SESLHD PROCEDURE COVER SHEET

Health
South Eastern Sydney
Local Health District

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SUMMARY	This document is a supporting plan for the SESLHD HEALTHPLAN. It outlines roles and functions of the SESLHD Mental Health Service and the recommended actions under the emergency management phases of prevention, preparation, response and recovery.

HEALTHPLAN – Mental Health Service Standard Operating Procedure (SOP) Emergency Response

SESLHDPR/332

1. POLICY STATEMENT

The HEALTHPLAN – Mental Health Service (MHS) Standard Operating Procedure (SOP) Emergency Response is a Supporting Plan to the South Eastern Sydney Local Health District Health Plan (SESLHD HEALTHPLAN). The SESLHD HEALTHPLAN supports the PD2014_012 New South Wales Health Services Functional Area Supporting Plan (NSW HEALTHPLAN), which itself is a supporting plan of the NSW State Emergency Management Plan (EMPLAN) (2018). This document shall be referred to throughout as the Mental Health Standard Operating Procedure (MHSOP).

The SESLHD MHSOP outlines the agreed roles and functions for the mental health services component that constitutes a whole of health response, incorporating an all hazards approach.

It identifies recommended actions under four emergency management phases: Prevention, Preparation, Response and Recovery (PPRR). Actions under the Prevention and Preparation phases are recommended to be carried out on a continual basis. Actions under the Response and Recovery phases are recommended to be carried out once the MHSOP has been activated.

The MHSOP will be activated by the SESLHD Mental Health Controller (MHC) following notification from the SESLHD Health Services Functional Area Coordinator (HSFAC) or the NSW State MHC. If notification comes from the State MHC first, the SESLHD HSFAC must be notified. Written authorisation is required for the activation of the MHSOP (see APPENDIX A).

2. BACKGROUND

2.1 Aim

This MHSOP aims to coordinate the response and resources of the SESLHD MHS when the SESLHD HEALTHPLAN has been activated.

2.2 Objectives

- To facilitate and enhance the effectiveness of SESLHD MHS resources to any major incident/emergency.
- To identify facilities and resources available within the SESLHD MHS.
- To set out specific responsibilities and tasks in relation to activation of the MHSOP.
- To detail the arrangements for review, testing, evaluation and maintenance of the MHSOP.
- To detail training requirements for SESLHD MHS personnel.

2.3 Scope

This MHSOP encompasses all Mental Health facilities in SESLHD and is designed for the coordination of all Mental Health resources in SESLHD. It will not be

activated if Mental Health resources are not required during an incident or emergency.

2.4 Principles

- The Mental Health emergency response should provide consultative support and, where appropriate, prevention and treatment services informed by best available evidence and consensus.
- The Mental Health emergency response will be implemented in partnership and collaboration with other key agencies in emergency and recovery but will be clearly identified as a component of the health response. There will be strong links within LHDs between Mental Health personnel and major hospitals and emergency departments.
- The Mental Health response will occur at appropriate levels in the emergency and recovery phases, linking to relevant interagency frameworks to deal with complex, dynamic and protracted processes.
- Operations will be conducted and managed at the local level of the region or area, with support from State-wide resources should local resources be overwhelmed.
- MHS management arrangements recognise the need to plan for surge requirements and sustainability of response.
- Core Mental Health services will be maintained throughout SESLHD during an emergency. Consumers with pre-existing psychopathology will continue to require and receive prioritised services with special attention to those with increased psychopathology in response to the event, previous clients who re-present, and new clients.
- Mental Health services will participate in SESLHD training programs and exercises and with other agencies in external training programs and exercises to ensure an effective response for NSW.
- Mental Health services are provided in a timely, fair, equitable and flexible manner, with a focus on those with the highest level of need. However, the provision of Mental Health services in an emergency may involve a change in normal priorities to ensure the greatest good for the greater number.
- Mental Health services may provide support to emergency personnel, including advice on normal response, Psychological First Aid (see APPENDIX B) and Mental Health consultation during operational briefings or debriefings.
- Intake documentation, clinical record keeping (a clinical log) and data collection are essential components of the Mental Health response.

2.5 Definitions

- **ABC model**: Assessment of client's level of arousal, behavioural disturbance and cognitive functioning.
- **Acute decompensation**: A loss of touch with reality with an inability to perform basic cognitive processing functions.

- **Acute Stress Disorder (ASD)**: Set of responses commonly observed in the first few days/weeks following a trauma or emergency. (Refer to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, known as DSM-5, for diagnostic criteria).
- **Chemical/Biological/Radiological/Nuclear (CBRN)**: Chemical/Biological/ Radiological/Nuclear threat or attack. These forms of attack have significant implications for the mental health of rescue workers and the community.
- **Community Managed Organisation (CMO)**: See 3.1 and 4.1 below.
- **Critical Incident Stress Debriefing (CISD)**: CISD is a formalised, structured method of group review of the emergency conducted in the first few days (48-72 hours post-event). It was developed for emergency workers and emergency personnel and may be helpful as a stress management process. However, it has not been established as preventing more severe consequences. It is not appropriate for everyone and should never be mandatory. In some cases it has been found to be harmful.
- **Debriefing**: A term historically used to describe immediate early intervention with those affected by trauma/emergency. Recent empirical findings have cautioned against the routine application of this approach. The term is still commonly used to describe preparatory briefings or follow-up debriefings for rescue and support workers.
- **Debriefing – Operational**: This is a routine process for emergency organisations and can provide an effective mechanism for reviewing the experience.
- **Debriefing – Psychological**: Refers to a less formalised process of debriefing than CISD and includes education and review processes. There is often a positive focus on resilience and coping strategies. There is no systematic research for psychological debriefing as an operationalised intervention, or for clear differentiation from CISD.
- **Department of Communities and Justice (DCJ)**: (formerly Family and Community Services (FACS)) Provides Disaster Welfare Services to support people who have been impacted by disasters i.e. floods, storms, bushfires and other emergencies. DCJ is responsible for coordination and delivery of welfare services including establishment/management of evacuation centres and ensuring immediate needs of affected people are met.
- **District Control Centre (DCC)**: Will be established at the District level and located in the Executive Unit, Level 4, The Sutherland Hospital. The DCC is a central command and control facility for emergency management and functions at a strategic level, ensuring continuity of operation of the health service.
- **First Level Early Response**: This entails 'Safety, Security, Survival' and 'Psychological First Aid'.
- **Health Services Functional Area Coordinator (HSFAC)**: Appointed by the Chief Executive, the HSFAC coordinates the whole of resources within the

LHD for the management of an emergency. Single point of contact/control for health operations in an emergency within their geographic boundaries. Coordinates support from within their LHD.

