STATE OF ALASKA

Behavioral Health Emergency Response Plan

2005

SIGNATURE PAGE

State of Alaska
Behavioral Health Emergency Response Plan
2005

The Undersigned formally authorize and promulgate this plan for use throughout the State of Alaska.

Karleen Jackson, DHSS Commissioner — Date: 12/8/05

Cristy Willer, DBH Director — Date: 12/8/05

Richard Mandsager, DPH Director — Date: 12/1/05

State of Alaska
Behavioral Health Emergency Response Plan

This Plan will be reviewed annually and revised if necessary.

Record of Changes

Change Number	Date	Subject	Page No.	Entered By

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STATE OF ALASKA
BEHAVIORAL HEALTH EMERGENCY RESPONSE PLAN

I. Foreword

The State of Alaska provides for the coordination of behavioral health disaster response services through the Department of Health and Social Services (DHSS), Division of Behavioral Health (DBH). This plan represents a complete revision of the original *State of Alaska Mental Health Disaster/Emergency Response Plan* adopted in 2001. The reason for developing a comprehensive revision of the prior plan is based upon the need for an *all-hazards* planning and preparation effort. The all-hazards concept provides for a matrix of response activities for any natural, man-made or terrorist event. This concept also assumes that most events will require the inter-operational coordination of multiple federal, state, and local agencies and organizations. The Federal government has mandated that the management of these disaster response efforts utilize the structure proposed by the National Incident Management Systems (NIMS). The revised plan (Plan) incorporates all the aspects of this new format.

The Oklahoma City bombing and the terrorist events of 9/11, more than any other disasters, has engendered an enormous amount of study of the cognitive, emotional and behavioral reactions of survivors and responders, and of community recovery. The growing body of research emerging from these and other events clearly demonstrates the need for behavioral health intervention and support and for research itself to have a place in disaster recovery. The Plan represents the best practices for behavioral health disaster response and recovery operations. While DBH recognizes a need for data collection and analysis it also recognizes the limits and barriers of disaster research, and will strive to include research protocols whenever and wherever possible.

The Federal Emergency Support Function (ESF) #8 - Health and Medical Services, and Homeland Security Presidential Directive Hspd-8 include the need for mental health disaster response services. The intent of this document is to support, augment and promote the integration of behavioral health disaster response services with existing state or local emergency plans and preparedness efforts.

II. Introduction

This Plan defines the policies, scope, operations, roles, responsibilities, and authorities that form the foundation of behavioral health response to disasters and emergencies. The purpose of the Plan is to coordinate behavioral health emergency services with other federal, state, and local disaster response and recovery organizations that may mobilize to any foreseeable event within Alaska. There are four primary goals:

1. To provide guidelines and materials for behavioral health disaster planning, preparation, and response and recovery activities for Division of Behavioral Health (DBH) and local CMHC
2. To outline the procedures for identifying, procuring, mobilizing, and deploying behavioral health resources in coordination with other state agencies and local CMHC
3. To outline the process to identify those who need special help, and to provide that help as quickly and effectively as possible based on victim centered needs.
4. To describe the roles and responsibilities for DBH personnel assigned to assist with disaster relief operations.

The Plan provides for comprehensive response to any state declared disaster, or federal Presidential Declared Disaster (PDD). The Plan provides a matrix of behavioral health response protocols for any human induced incident or accident, or terrorist event involving weapons of mass destruction (WMD). The Plan also provides for support of local emergencies which do not qualify as a state or federal disaster but which may require additional behavioral health response beyond the capacity of the local CMHC.

The Division of Behavioral Health relies upon local Community Mental Health Centers (CMHC) to provide initial behavioral health disaster response services, and to manage long term recovery efforts according to their capability and resources. CMHC will provide direct behavioral health disaster response services, and/or will assist with the coordination of activities provided through other local behavioral health responders, including volunteers from within and from outside the affected community. In some communities the CMHC will have fewer resources than other provider organizations. DBH strongly encourages the establishment of collaborative agreements between local CMHC and these other organizations, especially Indian Health Services (IHS) in communities where the organizations are separate. These agreements will help provide for the most efficient and comprehensive local response.

The Division of Behavioral Health will coordinate all state behavioral health disaster response activities. DBH will provide technical assistance, training, and behavioral health resources in support of local response operations. State resources may include funding, DBH regional staff, other regionally based CMHC staff, or special Critical Incident Stress Management (CISM) teams to be utilized for the support of unified first responder groups and local area businesses as requested. DBH will coordinate application for the FEMA / CMHS Crisis Counseling Program grants in the event of a Presidential Declared Disaster.

The Division of Behavioral Health will coordinate behavioral health service provision with the following response organizations according to existing Mutual Aid Agreements (Annex H):

American Red Cross
Salvation Army of Alaska
Critical Incident Stress Management Teams

The broad array of behavioral health disaster response services (Annex E) are provided according to the phase of a disaster and the type of event. Behavioral health responders will provide immediate service response within Emergency Operations Centers (EOC), mass shelters, hospital facilities, or other locations where large groups of people may gather. Long term recovery services will be provided through outreach to neighborhoods, schools, businesses and community events. These services will be initiated within hours post-impact and will end when directed by DHSS.

Many communities have populations that speak a language other than English. The need for interpreters may be crucial for behavioral health outreach and support. The procedures noted for enlisting interpreter assistance included in the Division of Public Health (DPH) Emergency Operations Plan, Annex B – "Risk Communications" will be followed by DHSS / DBH as indicated.

III. Situation and Assumptions

Situation

- Alaska is a vast territory, covering over 586,000 square miles and 6,640 miles of coastline. Over eighty percent of the state's communities are not accessible via a contiguous road system, and

must rely primarily on air transport and secondarily on shipping. Weather and climate conditions significantly impact both flight and shipping schedules, and can cause long delays which create critical periods of isolation for many communities.

- The peoples of Alaska enjoy remarkably diverse cultural differences based not only on ethnicity, but on the basis of rural vs. urban lifestyle and infrastructures.
- All Alaskan communities are liable to experience a variety of natural disasters. Most Alaskan communities retain a probable risk for a broad range of human-induced disaster events. Several Alaskan communities are at high risk for possible terrorist related events.
- All Alaskan communities have populations with special needs which may require concerted assistance immediately post-impact, and during long-term recovery.
- Tourism is one of the chief industries of Alaska. There are hundreds of thousands of Americans and foreign nationals that visit Alaska annually. This group poses significant challenges for behavioral health disaster response.
- Though DHSS/DBH is responsible for behavioral health disaster response, there are few employees available to provide direct services. The Department relies on local Community Mental Health Centers (CMHC) to provide or coordinate initial response to their communities, and to conduct long-term recovery efforts.
- Local behavioral health response, with few exceptions, is <u>currently</u> hampered by limited resources, lack of plans and planning, poor preparation and collaboration efforts, and the existence of very few trained staff.
- Substance abuse program services, and trained substance abuse treatment staff are not presently a part of all CMHC.

<u>Assumptions</u>

- Disasters, by their inherent conditions, produce the need for behavioral health response.
- Responding to the psychological and emotional impact of disasters for all people involved is an integral part of a comprehensive and effective disaster response and recovery strategy.
- The State of Alaska Behavioral Health Disaster Response Plan, and all local behavioral health disaster operations plans, provide for response, mitigation and recovery activities that address the immediate and long-term behavioral health needs of victims,

families, responders, and communities in the event of any natural or human-induced emergency or disaster.

- Behavioral health disaster response services address both mental health, and substance abuse issues, and provide for integrated response and recovery activities with medical, public health, American Red Cross, and faith-based services.
- Local CMHC which provide initial behavioral health disaster response services may need to stand alone as long as seven days following impact of a disaster.
- State declared and federal declared disasters may overwhelm the response capabilities of local CMHC and other service support provided through mutual aid agreements (MAA)
- The State of Alaska Behavioral Health Emergency Response Plan will supplement the State of Alaska Emergency Response Plan, and will be compatible with that plan.
- All disaster response services, including behavioral health services, are costly. Costs for behavioral health resources arranged through the Incident Management Team (IMT) will be assumed by State and/or Federal agencies.
- Most disaster events will draw behavioral health responders who are not connected with the state, or local CMHC, but whose efforts will need to be coordinated.
- The field of behavioral health disaster response is evolving, and evidence based practices continue to emerge and develop. Behavioral health response to any current or near future terrorist event will include known best practice response protocols and activities.
- Disaster response activities and outcomes will be documented whenever and wherever possible in a manner that will add to the body of knowledge in the field of behavioral health disaster response.
- This Plan will be an evolving work-in-progress. Various sections, and annexes, as well as presently stated situations are expected to change in response to developing circumstances at the local, state, and national level.
- Strong working relationships between the Division of Behavioral Health, other DHSS divisions, and other state departments along with collaborations with private organizations, especially CMHC, are necessary for the successful implementation of behavioral health disaster response services. These collaborative relationships will enhance present and future planning, preparation and response efforts.

- Disasters are fluid; depending upon the conditions, prevailing needs and situation (including political) CMHC may need to cross regional, business, cultural and historical boundaries to provide best comprehensive services.
- Behavioral health responders will be covered for liability as long as they practice within their area of skill and training, and operate under the auspices and supervision of the CMHC.

IV. Concept of Operations

General

The Department of Health and Social Services (DHSS) is responsible for planning and assistance with health and welfare activities prior to, during and following a disaster. DHSS relies on the Division of Behavioral Health (DBH) to provide and coordinate all behavioral health disaster response and recovery activities. The Division of Behavioral Health has specific responsibility to:

1. Provide cooperative coordination of emergency mental health services in any local, state or federally declared disaster (*DHSS Disaster Response Guide 2004*, Appendix 4)
2. Provide coordinated critical incident stress management (CISM) and other mental health services for events that involve mass casualties (Ibid., Appendix 3).
3. Fulfill all tasks and responsibilities referenced in all other state plans (see Annex D, this Plan).

Behavioral health all-hazards emergency and disaster response involves:

a. Pre-disaster planning and preparation
b. Response to all community incidents and local emergencies requiring behavioral health support
c. Practical, culturally appropriate, phase-sensitive continuum of care interventions for all state and/or federally declared disasters, including terrorist events and weapons of mass destruction
d. Provision of behavioral health disaster support resources to American Red Cross for all Aviation Disasters
e. Provision of long-term recovery services according to available funding and resources: as in a Presidential Declared Disaster (PDD) when funds are awarded through Federal Emergency Management Agency (FEMA) / Center for Mental Health Services (CMHS) Crisis Counseling Program grants.

CMHC (see Annex E for complete listing) are expected to respond to all disasters and emergencies that impact their catchment. Local behavioral health response efforts will be coordinated between the CMHC and the community Emergency Operations Center (EOC) based upon local emergency operations plans, and existing agreements. CMHC will establish a liaison within the local EOC for as long as necessary to coordinate initial resources and to establish needed response services. All requests for behavioral health resources will be channeled through the local EOC (see Figure 2).

Local Community Mental Health Centers accept responsibility to:

1. Develop an emergency / disaster response plan
2. Provide emergency and disaster response and recovery services at the local level
3. Maintain responsibility to ensure that their staff is trained to provide behavioral health disaster response services
4. Act as the 'point of contact' when ever possible for providing and directing local behavioral health disaster response and recovery services (unless state or federal resources are otherwise designated by the SECC or MAC group).
5. Be prepared to stand alone for as long as seven days.

The Division of Behavioral Health will assist local CMHC with the provision of behavioral health disaster response and recovery services as directed by DHSS in cooperation with the State Emergency Coordination Center (SECC). DHSS and DBH will establish a liaison at the SECC for any state or federal declared disaster to coordinate disaster health and welfare response activities. The DBH liaison will relay requests for behavioral health disaster resources to the Division of Behavioral Health Director. The Director will delegate authority to the designated Behavioral Health Disaster Response Coordinator to organize and supervise behavioral health disaster resources. The Disaster Response Coordinator will rely on the DBH Regional Coordinators to assist with operations. See Figure 3 for relationship of DBH within the SECC organization.

The Division of Behavioral Health, in support of CMHC, maintains responsibility to:

1. Provide technical assistance to Community Mental Health Centers (CMHC) for all phases of disaster operations.

2. Assist with the identification, location, procurement, mobilization and deployment of additional behavioral health resources with the SECC if an event overwhelms local CMHC capabilities
3. Seek discretionary funds as available and appropriate to help cover the cost of response activities which result from events that overwhelm local CMHC capabilities
4. Seek federal funding and assistance in the event of a Presidential Declared Disaster
5. Help identify volunteer behavioral health responders who are licensed and /or have disaster response training.

Behavioral health disaster response and recovery operations will be conducted according to three phases: pre-disaster, disaster emergency, and recovery.

Pre-Disaster Phase

Community Mental Health Centers will conduct all the following pre-disaster planning and preparation activities:

1. Develop agency Emergency Response Plan (ERP) in coordination with both state and local emergency response plans (See "Example Emergency Response Plan", Annex E).
2. Develop Mutual Aid Agreements (MAA) with other local provider organizations. NOTE: *Collaborative relationships and agreements are critical to confirm what services are available, when and where resources should generally be deployed, and how all available local resources can best be coordinated to fit community needs. CMHC will coordinate with local organizations such as hospitals, Public Health, American Red Cross, CISM teams and community faith-based organizations. Unless the CMHC is a part of Indian Health Services (IHS), and / or provides substance abuse programs, they should also develop agreements with local substance abuse programs, IHS and other local behavioral health providers.*
3. Assure that agency ERP is included as a supplement to their respective Community Emergency Response Plan
4. Coordinate planning and preparation activities with Local Emergency Planning Committee (LEPC), or other designated community emergency planning group
5. Provide for staff training in behavioral health disaster response and recovery
6. Participate whenever possible in local emergency response exercises
7. Inform consumers of agency emergency operations procedures

The Division of Behavioral Health will conduct the following pre-disaster planning and preparation activities:

1. Develop and annually update the *State of Alaska Behavioral Health Disaster Response Plan,* and make that plan available to all state-funded CMHC.
2. Provide technical assistance to CMHC with plan development, local community integration efforts as requested, and with staff training requirements.
3. Maintain records of behavioral health professionals trained by the state in behavioral health disaster response.
4. Assure that Regional Coordinators are trained in disaster response and have a working knowledge of the DBH Emergency Response Plan and the plans of the local CMHC in their region.
5. Develop and maintain collaborative relationships with other state departments and other disaster response organizations to support the coordination of local behavioral health response efforts.
6. Participate whenever possible in emergency response exercises with other DHSS divisions, and Division of Homeland Security and Emergency Management.
7. Collaborate with Division of Public Health in the development of DHSS Continuity of Operations Plan

Disaster Emergency Phase

Local CMHC will conduct behavioral health emergency operations in coordination with their local Emergency Operations Center, and according to their emergency response plan(s) and existing agreements. During a disaster emergency CMHC will be responsible for all the following:

1. Activate agency Emergency Response Plan
2. Establish agency Liaison at local EOC
3. Assess local behavioral health disaster response needs
4. Activate Mutual Aid Agreements as indicated to coordinate local area resources and response efforts
5. In the event of an Aviation Disaster coordinate all behavioral health response activities with the American Red Cross
6. Develop and implement initial behavioral health response activities
7. As needed request additional behavioral health support and resources from DHSS / DBH through local EOC in coordination with the SECC

8. According to CMHC resources and capability coordinate all volunteer behavioral health resources from within and from outside the community
9. In the case of a Presidential Declared Disaster (PDD) participate with DHSS / DBH representatives in preparation of FEMA / CMHS Immediate Services Program grant (ISP)
10. Upon award of ISP coordinate Crisis Counseling Program plan activities in cooperation with DBH

Division of Behavioral Health will conduct all the following disaster emergency activities:

1. Activate Behavioral Health Emergency Response Plan
2. Establish DBH Liaison at SECC
3. Initiate assessment of behavioral health disaster response needs for all affected areas within the state
4. In cooperation with the SECC arrange for immediate behavioral health service response through local CMHC in all affected areas
5. In cooperation with the SECC and local EOC assist with the identification, location, procurement, mobilization and deployment of additional behavioral health resources, including technical advisors, to all areas of need
6. Coordinate response activities, and provide for technical assistance and behavioral health resources according to this Plan, including Mutual Aid Agreements (Annex H)
7. In the case of a PDD coordinate application for the FEMA / CMHS ISP grant
8. Upon award of ISP, oversee Crisis Counseling Program activities at the local level
9. Coordinate with federal and / or state authorities for establishment of event specific research and data collection as indicated and funded

Recovery Phase

Behavioral health disaster response and recovery services may be required for an extended period of time following a major emergency event. Representatives of local CMHC and DBH will collaborate directly to meet the recovery needs of local communities and their populations.

