COMMUNITY MENTAL HEALTH DISASTER RESPONSE PLAN TEMPLATE

COMMUNITY MENTAL HEALTH DISASTER RESPONSE AND RECOVERY PLAN
(CMH-DRRP)

Forward

This Plan is the result of the Major Project of Lindsay Huddlestan, BA (CYC), MCP (Candidate), a student in the Master of Community Planning Program at Vancouver Island University. It is the result of a comprehensive literature review, interviews with industry professionals, and additional education in emergency response, trauma reduction and mental health supports for disaster victims. The template is adaptable to local governments and agencies. Local governments in British Columbia can benefit from this Plan to ensure best practice, rapid service and a reduction of potential psychological harm to communities.
COMMUNITY MENTAL HEALTH DISASTER RESPONSE PLAN TEMPLATE

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# Community Mental Health Disaster Response Plan Template

## Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>1</td>
</tr>
<tr>
<td>Authority</td>
<td>2</td>
</tr>
<tr>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>Assumptions</td>
<td>4</td>
</tr>
<tr>
<td>Jurisdiction Area(s)</td>
<td>5</td>
</tr>
<tr>
<td>Definitions</td>
<td>6</td>
</tr>
<tr>
<td>Stage 1: Pre-planning for an Event (Mitigation and Preparedness)</td>
<td>9</td>
</tr>
<tr>
<td>Stage 2: Response</td>
<td>12</td>
</tr>
<tr>
<td>Stage 3: Recovery</td>
<td>14</td>
</tr>
<tr>
<td>Appendix A – Mental Health Disaster Response and Recovery Coordinator (MH-DRRC), Attributes of successful candidates (for recruitment)</td>
<td>16</td>
</tr>
<tr>
<td>Appendix B – Disaster mental health affiliate programs and contact form</td>
<td>17</td>
</tr>
<tr>
<td>Appendix C – Community mental health disaster response and recovery plan – Needs Assessment Form</td>
<td>18</td>
</tr>
<tr>
<td>Appendix D – Literature review</td>
<td>23-49</td>
</tr>
<tr>
<td>References</td>
<td>48</td>
</tr>
</tbody>
</table>
COMMUNITY MENTAL HEALTH DISASTER RESPONSE PLAN TEMPLATE

PURPOSE OF THIS TEMPLATE

There is an identified need for a Template for a Community Mental Health Disaster Response and Recovery Plan (CMH-DRRP) that can be used to standardize mental health support in emergency and disaster response and recovery events. This Template describes the organization, scope and expectations for disaster preparedness/mitigation, response and recovery activities in order to provide local governments in British Columbia the information necessary to produce a mental health disaster plan meeting their own communities’ needs.

Local governments and agencies can utilize this document by filling out the appropriate areas.

The CMH-DRRP provides a clear template for local governments to:

1. anticipate individual needs of their communities,
2. collaborate/ build relationships with stakeholders,
3. build a plan to ensure services meet needs,
4. provide the most efficient service possible,
5. reduce suffering and psychological distress to individuals in the community, and;
6. ensure ongoing community resilience support through the Recovery phase.
COMMUNITY MENTAL HEALTH DISASTER RESPONSE PLAN TEMPLATE

AUTHORITY

The CMH-DRRP is developed by [name of local government] and under the supervision of [name of Mental Health Disaster Response and Recovery Coordinator] is subject to the review and approval of the [SELECT ALL REQUIRED: Mayor and Council, Chief Administrative Officer or designates, Director of Planning, Emergency Preparedness Coordinator, Human Resources Director, Director of Community Support Services]. The Mental Health Disaster Response and Recovery Coordinator is responsible for annual review of the CMH-DRRP and revision as needed, under the approval of the [ABOVE SELECTED LIST: CAO, etc.].
COMMUNITY MENTAL HEALTH DISASTER RESPONSE PLAN TEMPLATE

INTRODUCTION

Given the enhanced risk to communities due to climate change, as well as the existing risk of earthquake identified in British Columbia, the question is not if a natural disaster will strike, but when. The best defense against psychological distress is a comprehensive plan that can be initiated as seamlessly as possible when disaster events occur. The inclusion of local supports and external resources is central to providing rapid, effective support to communities should disaster strike. Identifying and connecting to these supports before a disaster event is key to best practice in emergency response for communities.

This Plan adheres to the British Columbia Emergency Management System (BCEMS) framework of Mitigation, Preparedness, Response, and Recovery.

Emergency mental health response may include:

- immediate assessment and intervention,
- short- and long-term psychosocial and emotional supports,
- linking resources,
- ongoing assessment of disaster response,
- bolstering social networks in community, and;
- the support of first responders/support person self-care education.

Because a disaster incident is sudden and disruptive, response and intervention require local community mental health services and support agencies to be prepared and respond immediately. Before, during, and after an incident, the [name of CMH-DRRP] will be required to cooperate with local, provincial, and federal agencies. This plan requires the collaborative, coordinated process of planning to clarify roles and ensure all stakeholders are both engaged in the planning process, and prepared to act when needed.
ASSUMPTIONS:

In emergency planning there must be assumptions to develop and organize policy. In the CMH-DRRP these include:

- Primary emergency response will ensure minimum loss of life and extend to reduction of harm, including psychological/emotional harm. Local government planners and emergency responders will have Psychological First Aid training to aid in mental health response efforts
- The governments of Canada and British Columbia are ready to respond to local government requests for support
- Everyone involved in the disaster event will be impacted whether individually or within the group context
- There may be impacted individuals found in all segments of the community, but those who may require more attention from disaster mental health response include:
  - children,
  - those with diverse-abilities,
  - the elderly,
  - those with low socio-economic status,
  - multicultural groups,
  - those requiring emergency medical care,
  - those with previous traumatic exposure,
  - those with preexisting mental illness diagnoses,
  - those with little- to no- social support, and;
  - human service, emergency workers and first responders.
- Best practice in disaster mental health support includes a rapid, collaborative and comprehensive community-based approach based in evidence and research.
**COMMUNITY MENTAL HEALTH DISASTER RESPONSE PLAN TEMPLATE**

**JURISDICTIONAL AREA(S):**

Describe the area(s) under the jurisdiction of this CMH-DRRP, emergency centres managed, demographics, and partnerships including specific emergency management agencies.

____________________________________________________________________________

____________________________________________________________________________

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DEFINITIONS:

British Columbia Emergency Management System (BCEMS): a comprehensive framework that helps ensure a coordinated and organized approach to emergencies and disasters. It provides a structure for a standardized approach to developing, coordinating, and implementing emergency management programs across the province. This consists of 4 stages: Mitigation, Preparedness, Response, and Recovery

Climate Change: a change of climate which can be directly or indirectly attributed to human activity that alters the global atmosphere, in addition to observed natural variability in climate

Critical Infrastructure: assets and services essential to the health, safety, security or economic well-being of Canadians and Canadian government functioning, including processes, systems, facilities, technologies, networks, assets and services. Critical infrastructure disruptions can result in catastrophic loss of life, harm to public confidence and adverse economic effects

Department Operations Centre (DOC): A Department Operations Centre is primarily concerned with supporting the emergency activities of agencies requiring specific functional support and ensuring that regular business activities continue. It can be established at the provincial, regional, or local levels

Disaster: an event that extends beyond the reach of customary resources and assistance, which may include: naturally occurring phenomenon of geophysical or biological origin, human action or error, including technological failures, accidents and terrorist acts

Disaster Psychosocial Services Program (DPSP): is a provincially-administrated program that develops and provides psychosocial services to communities responding and/or recovering from emergencies or disasters

Emergency Management British Columbia (EMBC): British Columbia’s coordinating agency for all aspects of emergency management

Emergency Operations Center (EOC): The base of operations for emergency services in the event of disaster or emergency. This is managed by the Emergency Preparedness Coordinator and the location is determined as needed

Emergency Preparedness Coordinator (may be called a director/planner/manager): This position is responsible for the day-to-day oversight, management, authority and decision-making within the local emergency service program. Generally this position chairs the local emergency management committee
Emergency Social Services (ESS): British Columbia's province-wide, community-based emergency response program. Emergency social services are the basic services people need after their community is affected by an emergency or disaster. This includes food, shelter, emergency health care and public information. The Red Cross, St. John's Ambulance, Salvation Army, the Society for the Prevention of Cruelty to Animals (SPCA), amateur radio associations and others work together with Emergency Social Services to provide disaster assistance services. Emergency Social Services is comprised of volunteers from local communities and administered by local governments.