- **Local Health District (LHD)**
- **Mental Health Controller (MHC)**: See 3.1 and 3.2 below.
- **Mental Health Emergency Response Team (MHERT)**: See 3.3 below.
- **Mental Health staff**: Mental Health staff employed in NSW Mental Health services. It is acknowledged that there are many others in community health and public hospital services that provide Psychological First Aid and referral to specialist care as part of any emergency response involving health services. Mental Health services should liaise regularly with Allied Health and Nursing services that are engaged in psychosocial support and work collaboratively with services in the delivery of the health response in an emergency or major event.
- **Post Traumatic Stress Disorder (PTSD)**: A term used to describe a group of responses that may be disabling in both the short and longer term. This is only experienced by a small percentage of the population. (Refer to DSM-5 for diagnostic criteria.)
- **Prevention, Preparedness, Response and Recovery (PPRR)**
- **Psychological First Aid**: Encompasses a range of processes that may be provided by first responders. These include: 'do no harm', active and compassionate support, triage for those with acute decompensation, keeping families/social groups intact, facilitating reunion with loved ones, providing accurate and clear information and protection from further harm. This first level early intervention is supported by comprehensive empirical findings and international consensus.
- **Triage**: In a mental health context triage may involve judgements relating to cognitive functioning and judgements related to risk to self/others. The ABC model can be used to assist those whose levels of arousal are threatening to self/others, those who are behaviourally disturbed to a significant degree and those with ongoing cognitive impairment (dissociative or organic states that may threaten safety or function). Systems must be in place for those who become acutely psychotic and need to be transferred to immediate care. Triage may also assist in identifying those at higher risk for subsequent follow-up.

3. RESPONSIBILITIES

3.1 State Mental Health Controller:

The State Mental Health Controller (MHC) is one of the five major contributing health service components that constitute the whole of health response incorporating an all hazards approach.

Responsible to: NSW State HSFAC during the time HEALTHPLAN is activated.

Responsible for:

- Controlling all Mental Health resources in NSW which are needed to respond to an emergency.
- Ensuring that core Mental Health services throughout the State are maintained during an emergency.
- Overall planning, activation, direction and control of the Mental Health response during the emergency and in the recovery phase as part of the health response.
- The provision of technical and clinical management advice on mental health issues during the emergency and in the recovery phase as part of the health response.
- Collaboration and liaison with relevant government agencies, and recovery and welfare community managed organisations (CMOs).

3.2 SESLHD Mental Health Controller:

Responsible to: The SESLHD HSFAC.

Responsible for:

- Advising SESLHD HSFAC in planning, activation and controlling all SESLHD Mental Health resources needed to respond to and recover from the impact and effects of a major incident/emergency.
- Maintaining a strategic overview of the emergency and the Mental Health approach.
- Filtering and clarifying communications between SESLHD HSFAC, the MHERT and the State MHC if required.
- Overall planning, activation, direction and coordination of the Mental Health response.
- Ensuring that the Mental Health response addresses immediate, medium and long-term needs, as well as facilitating the recovery process.
- Balancing the needs of the emergency response against the need to ensure that routine Mental Health services throughout the LHD are disrupted as little as possible.
- Ensuring the position is covered 24 hours a day, 365 days a year.

Specific Duties:

- Notify the SESLHD HSFAC of any major incident/disaster which requires or may require a Mental Health response.
- Upon activation of the MHSOP, proceed to the Mental Health Service District Control Centre (MHS DCC) or the District Control Centre as required (the MHS DCC is located on Level 2, Mental Health Unit, St George Hospital, 11 South Street, Kogarah while the District Control Centre is located in the Multipurpose

Meeting Room, Level 4, the Executive Unit, Sutherland Hospital, The Kingsway, Caringbah). Upon the request of the SESLHD HSFAC, a MH Liaison Officer may be requested to proceed to the District DCC.

- Provide the link between the SESLHD HSFAC and the Mental Health response.
- Provide advice concerning mental health issues to the SESLHD HSFAC.
- Discuss the proposed Mental Health response with the SESLHD HSFAC.
- Carry out the requests of the SESLHD HSFAC or State HSFAC.
- Liaise regularly with the SESLHD HSFAC, providing a minimum of one written situation report daily for the duration of the activation.
- Assess the mental health implications of the major incident/disaster, considering the likely mental health consequences, the likely mental health needs and the likely course of events.
- Assess the need to appoint a relief MHC and brief this person on handover.
- Maintain a strategic overview of the mental health needs and response, attempting to anticipate future developments.
- Plan and coordinate the Mental Health response, coordinate the deployment of Mental Health personnel and relevant others.
- Notify and place on standby the MHERTs (but they are NOT to proceed to the disaster site).
- Liaise, via the SESLHD HSFAC, with other health services responding to the major incident/emergency.
- Arrange Mental Health beds for any victims requiring admission for psychiatric or psychological reasons.
- At the request of the SESLHD HSFAC, authorise the use of MHERTs, or any other Mental Health resource if needed, and arrange for their transportation to the response site.
- Request, via the SESLHD HSFAC, the transport for the MHERT to the disaster site or designated area. Advise the Police Site Controller of the deployment of the MHERT to the site to ensure access through the Police cordon.
- Ensure correct documentation of all decisions and plans.
- Maintain communication with the major incident/disaster and response sites and with the mobilised Mental Health resources.
- Monitor the adequacy of the MHS response.
- Ensure the welfare of MHS personnel involved in the response, by arranging adequate relief.
- Devise strategies to control and best utilise volunteer Mental Health workers/ counsellors who are not part of the organised MHS emergency response.
- Liaise with the Facility Controllers to identify specific resources – such as social workers or counsellors – that can be utilised from Community Health Services to support the mental health requirements.
- Mobilise and deploy resources to aid in the recovery process.
- Seek expert advice and, if the situation warrants and at the direction of the SESLHD HSFAC, hand over control to a higher authority (State MHC).

- Ensure a post-event debrief for Mental Health personnel at the end of their shift and an operational debrief of the involved Mental Health services within seven days of the stand-down order.
- Provide a written report to the SESLHD HSFAC, subsequent to stand-down, as required.