During the Recovery Phase local CMHC will do all the following:

1. Implement agency business continuity plan (BCP) or continuity of operations plan (COOP) or procedures
2. Continue local needs assessment
3. Continue coordination with local EOC as indicated for behavioral health support services to community populations including first responder groups (a priority population)
4. In the case of a Presidential Declared Disaster (PDD) participate with DHSS / DBH representatives in preparation of CMHS Regular Services Program grant (RSP)
5. Upon award of RSP coordinate Crisis Counseling Program plan activities in cooperation with DBH
6. Advocate for, and participate in, community anniversary events, memorials, and remembrances activities as indicated
7. Cooperate with federal and / or state authorities for event specific research and data collection as appropriate
8. Review and revise as necessary agency emergency response plan

During the Recovery Phase DBH will do all the following:

1. Continue assessment of behavioral health disaster response needs for all affected areas within the state
2. Continue to coordinate behavioral health service response through local CMHC in all affected areas as indicated
3. Continue to coordinate as necessary with SECC the identification, location, procurement, mobilization and deployment of additional behavioral health resources, including technical advisors, to all areas of need
4. In the case of a PDD coordinate application for the CMHS RSP grant
5. Upon award of RSP, oversee Crisis Counseling Program activities at the local level
6. Advocate at the state level for consideration of State of Alaska participation with anniversary events, memorials, and remembrances activities as indicated

RESPONSE ORGANIZATION RELATIONSHIPS

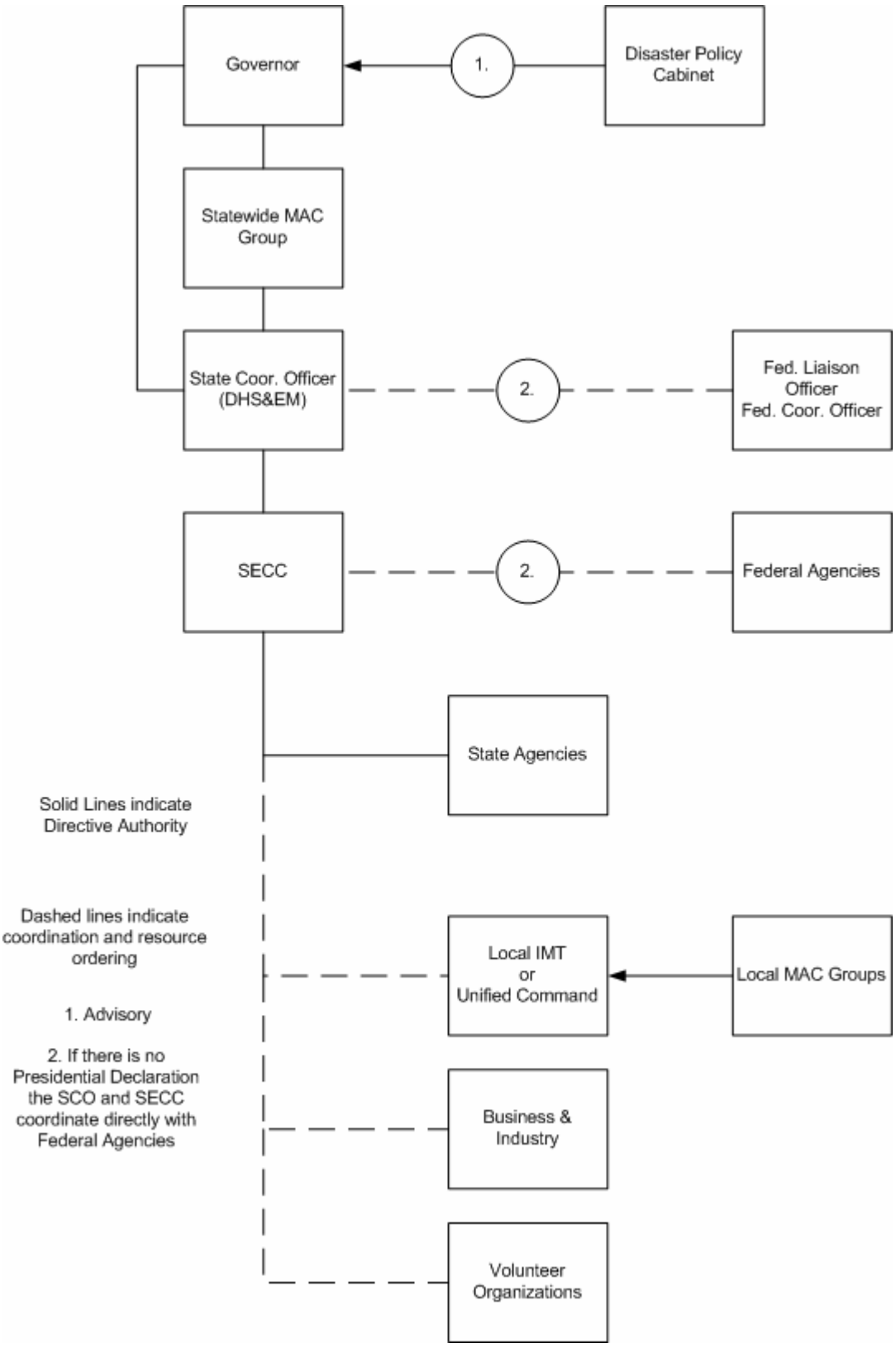


Figure 1

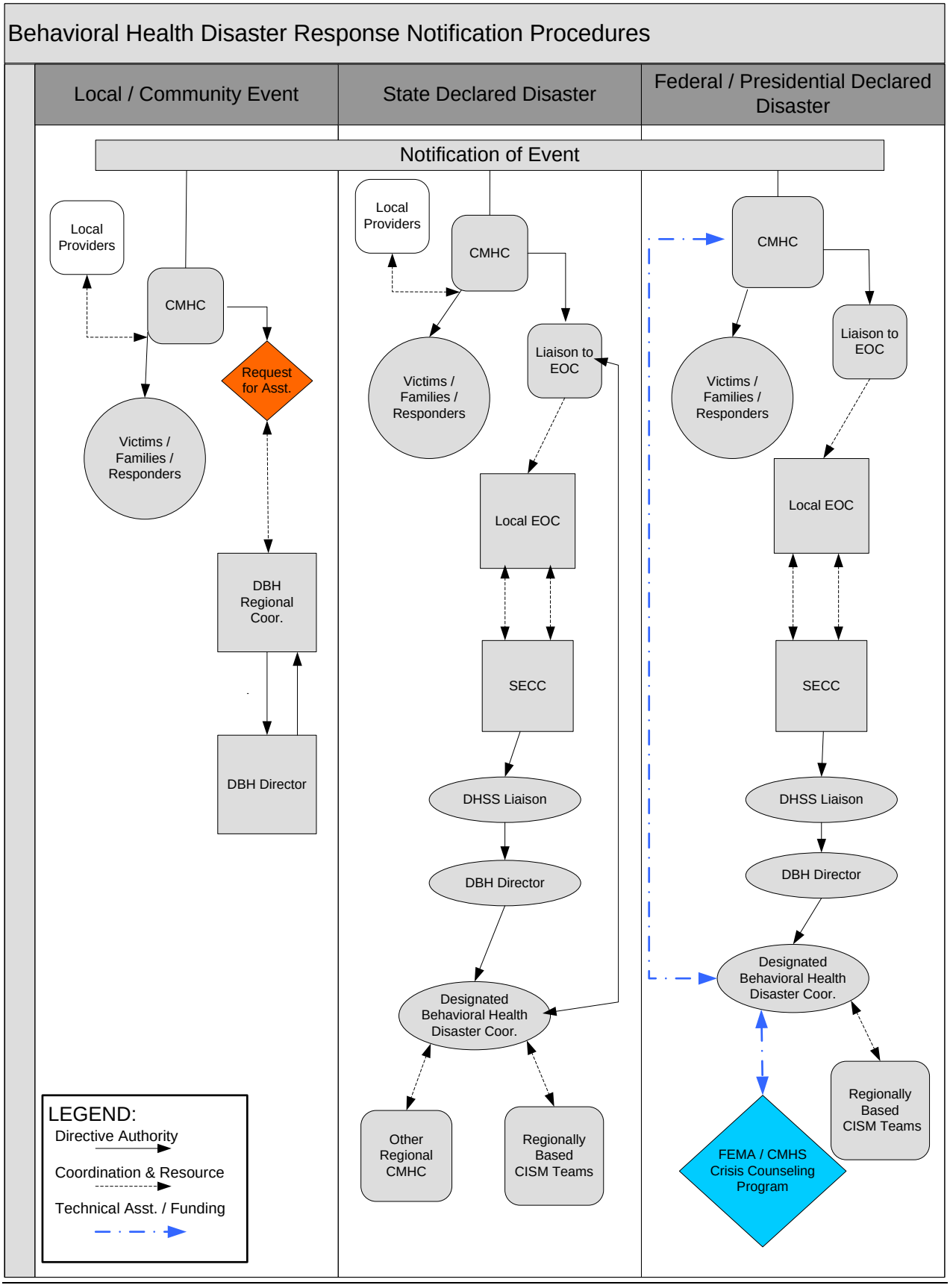

Behavioral Health Disaster Response Notification Procedures
Local / Community Event
State Declared Disaster
Federal / Presidential Declared Disaster
Notification of Event
Local Providers
CMHC
Request for Asst.
Victims / Families / Responders
DBH Regional Coor.
DBH Director
Local Providers
CMHC
Liaison to EOC
Victims / Families / Responders
Local EOC
SECC
DHSS Liaison
DBH Director
Designated Behavioral Health Disaster Coor.
Other Regional CMHC
Regionally Based CISM Teams
CMHC
Liaison to EOC
Victims / Families / Responders
Local EOC
SECC
DHSS Liaison
DBH Director
Designated Behavioral Health Disaster Coor.
Regionally Based CISM Teams
FEMA / CMHS Crisis Counseling Program
LEGEND:
Directive Authority
Coordination & Resource
Technical Asst. / Funding

Figure 2

Relationship of DBH within SECC Organization

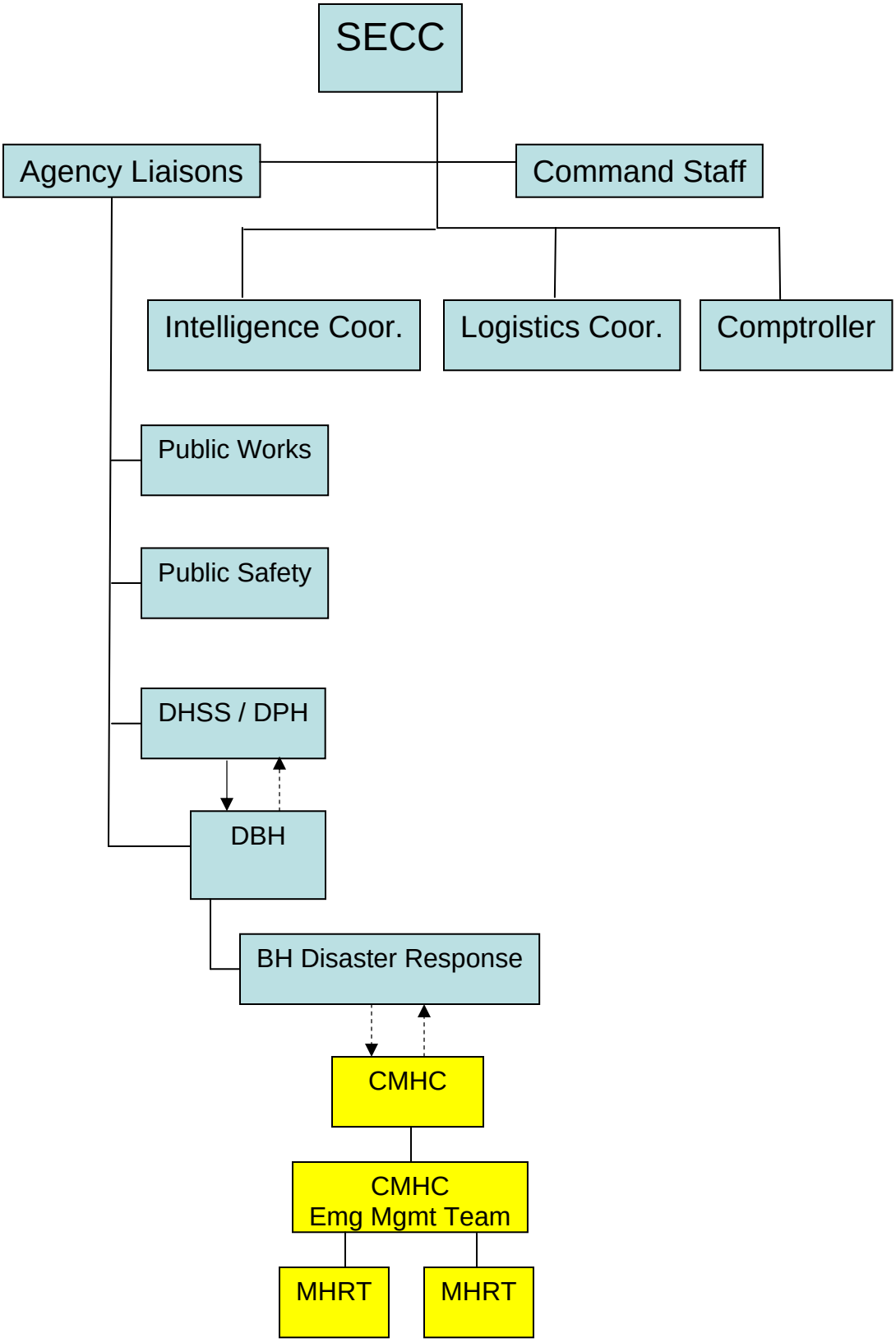


Figure 3

ANNEX A

"Terrorism"

PURPOSE

The purpose of this Annex is to:

- Provide a structure for understanding the psychological impact from terrorist events
- Outline the specific operational procedures for behavioral health response
- Provide reference documents for assisting with the behavioral health response to terrorist or weapons of mass destruction events

SITUATION

Terrorist events will create extraordinary circumstances for communities, individual victims, and first responders including behavioral health personnel. Intentional, malevolent events have a far greater potential for causing adverse psychological reactions than natural disasters. The Institute of Medicine "finds that terrorism and the threat of terrorism will have psychological consequences for a major portion of the population, not merely a small minority". Experts agree that "even conservative estimates highlight a staggering need for...acute mental-health needs following a CBRNE *(chemical, biological, radiological, nuclear, high-yield explosive)* event". Indirect health effects fall along a continuum from acute to chronic impacts. The response to these issues needs to be addressed separately and distinctly.