Government Operations Center (GOC): provides constant monitoring and reporting, national-level situational awareness, warning products and integrated risk assessments, as well as national-level planning and whole-of-government response management.

Inter-Agency Emergency Preparedness Council (IEPC): facilitates coordination of emergency plans and procedures that all government ministries must develop and set in place. The Council struck a steering committee from among its member agencies to oversee British Columbia Emergency Management Service (BCEMS).

Mutual Assistance Agreement: Pre-arranged agreement between two or more entities to provide assistance between those in the agreement.

Post-Traumatic Stress Disorder (PTSD): A psychiatric disorder defined by ongoing symptoms of trauma that can include intrusion, avoidance, negative and numbing emotions and beliefs, and anxiety or hyperarousal symptoms. Specific diagnostic criteria related to severity and length of symptoms must be met for this diagnosis to be given.

Psychological First Aid (PFA): A system of immediate, practical emotional support for those impacted by disaster. Psychological First Aid can be provided by both professionals and community members without formal healthcare training, however, training for Psychological First Aid itself is required. A study of Psychological First Aid on behalf of the American Centers for Disease Control and Prevention (CDC) developed core competencies for PFA with 6 domains:

1. initial contact, rapport building, and stabilization
2. brief assessment and triage
3. intervention
4. triage
5. referral, liaison, and advocacy
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Regional Emergency Operations Centre (REOC): Functions as an Emergency Operations Centre, but allows for multiple local governments or agencies to collaborate, coordinate, prioritize resources and coordinate public messaging

Trauma: The root of the word trauma is latin for “wound”. Trauma is a wound that impacts individuals spiritually, emotionally, psychologically and physiologically. Trauma can occur when an individual experiences an incident that falls outside of the usual range of coping ability
COMMUNITY MENTAL HEALTH DISASTER RESPONSE PLAN TEMPLATE

STAGE 1: PRE-PLANNING FOR EVENT (MITIGATION AND PREPAREDNESS)

1. Local Government to appoint a Mental Health Disaster Response and Recovery Coordinator (MH-DRRC). See Appendix A for attributes of appropriate candidates.

2. Audit current local government bylaw requirement(s) and emergency response plans
   - This can be performed by planning professionals, the Mental Health Disaster Response and Recovery Coordinator, local government administrators, etc.

3. The Mental Health Disaster Response and Recovery Coordinator (MH-DRRC) builds the Community Mental Health Disaster Response and Recovery Team (local government representative, planning, social services, community support groups (neighbourhood groups, parent advisory groups, high school youth groups, etc.), faith groups, emergency response coordinator(s), local members of psychiatry/psychology/counselling field, schools, etc.

   Mental Health Disaster Response and Recovery Team* consists of:

   3.1.1. a team leader
   3.1.2. media contact
   3.1.3. liaison with outside agencies/community
   3.1.4. resource developer
   3.1.5. 1 – 3 mental health professional(s) (consisting of: psychiatrist, psychologist, registered clinical counsellor, school counsellor)
   3.1.6. individual or group to develop and maintain a disaster resource list for mental health

   *all group members should have the following characteristics:
   - ability to focus in stressful situations,
   - ability to monitor and manage personal stress,
   - work well in a team,
   - have training in trauma and crisis response,
   - accept the responsibility of the group, including reading the literature review Appendix D, and;
   - have knowledge of the community.

3.1.2. Set expectations for meetings to update and review information and plans
   3.1.2.1. Establish which disaster events will be responded to by the group
   3.1.2.2. Establish how group will be contacted if a relevant disaster event occurs
   3.1.2.3. Establish group member roles in disaster event
COMMUNITY MENTAL HEALTH DISASTER RESPONSE PLAN TEMPLATE

4. Liaise with community stakeholders to:
   • determine disaster response with best practice
   • build relationship
4.1. Connect with mental health affiliates of Emergency Social Services to ensure rapid access to services and clear understanding of the system(s) in place
   4.1.1. Record in Appendix B – Forms provided (Disaster Psychosocial Services Program, Canadian Red Cross, Emergency Support Service, etc.)

4.2. Ensure Mutual Aid Service Agreement(s) for emergency services include mental health provisions. If not, arrange for opportunity to remedy this via meetings with emergency services, local governments, etc.

5. Identify individuals in support roles to take Psychological First Aid (PFA) training

5.1. Arrange for Psychological First Aid training to take place within 6 months and at regular intervals as more support individuals are identified

Mental Health Community Support Tip:

Offer PFA training to high school students in curriculum in addition to identified “support individuals”

5.2. Ongoing - Continue building awareness of importance of neighbourhood social connections when responding to and recovering from disaster events (Emergency Services in Qualicum Beach is practicing this through workshops, etc.) (Liaison Group Member may be best suited for this role).

Mental Health Community Support Tip:

See https://www.nanaimo.ca/docs/services/emergency-services/in_it_together_neighbourhood_preparedness_guide_web_final_2015.pdf for example of socialbolstering for community emergency preparedness.
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Infographic: Proposed Post-Disaster Flow

 Disaster Event → Deployment of Emergency Social Service (MH-DRRC)

Mental Health Assessment by Emergency Social Service and Referrals

State of Emergency Declared

Community Mental Health-Disaster Response and Recovery (CMH-DRR) Team Meeting for Next Steps

Referral for Services (Disaster Psychosocial Services Program, Emergency Social Services, Red Cross, etc.)

Mental Health Disaster Response and Recovery Coordinator (MH-DRRC) liaise with agencies

Ensure Ongoing Communication with Public, Including the Media

Ensure Ongoing Mental Health Services Including Referrals

Continued Implementation and Revision of Community Mental Health Disaster Response and Recovery Plan
STAGE 2: RESPONSE

Research shows mental health and psychological effects of trauma can be pervasive and affect disaster survivors for months and even years after an event. Important components of the response stage are inclusive programming, normalized attendance of supports, advocacy, case management for those identified as requiring higher-level mental health interventions, and the rebuilding of hope.

Community support programs can include:

- psychological debriefing
- crisis counselling
- interpersonal interactions that regulate traumatic stress (social support, social networks, interpersonal debriefing)
- reducing isolation
- cognitive behavioural therapy (CBT)
- advocating for victims
- rebuilding social networks
- regaining community networks as soon as possible
- utilizing a social work perspective to support survivors
- normalizing reactions
- anxiety management
- pharmacological intervention
- allowing for expression of experiences
- teaching coping strategies

In this stage, the CMH-DRR Coordinator will be deployed and connect with emergency response leaders, the CMH-DRR team will meet, complete a Needs Assessment (Appendix C) and implement the plan.
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Proposed Post-Disaster Plan Infographic (Printable)

1. **DISASTER EVENT**
2. **DEPLOYMENT OF EMERGENCY RESPONSE**
   - Including Mental Health Disaster Response and Recovery Coordinator (MH-DRRC), ESS
3. **SCREENING & ASSESSMENT**
   - Referral to MH-DRRC if needed for further service provision
4. **STATE OF EMERGENCY DECLARED**
5. **REFERRAL FOR DPRR SERVICE**
6. **CMH-DRRP TEAM MEETING TO DETERMINE RESPONSE**
7. **IMPLEMENT CMH-DRRP**
   - CMH-DRR Coordinator liaise with Provincial, local government agencies and community supports
8. **ENSURE ONGOING COMMUNICATION WITH PUBLIC, MEDIA**
9. **ENSURE ONGOING MH SERVICES INCL. REFERRALS**
10. **IMPLEMENT POST-DISASTER RECOVERY PLAN (STAGE 3)**
11. **COMPLETE NEEDS ASSESSMENT (APPENDIX C)**
Long-term recovery efforts are imperative to support communities affected by natural disasters to reduce impacts to individuals, families and communities. Research shows mental health and psychological effects of trauma can be pervasive and affect disaster survivors for months and even years after an event. When time passes after a disaster event, an inevitable reduction in outside resources will take place. As trauma symptoms can emerge long after an event, there is a real need for ongoing screening, assessment, and support. Long-term recovery efforts are imperative to support communities affected by natural disasters to reduce impacts to individuals, families and communities as resources wane.