3.3 Mental Health Emergency Response Team (MHERT)

- The MHERT may consist of up to 5 Mental Health clinicians with appropriate experience and training (including emergency exercises), one of whom will be the MHERT Leader.
- Each MHERT will work in pairs (except for the Team Leader) for a maximum of 12 hours a day, with at least one break every four hours, for a maximum of three consecutive days.
- The MHERT will have access to a Psychiatrist.
- The MHERT is responsible for providing Mental Health assistance at the designated area, proximal to the site of the incident or emergency (transport arrangements will be determined by the MHS DCC in consultation with the SESLHD HSFAC).
- The team must report to the On-Site Medical/Health Commander, present a list of team personnel, receive a briefing and further instructions.
- A MHERT may be site based or a composite MHS response team formed under direction from the SESLHD MHC to attend to the Psychological First Aid requirements of all people affected by an emergency.

Responsible to: All team members are responsible, via the Mental Health Team Leader, to the On-Site Medical/Health Commander.

Responsible for:

- Providing Mental Health assistance on-site and off-site in major incidents/ emergencies.
- Aiding the overall emergency response by collaborating with other services and working within a disciplined team structure. At all times, securing the site from further danger and providing emergency aid to physically injured patients (provided by first responders) must take precedence over Mental Health interventions (Psychological First Aid is generally provided after the first responders have attended to safety, security and survival needs).
- Being able to be contacted, formed and called to respond 24 hours a day, 365 days a year (i.e. there should be capacity to form a team as needed from a pool of appropriate personnel).

Specific Duties – at the Emergency Site:

- Providing assessment and treatment to persons demonstrating acute decompensation (e.g. acute anxiety, acute stress reactions, dissociation, panic

attacks, disorientation, acute psychotic reaction) and/or supporting responders providing direct care to those individuals (e.g. trapped persons).
- Providing advice to other responders with regard to general support and comfort, including Psychological First Aid to those affected by the emergency.
- Collecting details of disposition of physically injured victims (for later Mental Health follow-up as required).
- Providing supportive psychological debriefing sessions to emergency and other workers when appropriate.

Specific Duties – at the Recovery/Welfare Centre:
- Coordinating responses in collaboration with other sources of counselling (e.g. Red Cross, DCJ) as needed and ensuring that any persons requiring specialist Mental Health services are seen by the MHERT.
- Providing counselling informed by the principles of Psychological First Aid (support and comfort, protection and triage) where relevant.
- Providing assessment and screening for mental health issues where relevant.
- Providing triage and mental health and/or counselling treatment advice where relevant. This may include treatment advice for those identified to be suffering acute stress reactions and/or traumatic brain injury, and also includes those otherwise identified at risk of subsequent mental health problems.
- Ensuring the provision of initial bereavement counselling.
- Providing information about the range of psychological responses to emergencies and about how to access Mental Health services.
- Keeping adequate records of all persons seen and interventions offered (for both follow up and evaluation purposes).

3.4 Mental Health Emergency Response Team (MHERT) Leader:

The MHERT Leader is a member of the MHERT, nominated by the SESLHD MHC to command a MHERT which is being dispatched to the site of a major incident or emergency.

Responsible to: The On-Site Medical/Health Commander while at the site of a major incident/emergency and the SESLHD MHC at all other times until stood down.

Responsible for:
- The activities and welfare of the MHERT from the time of dispatch from the hospital unit to its return to base.
- Completing a record of MHERT personnel and handing this to the On-Site Medical/Health Commander on arrival at the site.

See Action Cards (APPENDIX C) for details of roles and responsibilities.

4. PROCEDURE

4.1 Standard Operating Procedures for MHERT

Before setting up and arranging any request for service received, the MHERT will need to know the following information:

- Who is making the call requesting the use of the MHERT?
- What authority does the person have to authorise a response?
- How are they involved in this specific emergency?
- What occurred (a brief overview)?
- Who was involved?
  - Primarily affected (people directly involved in the incident).
  - Secondarily affected (people not directly involved but with a legitimate support role or relationship to the people directly affected).
  - Tertiary affected (people who have knowledge of the people of the incident but not directly involved as a responder or supporter).
- When did the incident occur (hours/days ago)?
- Are interpreter services needed?
- What other counselling services are involved (health, DCJ, CMOs etc.) and how are the counselling efforts to be coordinated?
- Do the people involved know what the MHS offers and do they want the service?
- Have the people involved had any Psychological First Aid/defusing/counselling or other help?

NB: This information may be gathered by the MHC prior to the mobilisation of personnel.

In addition to this background information, Mental Health personnel will operate on the following principles:

- They will work in teams of at least two or three per session.
- The range of services offered will include: Mental Health first aid; trauma counselling; and crisis support. Referrals will be provided for people in need of ongoing post-trauma support.

4.2 Governance Structure

- During the activation of the MHSOP, staff selected for emergency roles will step aside from their normal rostered duties and assume their emergency positions.
- From the time the MHSOP is activated, until stand-down, SESLHD Mental Health staff are responsible to the SESLHD MHC or their delegate.
- In the event that the emergency situation escalates to State level, the SESLHD MHC reports to the SESLHD HSFAC and to the State HSFAC.
- The Mental Health emergency positions identified include the SESLHD MHC and the MHERT (consisting of one MHERT Leader and one to four Mental

Health team members, which may be a combination of Psychiatrists, Nurses and Allied Health staff).

- The MHSOP will be activated by the SESLHD MHC following notification from the SESLHD HSFAC or the NSW State MHC. If notification comes from the State MHC first, the SESLHD HSFAC must be notified.

4.3 Phases of Event Response

Prevention: Prevention (mitigation) measures are designed to avoid (or reduce) the potential impact of emergencies in the community.

Preparedness: This phase involves considering and planning for mental health issues which need to be incorporated in any response, ensuring that staff and resources are available for effective response in line with other agencies, appropriate training and best available evidence. This will involve ensuring adequate numbers of staff to provide a spectrum of prevention, early intervention, treatment and rehabilitative interventions.

Response: This phase requires the mobilisation of Mental Health personnel, as part of the health response, who are trained and skilled to provide emergency response as needed alongside other health and emergency agencies. In the first instance the SESLHD HSFAC will mobilise health resources from within SESLHD. If the event requires a multi-area or State-wide response, the resources will be coordinated by the State MHC. There will be strong links within SESLHDs between Mental Health personnel and hospital and emergency department staff. The response phase involves: provision of support, advice and Mental Health expertise as required; assessment of current and potential mental health needs in the immediate, intermediate and longer term; and establishment of documentation and monitoring processes. Identification of high risk/high need individuals and groups, and prevention, early intervention and treatment interventions to meet their needs are part of the response phase. This will manage with mental health impacts of stressors including trauma, loss, dislocation, searching for missing family and friends, impact of human malevolence and chronic stressors including those of resource loss. It will address pre-existing vulnerabilities, supportive networks, community and societal response and recognition, empowerment strategies, positive expectations for resilience and recovery and will be guided by the available evidence.