The primary goal of terrorism is to disrupt society by provoking intense fear and helplessness and compromising all sense of personal and community safety and trust. A terrorist incident will likely produce a 4:1 ratio of psychological casualties (i.e. "worried well") to actual injured or exposed victims. This figure, which can be much higher, represents a serious concern for first responders and hospitals. The trauma caused by a mass casualty event can induce "contagious somatization". Psychological reactions to a chemical or biological incident can mimic early neurological signs and symptoms to various agents and pose complications for medical triage and treatment. Table 1 compares the similarity of possible psychological and somatic reactions with the neurological symptoms of certain classes of chemical and biological agents.

A weapon of mass destruction (WMD) or CBRNE event is a low probability - high consequence event which has the potential to cause mass

casualties. The attendant behavioral health consequences are expected to be quite novel and will require creative and flexible response. The Population Exposure Model (Attachment A) categorizes populations according to a hierarchy of probable need. Table 2, "Matrix of Behavioral Health Implications for CBRNE Events", helps outline specific event characteristics and the social and individual issues related to each type of event, and lists the indicated behavioral health response and recovery activities. Mass casualties may be a consequence of any or all CBRNE events and is considered separately in the matrix. Finally, a mass casualty event related to exposure of chemical or biological agents is not limited to intentional release. Unintentional and accidental industrial or military release may occur as well and is no less pernicious in its effect socially and psychologically. The social and individual issues and the response and recovery implications noted in the Matrix may still be applicable. The likelihood that an unintentional chemical or biological event may occur in Alaska communities is presumably far greater than the possibility of a malevolent terrorist event.

ASSUMPTIONS

- There may be little or no warning
- Event may be 'slow moving', taking days or weeks to develop
- The event may be unrecognizable as a terrorist attack which may create:
    - Possible critical delay in identifying fact of exposure
    - Possible critical delay in identifying chemical or biological agent
- Event may have a very uncertain or unidentifiable 'low-point'
- There is a high probability of mass casualties or mass fatalities
- The general public will be unfamiliar with type of event
- There may be a sudden contrast of scene / abrupt change in reality, especially due to explosion or incendiary events
- Victims, responders and by-standers may experience exposure to gruesome or grotesque situations
- Biological and chemical events will require broad Public Health Care response
- All terrorist events will generate significant behavioral health impact and need
- Mass casualty events may tax surge capacities of local area hospitals / clinics forcing victims to be evacuated to other communities, including outside of Alaska

- Response needs may compromise accepted medical standards of care.
- All terrorist events by definition will require broad local, state, and federal multi-agency response
- There may be wide-spread public perception that government response systems are not prepared
- Event will necessitate comprehensive 'risk communication' efforts to the general public
- Politics and economics will impact response and recovery efforts
- Event will generate massive and continuing media coverage by local, national and possibly international news agencies
- Event may create significant and long-lasting environmental issues
- Multiple events may occur simultaneously, concurrently, or sequentially
- Event will cause extended duration for individual and community recovery

CONCEPT OF OPERATIONS

General

The *State of Alaska Behavioral Health Emergency Response Plan* is the base plan for response and recovery operations to all disasters, including terrorist events. However, terrorist events are so unique they require additional planning factors.

Comprehensive response to a terrorist event in Alaska may generate a need for significant behavioral health assistance and resources from outside the state. Local community mental health centers (CMHC) and their communities need to be prepared for dealing with people who are not familiar with our land, our climate and our people.

Terrorist events will require significantly increased security measures. The Federal Bureau of Investigation (FBI) is both the lead federal agency, and the lead agency among all agencies in the event of a terrorist attack. The FBI is responsible for crisis management response operations, and will establish a presence at both the SECC and local EOC. The Division of Behavioral Health (DBH) and CMHC will establish photo identification and credentials for their designated emergency response personnel which authorize them to represent their respective agencies for response and recovery activities.

Terrorist events will necessitate establishing crime scenes and conducting crime investigations. Victims and victims' families may become a part of these procedures. Open access to these people for the purposes of behavioral health support may be limited. Specific legal questions may arise regarding confidentiality. DBH will address these issues through their legal consul with the State of Alaska, Department of Law, Attorney Generals Office.

The Federal Emergency Management Agency (FEMA) is the co-lead federal agency with the FBI and is responsible for all consequent management response and recovery operations. These activities provide for "measures to protect public health and safety, restore essential government services, and provide emergency relief to governments, businesses and individuals" (*State of Alaska Emergency Response Plan, 2004,* Annex A, A-4). Relief services include the Crisis Counseling Program (CCP) grants. DBH, in cooperation with local CMHC, will automatically make application for these grants and implement CCP services in all affected communities.

Additional support and funding for victims of terrorist events may be arranged through the federal Department of Justice, Office for Victims of Crime (OVC). The OVC provides for *Formula* and *Discretionary* Grants through the Crime Victims Fund. These grants fund both victim compensation and victim assistance needs, which include crisis intervention and mental health counseling. The Division of Behavioral Health will assist with the application for these grants in collaboration with the State of Alaska Victims of Crime Compensation Board (VCCB).

CMHC are expected to collaborate with local area hospitals to define the roles and responsibilities for behavioral health responders assisting with hospital operations during and following a terrorist event. Behavioral health support may be crucial for assisting medical personnel with large numbers of people who do not require direct medical care. Behavioral health support services for hospitals may include the following:

- Assistance with triage procedures for "psychological casualties" following a biological or chemical event
- Assistance with crisis intervention, hospital discharge, and follow-up services for "psychological casualties"
- Behavioral health support and crisis counseling for victim families
- Liaison assistance with victim families for helping to update information on family members sent outside the community for medical care

- Providing behavioral health services 'off-site' in support of hospitals when hospitals have inadequate space, or invoke lock-down procedures to control for contagion
- Emergency psychiatric care (as available)
- Priority debriefing / crisis management services for hospital personnel and their families

Division of Behavioral Health will collaborate with the Division of Public Health (DPH) to provide behavioral health support during a mass prophylaxis effort as indicated. These services may include the following:

- Supportive presence at inoculation sites
- Assistance with 'risk communications' messages
- Practical assistance with logistical tasks at inoculation sites
- Priority debriefing / crisis management for Public Health personnel

DBH will assist DPH as well with information in support of epidemiological investigations following a biological or chemical event. DBH and local CMHC will also develop means to provide outreach to individuals and families who have been quarantined as a result of possible exposure to a biological agent. Behavioral health providers will coordinate this response with Public Health officials. Outreach services provided to quarantined individuals may need to be quite flexible and accomplished at a distance. Most outreach may need to be conducted via electronic interface such as the following:

- Land-line [telephone]
- Wireless [cellular connection]
- Internet
- Email
- Radio broadcast
- Television broadcast

"Comparison between Possible Psychological Reactions to a Chemical / Biological Event and Selective Symptoms of Specific Chemical and Biological Agents"

Domains	Psychological / Somatic Reactions	Category A Biological Agents	Category B Biological Agents	Nerve Agents	Chemical Agents of Opportunity
Physical Symptoms	• Headaches • Breathing Difficulties • Tremors • Sweating • Motor Agitation • Fatigue • Muscle Aches • Joint / Chest Pain • Involunt. urination • Tachycardia • Nausea/Vomiting • Drowsiness • Dizziness	○ Headaches ○ Breathing Difficulties ○ Fatigue ○ Muscle Aches ○ Joint Pain ○ Chest Pain ○ Flu-like Symptoms ○ Sweating	○ Headache ○ Respiratory Distress ○ Heavy Sweating ○ Physical Weakness ○ Chest Pain ○ Back Pain ○ Stomach Pain ○ Flu-like Symptoms	◆ Headache ◆ Shortness of Breath ◆ Twitching / Fasciculation ◆ Sweating ◆ Weakness / Fatigue ◆ Abdominal Pain ◆ Chest Tightness ◆ Rapid Heart Rate ◆ Nausea/Vomiting ◆ Runny Nose ◆ Involuntary urination	◆ Headache ◆ Nausea ◆ Dizziness ◆ Increased rate of breathing ◆ Chills ◆ Chest tightness
Mood Disturbances	• Sleep Disorders • Apathy • Labile Mood • General Anxiety • Irritability	○ Delirium ○ Shock	○ Delirium ○ Depression ○ Irritability	◆ Insomnia ◆ Nervousness ◆ Depression ◆ Irritability ◆ Drowsiness	
Cognitive Impairment	• Thought Disorders • Confusion / Disorientation • Delusions • Hallucinations • Memory Impairment	○ Dysphasia	○ Confusion ○ Hallucinations (advanced stages)	◆ Confusion ◆ Memory Deficits ◆ Impaired Judgement / Concentration ◆ Slowed information processing / word finding	◆ Memory Loss

Category A Biological Agents: *Anthrax, Botulism, Plague, Smallpox, Tularemia, Viral Hemorrhagic Fevers*
Category B Biological Agents: *Typhoid Fever, Cholera, Salmonella, Brucellosis, Q Fever, Ricin*
Nerve Agents: *Sarin, Tabun, Soman, VX, organophosphate pesticides*
Chemical Agents of Opportunity*: Hydrogen Cyanide, Cyanogen Chloride, Arsine, Chlorine, Phosgene*

Sources: Center for Disease Control (CDC)
Agency for Toxic Substances & Disease Registry (ATSDR)

"Matrix of Behavioral Health Implications for CBRNE Events"

	Event Characteristics	Social Issues (Groups & Community)	Individual / Family Issues	Implications for Response & Recovery
Chemical Release	1) Rapid onset of symptoms 2) Contamination thru exposure to victims 3) Requires rapid decontamination in field 4) May be gas or liquid 5) May result from accidental industrial release 6) Requires PPE 7) Variability of effective containment 8) Agents can persist in environment and create delayed reactions 9) Agents may pose complicated problems for clean-up / removal 10) May result in multiple deaths at scene 11) High level of toxicity (small amounts cause significant damage)	1) Concerns re: contamination 2) Anger toward authorities / industry re: release 3) Anger toward perpetrators of intentional event; desire for swift justice 4) Fear of long term effects 5) Anxiety, suspicion re: available information 6) May cause Mass Casualties (see corresponding chart below) 7) Public reaction to possible limitations of medical interventions 8) Contaminated areas may disrupt business, social activity 9) General disruption of social support systems 10) May generate high ratio of "worried well" 11) Event will generate legal / criminal investigation 12) Deaths of birds & animals 13) Extreme economic toll 14) May result in inter-ethnic or religious dissension	1) Embarrassment / discomfort with decontamination procedures 2) Discomfort, fatigue for medical / rescue personnel utilizing PPE 3) Grief, despair, hopelessness resulting from losses 4) Anxiety re: long term effects 5) First responders may experience intense anxiety at scene 6) Possible need for relocation 7) Average of 30% injured and 10% non-injured may possibly develop PTSD 8) Causes permanent scarring 9) Pervasive feelings of vulnerability / loss of control	1) Outreach to hospitals to provide psychological first aid for victims / family support 2) Outreach to hospitals to assist with "worried-well" 3) May need to screen for suicide 4) Outreach to schools 5) Possible need for public 'Crisis Management Briefings' 6) May need to staff mortuaries and / or provide support for body handlers 7) Psychological debriefing for medical personnel & first responders within 2-3 days post event (or as soon as practical) 8) Event may qualify as PDD / Need for CCP Grant 9) May need long-term plan to support displaced families

Event Characteristics + Social Issues + Individual / Family Issues = Implications for Response & Recovery

"Matrix of Behavioral Health Implications for CBRNE Events"

	Event Characteristics	Social Issues (Group & Community)	Individual / Family Issues	Implications for Response & Recovery
Biological Release	1) Delayed onset of symptoms 2) Most agents not infectious Exception: contact with skin legions or aerosol droplets (smallpox, plague) 3) Deaths at scene are rare 4) Time delay of agent identification by lab / accurate diagnosis on clinical grounds alone may not be possible 5) Agent's spread can often be effectively contained thru infection control measures 6) Disease may spread rapidly across local, national, international boundaries 7) Known diseases can be treated effectively with antibiotics / vaccines 8) Unknown agents / diseases will delay effective response and increase risks for medical personnel 9) May require mass prophylaxis 10) Logistical challenges re: mass distribution of antibiotics to general population 11) A few agents (smallpox, plague, viral hemorrhagic fever(s)) may be artificially introduced into environment	1) Fear of contagion 2) May cause Mass Casualties (see corresponding chart below) 3) Stigmatization of infected individuals / families 4) Variable public response to: -possible need for quarantine measures -closing public places -seizing property -imposing travel restrictions -mandatory vaccinations 5) Continuous demands for updated information / risk communications 6) Significant disruption of normal routines 7) Elderly, children and people with other illnesses at greater risk 8) Media may exacerbate public response 9) Death of birds & animals 10) Extreme economic toll 11) May result in inter-ethnic or religious dissension	1) Fear of contagion 2) Fear for children's / other family member's well-being 3) Quarantine creates significant family disruption, emotional distress, economic hardship 4) Medical responders & their families have to contend with possible deadly risks of job 5) Delayed health effects (cancer, birth defects) 6) Pervasive feelings of vulnerability / loss of control 7) Concerns re: safety of water and food	1) Psychological debriefing & follow up for medical personnel and first responders 2) Need to coordinate with Public Health Services: assist with mass prophylaxis; debriefing for staff; outreach to those quarantined 3) Psychological / psychiatric consult should be made available to SECC and for risk communications 4) Possible need for public 'Crisis Management Briefings' 5) May need to screen for suicide 6) Outreach to quarantined individuals and families 7) Grief counseling for affected families 8) May need long-term plan to support displaced families 9) Event may qualify as PDD / Need for CCP Grant

Event Characteristics + Social Issues + Individual / Family Issues = Implications for Response & Recovery

"Matrix of Behavioral Health Implications for CBRNE Events"

	Event Characteristics	Social Issues (Group & Community)	Individual / Family Issues	Implications for Response & Recovery
Nuclear / Radioactive Exposure	1) May be accompanied by blast and significant property damage / loss of life / thermal burns 2) May result from passive, accidental military or industrial release (slow moving event) 3) Exposure rates dependent upon: proximity, cloud dispersal, type of environmental contamination, type of device (nuclear / conventional) 4) Particles may be transferred person to person via touch 5) Requires PPE Level D 6) Environmental contamination may be long-term / necessitate evacuation / create inability to occupy ground, utilize water source 7) May create significant disruption of communications 8) No known medical treatment for radiation exposure 9) No identifiable low-point 10) Little or no warning 11) Radiation threat is invisible 12) Event may be acute AND chronic 13) Death of birds & animals	1) Fear of contamination 2) Need for massive decontamination of structures, transport vehicles, etc. 3) Uncertainty about health effects 4) May cause Mass Casualties (see corresponding chart below) 5) Suspicious distrust of information from authorities 6) Eroded confidence in controllability of technology 7) Social rejection of those who are contaminated / exposed 8) Safety concerns re: environment, water sources, food crops, etc. 9) Concerns re: birth anomalies 10) Health concerns re: genetic effects, cancer, fertility, immunologic suppression 11) Media surge 12) Broad economic impact 13) Divisive political issues 14) Results in more children sick than adults / children more prone to ionizing radiation	1) Fear of contamination 2) Dread of illness in self, children 3) Insecurity re: job, housing 4) Possible chronic sense of suspicion or mistrust of others 5) Elevated levels of depression, somatization, anxiety, hostility 6) Intrusive symptoms (obsessive thoughts, ominous dreams) 7) Possible 'over-protection' of children, family 8) Long-term impaired concentration 9) Information is a stressor 10) Certain cues (unusual odors, metallic taste, sirens) experienced as alarms 11) Exposure / contamination leads to social stigma 12) Distress for health, longevity of genealogical line	1) Focus should be on *Emotional Coping* vs. problem-solving coping. 2) Avoidance / Disengagement strategies may be most functional for survivors 3) Requires long term support and recovery efforts 4) Family oriented interventions may be more impactful vs. individual 5) Requires significant coordination between behavioral health services and primary care / medical services (esp. for somatization) 6) Individual illness is highly correlated with poorer psychological health 7) Unlike PTSD, stressors are ongoing and future oriented 8) Obsessive thoughts, suspiciousness, somatization are typically long-term issues 9) Event may qualify as PDD / Need for CCP Grant 10) May need long-term plan to support displaced families