Another consideration is the concept of hope and importance of the return of hope for survivors. Hope stems from the ability to think of a new future in the context of the event that has happened. Creating new hope after a disaster event can be difficult, but in long-term recovery, efforts to assist community members to rebuild hope can be a powerful aid to regain strength, connections and reinvest in the future. The planned disengagement of services when deemed appropriate is also an important consideration. Local services must have adequate resources to continue with care without the support of the Community Mental Health Disaster Response and Recovery team.

One final consideration in long-term recovery programming is the necessity of self-care. Both care providers and survivors (at times these can be one and the same) require self-care to manage the long-term stresses of disaster recovery. For those structuring programing, ensuring supports focus on self-care and compassion cannot be stressed enough.
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Proposed Post-Disaster Flow

1. Ongoing advocacy for services as external support agencies retreat and aid begins to recede.
   Case management for individuals requiring higher-level mental health/psychiatric support

2. Arrange community events that respect the loss but give opportunity to futurize and make new memories (anniversaries, memorials, celebrations of accomplishments)

3. Ongoing screening and assessment as symptoms may be emerging

4. Review and Revision as needed of the Community Mental Health Disaster Response and Recovery Plan


Ongoing Long-term Care Planning

- Ongoing Advocacy for Services/CASE MANAGEMENT
- Arrange Community Events
  - anniversaries, memorials, celebrations of accomplishments
- Ongoing Screening & Assessment
  - referral to MH-DRRC if needed for further service provision
- Review and Revision of MH-DRRC
- Planned Disengagement from Service Provision
APPENDIX A

Mental Health Disaster Response and Recovery Coordinator (MH-DRRC)

Attributes of successful candidates:

- ability to focus in stressful situations,
- ability to monitor and manage personal stress,
- work well in a team,
- have training in trauma and crisis response,
- accept the responsibility of the group, including reading the literature review Appendix D, and;
- have knowledge of the community, including local government, community support services, emergency response protocols
COMMUNITY MENTAL HEALTH DISASTER RESPONSE PLAN TEMPLATE

APPENDIX B

DISASTER MENTAL HEALTH AFFILIATE PROGRAMS AND CONTACTS

DATE __________________________

AFFILIATE ORGANIZATION ______________________________________________________

CONTACT PERSON NAME(S) ______________________________________________________

BEST CONTACT INFORMATION (phone, email, text, IM, etc.) __________________________

____________________________________________________________________________

BACKUP CONTACT _____________________________________________________________

BEST CONTACT NUMBER IN EMERGENCY

PRIMARY CONTACT _____________________________________________________________

SECONDARY CONTACT _________________________________________________________

DOES THIS ORGANIZATION HAVE A MUTUAL AID AGREEMENT WITH OUR LOCAL GOVERNMENT?

YES ___ NO ___

IF SO, PLEASE REFERENCE ANY PERTINENT INFORMATION BELOW: ____________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________
COMMUNITY MENTAL HEALTH DISASTER RESPONSE PLAN TEMPLATE

APPENDIX C

COMMUNITY MENTAL HEALTH DISASTER RESPONSE AND RECOVERY PLAN - NEEDS ASSESSMENT

TYPE OF EVENT (EARTHQUAKE, FIRE, FLOOD, ETC.)

____________________________________

LOCATION

____________________________________

DATE AND TIME OF EVENT

____________________________________

NUMBER OF AFFECTED INDIVIDUALS

VICTIMS

FAMILY MEMBERS

RESPONDERS

WITNESSES

INCIDENT COMMANDER(S) NAME

____________________________________

CONTACT #

____________________________________

EMERGENCY OPERATIONS CENTER LOCATION

____________________________________

CONTACT #

____________________________________
COMMUNITY MENTAL HEALTH DISASTER RESPONSE PLAN TEMPLATE

ON SCENE:

POLICE

FIRE

MENTAL HEALTH

AMBULANCE

ESS

RED CROSS

SALVATION ARMY

OTHERS : FILL

ARE KNOWN VULNERABLE POPULATIONS IN THE DISASTER AREA? LIST LOCATION(S), CONTACT(S) & CONCERNS:

1. FILL

2. FILL

3. FILL

4. FILL

5. FILL

ARE EXISTING BEHAVIOURAL HEALTH CENTERS THAT REQUIRE RELOCATION? (ie. RESIDENTIAL PROGRAMS, SAFE INJECTION SITES, ETC.). LIST LOCATION(S), CONTACT(S) & CONCERNS:

1. FILL

2. FILL

3. FILL
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4. FILL
5. FILL

HAS THE IMPACTED COMMUNITY EXPERIENCED A TRAUMATIC EVENT BEFORE?

IF YES, EXPLAIN DETAILS.

1. FILL
2. FILL
3. FILL
4. FILL
5. FILL

LOCATIONS OF OPEN SHELTERS

1. FILL
2. FILL
3. FILL
4. FILL
5. FILL

LOCATIONS OF SURVIVOR ASSISTANCE CENTERS

1. FILL
2. FILL
3. FILL
4. FILL
5. FILL
COMMUNITY MENTAL HEALTH DISASTER RESPONSE PLAN TEMPLATE

WHAT LOCAL MENTAL HEALTH SUPPORTS/RESOURCES HAVE BEEN REQUESTED?

1. FILL

2. FILL

3. FILL

4. FILL

5. FILL

WHAT MENTAL HEALTH RESOURCES ARE AVAILABLE NOW? WHERE ARE THEY LOCATED?

1. FILL

2. FILL

3. FILL

4. FILL

5. FILL

ARE MENTAL HEALTH INTERVENTIONS BEING PROVIDED? IF YES, BY WHOM, WHEN AND WHERE?

1. FILL

2. FILL

3. FILL

4. FILL

5. FILL

ARE EXTERNAL MENTAL HEALTH RESOURCES REQUIRED? IF YES, WHAT SERVICES ARE EXPECTED?
COMMUNITY MENTAL HEALTH DISASTER RESPONSE PLAN TEMPLATE

1. FILL
2. FILL
3. FILL
4. FILL
5. FILL
Community Mental Health Disaster Response Plan Template

Appendix D – Literature Review

This literature research utilized an historical research design which focused on analysis of textbooks, peer-reviewed journal articles, government resources and case study which provided relevant information on:

- Government policies and procedures for mental health supports in disaster situations including local government in Qualicum Beach, British Columbia, and at the provincial and federal levels in British Columbia and Canada;
- Historical natural disaster mental health responses;
- Outcomes of disaster on mental health and associated risks, protective factors and mitigation strategies;
- Exploration of potential post-disaster psychological diagnoses;
- Prevalence of psychological and emotional impacts of disasters in research;
- Recommendations for best practice to support mental health post-natural disaster.
People have historically been self-sufficient, relying on those close to them to provide necessities in times of adversity. Communities provided their own food and had systems in place to build infrastructure, support local economy, and have medical and spiritual needs met. With the advent of the industrial revolution, people became more reliant on “conveniences” such as grocery stores and electricity. For example, as recently as the 1950’s, Vancouver Island produced 85 per cent of its own food, while today it produces between 5 and 10 per cent. This creates a dynamic where residents are more reliant on outside resources for “necessities” and in the case of natural disaster, impacts can be compounded as survivors face a lack of resources that historically were locally available or not considered essential.

Roudini, Khankeh & Witruk (2017) performed an extensive exploration of disaster mental health preparedness and propose the following definition: mental health preparedness “should be a state of awareness and expectation of an individual’s psychological reactions to the disaster warning” (p. 4). Long-term social needs can be required after any natural disaster and mitigation of post-disaster distress to community is an important component of local government planning for emergency and disaster events. Natural disasters include earthquakes, wildfires, floods, tsunamis, droughts, volcanic eruptions, landslides, hurricanes and heat waves; with the exception of volcanic eruption, Coastal British Columbia is at risk from each of these natural disasters.

Statistics Canada reports that 8 per cent of Canadians experienced emotional or psychological impacts due to a crisis event, and of those, 1 in 4 required more than a year to recover from the effects. 43 per cent of Canadians (about 12.4 million) over the age of 15 reported experiencing a major emergency event or disaster in their community, with 73 per cent of these individuals reporting severe disruption to daily life, including inability to complete normal tasks.