Recovery: This phase involves the role of Mental Health services and response systems in returning the affected individuals, families and communities to functioning, to the extent possible. It will involve prevention and treatment strategies informed by the best available evidence. It will usually commence at the same time as the response phase. For the SESLHD MHS, this phase will involve mobilisation of resources including:

- Mental Health staff to assess and deliver appropriate Mental Health care for those at high risk or with established need, while providing support and advice to recovery systems.
- Supervision, review and monitoring of services delivered by other Mental Health providers with appropriate expertise, as required.
- Education, consultation, support and referral systems for other health, non-government, GP and community providers, with respect to mental health elements of recovery.
- Continuing delivery of Mental Health services to the community, including responding to the mental health impacts of the emergency with current clients.
- Participation in operational review and debriefing to inform future prevention, preparation and response planning.

4.4 Emergency Response

Stages of Activation. There are four recognised stages of activation for the MHSOP:

Alert: This occurs on receipt of notification of a situation which could escalate or which may require the coordination of Mental Health resources and support. The SESLHD MHC declares an 'Alert'. During this phase resource requirements are assessed, a MHERT Leader is nominated and kept informed.

Standby: This occurs on receipt of information that a major incident/emergency is imminent and may require deployment of Mental Health personnel and resources. The SESLHD MHC will assess the situation, inform emergency position holders and, if required, will put a MHERT on standby.

Response: This occurs on receipt of information that a major incident/emergency exists and there is a requirement for deployment of personnel and resources. This is the mobilisation and deployment of Mental Health resources where and when required. The SESLHD MHC orders a Call Out to deploy the resources on standby and personnel to perform the assigned tasks. Not all resources may be deployed, and some may remain on standby in reserve for subsequent relief.

Stand Down: This occurs when State-level and/or LHD level operations are no longer required, following the completion of the Mental Health response to a major incident/emergency. This does not necessarily mean that the resources will no longer be required. The recovery of normal activity during this phase may be prolonged. The resolution of the incident will require an operational debriefing in this phase, which should include psychological debriefing, evaluation and recovery. The debriefing is to be arranged by the SESLHD MHC and held within seven days after the emergency.

4.5 Emergency Notification

The MHSOP will be activated by the SESLHD MHC following notification from the SESLHD HSFAC or the NSW State MHC. If notification comes from the State MHC first, the SESLHD HSFAC must be notified. Following formal activation, all Mental Health personnel and equipment become the resources of the SESLHD MHC.

4.6 Staff Relief by Other Counselling Workers

Staff are to be relieved by another counselling worker every four hours where possible. A mini-debrief is to be provided after each session worked as required/needed.

4.7 Debriefing Information

Health Personnel Counselling

Post-incident stress management and counselling will be undertaken for all health workers involved in any major incident or emergency as soon as possible after the event if required. This must NOT be conducted by those involved in the site/emergency response.

4.8 Operational Report Responsibility

An operational report will be compiled by the SESLHD MHC within seven days of stand down and presented (as required) to the SESLHD HSFAC and the State MHC.

4.9 Coordination and Liaison

Liaison and cooperation between the emergency service organisations and NSW Ministry of Health services is essential. This is achieved through:

- Liaison with health representative(s) on State/District Emergency Management Committees. The SESLHD MHC is to liaise with the SESLHD HSFAC regarding appropriate representation on local emergency management committees.
- Appointment of Health Liaison Officers to the Emergency Operations Centres at the direction of the State and/or SESLHD HSFAC.

It is the role and responsibility of the State MHC to provide for Mental Health resource requirements in consultation with relevant systems of authority, with SESLHD Mental Health services and other Mental Health resources within this framework of authority. The State MHC will also link with appropriate liaison services in terms of local, state and national and emergency operations. The State MHC will report to the State HSFAC on the State Mental Health response.

4.10 Planning

Elements of Mental Health planning include:

- Coordination via the NSW Health Emergency Mental Health Advisory Group, chaired by the NSW Health State MHC.
- Coordination of emergency response including consultation, advice, specialist Mental Health team/s, Psychological First Aid, triage, support for families with deceased or missing members and linkages to forensic counselling.
- Provision for documentation, review, monitoring, oversight, supervision and identification of emerging need and progress through transition from emergency, recovery and return to functioning for individuals and the community.
- Participation in organisational/operational review or debriefing to provide learning to inform further response and provision of reports.

4.11 Health Communications

The Health Communications component aims to provide timely and accurate advice for the community and media using the principles of prevention, preparation, response and recovery.

It recognises the need for communication with healthcare workers across the LHD and that the media can play an invaluable role during an emergency. Health Communications will be provided by the SESLHD Media Unit – only designated spokespeople are to speak to the media.

4.12 Administration and Training

General

Responsibilities for the administration of LHD Functional Area Plans rest with the LHD Chief Executives and are reflected in their performance agreement. LHDs are to develop specific plans, reflecting the NSW HEALTHPLAN arrangements, which include Mental Health.

Logistics Support

Whenever possible, normal procedures for the acquisition of health service goods and services are to be utilised. Should Mental Health assistance be required, it should be requested through the State HSFAC.

Review, Testing and Evaluation

The SESLHD MHC is responsible for ensuring that the MHSOP is reviewed, tested, evaluated and maintained in a current state.

The MHSOP is to be reviewed by the SESLHD MHS District Document Development and Control Committee (DDCC):

- On a biannual basis (every two years).
- Following a debrief that highlights areas that require review and change.

- After any emergency exercise.
- After any changes in major incident emergency-related legislation.

All proposed changes to this MHSOP will be subject to SESLHD MHS DDCC recommendation, approval and endorsement prior to being incorporated into the MHSOP and approved by the SESLHD MHS Clinical Council, the Chair of the SESLHD Disaster Management Committee and the SESLHD MHC.

The SESLHD MHC is to support exercises conducted annually at the sites, with a view to:

- Ensuring all key participants are familiar with the contents of the MHSOP.
- Testing specific aspects of the MHSOP.

Exercises will need to be undertaken as follows:

- Small exercises that test individual facility plans.
- Exercises that test the coordination and communication within and between Mental Health services.
- Participation as a functioning service during a SESLHD exercise.
- Participation as part of major exercises controlled by the DCC.
- Participation at a State-wide exercise controlled by the State HSFAC or State MHC.

