local disaster drills.

E. To insure that CMHC's have current disaster plans that meet the requirements of the State Mental Health Disaster Plan.

F. To maintain a written plan for implementing these activities.

Hospitals

I. Purpose:

To provide for the safety of hospital and nursing home residents in the event of a disaster and to assist in the provision of crisis counseling services in the event of a disaster.

II. Responsibilities:

A. To insure that each facility has a current disaster plan that meets accreditation requirements and the requirements of the State Mental Health Disaster Plans.

- B. To insure that facility disaster plans are integrated with County Emergency preparedness Offices of the County in which they are located.
- C. In the event of a disaster, to ensure that a mechanism is in place access the available staff and bed capacity to determine the number of victims/evacuees who could be housed and/or treated in the hospital or nursing homes. In coordination with the Division of Community Care Systems services provide staff to assist with needs assessment and crisis counseling services in the field during a disaster.
- D. To have mutual aid agreements between facilities to accommodate evacuees.
- E. To maintain a current written plan for implementing these activities.**

¹It is envisioned that there would be one plan for the Richland County facilities and one with Anderson County for Harris Hospital.

REFERENCE V

Division of Children, Adolescents and Their Families

I. Purpose:

Crisis counseling services will be provided to children, adolescents and their families who are survivors of the natural or manmade disaster, including training and consultation to schools and agencies serving this population.

II. Responsibilities:

- A. Assist in coordinating the assignment of child mental health workers to response teams.
- B. Develop a training curriculum for teachers, guidance counselors and school administrators that is age appropriate, about the nature of trauma, how it is expressed by children and how to work with children to help them resolve the impact of the trauma.
- C. Assist in setting up day care areas at congregate sites like shelters, Disaster Application Center, feeding and relief sites.
- D. In coordination with the Office of Communications, develop guidelines for families about how to relate to their children about the event and ways families can relieve stress that will be experienced during and after a disaster.
- E. Provide direct service commensurate with the need.
- F. Work with other disaster agency representatives to coordinate efforts and resources.
- G. Maintain a written plan for implementing these activities.**
- H. Operate within departmental guidelines for implementation.**

REFERENCE VI

Services for Persons with Mental Illness and Deafness

I. Purpose:

To educate deaf mentally ill clients and family members about disaster preparedness and crisis counseling services available to deaf survivors.

Deaf and hard of hearing disaster victims are particularly vulnerable in an emergency situation. Clear communication and access to information needs to be assured. For people who rely on sign language or other visual communication modalities, the involvement of professionals with sign adequate language capabilities is crucial.

In a disaster situation, one or two "Deaf Disaster Response Teams" will be assembled, composed of DMH clinical personnel with fluency in American Sign Language. They will be accessible via pager and/or cellular telephone. When other Teams encounter deaf disaster victims, the Deaf Disaster Response Teams should be contacted and involved in relief efforts. In addition, the Deaf Disaster Response Team(s) will work closely with local deaf community resources to coordinate the location and identification of victims and culturally appropriate relief efforts.

All television broadcasts in an emergency area or situation need to be CAPTIONED, and if possible, a sign language interpreter should also be employed to convey emergency information in ASL.

II. Responsibilities:

- A. Assist in coordinating the assignment of Deaf Services staff and interpreters to response teams.
- B. For deaf staff assigned to response teams, assure interpreter services both during training and actual work in the field.
- C. Provide crisis counseling services to deaf disaster survivors and their families.
- D. Incorporate disaster preparedness planning into educational services for deaf mentally ill clients to include, but not be limited to, where their nearest shelter is and how to get there, how to survive the first 72 hours after a disaster and where to gather for assistance after the disaster.
- E. Maintain a written plan for implementing these activities.

REFERENCE VII Division of Quality Management

I. Purpose:

To assist the Division of Behavioral Healthcare Services in coordinating and implementing the State Mental Health Disaster Plan.

II. Responsibilities:

- A. Provide staff to assist with the community needs assessment phase.
- B. Provide assistance in coordinating response teams and providing 24 hour phone coverage of the MH EOC.
- C. Provide staff to perform Office of Planning development of the FEMA grant process.
- D. Maintain a written plan for the implementation of these activities.

Division of Administrative Services

REFERENCE VIII Office of Financial Services

I. Purpose:

To provide for the procurement, reassignment, coordination and utilization of supplies, equipment and vehicles in a disaster situation. To document the cost of DMH's response to a disaster and losses resulting from a disaster; procure goods and services that may be needed on an emergency basis including facilitating emergency contracts for training and grant writing; assist in the preparation and monitoring of grant budgets.

II. Responsibilities:

- A. Maintain a current inventory of state owned vehicles and their state of repair and have a mechanism for assigning the best vehicles for the use of disaster response staff on a priority basis.
- B. Develop a mechanism to provide for the temporary repair of community mental health center service sites and inpatient facilities sufficient to protect property and, if reasonable, render sites useable.
- C. Provide maintenance personnel to assist with debris removal and the delivery, set up, operation and servicing of equipment.
- D. Ensure the availability of printing services on a priority basis to print educational information for dissemination to the public.
- E. Coordinate and conduct property damage assessments of DMH owned property in the community and on hospital grounds which encompasses structural damage, as well as, supply, furnishings, equipment and vehicle losses.
- F. Coordinate insurance claims and, where appropriate, Federal Public Assistance claims for damage and loss reimbursement.
- G. Support the State Emergency Preparedness Division and the Budget and Control Board by assisting them with damage assessments to the extent that resources are available to do so.
- H. In coordination with the Division of Administrative Services, ensure that the cost of supplies, equipment, transportation, etc., of the response/recovery effort is well documented.
- I. In coordination with Human Resource Services, document all staff time with particular attention to overtime expenditures for those classes of employees for whom overtime pay is required under the Fair Labor Standards Act and assist in the recoupment of those costs in coordination with the Office of Planning and any grants that may be written.
- J. Provide for emergency contracting for supplies, equipment, personnel, service sites, training, or other services as may be needed.
- K. Develop and/or review projected FEMA grant budgets and assist in monitoring grant expenditures consistent with Federal requirements.
- L. Procure and/or provide supplies and equipment as may be needed including food, generators, chain saws, water and gasoline and containers for same, medication and medical equipment, etc., as may be needed to support response teams, affected staff and restore basic operations.
- M. Maintain a written plan for implementing these activities.**

REFERENCE IX

Office of Human Resource Services

I. Purpose:

To manage the human resource issues associated with a short term and long term response to a disaster.

II. Responsibilities:

- A. Establish policy ensuring flexibility in work hours requirements to permit the DMH to respond on the basis of the magnitude of the disaster.
- B. Establish policy to ensure that employees are not penalized on their performance appraisal for having volunteered or not volunteered for or been assigned to disaster work, including a recourse if the person's continued employment is not in jeopardy.
- C. Establish a mechanism to ensure that all DMH employees understand that while volunteers will be sought first for disaster response work, employees are subject to reassignment in order for DMH to meet its mandated responsibility.
- D. Develop mechanisms to permit rapid hiring of crisis counselors such that mechanisms are in place within five (5) working days after a Presidential Declaration of the Disaster.
- E. Establish a mechanism to provide liability coverage for in-state and out-of-state volunteers working under the auspices of the Department of Mental Health during a disaster.

F. Maintain a written plan for implementing these activities.

REFERENCE X
Division of Evaluation, Training, and Research
Inpatient Program

I. Purpose:

To provide for the safety of hospital residents in the event of a disaster and to assist in the provision of crisis counseling services in the event of a disaster. The Office of Continuing Education and Staff Development of ETR, and provide a trained workforce capable of responding to a disaster.

II. Responsibilities:

- A. To assist in meeting the requirements outline in the Disaster Plan for other DMH inpatient facilities in disaster planning and response.
 - B. Provide basic information to new DMH Employees about the role of the Department of Mental Health in disaster response and that they may be called upon as part of their work to assist in a disaster.
 - C. Assist in the location of and delivery of a curriculum to brief, train and orient response teams about their role and responsibility in disaster response; how debriefing differs from crisis counseling; how crisis counseling differs from traditional mental health treatment as a prelude to sending teams into the field.
 - D. Training curricula for training DMH staff in techniques of effective debriefing, crisis counseling and response team leadership for periodic and regular delivery to insure a trained workforce.
 - E. Maintain a process for the implementation of these activities.
-

REFERENCE X
Division of Evaluation , Training, and Research
Planning Grants Data Outcome and Evaluation

I. Purpose:

To develop and maintain procedures for collecting data related to needs assessment and documenting the Department's actions in order to support applications for Federal and State disaster assistance grants; write the Immediate and Regular Services Grant Applications as provided by FEMA and support by the national Center for Mental Health Services.

II. Responsibilities:

- A. Serve as liaison to the SC, EMD, FEMA and Center for Mental Health Services in the preparation and submission of Federal grant applications.
- B. In consultation with the Division of Community Care Services, the affected Community Mental Health Centers and inpatient hospitals, prepare grant applications that reflect the program focus, staffing and resource requirement needs to carry out an effective program of crisis counseling.
- C. Collect data from needs assessment teams, DMH DRT, SCEMD, FEMA, Red Cross and others to support grant applications and to document the Department's actions.
- D. In coordination with the Office of Public Safety, DMH DRT will represent DMH at appropriate briefings held at the Disaster Field Office

and report on the services provided by DMH and document service needs.

E. Maintain appropriate demographic, economic, social and geographic data as may be needed to facilitate the grant application process.

F. Maintain a written plan for implementing these responsibilities.

REFERENCE XI INFORMATION TECHNOLOGY SERVICES

I. Purpose:

To provide for the information and broad communications needs in responding to disasters.

II. Responsibilities:

A. Establish and maintain telephone or other appropriate communication lines to communicate between the MH EOC and various field operations.

B. Procure cellular or mobile phones as needed to facilitate communications.

C. Assist in the computerization of data collected as a result of all DMH disaster related activities.

D. Assist the Office of Planning in providing data and information needed to prepare FEMA grant applications and/or document grant activities.

E. Maintain a written plan for implementing these responsibilities.

REFERENCE XII OFFICE OF MULTICULTURAL SERVICES

I. Purpose:

To identify and train persons for SCDMH clinicians as well as non clinicians to be sensitive to people from diverse cultures in addition to those with limited English proficiency including English, American Sign Language Spanish so as to implement the disaster plan effectively.

II. Responsibilities:

A. In close collaboration with the office of Disaster Services, secure and develop appropriate materials for distribution to Community Mental Health Centers. These materials disaster, will address access a safe environment prior to the crisis and access to appropriate care after the disaster.

B. Ensure that each Mental Health has the necessary information to secure interpreter services they may require including but not limited to interpreter services they may require, including American Assign Language, English and Spanish critical.

C. Assure that identified staff provide clinical incident debriefing interventions are culturally and linguistically appropriate.

D. Assist members of the "Response Teams" in acquiring relevant knowledge to adequately address consumers of diverse ethnic backgrounds and Limited English Proficiency at a time of disaster.

APPENDIX A FORMS

NEEDS ASSESSMENT FORMS

Two sets of forms are used in the needs assessment process. The **"Initial Needs Assessment"** focuses on an in depth assessment of the status and capacity of the CMHC to provide on-going and disaster related mental health services. A preliminary evaluation of the magnitude of the disaster is also done to determine if outside assistance is needed and, if so, how much and what kind of help is needed during the first few days following impact.

The **"Long Term Needs Assessment"** form is for the routine collection of needs assessment data during the response phase. It focuses on documenting the magnitude of the disaster more fully, as well as, determining the types and locations of overall recovery services. It is used to guide the deployment of response workers during the recovery period and to document any grant applications for crisis counseling services.

INITIAL NEEDS ASSESSMENT

1. CMHC/FACILITY IMPACTED: _____

2. SERVICE AREA COUNTIES AFFECTED: _____

3. TYPE OF DISASTER: DATE OF DISASTER: DATE OF INSPECTION:

4. DAMAGE ASSESSMENT TO FACILITIES/SERVICE SITES (INDICATE LOCATIONS):

1.	5.
2.	6.
3.	7.
4.	8.

B. BUILDING DAMAGE: USE THE NUMBER OF THE LOCATION TO INDICATE THE TYPE OF EXTENT OF DAMAGE:

COMPONENTS	DESTROYED	HEAVY DAMAGE	LIGHT DAMAGE	NO DAMAGE
ROOF				
EXTERIOR				
INTERIOR				
FLOORS				
PLUMBING				
HEAT/AIR				
POWER				
RECORDS				
OFFICE FURNITURE				
COMPUTERS				
OFFICE EQUIPMENT				
SUPPLIES				
GROUNDS				
WINDOWS				
OTHER				

5. WHICH FACILITIES ARE OR CAN BE MADE SERVICEABLE?

LOCATION: 1. _____ ; 2. _____ ; 3. _____ ; 4. _____ ; 5. _____ ; 6. _____ ; 7. _____ ; 8. _____.