**Figure 1. CANADIANS REPORTING EXPERIENCE OF MAJOR EMERGENCY OR DISASTER IN THEIR COMMUNITY**

- 57% OF CANADIANS HAVE NOT EXPERIENCED A SEVERE EVENT
- 43% OF CANADIANS HAVE EXPERIENCED AN EVENT
- 75% OF THAT 43% REPORT SEVERE DISRUPTION TO LIFE
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Once affected by the negative psychosocial effects of a natural disaster communities can require significant resources and time; even generations to recover. Disaster mental health research among Canadians is an emerging field; statistics on total harm due to natural disaster are scarce, although Statistics Canada reports approximately 85 per cent of Canadians who have:

experienced a major emergency or disaster were able to resume their regular daily activities within two weeks...for about 6% of Canadians who endured a financial loss and 23% who experienced psychological impacts, full recovery from these consequences took more than one year.

While these statistics are helpful, they relied on self-reporting, and did not include the Territories, or certain vulnerable populations “those who are homeless, or living in care facilities”. The World Health Organization (2017) reports 4.7 per cent of Canadians are diagnosed with depressive disorders, and 4.9 per cent of Canadians with anxiety disorders (See Figure 2). In a 2011 study prepared for the Mental Health Commission of Canada, it was reported that by the age of 40, 1 of every 2 individuals in Canada will have- or have had, a mental illness (Smetanin et al., 2011).

CANADIAN ESTIMATE OF PREVALENCE OF DEPRESSIVE AND ANXIETY DISORDERS
WHO Region of the Americas: Canada Statistics

<table>
<thead>
<tr>
<th>DEPRESSIVE DISORDERS</th>
<th>ANXIETY DISORDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of population</td>
<td>% of population</td>
</tr>
<tr>
<td>Total cases</td>
<td>Total cases</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>DEPRESSIVE DISORDERS</th>
<th>ANXIETY DISORDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Years Lived with Disability (YLD)</td>
<td>Total Years Lived with Disability (YLD)</td>
</tr>
<tr>
<td>% of total YLD</td>
<td>% of total YLD</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prevalence</th>
<th>Total cases</th>
<th>% of population</th>
<th>Health Loss/Disease Burden</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>1 566 903</td>
<td>4.7%</td>
<td>261 307</td>
</tr>
<tr>
<td>Anxiety</td>
<td>1 652 746</td>
<td>4.9%</td>
<td>151 851</td>
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Research shows targeted prevention and support significantly reduce the impact of disaster on the mental health of communities affected by disaster. Prevention must include comprehensive planning which considers:

- the implications of disaster on a community;
- available resources;
- potential agreements with surrounding areas, and;
- practical strategies to buffer those affected from lasting harm.
Legislative requirements of emergency planning in Canada exist at the Federal, Provincial and local levels. An obstacle in Canadian planning for disaster mental health is the obscurely-termed Federal and Provincial legislative requirements which leave much room for interpretation. Social services are a requirement of legislation, but the definition of social service does not include mental health. Within the *Emergency Program Management Regulation (1994)* emergency social services are defined as “consisting of emergency feeding, clothing, lodging, registration and inquiry and personal services”. “Personal services” could be interpreted as provision of mental health treatment and support, yet mental health is not specified. Additionally, there is a recognition of rights for service to those with severe mental illness, yet in a crisis or disaster environment if a survivor develops severe mental health concerns, does this apply, or only to pre-diagnosed individuals? The wording within the legislation requires clarification to avoid uncertainty during a disaster and leave survivors vulnerable to lack of service.

Review of the legislation must note that with the exception of “mentally challenged persons” there is no mention of mental health or psychosocial supports. The *Emergency Program Management Regulation (1994)*, however, outlines the Minister of Health is responsible for providing “critical incident stress debriefing and counselling services” in the event of emergency. When interpreting the *Emergency Program Management Regulation (1994)* it appears that counselling services fall under the responsibility of the health sector, while social services are removed from that capacity. Those who are vulnerable require specific planning provision that is not addressed in Public Safety Canada’s whole-of-society approach that seeks to make provision for as much of society as possible through blanket planning which addresses the median population. This system is similar to that of the *all-hazards approach* utilized by such agencies as the Federal Emergency Management Agency (FEMA) in the United States where the needs of a median population are determined for service provision and planning. While some specialized resources for emergency planning for those living with disabilities exist such as the PreparedBC *Resources for People with Disabilities* handbook which highlight the diversity of needs in disaster settings, mental health provision is not included. The unique needs of the homeless population in disaster response and recovery is an emerging field which does require preplanning for service flow in times of disaster.

The Ministers Responsible for Emergency Management in Canada highlight the priority of government emergency management in Canada; at the Provincial and Federal levels the priority is minimizing loss of lives and preserving economic and infrastructural assets *before* psychological wellbeing. Provincial authorities designate local governments the authority to provide emergency mental health support with *no mandated oversight* which may be putting disaster survivors at risk of higher rates of psychological distress, somatic complaints, absenteeism, and relational problems.
## Community Mental Health Disaster Response Plan Template

### British Columbia’s Legislation and Local Government Interaction


<table>
<thead>
<tr>
<th>Level of Government</th>
<th>Legislation/Regulation</th>
<th>What it Does</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal</td>
<td>Emergencies Act</td>
<td>Authorizes special temporary powers for federal agencies to ensure safety and security during a national emergency. These measures are extraordinary and specific to four types of national emergencies:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Public welfare emergencies (natural or human disasters)</td>
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<tr>
<td></td>
<td></td>
<td>• Public order emergencies (threats to internal security)</td>
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<tr>
<td></td>
<td></td>
<td>• International emergencies (external threats)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• War</td>
</tr>
<tr>
<td></td>
<td>Emergency Management Act</td>
<td>Establishes the legislative foundation for an integrated approach to federal emergency management activities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Recognizes the roles that all stakeholders must play in Canada’s emergency management system</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Clarifies the leadership role and responsibilities of the minister responsible for public safety, including coordinating emergency management activities among government institutions and in cooperation with the provinces and other entities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Clarifies the emergency management responsibilities of all other federal ministers</td>
</tr>
<tr>
<td>Provincial (BC)</td>
<td>Emergency Program Act (EPA) (1996)</td>
<td>Clarifies the roles and responsibilities of the provincial government and local authorities (municipalities or regional districts)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Provides extraordinary powers to the provincial government and/or local authorities where required</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Requires local authorities to create and maintain an emergency management organization</td>
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<tr>
<td></td>
<td></td>
<td>• Allows for the provision of support to victims of disasters through the Disaster Financial Assistance (DFA) Program</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Exempts emergency service workers from civil liability</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Local authority may delegate any of its powers and duties under the Act to committees of a coordinator except the power to declare to state of local emergency</td>
</tr>
<tr>
<td></td>
<td>Emergency Program Management Regulation (EPMR)(1994)</td>
<td>Tasks government ministers with developing emergency plans and procedures</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Identifies the ministers responsible for coordinating government response to specific hazards</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Lists the duties of ministries and Crown corporations in an emergency/disaster</td>
</tr>
</tbody>
</table>
### Other provincial legislation and regulations, including:
- Environmental Protection Act
- Public Health Act
- Water Act
- Wildfire Act
- Transportation regulations


- Identifies the responsibilities and tasks assigned to provincial ministries, Crown corporations, and stakeholders that relate to the role/function addressed in the legislation/regulation

### Local authorities may:
- Enter into mutual aid agreements with other authorities
- Develop agreements with NGOs

### Local authority emergency plan must reflect the following:
- The potential emergencies and disasters within its jurisdiction
- Their relative risk of occurrence and potential impact on people and property
- Procedures for accessing resources such as personnel, equipment, facilities, and finance
- Procedures for implementing the plan
- Procedures to notify affected peoples of an impending disaster
- Procedures to coordinate the provision of food, clothing, shelter, transportation, and medical services
- Priorities for restoring essential services provided by the local authority and by other service providers
- A training and exercise program for staff and agencies assigned responsibilities in the plan
- Establish a procedure for periodic review and update of the plan
- Procedures for how guidance and direction is provided to the emergency management organization

### Local authority
- Tasks each local authority with establishing and maintaining an emergency management organization
- Empowers the local authority to appoint committees and a coordinator for the emergency management organization
- Authorizes the local authority to delegate its powers and duties under the Act as may be required
- Requires the local authority to prepare local emergency plans
COMMUNITY MENTAL HEALTH DISASTER RESPONSE PLAN TEMPLATE

The “Gap”

This research addresses a gap in planning at the level of local government in Canada: mental health supports for communities during and post-disaster. Emergency management in Canada is a multi-level system which requires the coordination and cooperation of all stakeholders to create best practice and outcomes for disaster survivors. Canadian government puts the onus on local governments to design and implement emergency response plans which meet legislative emergency planning requirements, ensure communities are supported with local services, and in accordance with local customs. This process is increasingly inclusive of volunteer agencies in an official capacity and planning has begun to acknowledge and integrate volunteer organizations into official emergency response plans. Although local government is responsible for the lion’s share of emergency response, “jealous defense of the constitutional division of powers has prevented the incorporation of municipal officials into policy discussions about national emergency management...perpetuating the virtual exclusion of municipalities from intergovernmental policy-making in this field” (Henstra, 2013, p. 191). Canada has comprehensive planning for emergency response regarding infrastructure and economic preservation and redevelopment, yet mental health response and recovery plans are comparatively lacking.