Exercises should be conducted as either desktop exercises or full simulation of actual emergencies. Exercises are to be planned in consultation with the LHD HSFAC. A range of exercises to cover various issues will be planned. Some examples are:

- Earthquake.
- Cyclone.
- Major transport collision with involvement of two buses.
- Flooding.
- Aircraft accident – either on/off airport.
- Major power failure.

The MHSOP is to be exercised, evaluated and reviewed in accordance with the above outlines and periodically as determined by the SESLHD MHC.

An operational debrief will be conducted and a full report on the exercise submitted by the SESLHD MHC to the SESLHD HSFAC.

These requirements will be reflected in the site plans.

Training

Mental Health education and training is essential to ensure a coordinated response in the event of MHSOP activation. The education and training will be tailored to

each component of the MHSOP in accordance with minimum competencies as defined by the NSW Health Emergency Mental Health Advisory Group, in collaboration with the State MHC. A Mental Health representative sits on the NSW Health Emergency Education Advisory Group to provide input.

SESLHD MHS will provide training to ensure adequate numbers of trained personnel and that there are personnel of all required levels of competence. A central register of trained Mental Health personnel is maintained by SESLHD. This will include training levels and dates of training.

All Mental Health personnel who will be rostered to be part of the Mental Health response to emergencies will require training and education in emergency management. At a minimum they must:

- Be familiar with the SESLHD HEALTHPLAN, NSW HEALTHPLAN and the NSW Health Disaster Mental Health Manual (2012).
- Be familiar with this document, which includes the task cards.
- Have an understanding of the full range of psychological responses to an emergency.
- Have specific skills in the provision of Psychological First Aid, case identification (including organic disorders), trauma and/or bereavement counselling.
- Have an understanding of the appropriate application of the above skills.
- Have general organisational and management skills.

There are three levels of Emergency/Disaster Mental Health Training. Each level is aimed at a different target group. Level 1 does not need to be completed in order to attend Level 2 or 3:

- **Level 1** – General Emergency Mental Health response based on Psychological First Aid is suitable for all front line Mental Health staff. This training is for intervention following mass emergencies and includes topics that cover:
  - Psychological First Aid; what it is and what it isn't.
  - Disaster and mass adversity.
  - The reality of disaster: preparation for entering the fray.
  - Core skills and their application.
  - Assessing further need: key principles for transition and aftermath.
  - Self-care for responders.
  - Vulnerable, at-risk population groups.

- **Level 2** – High level clinical skills and interventions for those who have previous skill and experience in emergency response and would be suitable to join a Mental Health deployment to a site or attend an evacuation centre and provide clinical leadership, consultation and advice.

- **Level 3** – Aimed at MHS Directors, MHS Managers and people with responsibility for coordinating staff and resources in an emergency.

Skills Training
Training is required for those personnel who may be needed to perform specific skills in unusual and difficult circumstances in the pre-hospital/emergency environment, including (but not limited to):

- Command, control, coordination and communications.
- Triage.
- Clinical assessment and interventions.
- Emergency Services roles and responsibilities.
- Treatment and transport.
- Leadership.
- Documentation.
- Mental Health aspects of emergencies.
- Public Health aspects of emergencies.

Key skills training for Mental Health personnel will follow national guidelines and will be in accordance with standardised systems of accreditation. Key criteria will be defined under the guidance of the State MHC and in consultation with the NSW Health Emergency Mental Health Advisory Group.

Skills Acquisition and Maintenance
Skills must be regularly rehearsed and continually practised to maintain proficiency and should be linked wherever possible to planned exercises and emergency scenarios. Mental Health services should participate in whole of health exercises.

Validation of Training
Training should be validated for both its effectiveness and efficiency:

- **Effectiveness**: Training is effective when it prepares the trainees to perform at the desired standard.
- **Efficiency**: Training is efficient when a satisfactory number and proportion of trainees meets the requirements of the training objectives for the least cost.

The NSW Health Emergency Education Advisory Group is responsible for providing a State-based training framework to ensure uniformity of training across the LHDs. The SESLHD MHC is responsible for ensuring training in emergency Mental Health response is provided to Mental Health staff. Training packages developed by individual LHDs should be reviewed by the NSW Health Emergency Education Advisory Group and the NSW Health Emergency Mental Health Advisory Group to ensure conformity with the State-based training framework.

Equipment
Mental Health staff participating in an emergency Mental Health response will require an emergency kit containing certain equipment and personal protective clothing, information and education handouts, medications and general items (see APPENDIX D), as well as Emergency Mental Health Intake Forms (see APPENDIX E). The local Mental Health Site Executive can advise the location of the emergency kit.

5. DOCUMENTATION

Separate documents to be read in conjunction with this document include:

- South Eastern Sydney Local Health District Health Plan (SESLHD HEALTHPLAN)
- PD2014_012 New South Wales Health Services Functional Area Supporting Plan (NSW HEALTHPLAN)
- NSW State Emergency Management Plan (EMPLAN) (2018)
- NSW Health Disaster Mental Health Manual (2012)
- NSW Ministry of Health Policy Directive PD2016_016 - NSW Health Influenza Pandemic Plan

6. AUDIT

An operational report will be compiled by the SESLHD MHC within seven days of stand down and presented (as required) to the SESLHD HSFAC and the State MHC.

7. REFERENCES

- South Eastern Sydney Local Health District Health Plan (SESLHD HEALTHPLAN)
- PD2014_012 New South Wales Health Services Functional Area Supporting Plan (NSW HEALTHPLAN)
- NSW State Emergency Management Plan (EMPLAN) (2018)
- PD2016_016 - NSW Health Influenza Pandemic Plan
- GL2018_017 - Major Incident Medical Services Supporting Plan
- GL2012_006 - HEALTHPLAN – Mental Health Services Supporting Plan
- NSW Recovery Plan (2021)
- PD2022_023 - Enterprise-wide Risk Management
- IB2018_031 - Emergency Management Education Framework
- NSW Hazardous Materials/Chemical, Biological, Radiological and Nuclear Sub Plan (June 2019)
- National Safety and Quality Health Service (NSQHS) Second Edition: Standard 1. Clinical Governance (1.23, 1.24)

8. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
August 2004	0	Approved by Area Emergency Management Committee.
February 2014	1	Endorsed by SESLHD MHS Clinical Council.
April 2014	1	Endorsed by SESLHD Emergency Management Committee.
May 2016	2v1	Reviewed by District Disaster Manager. Revisions incorporated.
July 2016	2v2	Reviewed by SESLHD MHS Clinical Nurse Manager and sent to MHS Service Directors for circulation with frontline staff. Feedback incorporated.
September 2016	2v3	Endorsed by SESLHD MHS Clinical Council.
November 2016	2	Approved by Executive Sponsor to publish.
May 2018	2	Risk rating changed from High to Medium – approved by Executive Sponsor.
October 2019	3.1	Routine review commenced. Minor review. Aligned with NSQHS Second Edition Links checked and updated.
October 2019	3.2	Reviewed by A Karooz Confirmed location of District Control Centre remains unchanged. Requested review by both the LHD HSFAC and Disaster Manager. Endorsed without change HSFAC.
October 2019	3.3	Incorporates feedback from SESLHD Disaster Management Unit.
November 2019	3.3	Endorsed by SESLHD MHS DDCC Endorsed by SESLHD MHS Clinical Council
December 2019	3.3	Approved by Executive Sponsor. Published by Executive Services.
October 2022	4.0	Routine review commenced. Document contents moved into new SESLHD Procedure template. Reviewed for gender diversity. Links checked and updated.
November 2022	4.0	Reviewed by SESLHD HSFAC. Endorsed, no changes
December 2022	4.0	Reviewed by DDCC – no changes identified. Endorsed for publication. Endorsed for publication by Executive Sponsor.
March 2023	4.0	Published by SESLHD Policy Team.

APPENDIX A:

AUTHORISATION

The South Eastern Sydney Local Health District Mental Health Service Standard Operating Procedure (SOP) Emergency Response has been prepared as a supporting plan to the South Eastern Sydney Local Health District Disaster Plan (SESLHD HEALTHPLAN).

This plan outlines the agreed roles and functions for the mental health services component that constitutes a whole of health response incorporating an all hazards approach.

The plan identifies recommended actions under four emergency management phases: Prevention, Preparation, Response and Recovery. Actions under the Prevention and Preparation phases are recommended to be carried out on a continual basis. Actions under the Response and Recovery phases are recommended to be carried out once the Mental Health Service Standard Operating Procedure (SOP) Emergency Response has been activated.

The Mental Health Service Standard Operating Procedure (SOP) Emergency Response is authorised by the South Eastern Sydney Local Health District Services Functional Area Coordinator (SESLHD HSFAC).

Separate documents to be read in conjunction with this document include the:

- South Eastern Sydney Local Health District Health Plan (SESLHD HEALTHPLAN)
- PD2014_012 New South Wales Health Services Functional Area Supporting Plan (NSW HEALTHPLAN)
- NSW State Emergency Management Plan (EMPLAN) (2018)
- PD2016_016 - NSW Health Influenza Pandemic Plan

Approved …….
Chairperson
SESLHD Disaster Management Committee
Date: …….

Approved ……..
SESLHD Mental Health Service Controller
Date: …….

APPENDIX B:

PSYCHOLOGICAL FIRST AID

Psychological First Aid is a term to describe the strategies developed to support and protect people psychologically through the acute phase of an emergency incident and the early aftermath. It involves principles of ensuring survival, safety, shelter, protection, comforting and practical and psychological support to facilitate return to functioning, family and ongoing life. It may also be utilised in other acute/emergency situations to assist those who are very distressed.

Psychological First Aid has been described in many different ways. The World Health Organisation in its Guide for Field Workers (2011) describes it as “a humane, supportive response to a fellow human being who is suffering and who may need support”.

A three level approach to psychological support following mass emergency:

There is consensus in Australian emergency Mental Health management that a multi-level or stepped approach is optimal. It is important to note that Psychological First Aid is a strategy woven into an organised emergency response process and forms part of an ‘All Hazards’ approach for Prevention, Preparation, Response and Recovery (PPRR) processes. They are:

LEVEL 1
Psychological First Aid (PFA) in the immediate aftermath.

LEVEL 2
Skills for Psychological Recovery (SPR) in the weeks and months following, as one of a range of programs for generic needs.

LEVEL 3
Specialised Mental Health interventions (as appropriate to need, or from about 4 weeks or longer onward) and targeted for those with established post-emergency psychiatric morbidity.

APPENDIX C:

ACTION CARDS

ACTION CARD 1

MENTAL HEALTH CONTROLLER

Action Summary

- Be point of contact for SESLHD HSFAC
- Plan operation control and resource coordination within Mental Health
- Notify SESLHD HSFAC
- Notify Community Health Controller (CHC) and Allied Health Manager, as required, of an incident/emergency involving Mental Health or appropriate resources from these supportive services
- Liaise with the CHC and Allied Health Manager for the coordination of required counsellors and social workers if needed
- Continuously monitor Mental Health response to incident/emergency
- Provide situation reports to the SESLHD HSFAC during activation of this plan
- Conduct an operational debrief for key people involved in the incident/emergency within Mental Health, Community Health and Allied Health as required
- Coordinate recovery operation
- Appoint a recovery operation person if required
- Be Mental Health representative on the District Disaster Management Committee
- Monitor maintenance and review of all emergency plans within Mental Health

ACTION CARD 2

MENTAL HEALTH EMERGENCY RESPONSE TEAM LEADER

Action Summary

- Provide staff with Action Role Cards if required
- Collect and check Mental Health emergency kits
- Ensure team is wearing identification tags
- Liaise with the On-Site Medical/Health Commander (on arrival at site) and set up in designated area, keeping in mind patient flow
- Request On-Site Medical/Health Commander provide assistance and support as necessary
- Commence triage, assessment and referral as required
- Be aware of location of individual team members at all times
- Assume responsibility for organising emergency kit and team to relocate, evacuate or return to Hospital, as directed by the On-Site Medical/Health Commander
- Maintain register of accountable drugs (if required within the Mental Health emergency kit) and return remaining supplies to appropriate area
- Coordinate team members to restock equipment on return to assembly site
- Organise debriefing sessions as required, including supportive psychological debriefing for team members if appropriate/required
- Notify MHC on return to base Hospital, restock and check emergency equipment
- Submit a written report to the MHC within seven days of the stand-down
- Attend District Mental Health debrief as required

ACTION CARD 3

MENTAL HEALTH EMERGENCY RESPONSE TEAM MEMBER

Action Summary

- Proceed to the designated site via emergency or other transport provided
- Receive a briefing and further instructions
- Commence work at site as directed by the On-Site Medical/Health Commander and the MHERT Leader

APPENDIX D: MENTAL HEALTH EMERGENCY KITS (MINIMUM CONTENTS)