6. WHAT TEMPORARY REPAIRS WILL NEED TO BE MADE?

1.	5.
2.	6.
3.	7.
4.	8.

6. PRELIMINARY AREA ASSESSMENT: (DATE SOURCE SHOULD BE AT THE COUNTY EMERGENCY OPERATIONS CENTER)

IMPACT DATA	NUMBER	TYPE LOSSES	ESTIMATED AMOUNT OF LOSSES
NUMBER OF SHELTERS OPENED		PERSONAL	\$
NUMBER OF SHELTERS		BUSINESS	\$
NUMBER OF FATALITIES		PUBLIC FACILITIES	\$
NUMBER OF INJURED		FARMING	\$
NUMBER HOSPITALIZED		AGRICULTURAL	\$

TYPE FACILITY	# DESTROYED	# DAMAGED	SERVICE DISRUPTION	YES	NO
HOUSES			WATER		
MANUFACTURING			POWER		
BUSINESSES			SEWERAGE		
SCHOOLS			PHONES		
HOSPITALS					
CHURCHES					

OTHER COMMENTS AND OBSERVATIONS: _____

TUS OF CENTER/HOSPITAL LEADERSHIP:

A. IS THE DIRECTOR ABLE TO REPORT FOR DUTY? _____

B. IF NOT, WHAT ASSISTANCE IS NEEDED? _____

C. IS THE ASSISTANT DIRECTOR ABLE TO REPORT FOR DUTY?

D. IF NOT, WHAT ASSISTANCE IS NEEDED?

E. WHO HAS THE DIRECTOR OR ASSISTANT DIRECTOR AUTHORIZED TO ACT IN THEIR BEHALF?

NAME: _____

PHONE NUMBER: _____

LOCATION: _____

F. WHAT NEEDS/PROBLEMS/CONCERNS WOULD THE DIRECTOR/ASSISTANT DIRECTOR LIKE TO HAVE ADDRESSED AS QUICKLY AS POSSIBLE?

2. STAFFING CAPACITY

STAFF LOSSES AND CASUALTIES	EMPLOYEES	FAMILIES	STAFF ABLE TO REPORT	NUMBER
NUMBER OF HOMES DESTROYED			FULL TIME	
NUMBER OF HOMES DAMAGED			PART TIME	
NUMBER OF OFFICE SITES DESTROYED			CONTRACT	
NUMBER OF OFFICE SITES DAMAGED			DELAYED RETURN	
NUMBER WITHOUT TRANSPORTATION			UNABLE TO LOCATE	
NUMBER KILLED				
NUMBER INJURED				
NUMBER HOSPITALIZED				

3. RESPONSE TEAM REQUIREMENTS:

RESPONSE TEAM STAFFING NEEDS	NUMBER	SPECIAL EXPERTISE	NUMBER
PHYSICIANS		INTERPRETERS FOR THE DEAF	
NURSES		COUNSELORS FOR THE DEAF	
PHARMACISTS		GERIATRIC SPECIALISTS	
COUNSELORS/SOCIAL WORKERS		CHILD/ADOLESCENT WORKERS	
PUBLIC SAFETY OFFICERS		FOREIGN LANGUAGE (SPECIFY)	
ADMINISTRATIVE SUPPORT STAFF		OTHER (SPECIFY)	
OTHER (SPECIFY)		OTHER (SPECIFY)	

COMMENTS AND RECOMMENDATIONS: _____

4. SUPPLY REQUIREMENTS: CHECK ALL THAT APPLY

ITEM	AMOUNT	ITEM	AMOUNT	ITEM	AMOUNT	ITEM	AMOUNT
FOOD		CANDLES		SLEEPING BAGS			
WATER		MATCHES		WET WIPES			
GASOLINE		CAMP STOVES		MEDICATIONS			

5. EQUIPMENT REQUIREMENTS: CHECK ALL THAT APPLY

ITEM	# & LOCATION	ITEM	# & LOCATION	ITEM	# & LOCATION
GENERATORS		TOOLS		TRUCKS	
CHAIN SAWS		VEHICLES		WALKIE TALKIES	
MOBILE PHONES		PLYWOOD		HAND RADIOS	

ADDITIONAL NEEDS: _____

6. DESCRIBE THE GENERAL EMOTIONAL STATE AND FUNCTIONAL CAPACITY OF LOCAL STAFF:

7. STATE NEEDS ASSESSMENT TEAM MEMBERS NAMES:

8. LOCAL NEEDS ASSESSMENT TEAM MEMBERS NAMES:

9. NAME AND PHONE NUMBER OF STATE NEEDS ASSESSMENT TEAM MEMBER AT THE COUNTY EOC:

DAILY NEEDS ASSESSMENT DATA

COUNTY: _____ DATE: _____

I. DAMAGE ASSESSMENT:

ITEM	# DAMAGED	# DESTROYED	ESTIMATED LOSSES
SCHOOLS			
CHURCHES			
BUSINESSES			
INDUSTRIES			
SINGLE FAMILY UNITS			
MOBILE HOMES			
MULTI-FAMILY UNITS			
PUBLIC BUILDINGS			
HOSPITALS			
UTILITIES			
ROADS			
BRIDGES			
AIRPORTS			
RAILROADS			
OTHER (SPECIFY)			

DESCRIBE AGRICULTURAL LOSSES: _____

II. CASUALTIES:

TYPE	NUMBER
FATALITIES	
INJURED	
HOSPITALIZED	
UNEMPLOYED	
HOMELESS	
SHELTERED	

III. DESCRIBE ANY OTHER LOSSES RELATED TO THE DISASTER OR PROBLEMS UNIQUE TO THE DISASTER:

COMPLETED BY: _____ DATE: _____

**DAILY NEEDS ASSESSMENT DATA
SHELTER AND DAC INFORMATION
(TO BE REPORTED DAILY FOR EACH SHELTER)**

SHELTER NAME					DAC NUMBER				
SHELTER NAME					LOCATION				
SHELTER LOCATION					# SEEN AT DAC				
# OF SHELTER STAFF					# APPS. TAKEN				
SHELTERS HAVE Y/N					# SEEN BY DMH				
WATER					EST. CLOSING DATE				
FOOD									
POWER									
MEDICINE									
CLOTHING									
BEDDING									
PHONES									
SHELTER NEEDS									
# OF MEALS SERVED									

SERVICES DATA:

SERVICES PROVIDED	# INDIV	# GRPS	# FAM	# ELD	# MINORITY	# CHILD/ADOL
CRISIS COUNSELING						
INFORMATION REFERAL						
ACTIVE LISTENING						
SUPPORTIVE COUNSELING						
EDUCATION						
DEBRIEFING						
DEFUSING						
SUPPORT SYSTEM DEVV./REDEV.						
DAY CARE/PLAY THERAPY						
OBTAIN RELIEF/RESOURCES						
OUTREACH						
ADVOCACY						
CONSULTATION						
TRAINING						
CRISIS INTERV./STABIL.						
OTHER (SPECIFY)						

PRESENTING PROBLEMS: GIVE THE NUMBERS OF PEOPLE BY AGE, SEX AND RACE FOR EACH PROBLEM LISTED.

TYPE PROGRAM	< 5 YRS	6-12 YRS	13-18 YRS	9-60 YRS	MALE	FEMALE	AA	C	NA	AS	H	O
AGITATION/ANXIETY												
CONFUSION/DISORIENTATION												
LOSS/GRIEF												
SADNESS/SITUATIONAL DEPRESSION												
NON-VIOLENT ANGER/ADULTS												
RELIEF/RESOURCES												
ACTING OUT CHILD/YOUTH												
SCHOOL ADJUSTMENT												
INFORMATION/REFERRAL												
NON-VIOLENT ANGER/CHILD- YOUTH												
SUBSTANCE ABUSE												
MAJOR MENTAL ILLNESS												
COMMUNITY/NATURAL SUPPORTS												
VIOLENT ACTING OUT/ADULT												
VIOLENT ACTING OUT CHILD- YOUTH												

SPECIAL SERVICE RECIPIENTS:

RECIPIENT	# OF INDIVIDUALS	# GROUPS	DE- BRIEF	DE- FUSE	EDUC.	CONSULT	TRAIN
LAW ENFORCEMENT							
SOCIAL SERVICES							
TEACHERS							
GUIDANCE COUNSELORS							
PUBLIC OFFICIALS							
HEALTH CARE PROVIDERS							
GENERAL PUBLIC							
OTHER (SPECIFY)							

DISASTER SERVICES CONTACT/DATA SHEET

TO BE COMPLETED BY EACH PERSON PROVIDING A DISASTER RELATED SERVICE

LOCATION OF SERVICE: _____ DATE: _____ TIME ON DUTY: _____
 STAFF NAME: _____ SS#: _____ TIME ON DUTY: _____

1	2	3	4	5	6	7	8
INDIVIDUAL/GROUP NAME	AGE	SEX	RACE	PROBLEM TYPE	SERVICE PROVIDED	STAFF TIME	#SERVED

Appendix B

Essential Documents

SC EMERGENCY MANAGEMENT DIVISION AND SC DEPARTMENT OF MENTAL HEALTH
COUNTY - MHC MODEL PLANNING DOCUMENT FOR CRISIS COUNSELING

Date: _____
ANNEX TO _____ COUNTY

EMERGENCY OPERATIONS PLAN

MENTAL HEALTH

I. GENERAL:

A. Purpose:

1. To organize within _____ County government the capability to meet the basic human needs of persons experiencing extreme emotional and psychological stress in a disaster situation.
2. To outline responsibilities and policy established for mental health service operations before, during and after a disaster, whether natural or man-made, including war.

B. Authority:

1. _____ County Ordinance Number _____
2. South Carolina Legislative Act Number 199, 1979.
3. South Carolina Legislative Act Number 223, 1967, as amended.

C. Definitions:

DISASTER CRISIS COUNSELING: Services provided by mental health professionals to disaster casualties such as bystanders, victims, relatives of victims and rescue workers who experience shock, anxiety, hysteria, and other extreme stress or loss such as damage to home or workplace, displacement, missing family members, mass casualties, etc.

D. Organization:

1. Organization chart for mental health is at Appendix 1.
2. The Director, _____ Mental Health Center is responsible for securing and coordinating all governmental and non-governmental agencies that comprise the mental health organization, which effectively supports the needs of the populace of the county during emergencies and disasters.
3. In _____ County, this has/has not been delegated to the Director of _____ County Satellite Office.

II. SITUATION:

During and following a disaster, whether natural, terrorism or war, some individuals or families having experienced extreme emotional or psychological stress will require mental health services. These services can be administered at the disaster site, shelter site, a medical facility, school, Disaster Assistance Center, mental health office or other designated area.

III. MISSION:

To coordinate the mental health resources available to _____ County through the _____ Mental Health Center and the MHC Clinic Office for treatment of persons experiencing emotional and psychological post disaster stress.

IV. EXECUTION:**A. Concept of Operations:**

1. On notification by the Director of _____ County Emergency Preparedness Agency that a disaster is imminent or has occurred, the Director, _____ Mental Health Center will activate its disaster plan and staff appropriate disaster service sites.
2. If notification is received by the mental health center from any other source, the County Emergency Preparedness Agency will be contacted to verify that an emergency exists.
3. Control of operations will be conducted from the Emergency Operations Center or the _____ County mental health office or as designated by the Director of the _____ Mental Health Center in consultation with the Emergency Preparedness Director.
4. If the mental health center emergency operations center is not co-located with the County Emergency Preparedness Agency, the mental health center shall sign a liaison to be present in the local County Emergency Operations Center.

B. Tasks:

1. Pre-Disaster Phase: The area Mental Health Center Director shall supervise and coordinate:

1. The development of plans and procedures for the provision of crisis counseling;
2. Establishment of a communications center and its operating procedure;
3. Staffing for the MHC Emergency Operations Center, Communications Center, and crisis counseling sites(s).
4. Planning for or using non affected area mental health center resources and staff.
5. Linkage and liaison with the County Emergency Preparedness Agency, Red Cross, etc.
6. Linkage and collaboration with other emergency service organizations essential in the conduct of crisis counseling.

2. Disaster Phase: The Area Mental Health Center Director shall:

1. Activate the mental health disaster plan upon notification of the Agency Director County Emergency Preparedness Agency or by other means.
2. Staff the crisis counseling site(s) and other appropriate disaster service sites.
3. Advise the County Emergency Operations Center (EOC) of actions taken and problems encountered.
4. Advise the State Mental Health Agency of actions taken and problems encountered.
5. Assign staff to the County Emergency Operations Center in a liaison role.

3. Recovery Phase: The Area Mental Health Center Director shall ensure that all mental health offices continue to maintain essential services as well as provide short and long term treatment to disaster survivors and related individuals as needed. The Area Mental Health Center Director shall perform the following:

1. Control Center:
 - (1) Maintain continuous contact with the County EOC and other emergency service organizations.
 - (2) Maintain a list of mental health staff on alert for "Away Teams" as required. See Appendix 2.
 - (3) Continue to ensure staffing of mental health emergency stations.
 - (4) Continue to ensure case finding activities and referrals of individuals requiring crisis counseling to an appropriate site.
2. Communications Center:
 - (1) Continue to receive information regarding mental health needs from agencies and resources engaged in recovery operations,
 - (2) Continue to process requests for additional resources to meet crisis counseling needs.
3. Crisis Centers and Other Disaster Service Sites shall continue to:
 - (1) Provide a calm atmosphere.
 - (2) Provide disaster related crisis counseling to individuals and families.
 - (3) Conduct referral operations as appropriate.