Event Characteristics + Social Issues + Individual / Family Issues = Implications for Response & Recovery

"Matrix of Behavioral Health Implications for CBRNE Events"

	Event Characteristics	Social Issues (Group & Community)	Individual / Family Issues	Implications for Response & Recovery
(High Yield) Explosion	1) High-order explosives create supersonic over pressurization wave 2) Low-order explosives create sub-sonic pressurization wave 3) High-order explosives may cause internal crush injuries not easily triaged at scene 4) All explosives may cause multiple, severe injuries (esp. head & thoracic), burns, loss of limbs, death 5) May create fires, unstable structures 6) May necessitate search and rescue efforts for trapped victims 7) Possibility of secondary devices create risk for First Responders to criminally perpetrated incident	1) Event creates shock, surprise, horror 2) Uncertainty re: cause or identification of perpetrator leads to anxiety, anger, fear of subsequent event(s) 3) May cause Mass Casualties (see corresponding chart below) 4) Media surge 5) Event will generate legal / criminal investigation 6) May result in initial citizen response to aid injured or trapped 7) Extremely large numbers of people will seek information about family and friends	1) Surviving victims may experience event amnesia 2) Surviving victims may experience survivor guilt 3) Loss of limbs, sight, hearing, bodily function, causes extreme trauma and need for life-altering adjustments 4) Injuries will cause permanent scarring 5) Sense of helplessness may be pervasive and long-lasting 6) Citizens at scene and first responders will experience traumatic reactions to injured, maimed and dead 7) Explosion may cause loss of property, loss of home (i.e. apt. building, hotel, etc.) 8) Criminally perpetrated event may result in long investigative and trial process preventing closure for individuals / families	1) Event will create need for long term recovery efforts 2) Need to coordinate services with other response organizations: American Red Cross, Office for Victims of Crime, local area hospitals 3) Possible need for public 'Crisis Management Briefings' 4) May need to staff mortuaries and / or provide support for body handlers 5) Psychological debriefing for medical personnel and first responders within 2-3 days post event (or as soon as practical) 6) May need long-term plan to support displaced families 7) Individuals & families may need support & information about justice system during long term investigative and trial process

Event Characteristics + Social Issues + Individual / Family Issues = Implications for Response & Recovery

"Matrix of Behavioral Health Implications for CBRNE Events"

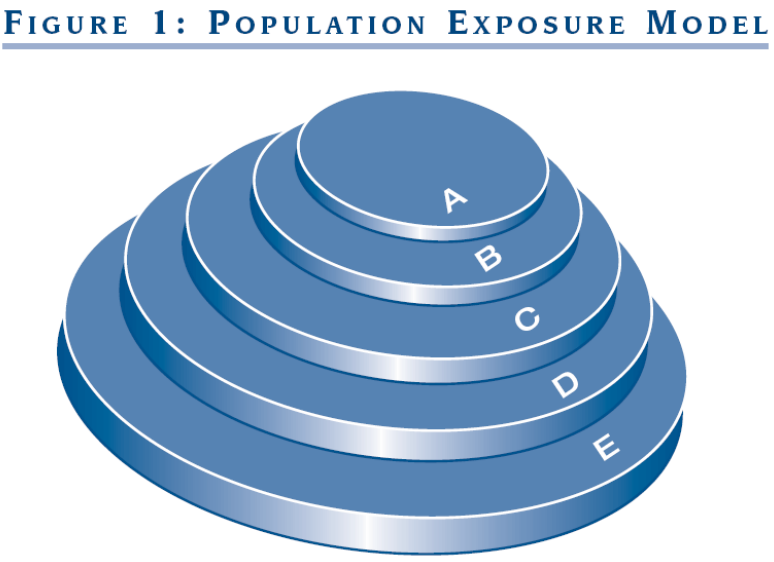
	Event Characteristics	Social Issues (Group & Community)	Individual / Family Issues	Implications for Response & Recovery
Mass Casualty	1) Multiple injuries or deaths may occur as result of any CBRNE event 2) Taxes capabilities of all response systems 3) Increases number of people (within and external to community) related to or associated with victims 4) Generates massive number of inquiries (local, state, national) regarding well-being of family and friends 5) Will always engender significant and continuous media coverage 6) Catastrophic numbers of casualties will necessitate compromise of normal medical standards of care 7) Creates problems with patient identification 8) Creates overwhelming problems for morgue services 9) Large numbers of responding volunteers require identification, certification, supervision, etc.	1) Causes collective trauma 2) Schools, arenas, etc. may need to be utilized as temporary morgues (creates stigma) 3) Typically becomes historical point of reference for community / state / nation 4) Disrupts business and normal social activities 5) May disrupt infrastructure and provision of needed support services 6) May result in significant number of children without parents 7) High probability that people and communities will respond cooperatively and adaptively to initial stage of event (historical response for natural disasters) 8) Disruption of social support networks 9) May cause negative reactions to limitations of medical community's capability to serve victim needs	1) Parent / family concerns about affects to children's emotional well-being 2) Complicated grief reactions 3) Significant family disruption 4) Isolation from normal social support 5) Most all succeeding events experienced with more intensity than normal 6) Long term exposure to event may result in increased family violence, divorce 7) People lose their *illusion of invulnerability*; anyone can be in the wrong place at the wrong time 8) Broad spectrum of intense psychological reactions experienced by victims, survivors and emergency responders 9) Event may require long duration for recovery	1) Severely injured may have approximately a 31% chance of developing PTSD 2) Uninjured victims may have approximately a 11% chance of developing PTSD 3) Complicated bereavement may elevate risk for depression & substance abuse 4) As high as 20% of first responders may require *individual* behavioral health intervention 5) Psychological debriefing for medical personnel & first responders within 2-3 days post event (or as soon as practical) 6) Need to coordinate services with other response organizations: Public Health; American Red Cross; Office of Victims of Crime (etc.) 7) Need to help children construct 'narrative' understanding of event 8) 3 Year span: anniversary dates may cause increased referrals for care / need for community acknowledgement 9) High risk of burn-out for behavioral health staff

Event Characteristics + Social Issues + Individual / Family Issues = Implications for Response & Recovery

Population Exposure Model*

Mental health providers new to responding to community disasters and widespread trauma must consider a community perspective as well as individual psychological effects. The collective social, political, environmental, and cultural impacts of community disaster interact with individual reactions and coping. A public health approach helps the provider develop a macro-view of the entire community and the gradations of effects and needs across population groups (Burkle, 1996). A concentric circle model, in Figure 1, depicts the spectrum of populations affected following large-scale disaster (Tucker et al., 1999; Wright, Ursano, and Bartone, 1990).

Figure 1: Population Exposure Model



A: Community victims killed and seriously injured; Bereaved family members, loved ones, close friends

B: Community victims exposed to the incident and disaster scene, but not injured

C: Bereaved extended family members and friends; Residents in disaster zone whose homes were destroyed; First responders, rescue and recovery workers; Medical examiner's office staff; Service providers immediately involved with bereaved families, obtaining information for body identification and death notification

D: Mental health and crime victim assistance providers; Clergy, chaplains; Emergency health care providers; Government officials; Members of the media

E: Groups that identify with the target-victim group; Businesses with financial impacts; Community-at-large

Deborah J. DeWolfe, Ph.D., M.S.P.H.

Reprinted From: US DHHS. "Mental Health Response to Mass Violence and Terror: A Training Manual". DHHS Publication No. SMA 3959, Rockville, MD: SAMHSA, 2004.

ANNEX B

"Aviation Disaster Protocols"

Aviation Disasters

Under the national *Aviation Disaster Family Assistance Act of 1996,* the American Red Cross has been designated as the lead agency to provide emergency mental health services following an aviation incident resulting in a "major loss of life". The American Red Cross is primarily responsibility for Victim Support Task #3, "Family Care & Mental Health". ARC will provide services to meet the acute stress and psychological needs of air incident disaster victims, their relatives and friends, as well as Red Cross volunteers, airline employees as requested and other individuals and groups who have responded to the aviation incident. If such a disaster occurs, the Red Cross will request the assistance of Red Cross trained mental health professionals, and the assistance of trained CMHC staff and DBH employees.

Notification of an air disaster, and request for assistance will originate with the affected airline which will contact the Chairman of the National Transportation Safety Board (NTSB). The NTSB will alert the National American Red Cross Director of Family Support Services who will in turn alert both Area and State ARC chapters to mobilize a response. The NTSB will coordinate federal assistance efforts with local and state authorities. The ARC will:

1. Provide liaison officer to the joint family support operations center to coordinate with other members of the operations staff ARC related issues and family requests for assistance. Additional personnel may be needed for crash scale 2 or 3 scenarios.

2. Coordinate and manage the numerous organizations and personnel that will offer their counseling and support services to the operation. It is important to monitor and manage this area so that families are not outnumbered and overwhelmed by well-intentioned organizations and individuals.

3. Employ an accounting system to accurately record cost data for specific cost categories for later reimbursement.

4. Activate local, state, and national ARC personnel to provide crisis and grief counseling to family members and support personnel. This includes coordinating with the airlines to contact and set up an appointment, if appropriate, with family members that do not travel to the site.

5. Assess the needs and available resources of other agencies and coordinate with them to ensure ongoing emotional support for workers during the operation and provide debriefings before departure.

6. Establish joint liaison with the airline at each medical treatment facility to track the status of injured victims and to provide assistance to their families.

7. Coordinate with the airline to establish areas for families to grieve privately.

8. Coordinate child care services for families that bring their children.

9. Arrange a suitable non-denominational memorial service days following the crash and a memorial service for any future burial of unidentified remains.

10. Provide families, at their request, referrals to local mental health professionals and support groups that are in the family member's local area.

ANNEX C

"Division of Behavioral Health Protocol & Procedure for Local Behavioral Health Emergencies Requiring State Assistance"

"Division of Behavioral Health Protocol & Procedure for Local Behavioral Health Emergencies Requiring State Assistance"

INTRODUCTION

The State of Alaska provides for the coordination of behavioral health disaster response services through the Department of Social Services, Division of Behavioral Health (DBH). The *State of Alaska Behavioral Health Emergency Response Plan, 2005* addresses the policies, scope, operations, roles, responsibilities, and authorities that form the foundation of behavioral health response to disasters and major emergencies. The *Plan* states that the Division relies upon local Community Mental Health Centers to provide the initial behavioral health response to any local emergency or disaster. The *Plan* also outlines the process by which the Division will support CMHC if local resources are overwhelmed by any disaster event. During a State or Federal declared disaster the Division will coordinate "…the identification, location, procurement, mobilization and deployment of additional behavioral health resources" through the State Emergency Coordination Center and local Emergency Operations Center structures.

However, all Alaskan communities may experience incidents which create a need for emergency behavioral health response, but which do not require the implementation of disaster response protocols addressed in the *Plan*. Most of these incidents can be addressed adequately by local or regional behavioral health resources. However, there are incidents which may either overwhelm the capability of local resources, or compromise these resources to the extent that they are unable to respond adequately to the present need. The *Plan* does not adequately address the protocols or procedural details for how the Division provides support to CMHC for these incidents. This document sets forth the protocol and procedure for the Division of Behavioral Health response to such local emergencies which require State assistance but which do not qualify as State or Federal declared disasters.

PROCEDURES

General

An event that impacts a single community or local area but which does not qualify as a state (or Federal) declared disaster may still require a substantial commitment of CMHC and / or other local behavioral health resources. It may temporarily reduce the CMHC capability to respond to other emergencies. CMHC will still attempt to provide behavioral health emergency response services with assistance provided through Mutual Aid Agreements. The costs associated with these efforts are assumed under the normal operating budget of the CMHC.

CMHC are obligated to contact the state regarding local emergency response for the following situations:

a. CMHC are required to report to DBH any missing, injured or deceased consumers.

b. If the event generates significant media coverage CMHC may be asked by DBH to provide regular updates or briefings.

If a community event or local emergency which requires behavioral health response results in the compromise of CMHC resources, the CMHC may request state assistance directly from the Division of Behavioral Health through contact with their respective DBH Regional Coordinator. Upon making such a request the CMHC will:

- Present to the DBH Regional Coordinator a verbal or written factual and detailed account of the incident to include:
    1. time, date, place and event description
    2. number and description of victims
    3. description of target populations requiring services
    4. any action taken by CMHC
    5. other organizations involved in response
    6. an explanation of why local resources are compromised
    7. description of needed services or resources
    8. an estimate of the scope of work involved including timeline
    9. name and contact information of CMHC Representative

Upon DBH acceptance and agreement of the request CMHC will:

- Provide initial coordination of deployed resources including:
    1. arrangements for lodging
    2. arrangements for ground transportation and food as necessary
    3. initial debriefing of incident
    4. description of community; maps; liaison as indicated
    5. arrangements for initial meetings
    6. contact information for other response groups
- Maintain record of expenses incurred for response efforts, and by deployed resources (see Allowable Expenses)
- Provide regular updates to DBH representative as indicated
- Provide verbal or written summary report to DBH representative at conclusion of response
- Reimburse deployed resources for all documented expenses
- Submit a modified budget at next quarterly report to DBH reflecting additional costs associated with emergency response and referencing the event in the narrative

Upon receipt of a CMHC request for assistance the DBH Regional Coordinator will act as the 'incident response coordinator' for DBH and is responsible for the following tasks:

- Document facts and details of the incident
- Assess the need for additional State supported behavioral health resources
- Notify Treatment & Recovery Manager (TR&M) of incident, and seek approval of CMHC request
- Confirm source of Emergency Funds
- Provide regular information update and debriefing to T&RM
- Directly, and / or in coordination with the DBH Designated Behavioral Health Disaster Coordinator, identify, locate, procure, mobilize and deploy

appropriate behavioral health emergency response resources to the affected community
- Debrief deployed resources regarding the incident, the request for services, specifics about the affected community, CMHC information, expense reporting, etc.
- Arrange for all deployed behavioral health emergency response resources to coordinate response efforts through the local or regional CMHC
- Coordinate with local or regional CMHC to:
    1. arrange for lodging, food and other needs for deployed resources as necessary
    2. provide accounting and reporting of all expenses incurred for response and by deployed resources
    3. submit modified grant budget reflecting all final response costs to Regional Coordinator for approval and reimbursement
- Follow up with CMHC and / or deployed resources regarding assessment of need beyond initial response
- Maintain final record of incident response
- Update Regional Emergency Funds utilization record
- Forward CMHC modified grant budget to Treatment & Recovery Manager for review, and / or assistance with approval and reimbursement

When contacted by a Regional Coordinator regarding a request for State assistance the Treatment & Recovery Manager will perform the following tasks:

- Review documented facts and details of the incident
- Notify Division of Behavioral Health Director of incident, and seek approval of request as necessary
- Provide regular information update and debriefing for Division Director
- Notify FMS Administrative Manager of incident response
- Assist Regional Coordinator with source and approval of alternative emergency funds as indicated or requested
- Assist with identification, location, procurement, mobilization and deployment efforts for behavioral health emergency response resources as indicated or requested by Regional Coordinator
- Coordinate with Division of Behavioral Health Director and Senior Staff to appoint Designated Behavioral Health Disaster Coordinator if necessary, and if such position does not already exist
- Review CMHC modified grant budget, and assist Regional Coordinator with approval process as indicated
- Debrief DBH Director of final resolution of incident response as indicated or requested
- Forward CMHC modified grant budget to FMS Manager for action as indicated

When contacted by a Regional Coordinator, or Treatment & Recovery Manager, or as appointed by a Section Manager or the DBH Director, the Designated Behavioral Health Disaster Coordinator will in response to a CMHC request for State assistance perform the following tasks directly, or in coordination with the Regional Coordinator:

- Act as primary ‘incident response coordinator’

- Perform all the tasks noted under responsibilities for DBH Regional Coordinator

Documentation Requirements

The Regional Coordinator or designated 'incident response coordinator' is responsible for maintaining a permanent record of any DBH incident response activity provided to local communities through the local or regional CMHC. Initial and final reports respectively should contain the following information:

- Date & time of contact, and name and contact information of person requesting assistance
- Facts and details of precipitating incident
- Rationale for CMHC request for State assistance
- Needs Assessment
- Any agreements, implied or expressed, between Regional Coordinator and CMHC
- Brief outline for initial plan of response
- Names and contact information of all parties associated with response effort
- Notation, or copies of update communications with DBH, CMHC and other resources
- Indication of resolution of incident response
- Copy of CMHC expense report / modified grant budget (final report)

The report may consist of handwritten notes, emails, letters, FAX, expense report, and copy of amended grant budget.