EQUIPMENT AND PERSONAL PROTECTIVE CLOTHING

- ***Helmet***
- Overalls
- Tabards
- Sturdy shoes protecting ankles
- Gloves (several pairs in latex to avoid blood, leather for protection/warmth)
- Mouth/nose masks (smell, protection)
- Ear plugs/muffs (noise)
- Sun protection (sunglasses, hat, sun block, lip salve)
- Bottled water, snacks
- Identification and access cards
- Rain jacket with reflectors, overalls, boots, hard hat (as required)
- Charged mobile phone/pager
- Pens, paper, forms (including APPENDIX E: Emergency Mental Health Intake Form)
- Whiteboard, markers
- Warm jackets with NSW Health logo
- Personal address book
- Personal medication (e.g. Panadol/bandaids)
- Money, iPod, books, comics, cards, pocket chess etc

INFORMATION AND EDUCATION HANDOUTS (TOPICS COVERED)

- Access to Mental Health services, including contact numbers
- Expected reactions to trauma/loss and suggestions on coping

MEDICATIONS (assess need to include according to emergency response required)

- For sedation [Benzodiazepine – diazepam IV and oral]
- For psychotic reaction [antipsychotics (haloperidol IV and oral) and anti-Parkinsonian (benztropine IV and oral)]
- For obtunding (benumbing/deadening) secondary to drugs/medication [naloxone, flumazenil]
- For mild abrasions etc [simple analgesics such as paracetamol, bandaids, antiseptic solution/cream, protective gloves]

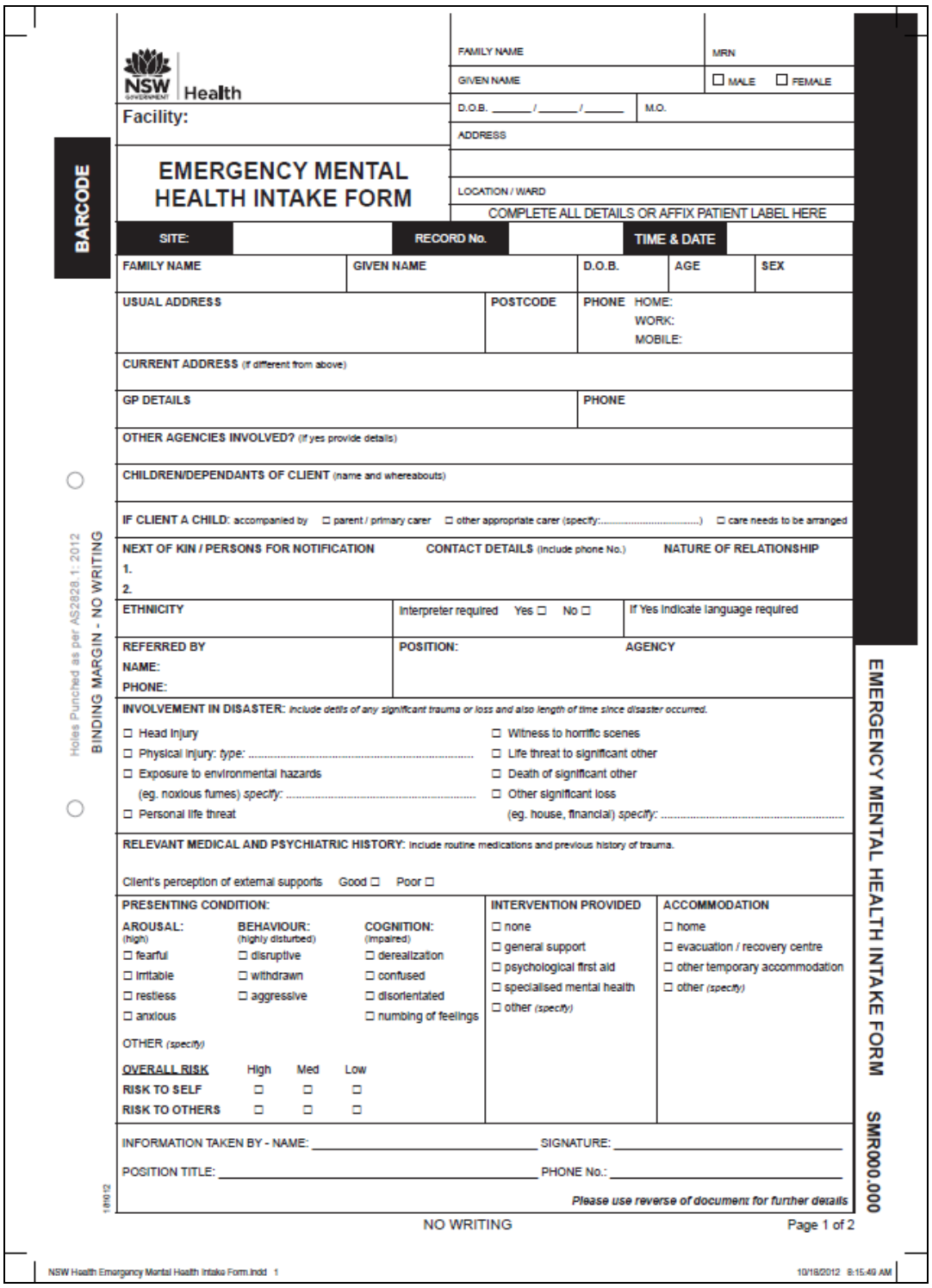
GENERAL (assess need to include according to emergency response required)

- Intravenous cannulas, bungs, operational site or equivalent barrier dressing
- Alcohol Swabs
- Tourniquets
- Needles – assorted sizes
- Syringes – assorted sizes
- Gloves
- Sharps container
- Waste disposal box

The local Mental Health Site Executive can advise the location of the emergency kit.

APPENDIX E:

EMERGENCY MENTAL HEALTH INTAKE FORM



NSW Health

Facility:

EMERGENCY MENTAL HEALTH INTAKE FORM

BARCODE

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. ____/____/____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SITE: | RECORD No. | TIME & DATE

FAMILY NAME | GIVEN NAME | D.O.B. | AGE | SEX

USUAL ADDRESS | POSTCODE | PHONE HOME: WORK: MOBILE:

CURRENT ADDRESS (if different from above)

GP DETAILS | PHONE

OTHER AGENCIES INVOLVED? (If yes provide details)

CHILDREN/DEPENDANTS OF CLIENT (name and whereabouts)

IF CLIENT A CHILD: accompanied by ☐ parent / primary carer ☐ other appropriate carer (specify:.....) ☐ care needs to be arranged

NEXT OF KIN / PERSONS FOR NOTIFICATION | CONTACT DETAILS (Include phone No.) | NATURE OF RELATIONSHIP

1.

2.