- (4) Offer emergency mental health assistance to persons experiencing shock, anxiety, depression, hysteria and other stress reactions.
 - (5) Conduct case finding.
 - (6) Debrief resource and rescue workers.
 - (7) Provide supplemental personnel as available.
4. Coordinating Instructions:
- (1) All referrals and requests for information will be transmitted through the Communications Center.
 - (2) All requests for Public Information Releases regarding mental health operations will be submitted to the Director, local Mental Health Center.
 - (3) Requests for assistance from mental health agencies outside the area served by Mental Health Center will be made through the mental health center director during a disaster, in consultation with the County EOC.
 - (4) This annex is effective for planning upon receipt and for execution upon order.

V. ADMINISTRATION AND LOGISTICS:

A. Administration:

Initial situation reports will be submitted to the Director, _____ Mental Health Center at the Emergency Operations Center as soon as practical. Reports will be consolidated and submitted to the Director, _____ County Emergency Preparedness Agency and the State Department of Mental Health for analysis and further distribution and include, but not be limited to:

1. Number of individuals who were provided crisis counseling during the emergency;
2. Types of problems encountered;
3. Resources used and recovery opportunities;
4. Needs assessment of potential users of crisis counseling services based on damage estimates and numbers of persons affected.

B. Logistics:

1. Supplies, transportation, and equipment necessary for emergency operations will be drawn from within the _____ Mental Health Center organization.
2. Additional requirements, if needed, will be requested through the County EOC, SC EMD and the SC Department of Mental Health as appropriate.

VI. DIRECTION AND CONTROL:

A. Direction and control of crisis counseling services will be coordinated by the Director, _____ Mental Health Center.

B. Line of Succession:

1. Director, _____ County Mental Health Clinic Office (if applicable).
2. Director, _____ Mental Health Center.
3. Medical Director, _____ County Mental Health Clinic Office or Mental Health Center (as applicable).
4. If the mental health staff/mental health center are incapacitated and cannot respond, refer to Appendix 3.

C. Communications:

1. Communications will be maintained through normal channels.
2. Additional communication may be requested through the County EOC or SC Department of Mental Health as appropriate.

VII. This plan will be reviewed and revised as needed annually by both parties and submitted jointly to the Emergency Management Division in the Adjutant General's Office and the Medical Director of the Department of Mental Health by September first of each

year.

 Director, _____ County Date
 SC Emergency Management Agency

 Director, _____ County Date
 Health Care

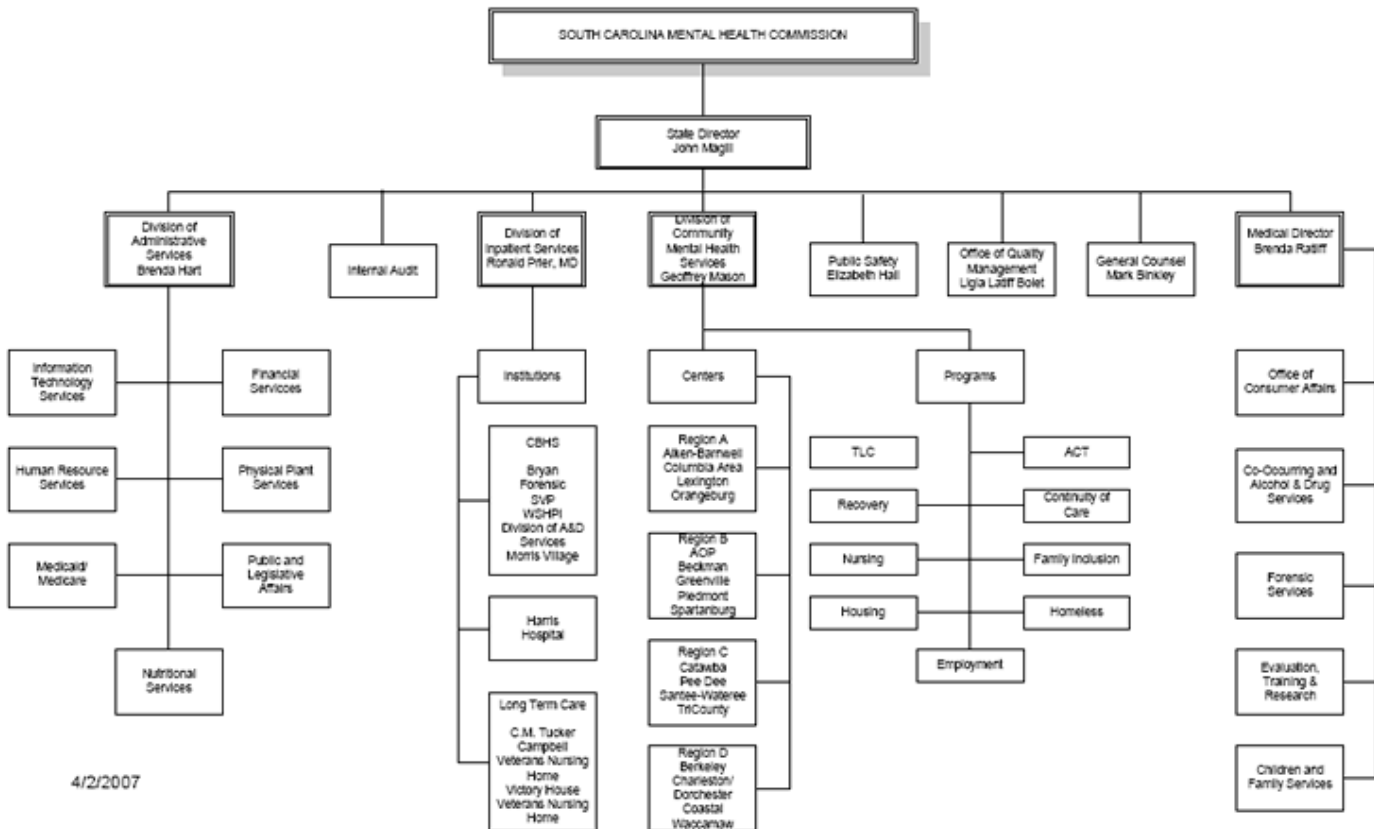
 Director, _____ County Date
 Mental Health Clinic Office

APPENDICES:

1. Organization Chart
2. Alert List
3. Adjacent County(ies)/Mental Health Center Backup List
4. Mental Health Requirements Statement

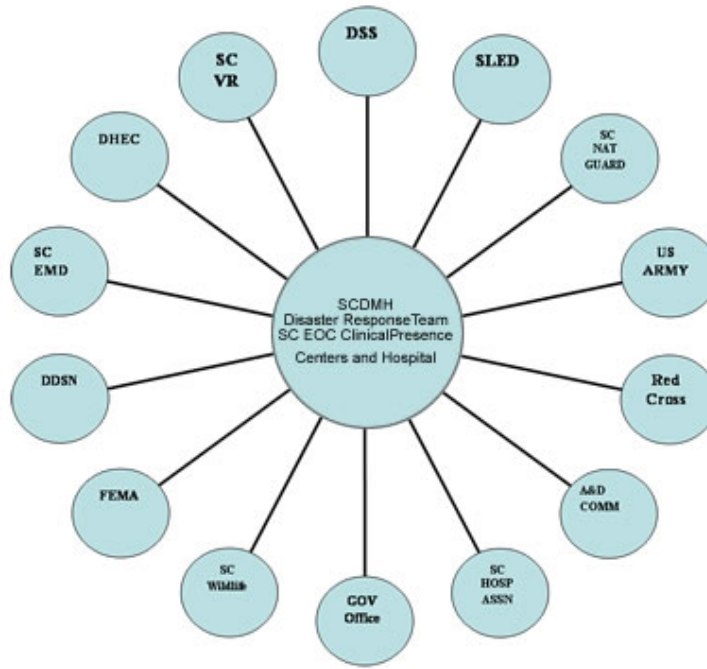
APPENDIX 1 TO ANNEX J - ORGANIZATION CHARTS

1. [SCDMH Organization Chart](#) (pdf format)



4/2/2007

2. SCDMH Disaster Response Team:



APPENDIX 2 TO ANNEX J - MENTAL HEALTH ALERT LIST

_____ COUNTY

(Key People Only)

TITLE/AGENCY	TELEPHONE
Director, _____ County Mental Health Clinic Office	
Director, _____ Mental Health Center Director	
Medical Director, _____ Mental Health Center	
DMH Disaster Manager	(803) 898-8579
Chief of Public Safety, Department of Mental Health	(803) 935-5470

(The alert list should be developed in the order of succession of first call responsibility)

APPENDIX 3 TO ANNEX J

ADJACENT COUNTIES/MENTAL HEALTH CENTERS

FOR _____ COUNTY EMERGENCY OPERATIONS PLAN

_____ AREA MENTAL HEALTH CENTER

_____ COUNTY

MENTAL HEALTH CENTER TELEPHONE

- 1. _____
- 2. _____
- 3. _____

(Centers/Clinics should be listed in order of succession if the mental health operation of the affected county is incapacitated in the emergency.)

APPENDIX 4 TO ANNEX J - MENTAL HEALTH REQUIREMENTS STATEMENT

(Equipment, supplies, personnel, etc.)

I. DISASTER SITE REQUIREMENTS:

II. HOST AREA REQUIREMENTS:

STATUTORY AUTHORITY

§ 25-1-420. South Carolina Emergency Management Division of Office of Adjutant General; administration; duties.

There is established within the office of the Adjutant General, the South Carolina Emergency Management Division (SC EMD).

The Division shall be administered by a director appointed by the Adjutant General, to serve to his pleasure, and such additional staff as may be employed or appointed by the Adjutant General.

The Division shall be responsible for the implementation of the following:

- (a) Coordinating the efforts of all state, county and municipal agencies and departments in developing a State Emergency Plan.
- (b) Conducting a statewide preparedness program to assure the capability of state, county and municipal governments to execute the State Emergency Plan.
- (c) Establishing and maintaining a State Emergency Operations Center and providing support of the state emergency staff and work force.
- (d) Establishing an effective system for reporting, analyzing, displaying and disseminating emergency information.

§ 25-1-430. Definitions.

As used in this article:

- (a) "Emergency Preparedness" shall mean the extraordinary actions of government in preparing for and carrying out all functions and operations, other than those for which the military is primarily responsible, when concerted, coordinated action by several agencies or departments of government and private sector organizations is required to prevent, minimize and repair injury and damage resulting from a disaster of any origin.
- (b) "Emergency" shall mean actual or threatened terrorist attack, sabotage, conflagration, flood, storm, epidemic, earthquake, riot or other public

calamity.

(c) "South Carolina Emergency Management (Civil Defense) Organization" shall mean all officers and employees of state government, county government and municipal government, together with those volunteer forces enrolled to aid them in an emergency and persons who may by agreement or operation of law be charged with duties incident to protection of life and property of this State during emergencies.

§ 25-1-440. Additional powers and duties of governor during declared emergency.

(a) The Governor, when an emergency has been declared, as the elected Chief Executive of the State, shall be responsible for the safety, security and welfare of the State and shall be empowered with the following additional authority to adequately discharge this responsibility:

(1) Issue emergency proclamations and regulations and amend or rescind them. Such proclamations and regulations shall have the force and effect of law as long as the emergency exists.

(2) Declare a state of emergency for all or part of the State if he finds a disaster has occurred, or that the threat thereof, is imminent, and extraordinary measures are deemed necessary to cope with the existing or anticipated situation. A declared state of emergency shall not continue for a period of more than fifteen days without the consent of the General Assembly.

(3) Suspend provisions of existing regulations prescribing procedures for conduct of state business if strict compliance with the provisions thereof would in any way prevent, hinder or delay necessary action in coping with the emergency.

(4) Utilize all available resources of state government as reasonably necessary to cope with the emergency.

(5) Transfer the direction, personnel or functions of state departments, agencies and commissions, or units thereof, for purposes of facilitating or performing emergency services as necessary or desirable.

(6) Compel performance by elected and appointed state, county and municipal officials and employees of the emergency duties and functions assigned them in the State Emergency Plan or by Executive Order.

(7) Direct and compel evacuation of all or part of the populace from any stricken or threatened area if this action is deemed necessary for the preservation of life or other emergency mitigation, response or recovery; to prescribe routes, modes of transportation and destination in connection with evacuation; and to control ingress and egress at an emergency area, the movement of persons within the area and the occupancy of premises therein.