Reports should be kept in a permanent file titled: Critical Incident Response, (name of CMHC), (Month, Year).

Confidentiality of consumer information shall be maintained by all DBH personnel according to all existing DBH policies, procedures and observed laws and regulations. Identifying consumer information shall be withheld from deployed behavioral health emergency response resources until such time as they arrive in the affected community and make contact with the local CMHC. Exceptions to this policy will be considered under the following conditions:

1. The identification of victims, victim families, or others associated with the incident will have a significant impact upon the choice of emergency response personnel, or the details involved in response planning
2. Behavioral Health emergency response providers need to know the identity of victims, victim families, or others associated with the incident in order to make informed decisions affecting professional boundaries, and / or ethical issues

Behavioral Health Emergency Response Resources

DBH personnel involved with the response to a CMHC request for assistance with a behavioral health emergency may draw from a number of resources. These include any of the following:

- CMHC staff from other regionally-based centers
- CMHC staff from centers located outside the region
- Approved CISM Teams consisting of personnel from within region
- Approved CISM Teams consisting of specific specialists located elsewhere in the state
- Volunteer American Red Cross Licensed behavioral health professionals
- DBH staff

All emergency response providers should make their own personal travel arrangements. Providers may also be required to bring sleeping bags, or other personal gear. Lodging, food, and other needs will be arranged by the local CMHC or their representative(s). All expenses (see Allowable Expenses below) incurred by emergency response providers should be submitted to the local CMHC, or representative(s) for reimbursement.

All emergency response providers deployed by DBH will coordinate all response efforts through the local or regional CMHC or representative(s).

Allowable Expenses

The following is an approved list of expenses eligible for reimbursement incurred by emergency response providers participating in behavioral health emergency response efforts directed by DBH and local CMHC:

- Air fare
- Ground transportation
- Per Diem (food allowance)
- Lodging expenses
- Photocopying
- Maximum $200 per day Honorarium for [self-employed] independent behavioral health contractors (as approved by DBH Director)

All expenses incurred by emergency response providers must be documented by receipt, and should be submitted to the local CMHC or representative(s) for reimbursement.

ANNEX D

"Division of Behavioral Health Responsibilities and Tasks"

"Division of Behavioral Health Responsibilities / Tasks as Stated or Assumed Under State Emergency Response Documents"

	DBH Responsibility / Task
DHSS Response & Recovery Guide, July 2004	
DHSS Roles & Responsibilities	"Coordinate, through the Division of Behavioral Health the provision of crisis counseling and outreach to victims in affected communities, and to rescuers." pg. 4
Emergency Coordination Center	Provide staff as required for DHSS Emergency Coordination Center in Anchorage or Juneau, pg. 6
Mass Casualty (Appendix 3)	"Activate State Mental Health Plan, provide/coordinate critical incident stress management and other emergency mental health services." pg 29
Human Services (Appendix 4)	"Coordinate . . . mental health resources." pg 31
State of Alaska Emergency Response Plan, 2004	
Functional Responsibilities (All)	"All state agencies are responsible for developing supporting checklists and standard operating procedures in support of this plan." pg 30
Coordination & Control	"Provide liaisons to SECC" pg 31
Communications	"Provide back-up communications resources as required" pg 33
Public Information	"As required, provide representatives to the JIC. Coordinate individual agency / departmental media releases with the JIC" pg 36
Human Services	"Assist those providing assistance to victims requiring special care" pg 39
Mass Casualty	- same as DHSS Guide, above- pg 47

	DBH Responsibility / Task
Finance & Administration	"Administer contracts and service agreements." "Collect disaster related cost data and furnish cost estimates and projections." "Document by project, the labor, materials, and services used for disaster emergencies." "Maintain an audit trail of billings and invoice payments." "Respond to SECC requests for personnel by mobilizing qualified personnel from other departments" pg 49-51
Terrorism Annex A (General)	"Support DHSS/DPH with functional responsibilities as required to operate as "Major Supporting State Agency" pg 52
Agroterrorism	"Oversee and coordinate the public health aspects of the response." (Assumes behavioral health response) pg 63
Bioterrorism	"Be prepared to provide support to local jurisdictions statewide" pg 67
Chemical	"Be prepared to provide support to local jurisdictions statewide" pg 69
Evacuation Annex C (General)	"Coordinate information on status of victims." "Provide assistance and technical advice with regard to evacuating special needs groups" pg 89

Division of Behavioral Health
Emergency Services Responsibility Checklists

Division of Behavioral Health Director

Pre-Disaster Phase

- ☐ Provide to the DHSS Commissioner's Office the names and contact information for at least two DBH disaster response coordinator contacts.
- ☐ Provide for disaster response training for Senior Staff, Regional Coordinators and designated disaster response coordinator(s) which includes review of State of Alaska ERP, DHSS ERP, and DBH ERP.
- ☐ Assure that the Division of Behavioral Health has an Emergency Response Plan and that the plan is reviewed annually and updated as necessary to remain in compliance and compatibility with all other state emergency response plans.
- ☐ Assure that the Division of Behavioral Health configures and integrates all business continuity requirements within the DHSS Continuity of Operations Plan
- ☐ Provide for confirmation through appropriate DBH personnel that all grantees with emergency services responsibility have a written, updated emergency response plan
- ☐ Provide for DBH participation in emergency response exercises with DHSS and/or the Division of Homeland Security, Emergency Management
- ☐ Provide for all the following regarding DBH emergency communications equipment:
    - Procurement of sufficient number of emergency communications equipment including lap-top computers, and satellite telephones
    - Accounting Records including equipment descriptions, serial numbers, and personnel to whom equipment is assigned
    - Procurement of annually updated service contract for Satellite Telephones
    - Distribution of equipment to all DBH personnel identified to assist with disaster response activities
    - Training for identified personnel in the use of Satellite Telephone equipment

Emergency Disaster Phase

- ☐ Activate State Behavioral Health Emergency Response Plan.
- ☐ Appoint DBH personnel to staff the DHSS initial disaster response team and the State Emergency Coordination Center (SECC) upon request of the Division of Homeland Security, Emergency Management
- ☐ Elicit from Division personnel as much accurate information as possible about local areas affected by the disaster as well as impacts on DHSS / DBH offices.

- ☐ Elicit from Division personnel information regarding critical personnel and supply needs.
- ☐ Provide for the relay of critical information to the DHSS / DPH Emergency Operations Center, or the SECC
- ☐ Assist designated disaster response coordinator(s) to identify, locate, procure, mobilize and deploy needed behavioral health resources in coordination with the SECC.
- ☐ Provide for the confirmation of the safety and well-being of all DBH personnel
- ☐ Assure that the designated disaster response coordinator(s) develop and submit, in cooperation with the affected local Community Mental Health Center (CMHC), the FEMA / CMHS Immediate Services Crisis Counseling Program grant (ISP) as indicated.
- ☐ Arrange for regular information updates and debriefing from DBH disaster response coordinator(s) regarding DBH response activities
- ☐ Arrange for event specific information updates for all DBH personnel as indicated

Recovery Phase

- ☐ Activate the DHSS / Division of Behavioral Health Continuity of Operations Plan or procedures as indicated.
- ☐ Arrange for alternate DBH personnel to relieve disaster response coordinator(s), Regional Coordinators and other emergency response personnel as indicated.
- ☐ Provide for critical incident stress management interventions for DBH personnel as indicated
- ☐ Provide for the implementation of policies and procedures regarding the event related death or serious injury of any DBH employee
- ☐ Apprise DHSS Commissioner as indicated of information related to DBH response efforts and associated costs, and details regarding local impact and need.
- ☐ Assure that the designated disaster response coordinator(s) develop and submit, in cooperation with the affected local CMHC, the FEMA / CMHS Regular Services Crisis Counseling Program grant (RSP) as indicated
- ☐ Provide for the review and update of the *State of Alaska Behavioral Health Emergency Response Plan* based upon experiences with response efforts to the current event

Division of Behavioral Health Regional Coordinator

Pre-Disaster Phase

- ☐ Provide accurate, updated personal emergency contact information to Division Director
- ☐ Confirm that all grantees with emergency services responsibility (CMHC) under your purview have a written, updated emergency response plan
- ☐ Maintain printed and/or digital copies of the *State of Alaska Behavioral Health Emergency Response Plan*, and all emergency response plans for those CMHC under your respective purview.
- ☐ As requested, provide technical assistance to CMHC regarding the development of emergency response plans, and the coordination of collaborative emergency response planning between CMHC and other local emergency response organizations
- ☐ al assistance to CMHC for the development of emergency response plans, and for the coordination of collaborative efforts for emergency services planning with other local community organizations
- ☐ Participate in DBH sponsored disaster response training
- ☐ Provide input for development of DHSS / DBH Continuity of Operations Plan to Division Director
- ☐ Participate as requested in emergency response exercises conducted by DHSS and/or Division of Homeland Security, Emergency Management

Disaster Emergency Phase

- ☐ Act as liaison between CMHC and DBH for emergencies which may require additional behavioral health resources but which may not cause activation of *State of Alaska Emergency Response Plan*
- ☐ Adhere to “Guidelines for All DHSS Employees” included in the DHSS Disaster Response & Recovery Guide
- ☐ As assigned by Division Director fulfill all responsibilities as DBH Liaison in the DHSS / DPH Emergency Operations Center, or the SECC in Anchorage or Juneau.
- ☐ Assist DBH Director and disaster response coordinator(s) identify, locate, procure, mobilize and deploy behavioral health resources in coordination with SECC.
- ☐ As assigned by DBH Director, be prepared to travel to site of local incident as part of DBH Incident Management Team to assist local CMHC with response efforts
- ☐ Assist disaster response coordinator(s) and CMHC develop and submit FEMA / CMHS Immediate Services Crisis Counseling Program grant (ISP) as indicated.
- ☐ Provide for use of personally assigned DBH emergency Satellite telephone to other needful state emergency personnel as directed by Division Director or SECC

Recovery Phase

- ☐ As assigned by DBH Director relieve job responsibilities of other Regional Coordinators, or disaster response coordinator(s)
- ☐ Assist disaster response coordinator(s) and CMHC develop and submit FEMA / CMHS Regular Services Crisis Counseling Program grant (RSP) as indicated.
- ☐ Provide feedback to DBH Director and disaster response coordinator(s) regarding update of *State of Alaska Behavioral Health Emergency Response Plan* based upon experiences with response efforts to the current event
- ☐ Assist with oversight of FEMA / CMHS RSP for any CMHC under your purview

Division of Behavioral Health Liaison to the SECC

Pre-Disaster Phase

- ☐ Provide accurate, updated personal emergency contact information to Division Director
- ☐ Maintain printed and/or digital copies of the *State of Alaska Emergency Response Plan*, the *State of Alaska Behavioral Health Emergency Response Plan*, and the *DHSS Response & Recovery Guide*
- ☐ Visit and familiarize self with the SECC in Anchorage and/or Juneau
- ☐ Participate in DBH sponsored disaster response training
- ☐ Participate as requested in emergency response exercises conducted by DHSS and/or Division of Homeland Security, Emergency Management

Disaster Emergency Phase

- ☐ Staff DHSS / DPH Emergency Operations Center, or SECC as assigned by DBH Director
- ☐ Assist with communication between SECC Command staff and DBH Director, DBH field staff, and / or CMHC Liaison in local Emergency Operations Center.
- ☐ Identify need and location for initial behavioral health services, including Critical Incident Stress Management services
- ☐ Identify special populations that may require behavioral health services, including first responder groups, other behavioral health staff, and local area businesses
- ☐ Arrange for the identification, location, procurement, mobilization and deployment of needed behavioral health resources in coordination with DBH personnel and the SECC
- ☐ Assist with coordination of behavioral health services and resources with recipient organizations including the American Red Cross, hospitals outside impacted area(s), Disaster Mortuary Teams, etc.
- ☐ Advocate for general care of SECC Command staff
- ☐ Regularly debrief DHSS Liaison, DBH Director, Regional Coordinators, and disaster response coordinator(s) as indicated
- ☐ Advocate for inclusion of behavioral health concerns / issues in Risk Communications messages to the general public; coordinate effort with DHSS / DBH communications officer and / or Joint Information Center (JIC)
- ☐ Maintain Activity Log which records problem situations, action taken and outcome

Recovery Phase

- □ As requested, assist DBH Director with implementation of DHSS / DBH Continuity of Operations Plan or procedures
- □ As requested, assist DBH Director with provision of critical incident stress management interventions for DBH employees
- □ As requested, assist DBH Director with Division response to any event related employee death or serious injury
- □ Provide feedback to DBH Director and disaster response coordinator(s) regarding update of *State of Alaska Behavioral Health Emergency Response Plan* based upon experiences with response efforts to the current event

Division of Behavioral Health Disaster Response Coordinator

Pre-Disaster Phase

- ☐ Provide accurate, updated personal emergency contact information to Division Director
- ☐ Maintain printed and/or digital copies of the *State of Alaska Emergency Response Plan*, the *State of Alaska Behavioral Health Emergency Response Plan*, and the *DHSS Response & Recovery Guide*
- ☐ Establish collaborative relationships with DHSS / DPH Emergency Manager, Division of Homeland Security, Emergency Management personnel, the Salvation Army Emergency Response Manager, the Coordinator for the State of Alaska Victims of Crime Compensation Board, and the Emergency Manager of American Red Cross, Alaska
- ☐ Attend coordination and planning meetings of various state-wide emergency management organizations or groups as available
- ☐ As requested, assist DBH Director with annual review and update of the *State of Alaska Behavioral Health Emergency Response Plan*
- ☐ Develop and provide behavioral health disaster response training to DBH Senior staff, and Regional Coordinators
- ☐ Provide input to DBH Director for development of DHSS / DBH Continuity of Operations Plan
- ☐ As requested, assist DBH Director with all aspects of the provision for DBH emergency communications equipment
- ☐ Coordinate participation of DBH in emergency response exercises conducted by DHSS and/or Division of Homeland Security, Emergency Management
- ☐ As requested, provide technical assistance to Regional Coordinators and/or CMHC regarding the development of CMHC emergency response plans, and the coordination of collaborative emergency response planning between CMHC and other local emergency response organizations

