

The incident
response
coordination team
essay sample



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Recommended Updates. Within the Incident Response Coordination Team (IRCT), the Incident Commander is responsible to maintain oversight of the general health and well-being of assigned emergency responders through the Safety Officer. Initially, the IRCT's only mental health position was the Behavioral Health Liaison Officer (BHLNO) who surveys the mental/behavioral health status amongst the local disaster victim population and reports back to the IRCT Commander.

The 2014 Disaster Behavioral Health CONOPS added another layer of oversight by creating the position for a second safety officer designated to oversee emergency responders' behavioral and mental health; the Behavioral Health Safety Officer (BHSO). Before this addition, the BHLNO (a mental health professional)—purely based on training and empathic impulse—monitored responders for signs of mental/emotional distress.

However, with increasing need and respect for mental health care teams, and particularly influenced by severe psychological trauma responders experienced following the massacre at Sandy Hook Elementary School, ASPR implemented the DBH CONOPS.

Draft Standard Operating Procedure for Signature. In order to elucidate the entirety of this project, and make its recommendations readily accessible throughout the federal disaster response network, the final deliverable for this practicum comprised was assemble the necessary updates, changes and

The purpose of the Standard Operating Procedure (SOP) is to provide information and guidance critical to creating behavioral health support for federal HHS response operations personnel—deployed to local, state,
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regional and all levels of command-and-control positions—before, during and after response activities; while also setting the behavioral and mental health force protection “ benchmark” for state response operations as well as volunteer coordination leadership working hand-in-hand with the local affected population.

Specifically, the duties and responsibilities outlined in the Department of Health and Human Services’ Disaster Behavioral Health Concept of Operations (DBH CONOPS) for both the Behavioral Health Liaison Officer (BHLNO) and the Behavioral Health Safety Officer (BHSO). Behavioral Health Liaison Officer Duties and Responsibilities. In accordance with the DBH CONOPS pages 37-38, BHLNO Job Aid (2014), the BHLNO is charged to liaise with federal, STT, local mental and behavioral health officials and other relevant partners; to include ASPR/ABC for federal oversight, planning and preparation.

His/her responsibilities The BHLNO should actively monitor and provide routine expert assessments, to the IRCT Commander, of the varied mental and behavioral health needs on-the-ground—for both the disaster-affected population and its responders—as well as the capabilities of, and services provided by, state/local entities. To The BHLNO audits and facilitates behavioral health force protection through education, promotion, and communication. In coordination with the BHSO and MHT Lead, develop mental and behavioral health in- and out-processing briefings for all federal response personnel reporting to the IRCT, including volunteers.

In cooperation with IRCT Leadership, establish and maintain records for tracking responder attendance to in- and out-processing briefs; consider incentives for 100% individual or group participation. Report completion/non-completion rates and or names to IRCT Commander as required. Locate, study, and promote use of mental and behavioral health self-assessment and -regulation tool (example at Attachment 8. 1). Establish and maintain regular contact with BHSO and MHT Lead; gather information necessary to determine responders' potential psychological needs, implement varied mitigation measures (examples provided in Attachment 8. 3), and report results to IRCT Commander.

During response operations, in cooperation with IRCT personnel, establish and regularly practice plans for communication during connectivity-challenged times (i. e. , compromised cell towers/internet, areas of low coverage, etc.). Download, update, and consult with SAMHSA Behavioral Health Disaster Response application; educate and encourage MHT members' use throughout response operations. Promote SAMHSA distress line as required; phone 1-800-985-5990, text ' TalkWithUs' to 66746, or <http://www. disasterdistress. samhsa. gov>.

Prepare for response operations through regular " continuing education" using recommended reading and training lists below. Behavioral Health Safety Officer Duties and Responsibilities. In accordance with the DBH CONOPS (page 39, BHSO Job Aid), determine and regularly provide expert assessments to IRCT Commander and BH LNO regarding responder mental and behavioral health needs as well as their abilities and effectiveness in the

field. Monitor and facilitate behavioral health force protection through education, promotion, and communication.

Gather and disseminate information as required. Monitor and evaluate potential exposure risks during response operations. Locate, study, and promote use of mental and behavioral health self-assessment and self-regulation tools (examples at Attachment 8. 1). Monitor IRCT members and responders for signs of psychological stress through direct observation, personal interaction, or third party concerns (see tracking tool at Attachment 8. 2); conduct daily briefings and address individuals privately, if appropriate.

Establish and maintain regular contact with BH LNO and MHT Lead; gather information necessary to assess responders' potential psychological needs; conduct and/or promote mitigation techniques and activities as needed (examples provided in Attachment 8. 3), and report general results to IRCT Commander. During response operations, establish and regularly practice plans for communication during connectivity-challenged times (i. e. , compromised cell towers and/or internet, areas of low coverage, etc.) with MHT Lead and/or members.

Download, update, and consult with SAMHSA Behavioral Health Disaster Response application; educate and encourage MHT members' use throughout response operations. Promote SAMHSA distress line as required; phone 1-800-985-5990, text ' TalkWithUs' to 66746, or <http://www.disasterdistress.samhsa.gov>. Prepare for response through regular " continuing education" using recommended reading lists, as well as online

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learning and training tools in the period prior to being activated to federal response operations. Such materials are conveniently found on the internet and freely available.

These include: 1) the Emergency Responder Health Monitoring and Surveillance Technical Assistance Document (<http://nrt.sraprod.com/ERHMS>); 2) the HHS Disaster Behavioral Health Concept of Operations (<http://www.phe.gov/Preparedness/planning/abc/Documents/dbh-conops-2014.pdf>); and Federal Occupational Health, Online (<https://www.foh.hhs.gov/>). Leadership and Implementation. Potential mitigating factors for preventing and/or avoiding more severe PTSD entail the service member's perceived level of preparation for, and susceptibility to threats within, any given combat deployment.

Primary contributing factors to these perceptions are the level to which a unit has developed cohesion and camaraderie (Blakeley & Jansen 2013), suggesting the more effort a unit commander exerts in providing a constructive supervisory structure and unit support, as well as encouraging social connectedness throughout, the more psychologically resilient the members of that unit will be as a whole. Accountability in Training and Education. Currently, the DBH CONOPS does not include a clear and binding mechanism to require all emergency responders to complete or participate in any training or education promoted within.

While all federal responders meet a minimum standard for deployability, those who are federal government civilians lack the controlled oversight of their uniformed counterparts. All uniformed forces personnel are required, by

law, to follow the orders of their component's commanding officers; without the authority to compel their compliance, the perceived tendency amongst civilian responders could lead to general disregard for certain governing policies. This behavior on such a large scale leads to frustration within responder teams, unreliable metrics and an overall lack of research.

Deployment managers An important recommendation from Price et al (2013) suggests more extensive research into the role of emotional and structural support in enhancing exposure therapies and other evidence-based treatments. With regard to evidence-based therapies, researchers achieved significantly lower PTSD symptomatology throughout all areas, in a TBI/PTSD-afflicted veteran population, following 7 weeks of inpatient treatment including cognitive processing therapy, cognitive rehabilitation, and psycho-education.

Prolonged exposure therapy also produced significant reductions in PTSD symptom severity within comorbid TBI/PTSD subjects (Bahraini et al 2014); this program was especially effective when combined with social support (Price et al 2013). These results show promise for the emergence of social connectedness as a mitigating factor in TBI/PTSD severity as well as smaller evidence-based PTSD treatments interventions' potential effectiveness in veterans with mild TBI (Price et al 2013 & Bahraini et al 2014).