(8) Within the limits of any applicable constitutional requirements and when a major disaster or emergency has been declared by the President to exist in this State:

(i) Request and accept a grant by the federal government to fund financial assistance to individuals and families adversely affected by a major disaster, subject to terms and conditions as may be imposed upon the grant but only upon his determination that the financial assistance is essential to meet disaster related expenses or serious needs that may not be otherwise met from other means of assistance.

(ii) Enter into an agreement with the federal government, through an officer or agency thereof, pledging the State to participate in the funding of the financial assistance authorized in sub item (i) of this item, under a ratio not to exceed twenty-five percent of the assistance.

(iii) Make financial grants to meet disaster related necessary expenses or serious needs of individuals or families adversely affected by a major disaster which may not otherwise be adequately met from other means of assistance. No individual or family may receive grants aggregating more than ten thousand dollars with respect to any single major disaster subject to the limitations contained in sub item (ii) of this item. The ten thousand dollar limit must annually be adjusted to reflect changes in the Consumer Price Index for All Urban Consumers published by the Bureau of Labor Statistics of the United States Department of Labor.

(iv) Promulgate necessary regulations for carrying out the purposes of this item.

(b) The Governor shall be responsible for the development and coordination of a system of Comprehensive Emergency Management which shall include provisions for mitigation, preparedness, response and recovery in anticipated and actual emergency situations.

(1) Any person who fraudulently or willfully makes a misstatement of fact in connection with an application for financial assistance made available pursuant to item (8) of subsection (a) of this subsection, upon conviction of each offense, must be fined not more than five thousand dollars or imprisoned for not more than one year, or both.

(2) Any person who knowingly violates any regulation promulgated pursuant to item (8) of subsection

(a) of this subsection is subject to a civil penalty of not more than two thousand dollars for each violation.

(3) A grant recipient who misapplies financial assistance made available by item (8) of subsection (a) of this subsection is subject to a civil penalty in an amount equal to one hundred fifty percent of the original grant amount.

§ 25-1-450. Duties of state, county and municipal governments for mutual assistance in emergencies.

State, county and municipal governments shall cooperate in developing and maintaining a plan for mutual assistance in emergencies.

(1) State government shall be responsible for:

(a) Establishing policies and developing a plan and procedures to insure maximum utilization of all state resources to minimize loss of life and injury to the populace and destruction or damage to resources and facilities of the State during emergencies resulting from enemy attack or natural or man-made emergencies.

(b) Providing state forces and resources to support local governmental emergency operations and coordinating support with local governments from other sources, including the federal government and those unaffected counties of the State, and implement mutual assistance agreements with adjoining states.

(c) Assuming direction and control of area or local government emergency operations when requested by the county legislative delegation or their designees or when local government authority has broken down or is non-existent or when the nature or magnitude of an emergency is such that effective response and recovery action is beyond local government's capability or when, in the event of a war emergency or declared natural or man-made emergency, state direction is required for implementation of a national plan.

(2) County and municipal governments shall be responsible for:

(a) Organizing, planning and otherwise preparing for prompt, effective employment of available resources of the county or municipality to support emergency operations of the municipalities of the county or to conduct emergency operations in areas where no municipal capability exists.

(b) Coordinating support to municipal emergency operations from other sources including state and federal assistance as well as support made available from other municipalities of the county.

(c) Developing and implementing a shelter/relocation plan to protect the populace from the hazards of a nuclear emergency and to provide for the congregate housing and care of persons displaced or rendered homeless as a result of a natural or man-made emergency.

THE ROLE OF THE DEPARTMENT OF MENTAL HEALTH

The South Carolina Department of Mental Health, under the leadership of the State Director of Mental Health appointed by the Mental Health Commission, is one of the statewide agencies that becomes part of the South Carolina Emergency Management Organization in the event of a disaster or emergency. The role of the Department of Mental Health is to prevent, minimize and repair the trauma, injury and damage of psychological stress which occurs in people as a result of natural and man made disasters, thus preventing future emotional problems in survivors. The goal is to work closely with those impacted by the emergency through the provision of Disaster Crisis Counseling and Trauma Services.

Crisis Counseling is a service provided by mental health professionals and ancillary mental health staff to disaster survivors such as witnessing by-standers, relatives of the dead, injured and missing, people suffering loss of housing, employment, workplace or school, and response personnel who experience stress as they carry out response and recovery activities.

The Department of Mental Health responds to emergencies at four levels.

(1) A local level response is required by mental health centers and hospitals in relation to local emergencies and county emergency preparedness offices.

(2) A state level response is required as a result of notification by the SC Emergency Management Division and through Gubernatorial Declaration or at the request of local mental health centers and hospitals.

3) A state level response is also required in collaboration with the SC Emergency Management Division and other agencies when there has been a Presidential Declaration of a disaster and a need for disaster assistance.

(4) An internal response within the Department of Mental Health is required when there has been a major disruption in the operation of a mental health center or hospital.

The State Director of Mental Health is responsible for the safety, security and welfare of the Department and the people entrusted to its care and the employees during a declared emergency. He is able to exercise these responsibilities by taking one or more of the following actions:

- (1) Issue emergency policies and procedures. Such policies and procedures have the effect of policy sanctioned by the Mental Health Commission for as long as the emergency exists.
- (2) Take necessary measures to protect people and property and to mitigate the effects of a disaster or the imminent threat thereof for a period not to exceed that of the declared emergency.
- (3) Suspend provisions of existing policy and procedure to conduct Department business if strict compliance with the provisions of these would in any way prevent, hinder or delay necessary action in coping with the disaster.
- (4) Utilize all available resources of the Department as reasonably necessary to respond to the event.
- (5) Transfer or delegate the supervision and direction of personnel and resources of the Department's administrative, clinical and operational components as necessary for purposes of covering essential services and performing emergency services.
- (6) Coordinate the performance of emergency duties and functions of employees with those of elected and appointed state, county and municipal officials and employees as assigned them in the State Emergency Preparedness Plan or by Executive Order.
- (7) Coordinate Department activities with an order directing or compelling evacuation of all or part of the citizens from a stricken or threatened area if this action is deemed necessary for the preservation of life or other emergency mitigation, response or recovery; using routes, modes of transportation and destinations in connection with evacuation plans; and to control ingress and egress at the emergency area, the movement of persons within the area and the occupancy of premises therein, as may be appropriate within the operational requirements of the Department of Mental Health, its centers and hospitals.
- (8) Within the limits of any applicable constitutional requirements and when a major disaster or emergency has been declared by the President of the United State to exist in this State:
 - (a) To request, accept and administer, through the Governor' Office and appropriate Federal officials, Federal grant funds to support an immediate capability to provide crisis counseling services to individuals and families adversely affected by disaster as authorized in Federal legislation.
 - (b) To request, accept and administer through the Governor and appropriate Federal officials a Federal grant to fund a crisis counseling regular program for individuals and families adversely affected by a major disaster.

Domestic Preparedness Readiness and Response Levels

SYSTEM	LOW	MINIMAL	POTENTIAL	CREDIBLE	INCIDENT

Emergency Operations Center – OPCODES	5-Day-to-Day operations to include normal tracing and exercises.	4-Possibility of an emergency or disaster situation that may require a partial or full activation of the SEOC.	3-Disaster or emergency situation likely or imminent. Full or partial activation of SEOC; active South Carolina Emergency Operations Plan and the appropriate specific impact hazard emergency plan.	2-Disaster or emergency situation in effect; maximum preparedness level; full activation of the SEOC.	1-Disaster or emergency situation in effect full-fledge emergency response operations on going; highest state of emergency operations.
FBI Threat Levels	5-Day-to-Day operations to include normal tracing and exercises.	4-Received threats do not warrant actions beyond normal liaison notifications or placing assets or resources on a heightened alert (agencies are operating under normal day-to-day conditions).	3-Intelligence or an articulated threat indicates a potential for a terrorist incident. However, this assessed as credible.	2-The threat is credible, and confirms a developing terrorist incident. Crisis management focuses on LEA actions for public safety and welfare, and to anticipate, prevent, and/or resolve the crisis. Consequence management focuses on contingency planning and repositioning of resources. The threat increases the significance when the presence of an AME capable of causing a significant destructive event is confirmed or a high probability that a devise exists. The threat is now a WMD terrorist situation requiring an immediate process to identify, acquire, and plan the use of Federal resources in lessening or averting the potential consequences.	1-Situation Progression, the potential for significant consequences may become imminent. Consequence management agencies re-deploy from the JOC to its EOC but maintain a liaison for the FBI OSC. Emergency management may pre-deploy state and federal consequence management assets. If a WMD terrorism incident has occurred which requires Federal resources? This incident has resulted in mass casualties. The response is primarily directed toward public safety and welfare and the preservation of human life and assistance to governments for consequence management takes priority.

<p>HSAS: Homeland Security Advisory Systems</p>	<p>Green-Low Risk Day to day operations to ensure preparedness and readiness.</p>	<p>Blue-General Risk Curtail routine operations where necessary. Verify that current policies and procedures insure internal and external communications' means are operational. Meeting of the Homeland and Security Council</p>	<p>Yellow-Significant Risk Increase security at all critical locations and activities. Activation of EOC where appropriate. Increase liaison activities with other state, federal and local agencies. Coordinate emergency plans and communications with border states. Implement necessary contingency and emergency response plans. Meeting of the Homeland Security Council.</p>	<p>Orange-High Risk Respond appropriately to intelligence EOCs fully operational. Coordinate with Armed Forces, active guard, and reserve. Restrict entry to critical allocations and events. Additional security at public events. Restrict leave or off-site training for all personnel.</p>	<p>Meeting of the Homeland Security Council. Red-Sever Risk React appropriately to intelligence that moved us to this level. Pre-position all especially trained teams and units. Where appropriate, close government and public facilities. Monitor, redirect and/or constrain transportation systems. Meeting of the Homeland Security System Council.</p>
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APPENDIX C - Operations in Detail

EMERGENCY OPERATIONS

A. Conglomerate Operations. For the purpose of hurricane-related activities, South Carolina state government response will operate on a regional basis. These regions are called hurricane conglomerates and consist of the Southern Coastal Conglomerate, the Central Coastal Conglomerate, the Northern Coastal Conglomerate, and the Western Hurricane Conglomerate. The * designates the lead county in the three coastal conglomerates. There is no designated lead county for the Western Conglomerate.

Southern Coastal Conglomerate	Central Coastal Conglomerate	Northern Coastal Conglomerate	Western Conglomerate
<p>Beaufort Jasper Colleton Hampton Allendale Bamberg Barnwell Aiken</p>	<p>Charleston Berkeley Dorchester Calhoun Orangeburg Lexington Richland</p>	<p>Horry* Georgetown Williamsburg Marion Florence Dillon Clarendon Sumpter Darlington Lee Marlboro</p>	<p>Abbeville Anderson Cherokee Chester Chesterfield Edgefield Fairfield Greenwood Greenville Kershaw Lancaster Laurens McCormick Newberry Oconee Pickens Saluda Spartanburg Union York</p>

B. Operations Terminology. To prevent confusion and misunderstanding, it is necessary to standardize terminology regarding evacuation issues.

1. Estimated Evacuation Clearance Times. Clearance time begins when the first evacuating vehicle enters the road network and ends when the last evacuating vehicle reaches an assumed point of safety.

2. Evacuation Zones. Areas in coastal counties vulnerable to storm surge inundation and rainfall-induced flooding.

3. Hurricane Tracking Tools. Several computer programs are used to track hurricanes during the life of a tropical storm. The primary program used in South Carolina is HURREVAC.

4. Voluntary Evacuation. In the event a hurricane begins to pose a threat to the coast, local officials or the Governor can recommend that those citizens who feel uncomfortable about the storm leave the area. This action is considered a voluntary evacuation. During a voluntary evacuation, mandatory evacuation shelters will be opened.

5. Mandatory Evacuation. The Governor is the only person legally authorized to order and compel evacuation in South Carolina. The SCEMD Director will recommend to the Governor that a mandatory evacuation be ordered, and will propose a timetable. During a mandatory evacuation, mandatory evacuation shelters will be opened in accordance with this plan.

6. Lane Reversal. Altering the flow of traffic in a manner that traffic on all available lanes is moving in the same direction. Based on the situation, information and recommendations provided by the ESF Evacuation Traffic Management (ESF-16), the SCEMD Director will assess the situation and in coordination with SCDPS and SCDOT, as well as the impacted counties, will make a recommendation to the Governor regarding implementation of the reversal plan.

7. Counter Flow. Altering the flow of traffic in such a manner to allow for at least one lane of traffic to remain in the normal flow direction. On a four-lane highway, three lanes of traffic would move in one direction with one lane moving in the opposite direction.

8. Protective Relocation. Inland counties are not vulnerable to the storm surge; however, they are at risk to the high winds and rain-induced flooding associated with hurricanes. In order to protect this population, it may be necessary to relocate those living in vulnerable structures or low-lying areas. The decision to issue a protective relocation order is the responsibility of each inland county's public officials based on local authority. The SEOC will assist the provide guidance and recommendations.