In British Columbia, the Disaster Psychosocial Services Program manages Provincially-administrated volunteers to provide support. Although this is a program administered by the Province, ultimately it is volunteers who are providing service, Canadian Red Cross programs, as well as locally-administered services which lack oversight and standardized treatment modalities. In the case of disaster mental health, the field is evolving and strategic planning has not yet been engaged for specific, standardized service provision.

Literature reinforces the need to address the gap in planning for mental health support to create plans prioritizing mental wellbeing on the same level as infrastructure and economic assets: “the mental health consequences of exposure to a natural or technological disaster have not been fully addressed by those in the field of disaster preparedness or service delivery” (Noji, 1997, p.101). For example, Parksville and Qualicum Beach, BC have a comprehensive new document: the Emergency Management Oceanside Emergency Plan, which is rooted in principles from the British Columbia Emergency Management System (BCEMS). The BCEMS is the Provincial government’s manual for emergency planning best practice for local governments. The Emergency Management Oceanside Emergency Plan doesn’t mention “psychosocial support” until the Recovery Phase, although research highlights the importance of early screening, intervention and treatment for disaster survivors to minimize harmful psychosocial impacts.

Canadian emergency planning’s sluggish approach to addressing social infrastructure (social capital, resilience-building measures, knowledge, community engagement) has become more pronounced,
especially as other countries launch federally-led initiatives to boost mental health support for survivors. Literature reports various reasons for this including:

- the legal authorities under which local governments enact emergency planning;
- the allocation of some federal emergency funding is disbursed to Provincial sources, then individuals, rather than local governments;
- the lack of political and public will to enact meaningful change as emergency response in Canada is culturally “reactive” rather than preventative;
- generalized language in legislation creates opportunity for Federal, Provincial and local governments to plan, or not plan, due to political climate, financial strain on local finances, and/or lack of expertise in comprehensive planning skills for emergency mental health;
- the Emergency Management Framework for Canada (3rd Ed.) states “the ultimate purpose of emergency management is to save lives, preserve the environment and protect property and the economy” which indicates the lack of priority given to mental health and social infrastructure in emergency planning at the federal level;

To better understand Canadian emergency management in the context of international trends and actions, an exploration of other countries’ implemented services for disaster mental health supports are listed below.

**Finland** has developed disaster mental health systems since the 1990s. The model was developed from a working party consisting of a national psychologists’ major disaster preparedness group, National Railway, Finnair, Armed Services, Police, and the Red Cross was initiated in 1993. This continued to develop over time and consisted of two levels; local crisis groups and a national specialized group for major incidents. What makes Finland stand out in the planning realm of disaster mental health is the speed which the system was developed and initiated. Another component of Finnish disaster-psychology is that rather than victims being directed to general services, “so-called everyday traumatic events and situations are included under the umbrella of special preparedness...this speeds up access to help and makes preventative work possible” (Saari, 2005, p. 17). In Finland, each level of society is required to create and maintain disaster preparedness plans. This system is rooted in the concept of mutual trust where authorities have collaborative agreements, comply with and trust decisions made by jurisdictional peers, and understand where legal responsibilities lie. The Health Care Act regulates health care services, and activities that come under the scope of social welfare are regulated by the Social Welfare Act. Finland’s additional mental health legislation is in Section 3 of the Emergency Powers Act, the Rescue Act (PeLL), and Sections 3-4 of the Presidential Decree on the Finnish Red Cross. Finland remains in the forefront of disaster psychosocial support.
COMMUNITY MENTAL HEALTH DISASTER RESPONSE PLAN TEMPLATE

In the United States, where the population is denser than Canada and natural disasters have been increasingly destructive to humans, the government has been developing mental health responses for disaster recovery. The United States of America’s Department of Health and Human Services’ Substance Abuse and Mental Health Services Administration (SAMHSA) provides resources including a Mobile Disaster Application (APP), Disaster Behavioral Health Information Series (DBHIS), Disaster Response Template Kit, Disaster Kit, Disaster Distress Helpline, and National Child Traumatic Stress Network (NCTSN) online resources and web-based learning site. The mobile application (APP) for use in disaster settings is geared to responders to ensure services are provided to survivors, as well as engage responders in the process of self-care. In addition there is a Crisis Counselling and Assistance Program Authorized under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act) Funded by the Federal Emergency Management Agency (FEMA). The services provided include (among others);

- face-to-face outreach in disaster settings;
- basic crisis counselling service;
- referrals;
- assessment;
- networking;
- media management;
- training for service workers, and;
- connections to family members.

The Crisis Counselling and Assistance Program offers a wide range of services but does require a Presidential declaration of disaster for short term behavioral health support which is enacted only when the capacity of need outweights the United States’ ability to provide care.

The variety and volume of services available, combined with ongoing development in training and technology such as mobile apps, demonstrate the United States’ high priority on mental health for disaster survivors and link between survivor mental health and overall wellbeing of citizens.

In Japan, where numerous disasters (for example, the 2011 Great East Japan Earthquake, tsunami and nuclear accident, and the 1995 Hanshin-Awaji Earthquake,) have had tremendous impact on citizens, there is a recognition of the damage to communities’ social and mental wellbeing which has guided Japanese government to make “disaster mental health care a pillar of its disaster response strategy” (Tanisho et al., 2015, p. 1). After the 1995 earthquake, Japan developed its first rapid-response Disaster Medical Assistance Team (DMAT) system which mobilized Mental Health Care Teams. There have been some challenges associated with this system including the extreme stigma surrounding mental illness in Japan, lack of functionality for multiple-disaster scenarios, and “inter-agency, inter-organization, and chain-of-command issues” (Tanisho et al., 2015, p. 2). In response to these challenges, the Ministry of Health Labour and Welfare (MHLW) and Japan’s psychiatric
COMMUNITY MENTAL HEALTH DISASTER RESPONSE PLAN TEMPLATE

Institutions created a system for Disaster Psychiatric Assistance Teams (DPAT) in 2013, yet the complexities of the multi-agency network are still being addressed. Japan is an example of a country with serious disasters (both man-made and natural), which has seen the need for disaster mental health response and prioritized it at the highest level. The functionality of the system remains evolving yet the process is engaged and systems are progressing.

In Canada, the community of High River, Alberta experienced a serious disaster when the vast majority of the community flooded in 2013. “In response to psychosocial need, the community very shortly after saw the need for counselling support and accessed specialised counselling services within a short time” (Rob Roycroft, RPP MCIP, Personal Communication, November 2018). As needs increased, they opened a counselling centre beside the Flood Recovery Task Force to offer therapeutic support. This center transitioned to a permanent service when the need for ongoing support to community was demonstrated (Rob Roycroft, RPP MCIP, Personal Communication, November 2018). This is a clear demonstration of best practice in meeting needs of a community in recovery and adapting to provide support as needed, yet the practice is not standardized and government responders and administrators had to resource supports after the event, rather than utilizing a plan of action that was in place.

Fort McMurray, Alberta experienced devastating wildfires in 2016 and eighteen months later over three thousand youth were measured against a similar town in Alberta for mental health symptoms. The results were clear; the Fort McMurray youth were experiencing statistically significant mental health symptoms compared to youth from the non-impacted community. Specifically,

- scores consistent with a diagnosis of depression (31% vs. 17%);
- moderately severe depression (17% vs. 9%);
- suicidal thinking (16% vs. 4%), and;
- and tobacco use (13% vs. 10%).