Emergency Disaster Phase

- ☐ As instructed by DBH Director, coordinate <u>all</u> behavioral health disaster response services for State of Alaska
- ☐ Implement all response and recovery protocols of *State of Alaska Behavioral Health Emergency Response Plan* as indicated, including activation of all Mutual Aid Agreements
- ☐ Maintain contact with DHSS / DBH Liaison to the SECC (or the DHSS / DPH Emergency Operations Center) for response coordination
- ☐ Conduct needs assessment for initial behavioral health disaster response services
- ☐ Assist with the identification, location, procurement, mobilization and deployment of needed behavioral health resources in coordination with other DBH emergency services personnel and the SECC

- ☐ Coordinate re-distribution and use of DBH communications equipment as needed
- ☐ Provide technical assistance and support to local CMHC as requested
- ☐ In cooperation with local CMHC lead in the development and submission of the FEMA / CMHS Immediate Services Crisis Counseling Program grant (ISP)
- ☐ Assist CMHC with identification of behavioral health volunteers who are licensed or certified by the State, and / or who have received disaster response training.
- ☐ Provide regular information updates and debriefing for DBH Director regarding DBH response activities
- ☐ As requested, assist DBH Director with regular information updates for all DBH personnel
- ☐ Advocate for general care of all DBH staff, and all behavioral health responders
- ☐ As assigned by DBH Director, be prepared to travel to site of local incident as part of DBH Incident Management Team to assist local CMHC with response efforts

Recovery Phase

- ☐ Continue all Disaster Emergency Phase tasks and activities as needed
- ☐ Develop needs assessment for long-term recovery efforts
- ☐ In cooperation with local CMHC lead in the development and submission of the FEMA / CMHS Regular Services Crisis Counseling Program grant (RSP)
- ☐ Provide to DBH Director a summary report of response efforts to date, associated costs, and details regarding local impact and need, and proposed long-term plan
- ☐ Provide continuing technical assistance to Regional Coordinator(s) and CMHC for implementation of FEMA / CMHS RSP grant
- ☐ Coordinate the review and update of the *State of Alaska Behavioral Health Emergency Response Plan* based upon experiences with response efforts to the current event

ANNEX E

"Reference Materials"

"Behavioral Health Disaster Response and Recovery Services"

- 24 Hour Outreach Services: Professional / Para-professional staff deployed to local Emergency Operations Center, shelters, Disaster Recovery Centers, hospital(s), community meeting halls, homes, neighborhoods, schools.

- Environments Assessment and Recommendations: Staff assesses for comfort, privacy, basic needs, sound, lighting, etc. and makes recommendations that address improvements for social and psychological well-being of victims / survivors, and response staff.

- Critical Incident Stress Management: Full range of debriefing, defusing and follow-up stress management services for first responder groups, emergency management personnel, public service workers, and other community groups and individuals as requested (e.g. employees of business impacted by event, etc.).

- Psychological First Aid: Practical interpersonal interventions that target acute stress reactions and immediate needs. The purpose is to establish safety and physical well-being, reduce stress related symptoms, promote self-efficacy, link to critical resources, and connect to social support.

- Facilitate and Teach Stress Management & Relaxation Skills: Staff encourages people to utilize stress reduction and relaxation behaviors that have worked for them in the past. Staff teach basic stress reduction and relaxation skills as needed for adults, adolescents and children.

- Facilitate and Teach Coping & Problem Solving Skills: Staff encourages people to utilize coping techniques that have worked for them in the past to help with sudden change, loss, uncertainty and lack of control. Staff teaches these basic skills as indicated, and assist people prioritize needs, and objectives, and formulate next steps.

- Brief Cognitive-Behavioral Interventions & Grief Counseling: Longer term interventions designed to address people's interpretations of event, modify maladaptive behaviors, and assist with the process of grieving personal loss.

- Substance Abuse Screening, Intervention & Referral: Relatively new focus of behavioral health disaster response intended to identify victims / survivors and first responders who exhibit difficulties with over-utilization of alcohol, and subsequent social and interpersonal problems. Interventions are brief and focused on acknowledgement of issues and referral for comprehensive treatment services, and providing follow up contact as indicated.

- Public Information & Risk Management Communications: Support given to community leaders and emergency management personnel regarding concerns for psychological and sociological impact of messages disseminated to public about an event. Staff may be called upon to help produce messages that address psychological care of children, or healthy recovery for adults, etc.

- Community Assistance with Trauma Recovery: Select staff provides support to community leaders and groups for activities that address collective trauma recovery. Focus is on inclusion of impacted groups, cultural awareness, symbolic activities, memorials, anniversary acknowledgements and remembrances.

- Community Faith-based Services: Spiritual and faith-based support and comfort provided to all emergency response groups, victims and families, and to the general community population. Services are provided by a consortium of local pastoral care representatives from various church and faith organizations. Care representatives should be present in all shelter facilities, hospitals, or other locations as requested. CMHC provide point of contact for service requests and coordination.

Incident Response Levels

The Division of Behavioral Health (DBH) has adopted the concept of incident response levels as referenced in the *State of Alaska, Division of Public Health Emergency Response Plan, 2004: Mass Casualty Annex*. The table has been written to reflect the conditions relevant to behavioral health disaster response. It is presented here as a guide for DBH personnel and for Community Mental Health Centers (CMHC) to aid with planning, preparation and response activities.

Level I Event

A Level I event is managed through normal local response without reducing the CMHC capability to respond to other emergencies. The event is assumed under existing budget and utilizes normal staffing patterns.

Examples

a) Consumer suicide
b) Disruptive behavior of consumer due to psychotic episode or substance abuse
c) Single dwelling house fire

Level II Event

A Level II event is one which impacts a single community or local area but may not qualify as a state declared disaster. A Community Event may require an increased commitment of CMHC and / or other local behavioral health resources (activated in accordance with Mutual Aid Agreements). It may temporarily reduce the CMHC capability to respond to other emergencies depending upon available resources. The event is assumed under existing budget, but may require alternative staff assignments.

Examples

a) Multiple family dwelling fire
b) Small aircraft crash (2-4 passenger)
c) Limited area flood or winter storm damage affecting infrastructure

Level III Event

A Level III event is likely to qualify as a state declared disaster and may require behavioral health response that extends beyond the capabilities of local CMHC and / or other behavioral health services provided through mutual aid agreements. It may require the temporary suspension of normal CMHC consumer services. The event may require an increased number of staff be reassigned to emergency response and may require extended work hours. The event may require additional behavioral health resources provided through state

assistance. Response costs which cannot be assumed under existing budget will be covered by State and/or Federal resources if operations are ordered and directed through the local EOC and SECC.

Examples

a) Earthquake with damage to primary community and outlying villages which may require use of temporary shelters, and closing of area businesses
b) Wide area flood or wild fire that threatens life and property and requires relocation of area populations
c) Small commuter aircraft crash (9 – 15 passengers)

Level IV Event

A Level IV event will exceed all local response capabilities, including all local behavioral health services and require a broad range of state assistance. The event is likely to qualify as a Presidential Declared Disaster. CMHC whenever possible will act as "point of contact" for the provision and coordination of local behavioral health disaster response services. Normal CMHC consumer services may be suspended for an indeterminate period. If the event qualifies as a PDD, all costs related to behavioral health services will be submitted for payment through CCP grants awarded to DBH by FEMA / CMHS.

Examples

a) Crash of large aircraft (20+ passengers)
b) Disaster involving High-capacity passenger vessel
c) Terrorist attack with no loss of infrastructure
d) Miller's Reach Fire, 2001

Level V Event

A Level V event is an incident of such magnitude that massive state and federal assistance is likely to be required. The event will unquestionably qualify as a Presidential Declared Disaster. Local behavioral health disaster response and recovery services will be significantly supported by state and federal resources for an extended period of time. Response costs will be assumed by multiple state and federal sources.

Examples

a) Oklahoma City Bombing, 1995
b) Major earthquake resulting in multi-regional damage and loss of life and severe disruption of infrastructure
c) Terrorist attack causing mass casualties and loss of infrastructure ("911")

COMMUNITY MENTAL HEALTH CENTER LIST ORGANIZED BY REGIONS AND CENTRAL COMMUNITIES

The following is a list of the current Regional Offices within the Division of Behavioral Health. Within each Region is a list of the central communities. The Community Mental Health Center with the Emergency Services/Disaster Response responsibility for that service area is identified. A list of the communities in each service area is also included. Each identified Community Mental Health Center is responsible to provide emergency services, develop or initiate the development of a mental health component to the disaster plan in their service area, and provide adequate training for their personnel.

Anchorage Regional Office

1. Anchorage

Northern Regional Office

2. Barrow
3. Bethel
4. Fairbanks
5. Fort Yukon
6. Galena
7. Tanana Chiefs Council
8. Kotzebue
9. McGrath
10. Nenana
11. Nome
12. Tok

Southcentral Regional Office

13. Copper Center
14. Cordova
15. Dillingham
16. East Aleutians Aleutians/Pribilofs
17. Homer
18. Kenai
19. Kodiak
20. Seward
21. Valdez
22. Unalaska
23. Wasilla
24. West

Southeast Regional Office

25. Craig
26. Haines
27. Juneau
28. Ketchikan
29. Petersburg
30. SEARCH Region
31. Sitka
32. Wrangell

ANCHORAGE REGIONAL OFFICE

3601 C Street, Suite 878
Anchorage, AK 99503
(907) 269-3600
FAX: (907) 269-3623

John Bajowski, Regional Coordinator (MH) – (907) 269-3609
Michelle Bartley, Regional Coordinator (SA) – (907) 269-3798

ANCHORAGE

COMMUNITIES IN SERVICE AREA

Municipality of Anchorage	Tyonek	Whittier

Anchorage Community Mental Health Svs
4020 Folker Street.
Anchorage, Alaska 99503

Jerry Jenkins, Director
jjenkins@alaska.net
Tele. 907-563-1000
Fax. 907-563-2045
Hotline. 907-563-3200

NORTHERN REGIONAL OFFICE

751 Old Richardson Highway, Suite 100A
Fairbanks, AK 99701
(907) 451-5045
FAX: (907) 451-5046

Sharon Walluk, Regional Coordinator (MH)
Larry Cagnina, Regional Coordinator (SA)

BARROW

COMMUNITIES IN SERVICE AREA

Anaktuvuk Pass	Barrow	Nuiqsut	Wainwright
Atqasuk	Kaktovik	Point Hope	

North Slope Borough
Community Mental Health Center
P.O. Box 69
Barrow, AK 99723

Merry Carlson, Health Director
merry.Carlson@north-slope.org
Phone: (907) 852-0366 Ext. 257
FAX: (907) 852-0389
24 Crisis Line (907) 852-0266
Or 1-800-478-0266

BETHEL

COMMUNITIES IN SERVICE AREA

Akiachak	Holy Cross	Napaskiak	Sleetmute
Akiak	Hooper Bay	Newtok	St. Mary's
Alakanuk	Kasigluk	Nightmute	Stony River
Aniak	Kongiganak	Nunapitchuk	Toksook Bay
Anvik	Kotlik	Oscarville	Tuluksak
Bethel	Kwethluk	Pilot Station	Tuntutuliak
Chefornak	Kwigillingok	Pitkas Point	Tununak
Chevak	Lime Village	Quinhagak	Upper Kalskag
Chuathbaluk	Lower Kalskag	Red Devil	
Crooked Creek	Marshall	Russian Mission	
Eek	Mekoryuk	Scammon Bay	
Emmonak	Mountain Village	Shageluk	
Grayling	Napakiak	Sheldon Point	

Yukon-Kuskokwim Health Corporation
P.O. Box 528
Bethel, AK 99559

John McIntyre, Behavioral Health
John_mcintyre@ykhc.org
Phone: (907) 543-6100
FAX: (907) 543-6159
24 Crisis Line: (907) 543-6300
Or 1-800-478-2642

FAIRBANKS

COMMUNITIES IN SERVICE AREA

Big Delta	Fairbanks	Fort Greely	North Star Borough
Delta Junction			

Fairbanks Community Mental Health
122 First Avenue, Ste. 5
Fairbanks, Alaska 99701

Suzanne Price, Executive Director
suzannep@fcmhc.org
Tele. 907-452-1575
Fax. 907-456-9761
Hotline. 907-452-1575

FORT YUKON

COMMUNITIES IN SERVICE AREA

Artic Village	Birch Creek	Circle	Venetie
Beaver	Chalkyitsik	Fort Yukon	

Yukon Flats CARE
P.O. Box 21
Fort Yukon, AK 99740

Lona Marioneaux-Ibanitoru
Care Center Director
ibanitoru@catg.org
Phone: (907) 662-2526
FAX: (907) 662-2627
24 Crisis Line: (907) 662-2640

GALENA

COMMUNITIES IN SERVICE AREA

Galena	Kaltag	Koyukuk	Ruby
Huslia		Nulato	

City of Galena
Yukon-Koyukuk Mental Health and
Alcohol Program
P.O. Box 17
Galena, AK 99741

Diana Weber, Director
dianasweber@hotmail.com
Phone: (907) 656-1617
FAX: (907) 656-1581
Or 1-800-478-1618

KOTZEBUE

COMMUNITIES IN SERVICE AREA

Ambler	Kiana	Kotzebue	Point Hope
Buckland	Kivilina	Noatak	Selawik
Deering	Kobuk	Noorvik	Shungnak

Maniilaq Counseling Services
P.O. Box 43
Kotzebue, AK 99752

Kimberly Haviland, Prog. Director
khaviland@maniilaq.org
Phone: (907) 442-7401
FAX: (907) 442-7306
24 Crisis Line: 442-7208Emg.Rm.