9. Reentry. Reentry is the transition from evacuation and landfall to the recovery phase. Once the threat of the hurricane has passed or the hurricane has made landfall and initial damage assessment reports are evaluated, the SCEMD Director will recommend that the Governor rescind the mandatory evacuation order and advise citizens to refer to local officials for direction on reentry. A recommendation to the Governor regarding reversing roadway lanes eastbound is based on initial damage assessments and guidance from the Evacuation Traffic Management ESF (ESF-16). Although the SEOC will immediately begin coordination of reentry operations, reentry is managed at the local level.

C. Sheltering Terminology. To prevent confusion and misunderstanding, it is necessary to standardize terminology regarding evacuation issues.

1. Voluntary Evacuation Shelter. In the event that the Governor recommends a voluntary evacuation, all voluntary evacuation shelters within the impacted conglomerate will be prepared to open within four hours.

2. Mandatory Evacuation Shelter. In the event a mandatory evacuation is ordered by the Governor, all mandatory evacuation shelters within the impacted conglomerate will be open within four hours of the mandatory evacuation decision. All voluntary shelters remain open.

3. Reverse Shelter. In the event that the demand for shelters exceeds the capacity of the voluntary and mandatory evacuation shelters, reserve shelters will be opened. This might occur because of a higher than anticipated shelter demand or because of a major hurricane (category 3-5).

4. Shelter Emergency Capacity. The number of evacuees that a shelter can accommodate. During a hurricane landfall event, capacity is base on 20 square feet per person.

5. Sheltering Requirement. An estimate of the vulnerable population needing shelter within each conglomerate. This value is a planning tool for the population that can be accommodated by the shelter emergency capacity.

State System of Operating Conditions (OPCON) levels:

Types of Activities

In order to make maximum use of advance warning, the State has adopted a system of Operating Condition (OPCON) levels. These OPCONs increase the State's level of readiness of a scale from 5 to 1. Each OPCON level is declared when a predetermined set of criteria has been met. OPCONs will not necessarily progress sequentially from 5 to 1. The OPCON placed in effect at any given time will be the appropriate one for existing conditions at the time. The SC CMD director will assign OPCON levels. OPCONs are designated by numbers as shown below:

OPCON LEVEL	Level of Readiness:
5	<p>DAY TO DAY: Throughout the Year (Storms more likely than terrorism)</p> <p>Day to day operations include normal readiness. Training and regularly scheduled drills are conducted throughout the year. Each Center and hospital will maintain a Response Plan which is reviewed and updated annually. DMH staff are pre-selected and oriented as "Away Team" members. Teams may consist of medical and clinical counselor staff in groups of three to four persons. Equipment to be used in the field will be identified and kept in good working order. Center and hospital Disaster Response coordinators attend DMH Quarterly training/orientation meetings in Columbia. During hurricane season (June 1-November 30), all storms are tracked and monitored at this level. Terrorism acts may reduce the timeframe between OPCON 5 and 1 dramatically.</p>
4	<p>ALERT: 48 - 96 Hours Prior to Event</p> <p>There is the possibility of an emergency or disaster situation that may require a partial or full activation of the SC Emergency Operations Center (SC EOC) and county EOC's. Normal weather monitoring by SC EOC staff or DMH Disaster Coordinators reveals that a hurricane condition may exist in the Atlantic Ocean. SC EOC then notifies the agencies on the various ESF's to facilitate the preliminary coordination and preparation of staff and equipment. The Agencies would then pass the information down to local operational levels to ensure an early readiness state. This activity heightens communications and provides a focal point of interest. Plans are reviewed and procedures are noted. The DMH Disaster Manager may be required to report to the SC EOC for "partial activation" and the DMH Disaster Manager would alert the DMH DRTeam members and agency director of full or partial activation of the SC EOC.</p>
3	<p>3 STAND BY: 36 Hours Prior to Event</p> <p>A natural disaster or terrorist act is likely or imminent and, as a result, the SC EOC and county EOC's are partially or fully activated. The decision will be based on the characteristics of the storm or other emergency. The EOC will fully activate the State Disaster Plan which triggers appropriate key support agencies to activate their respective plans. The Agencies will then enter a higher state of readiness by selecting and placing staff/equipment in designated storage areas. Upon notification and with the approval of the DMH Director or his designee, the DMH Disaster Manager will activate the DMH Disaster Response Team (DRT) to assemble in the response site of Room 404 with the appropriate communications equipment. At the same time, full notice is given to the centers and hospitals in the disaster zone so that they may complete necessary preparations and notify vulnerable consumer special populations like children, persons with deafness and the elderly. The primary events which will occur in this stage include evacuation discussions (including voluntary and mandatory evacuation), holding pre-evacuation conferences and many other preparatory activities.</p> <p>The DMH Disaster Manager will report to the SC EOC to facilitate the state and private agency response linkage while leadership at the DRT is assumed by Jac Upfield or Bruce Cannon. As the DRT receives condition reports and specific requests for services, the members will develop and implement plans to detail the requests within DMH resources.</p> <p>An assessment of local readiness is made, particularly in those coastal areas which may be directly affected by the storm. DDS and Red Cross plan when and where to open shelters. DOT strongly considers lane reversals to facilitate voluntary and mandatory evacuations. In inland centers and hospitals, disaster coordinators are implementing their disaster plans by</p>

	<p>identifying response processes, staff and materials. Communications with local Disaster Operations is formalized and mutual support is arranged. Lists of Away Team members are completed in each non affected center and hospital. Each member is given a general orientation as to the disaster area and expected conditions after the storm passes. The Office of Communications will prepare for news releases regarding activities to support local communities and special materials such as children's hurricane and tornado color books are made available. In short, DMH is prepared to provide requested services and staff following the post assessment period of the emergency. Attention to all communication systems will be increased.</p>
2	<p>FINAL PREPARATION: 20 - 24 Hours Prior to the Event</p> <p>The full emergency situation is in effect with all systems and agencies at maximum preparedness levels. Once a state-level decision is made that a voluntary or mandatory evacuation order or emergency is imminent, the level automatically moves to OPCON 2. All EOC's will be under "Full Activation" at this level. Both DMH and SC EOC operations are fully staffed and assessing the events around the disaster. DMH is making final assessments regarding resources like available beds to receive evacuees, food, medication, transportation and ability to respond quickly to local system requests.</p>
1	<p>LANDFALL AND RECOVERY: 24 Hours Prior to 72 Hours After</p> <p>Terrorism response or the emergency is currently occurring and continuous assessment is made during the event. Once the emergency or evacuation order is announced to the public, the level automatically moves to OPCON I. As soon as the initial disaster occurs, the SC EOC dispatches an assessment team to survey the damage and render a report on types of needs, extent of damage and specific resource needs. These findings are relayed to the SC EOC for processing by the state and private agencies there. This information is communicated to the DMH DRT to further detail in terms of needs vs. resources within DMH. The DRT communicates with local MHC's and hospitals to relay specific needs and to determine the location and time table to provide the resources. The DRT matches the requested need with larger system resources and dispatches the resources as expeditiously as possible. Away Teams receive final orientation and are sent into the affected area with necessary supplies. Communication occurs with team members throughout their five day rotation. The DRT also arranges for adequate debriefing as teams return from the disaster area. During the entire recovery phase, documentation is kept to use should a federal assistance grant be necessary. Such grants, if necessary, will be completed by the DMH Grants Coordinator with input from the local Disaster Coordinator, DMH Disaster Response Manager, DRT Coordinator and an appropriate FEMA representative. Grants which require a Principal Investigation will generally designate the local Disaster Coordinator for on site coordination. The DMH DRT will stay open and advise as long as the SC EOC indicates such need exists. Finally, brief overviews will be made available to the DMH Director and Senior Management throughout the operation.</p>

ROLES AND RESPONSIBILITIES OF DMH DISASTER RESPONSE MENTAL HEALTH "AWAY TEAM" MEMBERS

Disaster mental health roles and responsibilities are often complex and diverse. Thoughtful matching of responder skills and personalities to the specific assignment can help ensure success of mental health.

1. Crisis counseling: For most disaster survivors, traditional office type psychotherapy is not necessary or appropriate. Crisis intervention, brief treatment, support groups and practical assistance are most effective. Mental health staff must have a working knowledge and skill in these several modalities.

Qualifications of professional disaster mental health team members.

Ideally, the disaster mental health team should be multidisciplinary and multi-skilled. Staff should be experienced in psychiatric triage, first aid, crisis intervention, and brief treatment. They should have knowledge of crisis, post-traumatic stress and grief reactions, and disaster psychology. Survivors are often reluctant to come to mental health centers for services. As a result, staff must be able to provide their services in non-traditional community-based settings. Prior disaster mental health training and experience are highly recommended. In situations of mutual aid

where licensed professionals cross state lines to provide assistance in disaster, licensing in the impacted state may be waived under the Good Samaritan law. This issue should be investigated in instances of cross-state mutual aid.

Mental health responders should be well-acquainted with the functions and dynamics of the community's human service organizations and agencies. They should have experience in consultation, collaboration, and community education. Excellent communication, problem-solving, conflict resolution, and group process skills are needed, in addition to an ability to establish rapport quickly with people from diverse cultures and backgrounds.

Managers should pay careful attention to the state's scope of practice laws for various mental health professional disciplines. Individuals who provide formal assessment and counseling which fall into the definition of psychotherapy should be appropriately licensed and insured for professional liability.

2. Outreach: Working in disaster affected neighborhoods, mass care shelters, Disaster Application Centers or other community settings requires workers who are adept at such nontraditional mental health approaches as "spot consultations" and "over a cup of coffee" assessments and interventions.

3. Public education and information: Public education efforts require staff that are interested and effective in public speaking and working with the media. The development of fliers and brochures requires good writing skills.

4. Community liaison: Establishing and maintaining effective liaison with community leaders requires individuals who understand and are effective in dealing with organizational dynamics and the political process. Working successfully in the "grass roots" community requires someone who understands the local culture, social networks, formal and informal leadership, and is effective in establishing relationships at the neighborhood level. Liaison activities might include everything from attending school or church gatherings, participating in neighborhood meetings, or providing disaster mental health consultation to government officials.

Utilization of Volunteers:

Spontaneous volunteers who contact the DMH Emergency Operations Center will be referred to the Department of Labor, Licensing and Regulations-LLR-(telephone: 803 896-4300) for primary credential and legal screening. Upon receiving LLR approval for assignment to the disaster recovery process, DMH will consult with the American Red Cross, Department of Social Services and other VOAD partners to determine the best assignment venue for the volunteer. In most cases, the volunteer will be paired with local professionals to provide a mentor relationship in the assigned activity. Due to the variety of conditions and needs in the field, a homogeneous cadre of volunteers would better serve to meet a broad range of disaster situations. Peer counselors will be encouraged to participate fully in the recovery process. The field performance of volunteers will be evaluated by the Team Leader for relevance and appropriateness. All volunteer activity information will be included in the Team reporting assessments. Normal staff rotation schedules will apply to all volunteers. Any volunteer may be returned from the recovery area when, in the judgment of the Team Leader, performance falls below that which is acceptable.

Notice of Distribution:

All DMH mental health center and hospital Disaster Coordinators will be notified that this Manual is posted on the DMH World Wide Web site. They will be encouraged to copy the text and have readily available as an adjunct to their local Disaster Plan. Periodic opportunities for review and input are provided and notices of available updates are circulated. The Disaster Response Manager in the Office of the Medical Director is responsible for the updating and distribution activities.

Notice of the availability of this Disaster Response Manual on the DMH Web site will be provided to all members of the public and private response network comprised of state and private agencies operating within and outside the SC Emergency Management Division, MMRS partners, SC VOAD members, SAMHSA Advisory Council members, SAMHSA and CMHS consultants and local fire/life safety representatives.

Unified Community Crisis Counseling Teams ("Away Teams")

DMH has partnered with the other agencies represented in the SC Emergency Management Division's Emergency Support Function-8 to select, orient, assign and coordinate unified Community Crisis Counseling Teams composed of professionals who have behavioral health training and experience. The Teams will consist of representatives from mental health (DMH), substance abuse (DAODAS), public health (DHEC) and Vocational Rehabilitation (SC VR) developmentally disabled (DDSN). Thus, Team members so comprised, are prepared to bring combined agency resources to bear in the recovery process. These Teams will work collaboratively with the local Incident Command System leadership to provide a broad spectrum of counseling services. Teams will be rotated on a regular schedule which begins with an orientation to site conditions and needs and ends with an exit meeting at the end of the assignment.

School Related Disaster Response

The DMH Division of Children, Adolescents and their Families offer unique services to children and their families during and following All Hazards disaster events. Counseling staff with special training are grouped in teams and dispatched to the area with the disaster. Members have access to specially designed materials to inform, educate and aid youth and their families in the recovery process. DMH representatives will work closely with the SC Department of Education staff and Law Enforcement officials to coordinate all provided services. In the event of an emergency where the local community has exceeded local resources, assistance from DMH school-based mental health professionals is accessed through the following procedure:

- 1-Call your local mental health center and speak with the Director of Children's Services to specify your needs. (See the DMH Web site for center locations, names and phone numbers)
- 2-The Director will contact the appropriate professional(s) to send to your school as soon as possible.
- 3-If you are unable to reach the local mental health center for any reason, please contact the SC Department of Mental Health Public Safety Dispatch phone at 803 935-5470 and ask to be connected to the Children's Division in the agency Administration Building for assistance to meet your immediate needs.