In addition, self-esteem and quality of life scores were lower in Fort McMurray than the non-impacted community. This study reaffirms the negative impact that disaster had on the youth of the community at eighteen months post-disaster and highlighted the need for: (first), screening and diagnosis of youth at-risk for mental health challenges, and, (second), the need for ongoing and effective treatment for those impacted. The ongoing mental health impacts to the youth of Fort McMurray clearly display the outcomes of Canadian mental health supports for disaster victims.

An exploration of Manitoba’s disaster emergency management policy systems found slow-moving change processes hampered by departmental coordination challenges and ineffective communication between Provincial and local governments. Meaningful change to disaster policy was reported as occurring reactively to major events, rather than a proactive fashion: this reflects
Canadian emergency management systems in general and speaks to a need for anticipatory planning.

While some government agencies in Canada are beginning to plan for mental health support during and post-disaster, the following challenges have been identified:

- planning procedure does not articulate specific steps of disaster mental health support (a generic statement that mentions provision of support is generally utilized rather than the actual process that takes place).
- there is a clear lack of standardized practice in the realm of local government disaster mental health planning which can lead to miscommunication at times of emergency, overlap and/or gaps in service.
- top-down policy planning works against bottom-up response (Federal and Provincial governments dictate policy) with low engagement from local governments who generally provide initial emergency response.

Implications for government in British Columbia and Canada are potentially vast should planners adopt strategies to address mental health supports at local government levels to boost resilience, minimize recovery time and improve the wellness of communities in the wake of disaster.

“Those with higher levels of social support recover faster than those with lower levels” (Gist & Lubin, 1999, p. 75).

Case Study: Current Mental Health Procedures for Disaster in the Town of Qualicum Beach - Local Government Systems

Below is a case study of the Town of Qualicum Beach’s current mental health support procedures in the event of a natural disaster and suggestions for the Town of Qualicum Beach specifically to boost resilience and reduce mental health impacts. This case study supported the development of the Community Mental Health Disaster Response and Recovery Plan (CMH-DRRP).

The Town of Qualicum Beach is a municipality with a population of 8943. The Town belongs to the Emergency Management Oceanside group including the Town of Qualicum Beach, City of Parksville and Regional District of Nanaimo Electoral Areas E, F, G and H. The Town of Qualicum Beach relies on outside agencies and volunteers to provide mental health care post-disaster such as the Canadian Red Cross, Disaster Psychosocial Services Program (provincially-administrated) and Emergency Support Service through the Regional District of Nanaimo, but local government policy lacks a
COMMUNITY MENTAL HEALTH DISASTER RESPONSE PLAN TEMPLATE

counte mental health support plan to ensure services are cohesive and run smoothly in times of crisis. Strategic planning for inter-agency collaboration in regard to disaster mental health is broad as the Emergency Preparedness Plan out-sources mental health supports and does not define the specific services and programs that provide aid. The current disaster mental health support system has little to no medical affiliation which may increase risk for individuals suffering from acute psychiatric symptoms during/after a natural disaster.

The Town of Qualicum Beach’s emergency programs work collaboratively to provide emergency supports that include disaster response and recovery efforts through Emergency Management Oceanside (EMO), which provides round-the-clock emergency planning, monitoring and support to ensure the area has effective services. The Town of Qualicum Beach belongs to the Mid Island Emergency Coordinators and Managers (MIECM). This group is a committee of emergency managers from mid Vancouver Island communities, Island Health, and a provincial government representative from Emergency Management British Columbia (EMBC). This committee works to plan for, lead, and support communities faced with emergency events. In 2018, the Mid Island Emergency Coordinators & Managers (MIECM) produced the Emergency Management Oceanside Emergency Plan document which is essentially a mutual aid agreement for Parksville, Qualicum Beach and the Regional District of Nanaimo Electoral Areas E, F, G and H. This plan includes some mention of social services including:

- **Mitigation Phase**: purpose to reduce social disruption;
- **Site Response Tasks** which include “coordinate provision of essentials such as food, clothing, lodging, emotional support, information and family reunification” (p. 16);
- **Recovery Phase**: Provision of Psychosocial support;
- **Recommended development of Community Resilience Centers** that include critical inter-agency and inter-governmental collaboration to provide assistance to community members, build capacity and boost resilience;
  - Community Resilience Centers are meant to support individuals in creating personal action plans, connecting with appropriate agencies for needed supports, and to provide psychosocial support and trauma counselling;
- **Emotional/Psychosocial Support** is listed in the “Medium-Term” Stage of Recovery which is identified as “weeks-months”;
- **Local jurisdiction for social/emotional support** identified as:
  - Community Disaster Recovery;
  - Emergency Support Services.
Community Mental Health Disaster Response Plan Template

The Town of Qualicum Beach has a population of predominantly senior citizens (the oldest population per-capita in Canada) with an average age of 60.1, compared to the Province’s average of 42.3. 52.1 per cent of the population of Qualicum Beach is 65 years old or more which puts particular challenges on the community should disaster strike. Individuals of advanced age may:

- be less mobile which increases isolation;
- have pre-existing physical challenges, and;
- have specific care needs that may not be attended to in a disaster environment.

These age-related challenges are all risk factors for developing mental health concerns post-disaster and as such are of importance to note in the context of community planning. Indeed, for planning professionals in all communities with an aging population, these risk factors will be the same and are critical to reflect on to reduce mental health suffering and potential lasting effects on individuals, families, and communities. For seniors who require care pre-disaster but are not in a full-time care facility, it is likely that resources in the short term may not address care needs. In this scenario, the onus is on those around the individual requiring care to provide additional support(s). Communities can boost resilience and potentially reduce negative mental health effects from disaster event response and recovery with supports which:

- have strong social cohesion;
- go into effect immediately in disaster events;
- enable citizens to provide support to each other.

The suggested Community Resilience Centers in the Emergency Oceanside Management Plan follow principles of best practice in mental health support for disaster response and recovery. These centers are proposed to activate when needed to:

- collaborate/coordinate with provincial, community, business and not-for-profit agencies;
- provide assistance to individuals with the recovery process via a “one-stop shop” approach that can accommodate as needed to support those with more complex recovery requirements.

Specific steps of the proposed Community Resilience Centers:

- Complete a capacity and needs assessment with community residents;
- Assist individuals in completing their personal action plan;
- Ensure that those with urgent needs are connected with appropriate agencies/groups including:
  - Pursuing family reunification efforts;
  - Providing psychosocial support services including trauma counselling.
CURRENT PRACTICE FOR EMERGENCY MENTAL HEALTH IN QUALICUM BEACH FLOW

1. Event,
2. Deployment of ESS,
3. State of Emergency Declared
4. Referral for Services (Disaster Psychosocial Services Program, Emergency Social Services, Red Cross, local community supports)
   a. *Recommended: Implementation of Community Resilience Centers including post-disaster community psychosocial support (the details of how this is provided are not standardized; primarily the ESS, Red Cross and Disaster Psychosocial Services Program would be utilized).

Highlights of the Town of Qualicum Beach mental health emergency systems case study:

- compliance with Provincial regulations and knowledge of local service providers;
- a lack of information on specific available mental health services, and;
- focus on mental health support outsourcing.

The Town of Qualicum Beach Emergency Program Bylaw No. 416, 1985 is the Town’s emergency bylaw that gives direction for administration of services and although the bylaw is legally still in effect, many parts of the bylaw are now out of date and no longer in use, while others are valid (Luke Sales, Director of Planning, Town of Qualicum Beach, personal communication, 2018). Emergency Program Bylaw No. 416, 1985 (3.3) designates responsibility for emergency planning and supports to an Emergency Program Committee and Emergency Program Coordinator. Of particular interest to this project, is the ability for Council to appoint other staff as needed to provide emergency services.