ETHNICITY | Interpreter required Yes ☐ No ☐ | If Yes indicate language required

REFERRED BY
NAME:
PHONE: | POSITION: | AGENCY

INVOLVEMENT IN DISASTER: *Include details of any significant trauma or loss and also length of time since disaster occurred.*

- ☐ Head injury
- ☐ Physical injury: *type:* .....
- ☐ Exposure to environmental hazards (eg. noxious fumes) *specify:* .....
- ☐ Personal life threat
- ☐ Witness to horrific scenes
- ☐ Life threat to significant other
- ☐ Death of significant other
- ☐ Other significant loss (eg. house, financial) *specify:* .....

RELEVANT MEDICAL AND PSYCHIATRIC HISTORY: Include routine medications and previous history of trauma.

Client's perception of external supports Good ☐ Poor ☐

PRESENTING CONDITION:

AROUSAL: (high)	BEHAVIOUR: (highly disturbed)	COGNITION: (impaired)
☐ fearful	☐ disruptive	☐ derealization
☐ irritable	☐ withdrawn	☐ confused
☐ restless	☐ aggressive	☐ disorientated
☐ anxious		☐ numbing of feelings

OTHER *(specify)*

OVERALL RISK	High	Med	Low
RISK TO SELF	☐	☐	☐
RISK TO OTHERS	☐	☐	☐

INTERVENTION PROVIDED
- ☐ none
- ☐ general support
- ☐ psychological first aid
- ☐ specialised mental health
- ☐ other *(specify)*

ACCOMMODATION
- ☐ home
- ☐ evacuation / recovery centre
- ☐ other temporary accommodation
- ☐ other *(specify)*

INFORMATION TAKEN BY - NAME: _____ SIGNATURE: _____

POSITION TITLE: _____ PHONE No.: _____

Please use reverse of document for further details

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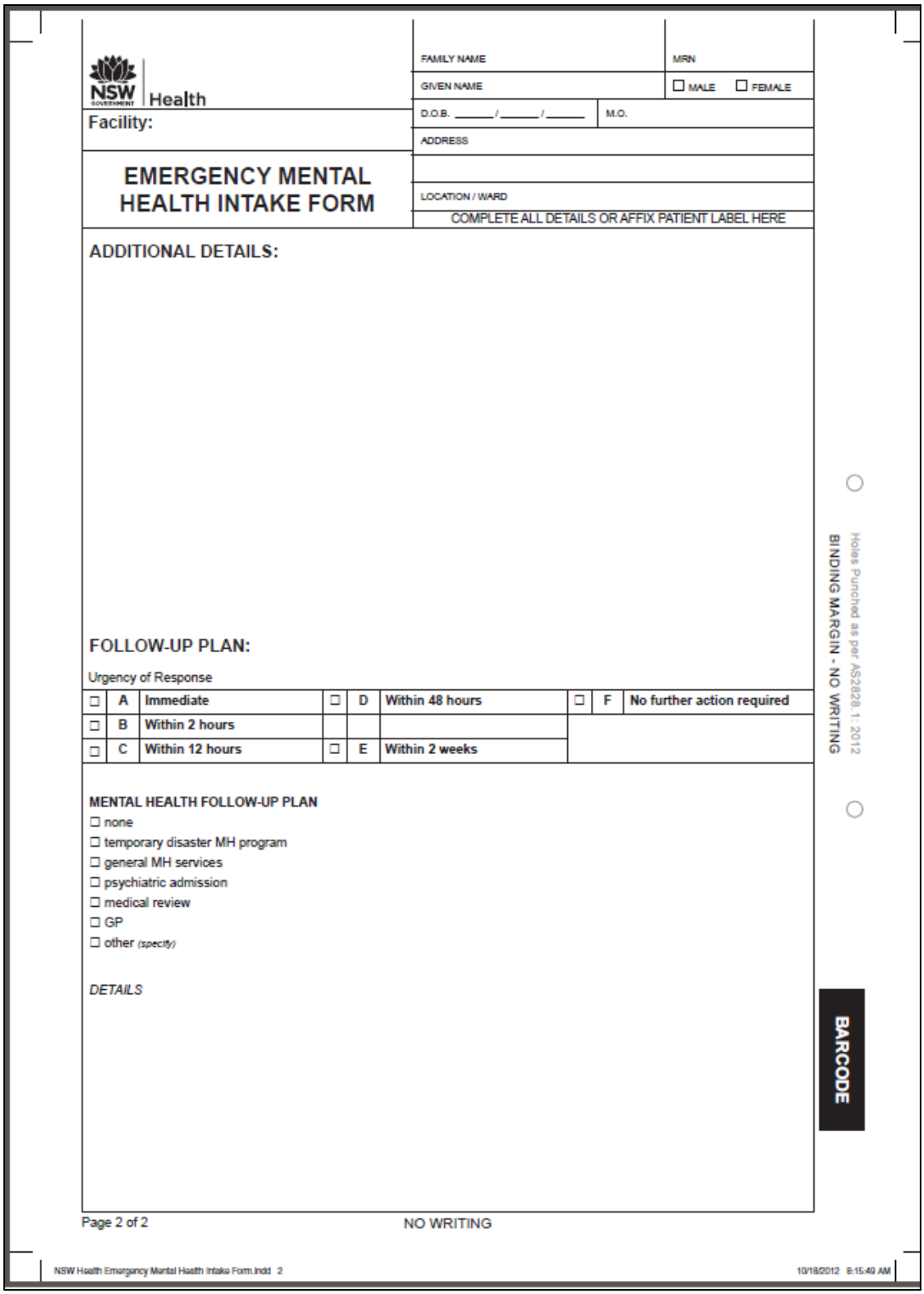
EMERGENCY MENTAL HEALTH INTAKE FORM SMR000.000

1/8/12

NO WRITING

Page 1 of 2

NSW Health Emergency Mental Health Intake Form.indd 1 10/18/2012 8:15:49 AM



NSW Health

Facility:

EMERGENCY MENTAL HEALTH INTAKE FORM

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____/_____/_____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

ADDITIONAL DETAILS:

FOLLOW-UP PLAN:

Urgency of Response

☐	A	Immediate	☐	D	Within 48 hours	☐	F	No further action required
☐	B	Within 2 hours						
☐	C	Within 12 hours	☐	E	Within 2 weeks			

MENTAL HEALTH FOLLOW-UP PLAN

☐ none
☐ temporary disaster MH program
☐ general MH services
☐ psychiatric admission
☐ medical review
☐ GP
☐ other *(specify)*

DETAILS

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BINDING MARGIN - NO WRITING

BARCODE

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