Interface with Disaster Plans of Other Agencies

This Plan has been reviewed by the Administration of Department of Alcohol and Other Substance Abuse Services, American Red Cross, the SC Emergency Management Division and the Department of Health and Environmental Control to be used to cross reference the four Plans in terms of ensuring joint planning and implementation of disaster response services. Such common elements prepare the way for the pooling and distribution of human and material resources. A joint Emergency Operations Center at DMH will be operated by staff from DMH (Disaster Response Team) and the Alcohol and Other Substance abuse agency. Finally, the DMH Community Crisis Counseling Response Teams sent into the disaster area will be composed of staff from these agencies.

Memoranda of Agreement with Related Agencies

The DMH Disaster Response Manager regularly participates in the review and update of the SC Emergency Management Division several specific Disaster Plans. As a result, the DMH is specifically referenced as the designated provider of Disaster Crisis Counseling in a number of citations in the Plans. These reference points are agreed upon by DMH and the other agencies participating in the review process. As the lead agency in Disaster Crisis Counseling, DMH works diligently with other service agencies like American Red Cross, the Department of Social Services (ESF-6) and the Department of Alcohol and Other Drug Abuse Services (ESF-8) to coordinate the respective crisis counseling training and assignment of response teams in times of all hazard disasters. To clarify these roles and responsibilities, DMH has detailed Memoranda of Agreements with the American Red Cross and the SC Department of Social Services (see Appendix). Generally, DMH has agreed that, to the extent possible at the time, the agency will provide both professional and line staff to assist with a multitude of disaster related activities ranging from disaster crisis counseling on the one hand to evacuation shelter services on the other. Each request for staff and/or materials will be evaluated on the basis of the nature and extent of the disaster combined with agency resources availability at the time. It is agreed that each agency will collaborate closely and pledge mutual support to ensure adequate and timely recovery.



for Volunteer Staff Members on "Away-Teams"

- Tetanus toxoid vaccine will be available before departure.
- You will be required to attend an orientation and training session.
- You will be provided proper identification.
- You will be assigned to a site coordinator.
- Transportation, housing and food will be provided.
- Prepare for camp-like conditions to cover three days.
- Be prepared to assist victims who are in physical and mental distress.
- You will be in the disaster area a maximum of 5 days.

- You will be debriefed upon return (1.5 to 2 hrs.).

CHECKLIST

FOR DISASTER MENTAL HEALTH "AWAY TEAMS"

PRIOR TO DISASTER:

	Pre-designate the Go Team members/location
	Include multicultural, multi-language capability to reflect makeup of community
	Include special population workers (children, older adults)
	Orient the Go Team members in disaster mental health outreach techniques and disaster resources
	Train the team on personal and family disaster preparedness; all team members have personal disaster kit (food, water, clothes, sleeping bag, cash, medications, hygiene supplies, flashlight etc.) in trunk of car
	Provide the team with identification cards recognized by S.C. emergency management and local law enforcement officials
	Assemble supplies and equipment for immediate use by team (distribute to team in advance or keep in accessible location)
	Provide cellular phones or arrange with local amateur radio group to provide communication linkage
	Give them a resource directory
	Have brochures and fliers on common disaster reactions, ways to cope, and where to call for help (may leave blank space for disaster hotline numbers); in multiple languages, in needed
	Provide pens, paper, necessary forms, clipboards
	Complete simple data collection forms to track services delivered, funds expended, and to collect needs assessment data for FEMA and other available grants
	Have the office of Communications prepare sample public service announcements (PSAs), news articles, and sample interviews for radio and television; distribute as appropriate.
	Identify and establish relationships with community agencies that will be key to successful outreach efforts: American Red Cross, schools, agencies serving special populations
	Identify special populations or groups in community likely to be vulnerable in disaster; outline outreach strategies and key resources for each group.

DISASTER RESPONSE:

	Identify sites or shelters where groups of survivors are likely to gather (shelters, food kitchens, community centers, hospitals, schools, the morgue, standing in lines, at roadblocks, in neighborhoods, etc.)
	Contact survivors via letters, phone calls, or door-to-door visits; provide informal assessment, education, support and resources
	Establish and maintain contact with agencies, caregivers, key community members, and businesses used by survivors
	Provide public education to community-at-large regarding common reactions, coping strategies, and where to call for help
	Use print and electronic media for articles, interviews, public service announcements, paid advertisements, call-in, TV shows
	Provide public speakers to civic groups, service clubs, PTAs, churches, etc.
	Attend community gatherings and meetings, fairs, and other events; circulate and talk with survivors for informal assessment, education, support, and providing resources

	Hang posters on bulletin boards, buses, bus stops, in clinics, waiting rooms, and other public places
	Distribute brochures and fliers door-to-door, in shopping bags, on literature racks, in department, etc.)
	Acquire or develop boy and girl game activities or coloring books for children
	Train and educate community professionals, caregivers, and informal support systems of survivors regarding mental health aspects of recovery and how to help survivors
	Consult with community professionals and caregivers to facilitate their work with survivors
	Help community organization efforts among survivors or among informal resource groups
	Help community organization efforts among survivors or among informal resource groups

MENTAL HEALTH SERVICES IN DISASTER SHELTER OPERATIONS CHECKLIST

PRE-DISASTER

	Develop a memorandum of understanding between mental health and the American Red Cross.
	Train mental health staff on the disaster mental health plan, roles, and responsibilities.
	Cross-train mental health staff in American Red Cross operations.
	Provide mental health staff with identification cards recognized and approved by emergency management and law enforcement officials.
	Have mental health supplies and materials preassembled for transport to shelter, including mental health brochures in languages appropriate to the community population.
	Clarify procedures with Red Cross for administering medications and record keeping in the shelter.

DISASTER RESPONSE

	Wear proper identification.
	Meet with shelter manager and Red Cross nurse, review and clarify mental health roles and responsibilities.
	Obtain briefing on conditions, tour the shelter, become familiar with operation.
	Assess population of survivors for special needs, e.g., children, older adults, mentally ill, specific ethnic groups, drug/alcohol dependents, individuals experiencing severe loss or trauma, language interpreter services.
	Develop mental health staffing schedule according to needs.
	Set up quiet area for mental health consultations, and drug/alcohol detoxification room if needed. Consult with shelter manager and nurse as needed regarding shelter environment, needs of individual survivors, and stress management for shelter staff.
	Assist in establishing sources of information for shelter: Disaster Welfare Inquiry, newspapers, bulletin boards, briefings by emergency officials, brochures about resources, etc.
	Assist in establishing activities to promote stress reduction for shelter residents and staff, e.g., childcare, recreation, exercise, support and debriefing groups.
	Circulate through the shelter and provide brief assessment, intervention, comfort, assistance, and follow-up for individual shelter survivors and staff as needed.
	Distribute brochures on mental health reactions of adults and children to disaster, self-help stress management suggestions, and where to call for additional help.
	Provide staff support groups, stress reduction activities, brief supportive counseling services, and debriefings for shelter staff and volunteers.
	Provide in-service training or consultation to shelter staff about mental health issues pertinent to the shelter population.
	Provide a summary report of mental health conditions and significant activities to each new shift of mental health and American Red Cross personnel.

	Set up a charting system for persons receiving psychiatric evaluations, medications, or intervention of more than a brief nature.
	Keep accurate records of numbers of people seen, problems they were experiencing, and types of interventions given.
	Maintain records of staff hours, supplies, and costs associated with their shelter assignment.
	With agreement of Red Cross Management, provide debriefing for Red Cross personnel at the end of shelter operations (if other mental health resources are not providing the service).
	Arrange debriefing by outside resource for mental health personnel at the end of shelter operations.

POST-DISASTER

	Provide recognition to mental health staff for contribution to the disaster effort, including those who stayed at the clinic or office to "mind the store."
	Arrange a critique for mental health staff to evaluate effectiveness of their shelter operations.
	Revise disaster plan, policies, procedures, and memoranda of understanding, based on recommendations from the critique.

STATE LEVEL EMERGENCY MANAGEMENT

General:

The authority and responsibility for emergency management at the state level belong to the Governor or his/her designee. While state laws vary, the Governor is typically given the powers or options to do the following:

1. Suspend state statutes, rules and regulations.
2. Procure materials and facilities without regard to limitations of existing law.
3. Direct that evacuation be initiated.
4. Control the entrance to and exit from the disaster area.
5. Authorize the release of emergency funds.
6. Activate emergency contingency funds and reallocate state agency budgets for emergency work.
7. Issue state or area emergency declarations and invoke appropriate state response actions.
8. Apply for and monitor federal disaster and emergency assistance.

Specific

Day to day emergency management responsibilities are delegated by the Governor to the lead agency in the state, called the SC Emergency Management Division. Various other state agencies are mandated to carry out assigned activities related to mitigating the effects of an emergency and to cooperate with each other and other political subdivisions in providing assistance.

The responsibilities of the SC Emergency Management Division are as follows:

1. Prepare and maintain a comprehensive state emergency plan and emergency management program.
2. Assign emergency functions to various state agencies, and coordinate the activities of the agencies in developing the state emergency plan.
3. Ensure that all personnel assigned specific responsibilities in support of the state plan are adequately trained and prepared to assume those responsibilities.

4. Support and facilitate local government preparedness efforts, to ensure that disasters are handled at the lowest government level; write standards and requirements for county and municipal plans; and review and maintain a file of current plans that are developed or updated under those standards.
 5. Oversee the damage assessment process following emergencies.
 6. Administer and coordinate state resources providing assistance requested by the county or affected area, and request federal disaster assistance, if warranted.
 7. Administer the state mutual aid system, with regional or state staff assisting local emergency operations at the request of local disaster coordinators.
 8. Maintain mutual aid agreements with adjoining states.
- When a disaster exceeds the local government's ability to respond effectively, the state Emergency Management Division activates functions that are essential to a coordinated response in support of the local jurisdiction.

ORIENTATION OF DISASTER STAFF TO COMMUNITY ASSIGNMENTS

In addition to training, managers should be sure that an orientation to the disaster is provided to mental health staff before deployment. The following topics should be covered:

1. Status of the disaster: nature of damage and losses, statistics, predicted weather or condition reports, boundaries of impacted area, hazards, and response agencies involved.
2. Orientation to the impacted community: demographics, ethnicity, socioeconomic makeup, pertinent politics, cultural mores, language requirements, etc.
3. Local Community and disaster-related resources: handouts with brief descriptions and phone numbers of human service and disaster-related resources. FEMA or the state Office of Emergency Services (OES) usually provides written fliers describing state and federal disaster resources once Disaster Application Centers (DACs) are opened. If available, provide them to all staff. Provide workers with a supply of mental health brochures or fliers to give to survivors, outlining normal reactions of adults and children, ways to cope, and where to call for help. For volunteers or mutual aid personnel, provide a brief description of the sponsoring mental health agency.
4. Logistics: arrangements for workers' food, housing, obtaining messages, medical care, etc.
5. Communications: how, when, and what to report through mental health chain of command; orientation to use of cellular phones, two-way radios, or amateur radio volunteers, if being used.
6. Transportation: clarify mode of transportation to field assignment. If workers are using personal vehicles, provide maps, delineate open and closed routes, indicate hazard areas; provide appropriate agency approved identification materials.
7. Health and Safety in a disaster area: outline potential hazards and safety strategies (e.g., protective action in earthquake aftershocks, flooded areas, etc.). Discuss possible sources of injury and injury prevention. Discuss pertinent health issues such as safety of food and drinking water, personal hygiene, communicable disease control, disposal of waste, and exposure to the elements. Inform of first aid/medical resources in the field.
8. Field assignments: outline sites where workers will be deployed (shelters, meal sites, etc.). Provide brief description of the setup and organization of the site and name of the person to report to. Provide brief review of appropriate interventions at the site.
9. Policies and procedures: briefly outline policies regarding length of shifts, breaks, staff meetings, required reporting of statistics, logs of contacts, etc. Give staff necessary forms and inform where to return forms.
10. Self-care and stress management: require the use of "buddy system" to monitor each other's stress and needs. Remind responders of the importance of regular breaks, good nutrition, adequate sleep, exercise, deep breathing, and positive self-talk, appropriate use of humor, "defusing" or talking about the experience after the shift is over. Inform workers regarding required debriefing to be provided at the end of each tour of duty in the field.