The Town of Qualicum Beach Official Community Plan Bylaw 800, 2018, Schedule 1 (2.6) outlines policy for Safety and Emergency Preparedness, but this bylaw focuses on fire safety, crime prevention and infrastructure emergency preparedness rather than mental health or psychosocial supports during- or post- emergency. Of note, the Official Community Plan Bylaw 800, 2018 Schedule 1, 2.6.4 states: “the Town shall continue to support and modify, as necessary, the emergency response and preparedness program administered by the Town” (p. 76). This is a critical section as the wording allows for the addition of additional mental health and psychosocial support for disaster response and recovery should Council choose to. This is indicative of many local governments in Canada as emergency laws are vaguely worded which allows local governments to address emergency planning as they see fit, rather than ensuring a minimum of mental health care for citizens.
Oceanside Emergency Social Services (Oceanside ESS) is a program of volunteers that provide immediate, short-term 72 hour support in the event of disaster. The support provided by Emergency Social Services in relation to mental health and wellness is primarily comforting from volunteers. Training for Oceanside Emergency Social Service volunteers is customarily free and facilitated by the Justice Institute, Salvation Army, and Red Cross Instruction.

While there is a generic Local Government Guide for Community Mental Health Emergency Operations Center Plan outline for local governments to utilize, the following recommendations are made to ensure best practice in the Town of Qualicum Beach for mental health emergency planning:

a) utilize current policy Bylaw No. 416, 1985, Bylaw 800, 2018 to include provision for mental health support in the event of emergency/disaster, specifically the proposed Community Mental Health Disaster Response and Recovery Plan (CMH-DRRP);

b) review of Bylaw No. 416, 1985 to either revise or repeal this document, reducing confusion in legislation;

c) create an amendment to the Emergency Management Oceanside Emergency Plan to apply principles of psychosocial and emotional support which specifically outline the plan in detail for mental health support.
Community Mental Health Disaster Response Plan Template

Risk Factors for Coastal Vancouver Island, and the Town of Qualicum Beach

Accelerated global sea-level rise and climate-change-related coastal threats (including storm frequency) put coastal areas at risk. Coastal British Columbia is at risk for natural disaster including earthquake, wildfire, tsunami, flood, drought, and severe storm damage. In a 2018 report from BC Hydro and Power Authority it was reported that the past five years have seen a 300 per cent increase in individual storm events requiring Hydro response in British Columbia. This trend has shown a continual increase in storm frequency and severity which has caused widespread damage and even human life.

With reported populations at-risk so vast for enhanced psychological issues, prevention and reduction of mental health symptoms and challenges merit high priority from local governments’ emergency planning.

The Effects of Natural Disaster on Community Mental Health

Disasters can be viewed from an ecological perspective; environmental, psychological, social, political, and cultural. The ability of individuals and community to cope is interwoven; support systems must consider their reactions as impacting each other and “shaping the identity of the coping community” (Gist & Lubin, 1999, p. 26).

Figure 8.
Disaster Impacts from an Ecological Perspective
Social infrastructure (size, activeness, and closeness of social network), perceived support, and received support were found to protect disaster victims so understanding how community is impacted as a whole is important to planning for disaster response and recovery. It is imperative to plan inclusive supports that give space for all impacted individuals, keeping in mind that everyone should have equal access to support as needed. Issues pertaining to social justice arise in research of mental health support for disasters.

Specifically the following are identified as challenging for support systems during disaster recovery:

- the inequality of supports provided during crises emerging from existing biases, and;
- societal inequalities due to:
  - gender;
  - age;
  - socioeconomic status, and;
  - perception of need.

As helping agencies or groups work to support those affected, attention must be given to the inherent belief systems of “outsiders”, “professionals”, and those with different cultural contexts as they work collaboratively with a disaster-impacted community. Disasters are documented as exacerbating pre-existing societal inequalities and as such:

there is a cruel irony in disasters. Socially, politically, morally, and religiously sanctioned patterns of inequality fuel further discrimination and deprivation... Well-publicized examples of altruism and solidarity in times of crisis should not obscure the fact that pattern of neglect is equally real. (Gist & Lubin, 1999, p. 33)

The Economic Impact of Mental Health

Smetanin et al. (2011) explain the financial cost of mental health to Canadians; in 2012, mental health was assessed as costing Canadians $22 billion annually. Those who lose their employment to disaster are at higher risk for mental health complaints which in turn impacts the economy; this cyclic problem is difficult to halt and can have lasting effects for workers and their families. When including the cost of health care, loss of productivity and health-related quality of life loss, mental health challenges have substantial impact on the economy and society.

Should residents experience negative outcomes from post-traumatic stress disorder they are at higher risk to miss days of employment which can cost employers and government services. In 2011, approximately 2 out of every 9 workers in Canada (21.4 per cent of the working population) were estimated to have a mental illness that could impact their work. Estimates suggest by 2041, people
COMMUNITY MENTAL HEALTH DISASTER RESPONSE PLAN TEMPLATE

living with a mood or anxiety disorder annually will increase by 22.9 per cent, reaching over 4.9 million people (11.4 per cent of the total population).

Another factor of economic impact is costly litigation that can result from perceived injustice by those stuck in denial regarding the traumatic experience. When disaster survivors are unable to move into acceptance of the new reality (see page 98, the reorientation stage), they can engage in a search for blame, private prosecution, and/or complaints to media and government representatives. The economic costs associated with assessing such complaints must be contemplated when assessing costs associated with planning, response and recovery supports for mental health.

In Canada, government funding pays for response and recovery initiatives and in some cases is augmented by philanthropic supports. The image below demonstrates the financial impact of emergency management in Canada at the Federal level. In the 2017-18 fiscal year it was projected that over 72 per cent of the budget for Public Safety Canada would be spent on Emergency Management. Even with these funds seemingly high, Canada’s federal expenditures for emergency planning and response is low in comparison to countries such as Australia and the United States, where significant investments are made to emergency resilience efforts (Henstra, 2013).

Figure 7.
SPENDING PIE CHART – PUBLIC SAFETY CANADA

![Pie chart showing spending allocation of Public Safety Canada's planned spending by program for 2017-18](image)

**Source:** Public Safety Canada 2017-2018 Departmental Plan

A Note on the Benefits of Natural Disaster

This project explores the psychological distress, negative impacts and challenges presented by natural disasters. There are, however, positive outcomes for some that bear mention. Studies have reported the suffering and struggle inherent to trauma recovery can produce significant transformation and growth. Tedeschi & Calhoun (1996) identify positive outcomes in the emergence
of a new, positive perception of Self, enhanced ability to communicate with others and utilize supports, and a new view of life. This does not, however, mean that mental health planning and support isn’t required, or to a lesser extent. Mental Health need outweighs available resources in everyday circumstances in every country, so when a natural disaster strips away resources while increasing need, support is imperative.

Planning for Natural Disaster and Mental Health

The World Health Organization (WHO) defines disaster as “an occurrence disrupting the normal conditions of existence and causing a level of suffering that exceeds the capacity of adjustment of the affected community” (World Health Organization, 2002, p. 3). The Town of Qualicum Beach defines a disaster as a “critical situation that has exceeded the emergency response resources of the Municipality and, those available from neighbouring Municipalities through mutual aid agreements” (Town of Qualicum Beach Emergency Program Bylaw No. 416, 1985, 2.1 c, p. 2).

Put plainly, events that extend beyond the reach of customary resources and assistance can be defined as disasters. Yearly, these events affect almost 160 million people worldwide, killing approximately 90,000 people. The Sendai Framework for Disaster Risk Reduction 2015-2030 is an internationally-adopted risk-reduction policy designed to support communities to build disaster resilience. This framework highlights the need for psychological support responses for disaster survivors; its adoption by United Nation Member States in 2015 signifies international commitments to both resilience through pre-planning, and psychological support post-disaster.

Modalities of treatment for mental health support vary depending on the needs and wants of each community, but the principles of intervention remain fixed: promote a sense of safety, calming, self- and collective efficacy, connectedness, and hope.