MCGRATH

COMMUNITIES IN SERVICE AREA

McGrath	Nikolai	Takotna	Telida
Medfra			

Behavioral Health McGrath
229 Joaquin St
McGrath, AK 99627
24 Crisis Line: 1-866-584-6248

Dustin Parker, Director
dparker@mcgrathalaska.net
Phone: (907) 524-3400
FAX: (907) 524-3519

NENANA

COMMUNITIES IN SERVICE AREA

Anderson	Clear	Healy	Nenana
Cantwell	Denali Park		

Railbelt Mental Health & Addictions Program
P.O. Box 159
Nenana, AK 99760

Keri Frazier, MH Clinical Supervisor
Traci Wiggins, Executive Director
rmha@mtaonline.net
Phone: (907) 832-5557
FAX: (907) 832-5564

NOME

COMMUNITIES IN SERVICE AREA

Brevig Mission	Golovin	Savoonga	Teller
Diomede	Koyuk	Shaktoolik	Unalakleet
Elim	Nome	Shishmaref	Wales
Gambell	St. Michael	Stebbins	White Mountain

Norton Sound Community
Mental Health Center
P.O. Box 966
Nome, AK 99762

Charles Beck, Director
cbeck@nshcorp.org
Phone: (907) 443-3344/443-3290
FAX: (907) 443-5915
24 Crisis Line: (800) 559-3311

TANANA CHIEFS CONFERENCE REGION

COMMUNITIES IN REGIONAL SERVICE AREA

Alatna	Evansville	Manley	Stevens Village	Allakaket	
Fairbanks	Minto	Tanana	Bettles	Hughes	Rampart
Wiseman					

Tanana Chiefs Conference, Inc .
Mental Health & Alcohol Program
122 First Ave. Ste. A 600
Fairbanks, AK 99701
24 Crisis Line: (907) 452-4257

Josephine Huntington
Director of Health Services
josephine.huntington@tananachiefs.org
Phone: (907) 452-8251 ext 3141
FAX: (907) 459-3950

TOK

COMMUNITIES IN SERVICE AREA

Alcan	Dot Lake	Healy Lake	Tanacross
Boundary	Dry Creek	Northway	Tetlin
Chicken	Eagle City	Northway Junction	Tok
Eagle Village	Northway Village		

Tok Area Counseling Center
P.O. Box 398
Tok, AK 99780
24 Crisis Line: (907) 883-5111
Alaska State Troopers

Jonathan Lundy, M.A. Director
Tokcmch1@aptalaska.net
Phone: (907) 883-5106
FAX: (907) 883-5108

SOUTHCENTRAL REGIONAL OFFICE

3601 C Street, Suite 878
Anchorage, AK 99503
(907) 269-3600/269-3695
FAX: (907) 269-3623

Viki Wells, Regional Coordinator

COPPER CENTER

COMMUNITIES IN SERVICE AREA

Chistochina	Gakona	Kenny Lake	Slana
Chitina	Glennallen	McCarthy	Tazlina
Copper Center	Gulkana	Mentasta Lake	

Copper River Mental Health Center
Mile 104 Richardson Hwy, Drawer "H"
Copper Center, AK 99573

Dr. Phil Mattheis, BH Director
phil@copperriverna.org
Phone: (907) 822-5241
FAX: (907) 822-8801

CORDOVA

COMMUNITIES IN SERVICE AREA

Chenega Bay	Cordova	Eyak	Tatitlek

Sound Alternatives
602 Chase Street
P.O. Box 160
Cordova, AK 99574

John Miller, PhD., Interim Director
jmiller@cdvcmcc.com
Paddy Barnes, Chief Financial Offcr
PBarnes@cdvcmcc.com
Phone: (907) 424-8300
FAX: (907) 424-8645
24 Crisis Line: (907) 424-8000

DILLINGHAM

COMMUNITIES IN SERVICE AREA

Aleknagik	Ekwok	Manokotak	Platinum
Chignik	Goodnew Bay (Mumtak)	Newhalen	Port Alsworth
Chignik Lagoon	Igiugig	Naknek	Port Heiden
Chignik Lake	Illiamna	New Stuyahok	South Naknek
Clarks Point	Kokhanok	Nondalton	Togiak
Dillingham	King Salmon	Perryville	Twin Hills
Egegik	Koliganek	Pilot Point	Ugashik
Ekuk	Levelock		

Bristol Bay Area Health Corporation
Behavioral Health Department
P.O. Box 130
Dillingham, AK 99576

Joan Ribich, Director
jribich@bbahc.org
Phone: (907) 842-1230
FAX: (907) 842-5174
24 Crisis Line: (907) 842-5354
Or 1-800-510-1230

EASTERN ALEUTIAN ISLANDS

COMMUNITIES IN SERVICE AREA

Akutan	False Pass	Nelson Lagoon
Cold Bay	King Cove	Sand Point

Eastern Aleutians Tribes
1600 A Street, Suite 104
Anchorage, AK 99501

Chris Devlin, Executive Director
lcdevlin@gci.net
Phone: 277-1440
Fax: 277-1446

Eastern Aleutians Tribes
PO Box 206
King Cove, AK 99612

Leslie Bennett, BH Coordinator
leslie.b@gci.net
Phone: 497-2342
Fax: 497-3110

24 Hour Hope Line:1-800-478-2673

HOMER

COMMUNITIES IN SERVICE AREA

Anchor Point	Homer	Nikolaevsk	Port Graham
Fritz Creek	Nanwalek	Ninilchik	Seldovia

South Peninsula Behavioral Health Svs
Community Mental Health Center
3948 Ben Walters Lane
Homer, AK 99603
24 Crisis Line: (907) 235-0247
(South Peninsula Hospital – after 5 pm)

Kemper Breeding, Exec Director
kbreeding@acsalaska.net
Phone: (907) 235-7701 8-5 pm
FAX: (907) 235-2290
(907) 235-3150

KENAI

COMMUNITIES IN SERVICE AREA

Kasilof	Nikiski	Soldotna	Sterling
Kenai			

Central Peninsula Counseling Services
506 Lake Street
Kenai, AK 99611
24 Crisis Line: (907) 283-7511

Ted Schiffman, Director
tschiffman@cpcservices.org
Phone: (907) 283-7501
FAX: (907) 283-9006

KODIAK

COMMUNITIES IN SERVICE AREA

Akhiok	Larsen Bay	Ouzinkie	Port Lions
Kodiak	Old Harbor		

Providence Kodiak Island Mental Health Center
717 East Rezanof Drive
Kodiak, AK 99615

Scott Selby, Director
sselby@provak.org
Phone: (907) 481-2400
FAX: (907) 481-2419
24 Crisis Line: (907) 486-3281

SEWARD

COMMUNITIES IN SERVICE AREA

Bear Creek	Hope	Primrose	Seward
Cooper Landing	Moose Pass		

Seaview Community Services
P O Box 1045
Seward, AK 99664
24 Crisis Line: (907) 224-3027

Melissa Witzler Stone, MSW
Executive Director
mstone@seaviewseward.org
Phone: (907) 224-2960
FAX: (907) 224-7081

UNALASKA

COMMUNITIES IN SERVICE AREA

Unalaska (Dutch Harbor)

Iliuliuk Family & Health Services, Inc.
P.O. Box 144
Unalaska, AK 99685
24 Crisis Line: (907) 581-1233
Department of Public Safety

Elaine Fahrenkamp
Mental Health Director
efahrenkamp@ifhs.org
Phone: (907) 581-1202
FAX: (907) 581-2331

VALDEZ

COMMUNITIES IN SERVICE AREA

Valdez

Valdez Counseling Center
P.O. Box 1050
Valdez, AK 99686
Peggy Flascher, MS, Director

Peggy Flascher, MS, Director
pflascher@valdezrha.org
Phone: (907) 835-2838
FAX: (907) 835-592
24 Crisis Line: (907) 825-2999

WASILLA

COMMUNITIES IN SERVICE AREA

Big Lake	Meadow Lakes	Sutton	Wasilla
Houston	Palmer	Talkeetna	Willow
Knik			

Behavioral Health Services of Mat – Su
1363 W. Spruce Ave.
Wasilla, Alaska 99654

Mary Alice Larson, Exe. Director
lifequest@lifequest.org
Tele. 907-376-2411
Fax. 907-352-3363

WEST ALEUTIAN & PRIBILOF ISLANDS

COMMUNITIES IN SERVICE AREA

Atka Nikolski St. George Island St. Paul Island

Aleutian/Pribilof Island Association
201 East 3rd Avenue
Anchorage, Alaska 99501
Dimitri Philemonof, President, CEO
Kelly Simeonoff, Health Director
Michelle Klass, Assistant Health Director
MichelleK@apiai.com
Phone: (907) 276-2700

Aleutian/Pribilof Island Association
Oonalaska Wellness Center
PO Box 1130
Unalaska, AK 99685
Noel Arakelian, BH Coordinator
Phone: 581-2742
FAX: (907) 279-4351

SOUTHEAST REGIONAL OFFICE

350 Main Street
P.O. Box 110620
Juneau, AK 99811-0620
(907) 465-3370
FAX: (907) 465-2677

Marian Owen, Regional Coordinator (MH)
Marilee Fletcher, Regional Coordinator (SA)

CRAIG

COMMUNITIES IN SERVICE AREA

Craig Kassan City Meyers Chuck Thorne Bay
Hydaburg Klawock

Communities Organized for Health Options (COHO)
Mental Health Services
P.O. Box 805
Craig, AK 99921

Doug Veit, MSW, Mental Health Dir
Lonnie Walters, Executive Director
coho@aptalaska.net
Phone: (907) 826-3662
FAX: (907) 826-2917

Craig Police Department After Hours: 911 or (907) 826-3330

HAINES

COMMUNITIES IN SERVICE AREA

Haines	Klukwan	Mosquito Lake	Skagway

Lynn Canal Counseling Center
P.O. Box 90
Haines, AK 99827

Elizabeth McMullan, LCSW, Dir.
canal@wytbear.com
Phone: (907) 766-2177
FAX: (907) 766-2977

JUNEAU

COMMUNITIES IN SERVICE AREA

City & Borough of Juneau	Gustavus	Elfin Cove	Pelican
Tenakee Springs			

Juneau Alliance for Mental Health Inc.
3406 Glacier Highway
Juneau, AK 99801

Brenda Knapp, Executive Director
brendak@jamhi.org
Phone: (907) 463-3303
FAX: (907) 586-3877
24 Crisis Line: (907) 796-8447

KETCHIKAN

COMMUNITIES IN SERVICE AREA

Annette	Hyder	Kupreanof	Port Alice
Coffman Cove	Ketchikan	Metlakatla	Saxman

Gateway Center for Human Services
3050 5th Avenue
Ketchikan, AK 99901

Kevin Murphy, Director
kevinm@city.ketchikan.ak.us
Phone: (907) 225-4135
FAX: (907) 247-4135
24 Crisis Line : (907) 225-4135

PETERSBURG

COMMUNITIES IN SERVICE AREA

Petersburg

Petersburg Mental Health Services
P.O. Box 1309
Petersburg, AK 99833

Susan Ohmer, LCSW, Director
ohmero@aptalaska.net
Phone: (907) 772-3332

FAX: (907) 772-2122
24 Crisis Line: (907) 772-3332
Petersburg Police Department

SEARHC AREA

COMMUNITIES IN SERVICE AREA

Angoon	Kake	Pelican
Haines	Klawock	
Hydaburg	Klukwan	

Southeast Alaska
Regional Health Corporation
222 Tongass Drive
Sitka, AK 99835

Patrick Hefley M.P.H.,
Program Director, Behavioral Health
Pat.Hefley@searhc.org
Phone: (907) 966-8715
FAX: (907) 966-2253

Mt. Edgecumbe Hospital
Phone: (907) 966-2411 (Emergency, Evenings/Weekends)
Ask for Psychiatrist on Call

SITKA

COMMUNITIES IN SERVICE AREA

City & Borough of Sitka	Hoonah	Port Alexander	Yakutat

Sitka Counseling & Prevention Services
701 Indian River Rd.
Sitka, Alaska 99835

Janie Popour-Hogue, Exe. Dir.
jhogue@scpsak.org
Tele. 907-747-3636
Fax. 907-747-5316

WRANGELL

COMMUNITIES IN SERVICE AREA

Wrangell

Wrangell Mental Health Services, Inc.
P.O. Box 1615
Wrangell, AK 99929

Mark T. Walker, LCSW, Director
mark@wrangellservices.com
Phone: (907) 874-2373
FAX: (907) 874-2576

Wrangell Medical Center
(907) 874 – 7000 24 Crisis

“CMHC Emergency Response Plan Contents Checklist”

- ☐ Statement of Purpose
- ☐ Description of CMHC Program Structure and Services
- ☐ Identification of Emergency Coordinator and MHRT Personnel
- ☐ Description of how CMHC is coordinated with community EOC
- ☐ Contact / notification lists of agency personnel and EOC Liaison(s)
- ☐ Contact lists of state contacts / resources
- ☐ Instructions for requesting state assistance (community event, and state or federal declared disaster)
- ☐ Policies / Procedures for managing outside resources and volunteers
- ☐ Description, sequence of response activities (activation, deployment, debrief, etc)
- ☐ Protocols for responding to specific situations or events (optional)
- ☐ Protocols for responding to community populations with special needs
- ☐ Agency and Program Evacuation procedures
- ☐ Consideration for Risk Communications / Public Debriefing procedures (optional)
- ☐ Provision for cost accounting & data collection
- ☐ Inclusion of Continuity of Operations plans for services to existing consumers
- ☐ Provisions for employee self & family care; employer’s role for assisting with employee protection/well-being; protocols for responding to employee victims
- ☐ Consideration for field workers support needs (food, water, comm’s, etc.)
- ☐ Criteria and notation of responsibility for updating plan
- ☐ MAA with other behavioral health resources (local and neighboring)
- ☐ MAA with Community Faith-based organizations, ARC, Hospital(s), DPH, CISM
- ☐ Glossary of Terms
- ☐

Example

EMERGENCY RESPONSE PLAN

For DBH Grantees with
Emergency Services Responsibility

- COMPANY LOGO -

Agency Name

Behavioral Health Emergency Response Plan

Month, Year

Signature Page

_____ _____

(Chair, Board of Directors) (Date)

_____ _____

(Executive Director) (Date)

_____ _____

(Other) (Date)

_____ _____

(Other) (Date)

Agency Name

Behavioral Health Emergency Response Plan

This Plan will be reviewed annually and revised if necessary.

Record of Changes

Change Number	Date	Subject	Page No#	Entered By

Table of Contents

List of Figures and Charts

I. Forward

The State of Alaska provides for the coordination of behavioral health disaster response services through the Department of Health and Social Services (DHSS), Division of Behavioral Health (DBH). The Division of Behavioral Health relies upon grantees with emergency services responsibility to provide or coordinate initial behavioral health disaster response services to any event that befalls their catchment area, and to coordinate long term response efforts.

The (*agency name*) Behavioral Health Emergency Response Plan (Plan) is written in accordance with the precepts established in the State Division of Behavioral Health Emergency Response Plan. The Plan is based upon an *all-hazards* concept which addresses behavioral health response protocols for all the possible hazards endemic to the (*specific geographic*) region.

The Plan exists as a supplement to the (*name of community*) commmunity Emergency Response Plan. The planning, preparation and response activities of this Plan are integrated and coordinated in a collaborative manner with other local emergency management, planning and response groups.

The Plan is considered to be a dynamic document and will be reviewed annually for changes based on new situations, developing circumstances at the local, state, and federal level, and evolving knowledge and technology in the field of emergency behavioral health.

II. Introduction

The purpose of this Plan is to ensure an efficient, coordinated, effective response to the behavioral health needs of the affected populations in times of disaster. There are four primary goals:

1. To provide guidelines for agency disaster planning, preparation, and response activities
2. To describe the roles and responsibilities for administrative and clinical personnel assigned to assist with disaster relief operations

3. To outline the procedures for mobilizing, coordinating and deploying behavioral health resources in cooperation with local area disaster management
4. To outline the process to identify those who need special help, and to provide that help as effectively as possible based on victim centered needs.

Behavioral health emergency response services are included in the (*section of the local incident command structure*):

(insert diagram here)

The Plan provides for the coordination of behavioral health resources within the community through Mutual Aid Agreements with the following organizations (See Annex F):

(*organization name*)
(*organization name*)
(*organization name*)

The Plan provides for the coordination of behavioral health resources from outside the community through the emergency operations section of (*agency name*). These resources will be requested through DHSS / DBH or the (*local incident command structure*) according to need. These resources include state and/or federal personnel officially deployed to assist with local response activities and training needs, and to provide technical assistance. Resources also include funding through state emergency funds as available, and FEMA / CMHS Crisis Counseling Program Grants offered as a result of a Presidential Declared Disaster and coordinated through DHSS / DBH.