DISASTER RESPONSE: IMPACT ON STAFF

Disaster workers go through a series of emotional phases related to the nature of their jobs. At times, workers may feel "out of sync" with the reactions of survivors. This is especially common in the early hours and days of the disaster while workers are still making heroic efforts to organize and deliver services. At other times, mental health workers may closely identify with survivors and experience their emotions vicariously. While it is impossible to specify exactly what a given mental health worker will experience at any one point in time, the following are the usual disaster worker phases:

Alarm phase. This phase involves comprehending and adjusting to the news of the disaster, collecting and making sense of whatever facts and information are available, and gearing up to respond. In a warning period in which workers are waiting to see whether an event will materialize (a tornado watch, for example), they may experience vague feelings of anxiety, restlessness, and irritability. Post-impact, workers, like survivors, may initially feel shocked and stunned. An orientation or briefing for workers before they first enter the disaster area can help to prepare them for the conditions they may find, and can help to reduce some emotional shock.

Mobilization phase. Workers quickly recover from their initial shock and start developing and coordinating plans. Supplies, equipment, and personnel are inventoried and local community needs are assessed. Mental health center/hospital aid may be requested. Staff are selected and activated.

Action phase. Workers actively and constructively work at necessary tasks. There are two aspects to the mental health action phase (New Jersey Office of Emergency Management, Dec. 1991):

A. Response. This phase occurs immediately before, during and after the impact. Mental health response activities may include staffing at shelters, first aid stations, meal sites, morgues, Emergency Operations Centers, or command centers. There is usually a high level of activity and often a high level of stress. Many frustrations may occur due to adverse conditions, lack of equipment, communication breakdowns, and the like. Nevertheless, workers proceed diligently and often heroically, frequently ignoring their own fatigue and injuries. During disaster operations that continue for more than a day or two, worker burnout can occur if needs for breaks, food, sleep, and stress management are ignored.

B. Recovery. Short-term recovery includes activities intended to return vital life-support systems to more normal levels of operation. Psychological first-aid, crisis intervention, and defusing are short-term mental health recovery activities. Long-term recovery activities are designed to return life to normal or improved levels. Long-term mental health recovery activities include outreach, consultation and education, individual and group counseling, community organization, advocacy, and referral to community resources. Mental health recovery services in the long-term may extend to or beyond the first anniversary of the disaster. Recovery-phase disaster work has a slower pace and can be less immediately rewarding than early-phase response. Because disaster survivors do not usually seek out counseling services in large numbers, outreach and community education activities comprise a large part of recovery activities. Because of the lack of large numbers of clients, combined with the difficulty of evaluating effectiveness of outreach and education efforts, workers can lose heart and question the value of their work.

The emotional impact of disaster is especially strong for workers if contact with survivors is prolonged. Staff identify with and sometimes take on the frustrations in their rebuilding efforts. Continuous exposure to survivors' stories of loss and grief can be painful for workers, and, if unrecognized, can play into an unconscious desire to avoid listening to painful material.

Letdown phase. This phase involves the transition from the disaster operation back into the normal routine of work and family life. It can be a difficult period for workers if feelings have been suppressed or denied during the action phase, and the feelings now begin to surface. In addition, workers may experience feelings of loss and "letdown" as they move out of the challenging disaster assignment and return to their usual activities.

WORKER STRESS REACTIONS DURING THE DISASTER

The following are some list of common disaster worker stress reactions. They are provided to alert workers and supervisors to what stress reactions commonly occur, and to help them in determining if they are experiencing a problematic level of stress. Usually, the symptoms are normal in every way, and simply suggest a need for corrective action to limit the impact of a stressful situation. In some situations, stress symptoms may be delayed for weeks, months, or years following the event.

No clear-cut guide exists for how and when to know if workers are experiencing excessively high stress levels. One fact is clear: workers are usually not the best judges of their own stress, as they tend to become intensely involved in the disaster work. Therefore, a buddy system, where coworkers agree to keep an eye on each other's stress reactions, can be important.

Table 1 shows the common stress reactions that may occur for disaster workers.

**TABLE 1
COMMON DISASTER WORKER STRESS REACTIONS**

PSYCHOLOGICAL/EMOTIONAL

Feeling heroic, invulnerable, euphoric
Denial
Anxiety and fear
Worry about safety of self or others
Generalized anger
Irritability
Restlessness
Sadness, grief, depression, moodiness
Distressing dreams/unsatisfying sleep
Guilt or "survivor guilt"
Feeling overwhelmed and hopeless
Feeling isolated, lost or abandoned
Apathy, emotionally neutral
Over identification with survivors

COGNITIVE

Memory problems
Disorientation
Confusion
Slowness of thinking and comprehension
Difficulty calculating, setting priorities, making decisions
Poor concentration
Limited attention span
Loss of objectivity
Unable to stop thinking about disaster
Blaming

BEHAVIORAL

Change in activity levels
Decreased efficiency and effectiveness
Difficulty communicating
Increased use of humor
Outbursts of anger and/or frequent arguments
Inability to get proper rest and feelings of being "let down"
Change in eating habits: too much or too little
Change in sleeping patterns
Change in patterns of intimacy, poor sexual performance
Change in job performance
Periods of crying and depression
Increased use of alcohol, tobacco, and other drugs to excess
Social withdrawal, increased silence
Vigilance about the safety of the environment
Avoidance of activities or places that trigger negative memories
Proneness to accidents and falls

PHYSICAL

Increased heartbeat and breathing pattern
Increased blood pressure
Upset stomach, nausea, diarrhea
Change in appetite, weight loss or gain
Sweating or chills
Tremors (hands, lips, facial area)
Muscle twitching
"Muffled" hearing
Tunnel vision
Feeling uncoordinated

Headaches
 Soreness in muscles
 Lower back pain
 Feeling a "lump in the throat"
 Exaggerated startle reaction
 Fatigue
 Menstrual cycle changes
 Change in sexual desire
 Decreased resistance to infection through immune system suppression
 Flare-up of allergies and arthritis
 Hair loss

Table 2 provides a list of physical stress reactions that require prompt medical evaluation.

TABLE 2
PHYSICAL STRESS REACTIONS REQUIRING PROMPT MEDICAL EVALUATION

Chest pains
 Irregular heartbeat
 Difficulty in breathing
 Fainting or dizzy spells
 Collapse
 Unusually high blood pressure
 Numbness or paralysis of part of body
 Excessive dehydration
 Frequent vomiting
 Blood in stool

HOW TO KNOW WHEN STRESS REACTIONS BECOME A PROBLEM

Usually, worker stress reactions will diminish with practice of stress management approaches, the passage of time, the ability to talk about the event and its meaning, and the support of family, friends, and the worker's organization. Sometimes, the disaster or disaster work may be so stressful for the worker that symptoms do not seem to diminish on their own. The following are some guidelines for separating normal stress reactions from those that may be problematic:

Duration: the duration of a stress reaction will depend on the severity of the event, the meaning of the event to the worker, and the individual's coping mechanisms and support system. Stress symptoms related to the actual disaster usually subside in about six weeks to three months. Intense symptoms lasting longer may require professional assistance. Stress reactions related to the stressors of the disaster assignment can continue as long as the worker is in his/her disaster role. Careful attention should be paid to eliminating occupational stressors, providing organizational supports for workers, and building stress management strategies into the workplace. In addition, it is important to provide workers with anticipatory guidance about transition back into regular work roles and activities.

Intensity: This is a highly subjective criterion. However, any symptoms that seem acutely intense, disturbing, or out of control to the worker may require professional assistance. In particular, unusual physical reactions, visual or auditory hallucinations, extremely inappropriate emotions, phobic or panic reactions, antisocial acts, serious disorientation, or suicidal or homicidal thoughts should receive mental health assistance.

Level of functioning: Any symptoms that seriously interfere with an individual's functioning at work, at home, or in social relationships should be considered for mental health assistance.

ORGANIZATIONAL SUPPORT FOR MENTAL HEALTH STAFF IN THE IMMEDIATE RESPONSE PHASE

In the response phase during and immediately after impact of the disaster, the provision of certain supports for workers can help mitigate stressors and help workers to remain effective in their jobs. There are a variety of services such as communications, food, shelter, and supplies that are essential to "keep the organization going." In a large-scale disaster mental health operation, the organization must consider assigning a logistics coordinator to this function. The following should be considered.

Assistance with locating and checking on families

When disaster strikes during work hours, employees' prime concern will be learning information about the well-being of their families. Worker

anxiety will increase and efficiency will markedly decrease until such information is obtained. Some anxiety may be mitigated if workers have disaster plans at home, and know that their family members have the skills and supplies to take care of themselves. Nevertheless, staff will need information about the status of their families.

If workers do not have information about the well-being of their families, the organization should make every effort to help them in obtaining information. All agencies with disaster responsibilities should have a pre-established plan for how employees will check on their families if disaster strikes during the work hours. It has been suggested that each employee should have on file a regularly updated list of family members, addresses, phone numbers, and usual whereabouts during given hours of the day. Employees are strongly encouraged to establish a plan with their family members by which the family will make every effort to contact the workplace to report on family well-being. This is especially important in those situations where employee roles are essential and they may not immediately be able to leave the workplace.

If conditions allow, staff may be released to go home and take care of their families before reporting to duty for disaster response. In the situation where staff cannot be released (on an inpatient unit, for example), there are several options. When additional staff report for duty, staff can be released to check on families. Staff in less critical roles (clerical staff, for example) may be assigned to family locator functions, and may go into the community to check on families, conditions permitting. If phones are working, one line can be dedicated to family search activities.

Debriefing of mental health staff

It is essential that disaster mental health workers begin to process their own emotions about the disaster before attempting to help survivors. It is strongly recommended that a pre-deployment briefing or other group discussion of workers own reactions be conducted for workers before deployment.

Utilization of a team approach

Whenever possible, mental health personnel should be assigned to work in teams of two. If there are not enough mental health workers to allow this arrangement, staff can often work in a team assignment with public health nurses, Red Cross workers, or other human service-type disaster responders. This ensures a system by which staff can serve as a check-and-balance for each other in assessing needs, making decisions, setting priorities, etc. in the chaotic disaster environment. It also provides staff with a "buddy system" for monitoring each other's stress level and providing support and encouragement.

Briefing

Provide workers with as much information as possible about what they will find at the disaster site. This may involve a quick briefing before sending workers into the field, or a briefing for new staff as they arrive at the scene. This forewarning can help personnel gear up emotionally for what they may find.

Work related supplies

Pens, paper, data collection forms, name tags, educational brochures on disaster stress reactions and stress management, and any other necessary supplies should be sent with workers to the worksite.

Official identification

Official identification cards that are recognized by law enforcement will be necessary to enter the disaster site. In addition, name tags will be important once staff get to their assigned worksite. Most disaster survivors do not see themselves as needing mental health services, and may shy away from talking to staff that have name tags saying "psychologist" or "psychiatrist." Experience has shown that titles like "crisis worker," "crisis services," or "health services" are less intimidating to survivors.

CHECKLIST

SUPPORT AND STRESS MANAGEMENT FOR DISASTER MENTAL HEALTH RESPONSE WORKERS

PRE-DISASTER ACTIVITIES

	Develop a mental health disaster plan that specifies responsibilities and functions of mental health personnel in time of disaster.
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	Train mental health staff in disaster roles, responsibilities, principles of disaster mental health practices, and stress management for disaster workers.
	Participate in regular area and statewide disaster exercises.
	Strongly encourage all mental health staff to have family, school, and workplace disaster preparedness plans.
	Prepare or obtain brochures on disaster work stress.
	Provide mental health staff with identification cards recognized and approved by emergency management and law enforcement officials.
	Purchase or designate supplies and equipment to be used in time of disaster.

DISASTER RESPONSE ACTIVITIES

	Support and assist mental health staff in locating their families and assessing personal losses.
	Brief staff regarding conditions in the field before deploying them to their assigned sites.
	Provide staff with necessary supplies, including brochures on disaster worker stress management and self-care.
	Establish chain of command and supervision from Emergency Operations Center to field staff; brief staff.
	Establish a mechanism for communicating with staff in the field; provide staff with necessary communications equipment.
	Arrange for food and shelter for staff in field, if necessary.
	Determine safe routes to sites where workers will be assigned; provide escort of transportation for staff if necessary.
	Be sure all staff have official identification.
	Deploy staff in teams of two or more.
	Ensure team coordination with other community resources, e.g., American Red Cross Disaster Services.
	In the field, observe staff for signs of stress; encourage good stress management practices.

DISASTER RECOVERY ACTIVITIES

	Assign staff to work in teams on long-term recovery projects.
	Provide regular in-service training and consultation to staff.
	Provide regular, periodic debriefing or support groups.
	Observe staff for signs of stress and burnout; encourage good stress management practices.

POST-DISASTER ACTIVITIES

	Provide debriefing by a trained facilitator for staff at the end of the disaster assignment.
	Engage staff in a critique of the disaster operation or project.
	Provide recognition to staff who participated in disaster operations as well as those staff who "held down the fort" by covering regular work assignments.