Considerations to guide community supports in the early to mid-term stages of recovery:

1. Promote a sense of safety;
2. Promote calming;
3. Promote sense of self– and collective efficacy;
4. Promote connectedness, and;
5. Promote hope
All planning and policy makers must acknowledge the outcomes of psychological distress that can impact their communities should mental health plans for disaster response and recovery be ignored:

### Negative Psychological Outcomes of Natural Disaster

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<thead>
<tr>
<th>TABLE 2. NEGATIVE OUTCOMES OF NATURAL DISASTER ARE REPORTED AS:</th>
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<tbody>
<tr>
<td>• post-traumatic stress</td>
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<tr>
<td>• post-traumatic stress disorder</td>
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<tr>
<td>• anxiety disorders</td>
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<tr>
<td>• depression</td>
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<tr>
<td>• complicated/traumatic grief</td>
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<tr>
<td>• externalizing disorders</td>
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<tr>
<td>• academic/social impairments</td>
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<tr>
<td>• severe problems in relationships (family, work, community)</td>
</tr>
<tr>
<td>• temporary or permanent incapacity for work (absenteeism)</td>
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<tr>
<td>• somatic malaise (physical illness resulting from mental illness)</td>
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<tr>
<td>• criminal and/or antisocial behaviour</td>
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<tr>
<td>• psychiatric disorders</td>
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<tr>
<td>• distress</td>
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<tr>
<td>• interpersonal challenges</td>
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<tr>
<td>• severe problems in relationships</td>
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<tr>
<td>• more prone to accidents</td>
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<tr>
<td>• increased substance misuse</td>
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<tr>
<td>• alcohol and drug reliance</td>
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<tr>
<td>• social isolation</td>
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<tr>
<td>• heavily burdened social systems</td>
</tr>
<tr>
<td>• coping challenges</td>
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<tr>
<td>• increased vulnerability for poor choices/decisions</td>
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<tr>
<td>• inability to recover</td>
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</table>

Literature asserts that trauma is the most prevalent mental health condition post-disaster and can impact the social, medical and economic systems of communities, creating compound challenges for those affected. Of specific interest to planners is the persistent nature of trauma which can remain subconscious, sometimes manifesting years after an event. Planning professionals must have an understanding of traumatic events to successfully mitigate harmful outcomes.

Distinguishing features of a **traumatic event** are:

1. Unpredictability;
   - sudden and unexpected event(s) that can’t be prepared for psychologically.
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2. Uncontrollability;
   - the event cannot be prevented or shaped by one’s behaviours or actions.
3. The event tests/changes the values and priorities of those impacted;
   - enhanced awareness of our vulnerability;
   - world-view and outlook changes;
   - values and priorities change.
4. All-encompassing change;
   - the event and subsequent challenges require a “demanding process of adaptation” (Saari, 2005, p. 23).

Best Practice to Reduce Impact on Mental Health

Fostering psychological functioning and minimizing psychiatric disorder and disease requires rapid, effective and sustained mobilization of health care resources. Pre-existing knowledge of communities’ resilience/ vulnerability and knowledge of psychiatric/ psychological responses to such events before they occur enables leaders to promote resilience, facilitate recovery and sustain the social cohesions of communities.

Planning professionals must consider the following to mitigate mental health challenges from disaster events:

- Inter-agency collaboration to developing concrete disaster plans for mental health supports;
- clear pre-emptive plans including (when necessary) mutual aid agreements, to alleviate opportunities for division and allow each agency to focus on the work that needs to be done;
- community-based, local programs rather than traditional, patient-initiated mental health services;
- programs aimed at all survivors and other impacted individuals to eliminate the need for “subjective need assessments” (Saari, 2005, p. 82), normalize participation in services, and reduce stigma of mental illness;
- culturally-informed intervention, especially in multi-cultural societies such as Canada.

An issue that pertains to community support yet had little representation in the literature review is that of consent. The issue of consent is central to human service work, yet there is little mention of consent in service plans for community mental health supports during disaster response. Consent is a crucial part of the work that counsellors and support professionals do when the work is interpersonal and supportive. Miller (2012) highlights the need for consent in disaster settings; that in many instances external supports are brought in consisting of “professionals” who can quickly
convene and plan without collaborating with the community itself. Full participation is recommended to enlist community in the disaster response and recovery process, which aligns with best practice research that suggests communities are supported through promoting resilience, highlighting strengths, enlisting natural leaders to support those in administration, and have community take an active role in program design. Full participation includes consent which values the voice of community at the table as equals with “professionals” as decisions are made.

**Community Cohesion and Social Capital as Best Practice**

Social cohesion among neighbours mitigates the impact of psychological consequences following natural disaster. Higher levels of community collective efficacy are associated with lower levels of post-traumatic stress disorder, hence supports enhancing resilience and community strengths are important preventative measures intervening at community levels can be cost-effective, practical and have greater reach to those who would not normally seek out supports.

**Community resilience can be supported through building-up capacity of adaptive functioning (or coping skills), through:**

- economic development;
- social capital (the social networks that provide benefits to members);
- information;
- communication, and;
- community competence.

In the early phase of disaster recovery, there is often a sense of cohesion and working together that is followed by “disillusionment, mistrust and anger” (Ursano et al, 2017, p. 5) as individuals search for someone to blame for the event and outcomes. When mental health supports reinforce community cohesion and allow for a return of routine as quickly as possible, this encourages social supports that are valuable to the recovery process.

**Leadership**

The importance of leadership in disaster response and recovery cannot be overstated; when a natural disaster occurs, leaders become crisis managers. In crisis situations, people expect leaders to mitigate negative outcomes, guide them away from harm, explain what happened and reassure that this will not happen again. Whether reasonable or not, the expectations of leaders in times of disaster are vast. Boin at al. (2005) outline “five core tasks of crisis leadership: sense making...decision-making...meaning making...terminating...and learning” (Helsloot & Ruitenberg, 2004, p. 350). These tasks are ideally suited to disaster leadership and fit with the psychological
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needs of survivors; making meaning of an event is repeatedly shown in research as beneficial for recovery, as is a transition period to “normal” activities and need for survivors to see leaders taking action to learn from an event which decreases the potential for future harm. In particular, meaning-making can be achieved by the following:

1. communicating publicly that which survivors are unable to express themselves;
2. deliberate re-framing of events, and;
3. the use of rituals and symbolic acts.

Leaders are uniquely qualified to make meaning of a disaster event so pre-planning for this need is a positive step in disaster planning for mental health needs in community. Coordination of response, which has been identified as fundamental to best practice in disaster mental health response, must be carried out by strong leaders who possess understanding of available resources and how to engage them. Leaders during disaster response and recovery must provide clear communication and engage with media, demonstrate empathy, be able to function in stressful situations, adapt, and themselves be able to utilize strong self-care.

This project’s proposed Community Mental Health Disaster Response and Recovery Plan suggests the appointment of a Mental Health Disaster Response and Recovery Coordinator (MH-DRRC) who would provide strong leadership and oversee all aspects of mental health response and recovery efforts. That said, Landau & Saul (2004) propose a multisystemic approach which encourages those in the community with natural leadership to engage their skills to support the recovery process. Those in positions of authority within the community can create opportunities to delegate leadership for these natural leaders as needs are heightened during disaster recovery.

Challenges for Supports

When planning for mental health response in disaster recovery, the specific challenges inherent to disaster support must be considered by local governments. Already over-burdened and wait-listed social service support systems are made vulnerable during emergencies as;

a) workers are affected by the disaster in their own lives;
b) the systems are under duress as infrastructure may be damaged, creating hardship in service provision;
c) displacement, injury, stress or death can reduce availability of social service staff;
d) social service staff experience burnout and/or vicarious trauma and are unable to function in their roles;
e) agencies providing parallel services can become divisive and work against each other, creating confusion and reducing positive impacts of service.
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In addition, demands on support workers are great post-disaster due to the high number of individuals affected; “taking the psychological perspective into account in defining victims places fresh demands on crisis work” (Saari, 2005, p.34). A conservative estimate places 10-30 psychological victims for each medical victim [dead or injured]).

When natural disaster events occur, often there is an influx of aid from outside sources which can lead to confusion and overlap in services. That said, it cannot be assumed that community-level support will increase during disaster:

> “a more nuanced understanding of community responses to disasters suggests that social support processes not only are responses to disasters, but are themselves affected by disasters. Although rapid-onset natural disasters initially mobilize support, ongoing demand overcomes and depletes support resources, resulting in the deterioration of social support and social embeddedness”. (Cline et al., 2010, p. 3)

The ongoing allocation of resources is a challenge for communities without disaster events and attention must be paid to the provision of local supports as outside resources are retracted. Research has been abundant in the emerging field of disaster mental health support which creates opportunity for Canadian policy makers and planners to create systems which reduce long-term costs, improve outcomes for survivors, and boost resilience.
Community Mental Health Disaster Response Plan Template

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