SCDMH Division of Disaster Response Management

SCOPE OF DISASTERS

Level I: (Limited Scope)

- An incident that causes a single or several (usually less than ten) casualties at a single site.
- The impact of the incident affects more than one individual family because of its nature (e.g., human-induced tragedy, is witnessed by

- numerous people, directed towards a particular group, causing fear and anger among a residential, cultural or work community).
- This level of incident does not involve any activation of the DMH State Disaster Plan.
- The event is localized to a single family, residential or work group and the immediate response by emergency caregivers is brief and handled by local resources. The mental health center response is triggered by a request from the affected community to provide intervention.
- The need is for limited, planned post-disaster intervention and possible referral for aftercare recovery services.

In the event of a Center Specific loss or tragic event which impacts the entire Center, The Office of the Medical Director, Division of EPPR upon the request of the affected organization shall ensure the operations of the Center are covered by clinical and administrative staff and shall provide post traumatic stress debriefings as requested.

Level II: (Moderate):

- Disaster affecting multiple family units; multiple human casualties/injuries, property damage (usually contained to single site) and severe impact on local resources, localized management.
- Local mental health center resources are not adequate to respond and may require non-affected centers and hospitals to assist through mutual agreement.
- Many necessitate the establishment of shelters when evacuation is necessary and/or reception centers for identification of survivor and victims and provision of entitlement(s). Requires coordination with the ARC and DMH Disaster Coordinators as well as lead agencies at shelter or reception center; mental health responders will be needed on site either at disaster, shelter or reception center as well as for planned post-disaster intervention and follow-up. Necessitates tracking of survivors.

Level III: (Severe/Major): May be large scale natural event or massive act of terrorism

- Resources are overwhelmed, heavy human casualties, extensive property damage; local/state emergency declared and may include application for Presidential Declaration of Disaster.
- Requires ongoing onsite and shelter assistance with integrated, planned intervention, ongoing assistance for social services and follow-up recovery activities.
- Will require assistance from centers and hospitals outside the region and, perhaps, statewide/national, extensive in terms of impact on physical safety, time of duration, etc.
- Differentiated from Level II by length of immediate impact and need for increased on-site assistance, need for coordination with crisis response teams outside the geographic area.

SCDMH DISASTER MATRIX: Local and State Declared

Local Community Disasters:

LOCAL DISASTER is any event, real and/or perceived, which threatens the well being (life or property) of citizens in one local community

A LOCAL DISASTER is manageable by local representatives without a need for outside resources.

RESPONSE is by local government, such as mental health center staff, police, fire chief, mayor or county judge and/or other legal authority of local government.

A RESPONSE by a Community Mental Health Center (CMHC) is NOT required by State Authority. The CMHC MAY choose to respond if a request is made by local officials and/or a need is evident.

There is no set time of duration for response to a local disaster and this type of disaster is not usually reimbursable.

STATE DECLARED DISASTERS:

A STATE DISASTER is any event, real and/or perceived, which threatens the well being of citizens in multiple cities, counties, regions, and/or overwhelms a local jurisdiction's ability to respond, or affects a state owned property or interest.

A STATE DECLARED EMERGENCY can only be designated by the Governor or his/her designee. Response and Recovery is the responsibility of the SC Emergency Management Division and its public and private sector partners.

A RESPONSE MAY BE required depending upon the magnitude, nature and duration of the emergency or disastrous event. The SC Department of Mental Health (SCDMH) may also supplement local resources with hospital and center staff and/or other staffing opportunities.

The DURATION OF RESPONSE for this category of disaster is generally for the duration of the event or until it is jointly determined by the SCDMH and the SC Emergency Management Division, that a response is no longer necessary and/or appropriate.

This type of disaster may not be REIMBURSABLE. Only under highly unusual circumstances would the SCDMH be allowed to apply for funds.

Disaster Matrix Graphic

Disaster Definition		Ownership	Response Required	Duration of Response	Reimbursable
Local	A local disaster is any event, real and/or perceived, which threatens the well being (life, property) of citizens in one municipality. A local disaster is manageable by local officials without a need for outside resources.	Local government, such as a mental health center, police or fire chief, mayor or county judge and/or other legal authority.	A response by a Community Mental Health Center is NOT required by the State Authority. The mental health MAY center choose to respond if a request is made by local officials and/or a need is evident.	Not applicable.	YES/NO YES, upon requested and approval by the State and Federal authorities. If a disaster is approved for "Public Assistance," a municipality may apply for reimbursement. YES, if the SCDMH seeks Federal Crisis Counseling Program Grant or through the Governor's office.
State	A state disaster is any event, real and/or perceived, which threatens the well being of citizens in multiple cities, counties, regions, and/or overwhelms a local jurisdiction's ability to respond, or affects a state owned property or interest.	A state declared emergency can only be designated by the Governor or his/her designee. Response and recover is the responsibility of the SC Emergency Management Division.	A response MAY BE required depending upon the magnitude, nature and duration of the emergency or disastrous event. The SCDMH may also supplement local resources with hospital staff and/or other staffing opportunities.	For the duration of the event or until it is jointly determined by the SCDMH and the SC Emergency Management Division, that a response if no longer necessary and/or appropriate.	NO Only under highly unusual circumstances would the SCDMH be allowed to apply for contingency funds from the Governor's office.
Federal	A federally declared disaster is any event, real and/or perceived, which threatens the well being of citizens, overwhelms the local and state ability to respond and/or recover, or the event affects federally owned property or interests.	A federally declared disaster can only be designated by the President of the United States. The Governor of a state must request a Presidential Declaration.	YES A response will be required according to actual or perceived need.	For the duration of the event or until it is jointly determined by the SCDMH and the SC Emergency Management Division, that a response is no longer necessary and/or appropriate. For the duration of the grant period, if a Federal Crisis Counseling Program Grant is obtained.	YES/NO YES, upon requested and approval by the State and Federal authorities. If a disaster is approved for "Public Assistance," a municipality may apply for reimbursement. YES, if the SCDMH seeks Federal Crisis Counseling Program Grant or through the Governor's office.

NASMHPD: All Hazards Disaster Planning – December 2002

Hazard-Specific Planning

In the context of plan content that applies to nearly all types of events, there is a need to plan for the specific and sometimes unique aspects of these different events. Events may have unique characteristics that lead to special psychosocial consequences that have significant implication for the DMH (i.e. slow-rising, long-standing flooding may result in delayed reconstruction or repair to homes and may result in victims spending longer periods of time in shelters or with friends and families, which can generate additional individual and family stress).

In addition, some types of events are accompanied by significant government regulations that have serious impact on the response and recovery, and may impact psychosocial sequelae. For example, the locations where suspected terrorist events occur are considered crime scenes. This may result in delayed body recovery and release of surviving victims. It may result in recovery workers also becoming witnesses for criminal proceedings. These special factors can have a significant impact on the course and timing of psychological recovery.

Hazard-specific planning by the DMH should also occur in the context of such planning by the SC Emergency Management Division (EMD). The DMH workers will have performed significant and detailed risk assessments that can be utilized by the DMH. This planning will also include identification of events when an agency other than emergency management (e.g., the FBI or military) is in control of the response. Plans should include identification of types of risks as well as geographic areas that are believed to be at risk. Not all states are susceptible to the same risks, and different portions of states may be at greater or lesser risk for different types of events. In addition, the DMH may have facilities in high-risk areas or facilities that are to be used as back-up facilities.

A detailed listing of types of risks a state may experience can be found in the matrix in Appendix A.

Terrorism

Planning for the consequences of terrorist acts presents numerous challenges. The national experience and the experience of most individual states is limited. There are many types of potential terrorist acts to consider during planning. The scientific knowledge about the psychological and medical aspects of some types of terrorist acts, especially bioterrorism, is not as precise and complete as had been thought. Because there is so much emphasis currently on preparing for a wide variety of terrorist incidents, the planning environment is changing very rapidly, with new laws, guidelines, and key players emerging constantly.

In some cases the DMH plan could reference the EMD plan. There may also be reluctance to put some material in a plan that is posted on the Web or is otherwise easily accessible to a very wide audience. Again, taking the lead of the DMH may be the best strategy. With these factors in mind, the DMH plan for terrorism should be developed by being informed of the following issues.

- An understanding of potential hazards such as chemical, biological, nuclear/radiological, explosive, cyber, or combined events. There are many types of events that might stem from these overall classifications. States with rural areas and Agri-business industries should also include Foreign Animal Diseases (FADs) that may be introduced accidentally or criminally. Planning should reflect those types of events that EMD has included in their planning.
- Identification of potential targets that reflect or are consistent with those identified by the EMD. This will not only ensure that there has been DMH and EMD communication on these potential targets, but that planning between the two agencies is consistent.
- Description of (or reflection of the DMH plan's) situational assumptions such as environment (e.g., prevailing winds), populations and population centers, urban city, infrastructure (water, sewer), transport patterns (roads, railways), airports (public, private, military), trains/subways, government facilities (non-military), military installations, recreation facilities, facilities containing hazardous materials, and other high-risk targets such as financial institutions, universities, hospitals, research institutes, schools, and daycare centers. By completing a description of situational assumptions, the DMH will ensure that planning is consistent with EMD, while considering where needs may occur, what mental health resources may be at risk, and where to place preparedness priorities.
- Description of the SMHA's terrorist incident management protocol with special attention to aspects where incident management may be different than in other types of disasters.
- Reflection of state emergency plan's modeling of potential releases of hazardous materials or biological agents. This will again increase the potential of DMH/EMD plan coordination, as the SMIHA will be able to identify specific scenarios that may generate special mental health needs (e.g., evacuations, decontamination sites, etc.), assess vulnerability of mental health service sites, identify alternative sites, evaluate the deployment of mental health resources, etc.
- Documentation of how incident management by the DMH reflects roles of other state and various federal agencies and resources.
- Description of how plan's consequence management reflects involvement of various federal components (such as FEMA, SAMHSA/CMHS resources, Office for Victims of Crime in the Justice Department, and Safe and Drug Free Schools in the Department of Education).
- A reflection of the state emergency plan in cases where terrorist events trigger different response, authorities, and policies within the

functional annexes described in the previous section.

- Collection of links to health and medical entities to assist in screening potential victims for mental disorders and psychogenic symptoms, functional impairment, substance abuse, etc. One of the great concerns following a bioterrorist incident is the rapid utilization of health and medical resources to not only those who have been exposed but those who believe they have been exposed. This is an area where close collaboration in the planning and response phase among the DMH, the health agency, local hospitals, and other health care facilities is paramount.
- Links with the health agency for surveillance, screening, consultation, intervention planning, and risk communication. In events that have major public health implications, the state health agency will have a lead role. The valuable role that the DMH can and should play in the activities described is often not understood by the state health agency. Collaboration in the planning process can result in enhanced response by both the DMH and health agency.
- A description of the DMH's authority in risk communication and response. As noted before, this is an area where collaboration between the DMH, DHEC, and the state emergency management public information structure is critical.

Continuity of Operations for the State Mental Health Agency(SCDMH)

No organization can mount a response to a disaster if the fundamental operations of that organization are not functioning. DMH is no exception. In addition, there are preexisting and ongoing responsibilities of the DMH that do not stop, even when disaster strikes. As a result, part of a meaningful plan is the provision for the DMH to continue its essential functions when disaster strikes through a Continuity of Operations Plan (COOP). In many states, these issues will be contained in documents separate from the DMH Disaster Plan. In some states, it will be integrated as part of the disaster plan. In any case, there is certainly a role for disaster planners in preparing for worker stress issues inherent in any situation that would activate a COOP. To ensure continuity of essential operations, the following items should be addressed.

- A statement of goals for the Continuity of Operations Plan is necessary. The goal in most states is to maintain or reestablish vital functions of the DMH during the first 72 hours following any event that would seriously compromise or halt normal operations.
- As in other components, there should be documentation of coordination with the overall state Continuity of Operations Plan.
- The plan should identify vital functions, records, and data to be maintained within the first 72 hours.

FEDERALLY DECLARED DISASTERS:

A **FEDERALLY DECLARED** disaster is any event, real and/or perceived, which threatens the well being of citizens and overwhelms the local and state ability to respond and/or recover, or the event affects federally owned property or interests.

A **FEDERALLY DECLARED** disaster can only be designated by the President of the United States. The Governor of a state must request a Presidential Declaration of disaster.

A **RESPONSE** will be required and the level of response will be according to actual or perceived needs.

The **DURATION OF RESPONSE** for this type of disaster will be for the duration of the event or until it is jointly determined by the SCDMH and the SC Emergency Management Division, that a response is no longer necessary and/or appropriate. For the duration of the grant period, if a Federal Crisis Counseling Program Grant is obtained.

This type of disaster will be reimbursable only upon request and approval by the State and Federal authorities. If a disaster is approved for "Public Assistance", a municipality may apply for reimbursement. Also, if the State Authority seeks a Federal Crisis Counseling Program Grant or through the Governor's Office funds for these services will be made reimbursable.

Appendix D - Miscellaneous

[Link to National Incident Management System Testing \(NIMS\)](#)

[Heat Wave: A Major Summer Killer](#) (.pdf format)

Criteria for the [Selection of Disaster Crisis Counselors](#) (.pdf format)