The Plan provides a description of the organization, its programs and services, the addresses and locations of satellite offices and business buildings, and includes an organization chart and a list of all communities

served in the catchment area, and a list of assigned emergency response positions. (See Annex B).

III. Situation and Assumptions

SITUATION

The following information describes the community of _____ and its neighboring communities:

- _____ is located _____
- The population of _____ is _____
- The ethnic distribution of the population is (*% Ak. Native; % Caucasian; % Hispanic; etc.*)
- The demographic distribution of the population is (*No.# or % adults; No.# or % children / ages; No.# or % of other special needs populations; etc.*)
- _____ is accessed via (air, boat, road, etc.)
- Medical Health Services are provided by _____
- Behavioral Health Services are provided by (*local provider names*)
- The type of disaster events which could occur are _____
-
-

ASSUMPTIONS

- Disasters, by their inherent conditions, produce the need for behavioral health response.
- Responding to the psychological and emotional needs of all people impacted by a disaster is an integral part of a comprehensive and effective community disaster response and recovery strategy.
- Local behavioral health disaster response services will address mental health, and substance abuse issues, and provide for integrated response and recovery activities with medical, public health, local or state American Red Cross, and faith-based services.
- The (*agency name*) will coordinate local behavioral disaster response services, and will seek additional state or federal behavioral health resources as needed, through the (*local incident command structure*).

- Employees of (*agency name*) will attend to family and personal welfare before trying to report to work.
-
-

IV. Concept of Operations

OPERATIONS – General

The (*agency name*) will conduct behavioral health emergency response operations according to the following guidelines:

1. Provide normal emergency response services (not related to disaster events) to existing and new applicant consumers according to current agency policies and procedures.
2. Provide culturally appropriate, phase-sensitive behavioral health disaster response services within catchment area through
    a. Activities provided directly by agency staff, and / or
    b. Coordination of activities provided through other resources from within and / or from outside the community or catchment area.
3. Coordinate provision of behavioral health disaster response services with (*local incident command structure*)
4. Coordinate provision of behavioral health disaster response resources for all local Aviation Disasters with American Red Cross as requested
5. Cooperate with State Division of Behavioral Health in development of FEMA / CMHS grant application(s) in the event of a Presidential Declared Disaster, and coordinate Crisis Counseling Program(s) as indicated.

The Executive Director, or alternate in descending line of succession, will announce emergency status for the agency and invoke this Plan (The agency Incident Command Structure is depicted in Figure 1).

The Executive Director will then initiate contact with the Emergency Response Coordinator and all Team Leaders via the (*telephone contact tree*). The Emergency Response Coordinator and all Team Leaders will execute all emergency response procedures outlined in this Plan and according to their individual Responsibilities Checklist.

Agency Incident Command Structure

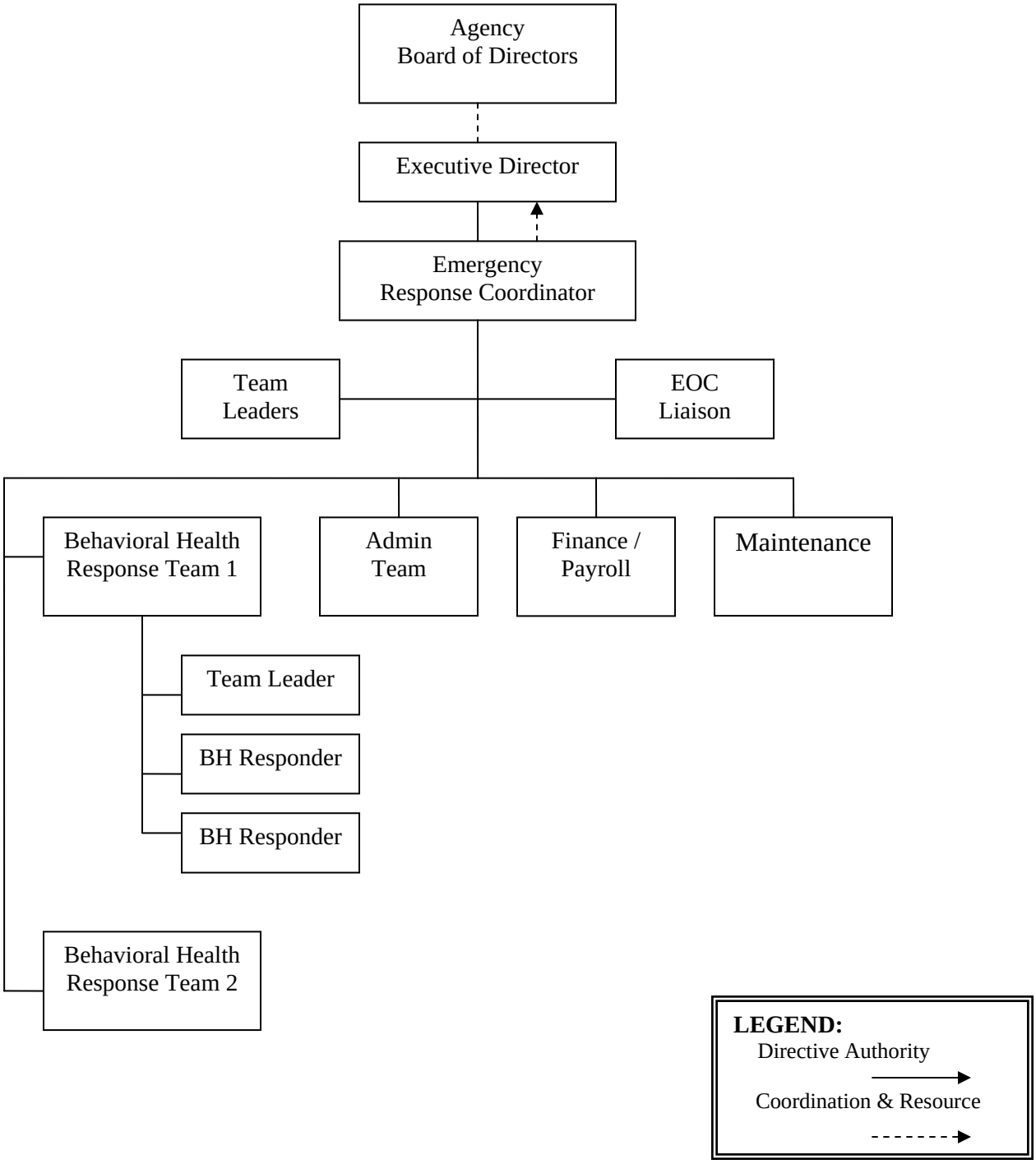


Figure 1

Local emergencies and disaster events will be categorized according to the following Incident Response Levels:

Level I Event

An event that is handled through normal local response without reducing the CMHC capability to respond to other emergencies.

Examples

d) Consumer suicide
e) Disruptive behavior of consumer due to psychotic episode or substance abuse
f) Vehicle accident with fatalities

Level II Event

An event that may require a greater commitment of CMHC or other local behavioral health resources to reduce the crisis or reduce stress and disruption of victims.

Examples

d) Multiple family dwelling fire
e) Small aircraft crash
f) Limited area flood or storm surge

Level III Event

An event that is likely to extend beyond the response capabilities of local CMHC and mutual aid agreements, and that will require some state assistance.

Examples

d) Earthquake with minor damage to primary community and outlying villages
e) Wide area flood or wild fire that threatens life and property and requires relocation of area populations
f) Hazardous Materials Level II incident

Level IV Event

An event that will exceed all local response capabilities, and in most instances qualify as a state declared disaster, and which will require a broad range of state assistance, and / or federal assistance.

Examples

e) Crash of large aircraft
f) Disaster involving High-capacity passenger vessel

g) Terrorist attack with no loss of infrastructure

Level V Event

An event of such magnitude that massive state and federal assistance is likely to be required, and which clearly qualifies as a Presidential Declared Disaster

Examples

d) Major earthquake resulting in multi-regional damage and loss of life
e) Terrorist attack with loss of infrastructure

The behavioral health needs for Level I and Level II events can normally be addressed directly by agency resources or through mutual aid agreements with other local provider organizations. The agency will report to DBH any missing, injured or deceased consumers which results from any incident. If a Level I or II event affects state interests the agency will provide regular reports and briefings to DBH as requested.

Additionally, there may be incidents at Level I and II which may either overwhelm the agency's capability, or compromise agency staff to the extent that they are unable to respond adequately to the present need. In such a case the agency will do all the following to request and receive assistance directly from DHSS / DBH:

1. Document facts and details of the incident including:
   1.1. Incident; date, time
   1.2. Victims involved; name(s), age(s), relationship to agency
   1.3. Community response; response organizations & contact names
   1.4. Justification for state supported resource
   1.5. Type of resource(s) requested, estimated number, time/date needed, costs involved
   1.6. Agency coordinator name and contact information
2. Contact DBH Regional Coordinator with information and request
3. Coordinate the following:
   3.1. Lodging, food and other needs for deployed resources
   3.2. Accounting and reporting of all expenses incurred for response
   3.3. Progress updates, and final incident report
4. Amend block grant budget to reflect total cost of response, and submit to DBH for approval

Additional resources that are required beyond those provided within local capability for Response Levels III, IV and V will be arranged through the (*local incident command structure*).

OPERATIONS – Emergency Response Phases

Behavioral health disaster response and recovery operations will be conducted according to three phases: pre-disaster, disaster emergency, and recovery.

Pre-Disaster Phase

Pre-disaster operations will include all the following:

1. Develop agency Emergency Response Plan
2. Develop Mutual Aid Agreements with other local provider organizations
3. (*Collaborate with communities served in catchment regarding protocols for provision of behavioral health disaster response & recovery services*)
4. Assure ERP is attached as supplement to Community Emergency Response Plan
5. Identify agency staff for key disaster response positions & teams
6. Assign agency representative to attend meetings of (*local emergency planning committee (LEPC) or emergency management group*)
7. Provide for staff training
8. Inform consumers of agency procedures during disaster emergency phase
9. Include "Behavioral Health Disaster Response Services" in listing of existing agency services on agency brochures, etc. as appropriate and indicated to inform the general public
10. Participate whenever possible in emergency response exercises with other community response organizations
11. Arrange for alternative emergency facility(s) as available

Emergency Disaster Phase

Emergency disaster operations will be conducted in coordination with the (*local incident command structure*) based upon local emergency response plan(s) and existing agreements. The agency procedures to be followed during the emergency disaster phase shall include:

1. Implement all safety and evacuation procedures according to need and to existing agency policies and procedures (See Annex C).
2. (*Arrange for basic needs and alternative living arrangements for consumers involved with residential programs*)
3. Assess damage to agency buildings and structures
4. Report facility damages and existing, or potential hazards to proper authorities as soon as reasonably possible
5. Test telephone and computer systems for operability
6. Allow all agency staff to attend to immediate needs for self and family members
7. Contact staff with emergency response assignments and schedule initial briefings and planning meetings
8. Establish agency representative at local EOC
9. Conduct initial needs assessment in cooperation with (*local emergency management personnel, American Red Cross, local schools, churches, other organizations as indicated*)
10. Investigate any existing safety concerns with (*local emergency management personnel, public health, etc.*) for agency staff preparing to deploy for community assignments
11. Investigate support needs (food, water, communications, etc.) for staff with emergency response assignments and make appropriate arrangements to secure and provide supplies as indicated
12. Deploy behavioral health response teams to areas of immediate need (e.g. shelters, family assistance centers, hospitals) according to existing agreements and/or requests for assistance
13. Hold initial briefing and planning meetings; Develop and implement initial response activities
14. Inform consumers of availability of services
15. As needed, request and coordinate additional assistance from other local providers according to Mutual Aid Agreements (See Annex F)
16. As needed, request additional state assistance from DHSS / DBH through local EOC
17. Establish administrative support services to handle telephone calls, collate contact & service data, provide for financial accounting of response costs

18. Coordinate utilization of volunteer behavioral health resources from within and outside community
19. Participate with DHSS / DBH representatives in preparation of FEMA / CMHS Immediate Services (Crisis Counseling Program) Grant in case of Presidential Declared Disaster
20. Arrange debriefing(s) for staff with emergency response assignments
21. Identify agency employees missing, injured or deceased as result of disaster, and/or employees who are victims as result of injury or death of family member(s), property loss, or damage to home
22. (*Follow agency protocols / policies & procedures for responding to employee victims*)
23. Coordinate with (*local incident command structure*) to arrange defusing services for first responder teams
24. Collaborate with (*local incident command structure*) as indicated or requested for any public information messages
25. (*Provide trained staff to participate in Death Notification [team] as requested by proper authority*)

Recovery Phase

Behavioral health disaster response services and activities provided during the recovery phase will be tailored to the specific needs of the community and its populations, according to the event characteristics. The (*agency name*) will follow the general guidelines listed below:

1. Continue needs assessment in cooperation with (*local emergency management personnel, American Red Cross, local schools, churches, public health, other organizations as indicated*)
2. Participate with DHSS / DBH representatives in preparation of FEMA / CMHS Regular Services (Crisis Counseling Program) Grant in case of Presidential Declared Disaster
3. Coordinate with (*local incident command structure*) to assist with arrangement of public debriefing services as indicated or requested
4. Continue all needful Emergency Disaster Phase services and tasks as indicated
5. Implement continuity of operations procedures, and reestablish interrupted consumer services
6. Rotate shifts and assignments for staff with emergency response assignments as indicated

7. Continue coordination of volunteer resources from within and outside community
8. Develop and implement long-term behavioral health recovery services and activities
9. Review Emergency Response Plan and response protocols for updated change(s)
10. Implement Crisis Counseling Program established through [awarded] FEMA / CMHS Regular Services Grant
11. Advocate for, and participate in, community anniversary events, memorials, remembrances activities, etc.

ANNEX A

Employee Contact List
Responsibility Checklists

Personnel Contact List

Executive Management	Office	Home	Cell
Executive Director			
Clinical Director			
Chief Financial Officer			
Administration Mgr.			

Program Supervisors

Team Leaders

Clinical Staff

Administration Staff

Maintenance Staff

EXECUTIVE DIRECTOR

Pre-Disaster Phase

- ☐ Provide for creation of agency Emergency Response Plan
- ☐ Provide for creation of Business Continuity Plan / procedures
- ☐ Provide for annual review and update of Plan(s) as necessary
- ☐ Assure agency Plan is supplement to community Emergency Response Plan
- ☐ Assure agency representation on (*local emergency planning committee (LEPC) or emergency management group*)
- ☐ Assure development of agency evacuation and safety plans
- ☐ Assure establishment of (*protocols, policies & procedures for responding to employee death, injury, or victimization due to disaster event*)
- ☐ Provide for the development of Mutual Aid Agreements in support of agency Plan and disaster response service activities
- ☐ (*Appoint or act in capacity of*) agency Emergency Response Coordinator
- ☐ Appoint Emergency Administrative Support Supervisor
- ☐ Appoint Emergency Comptroller
- ☐ Appoint Manager for Facilities, Vehicles & Emergency Supplies
- ☐ Provide for basic behavioral health disaster response training for all clinical staff, and administrative staff involved with response service activities

Emergency Disaster Phase

- ☐ Invoke agency Emergency Response Plan
- ☐ Assess damages to facility(s); report damages and any existing or potential hazards to appropriate authorities as indicated
- ☐ Notify Board of Directors of agency status
- ☐ Assure safety of staff on duty, and consumers in agency facility(s)
- ☐ Arrange for use of alternative facility(s) as necessary
- ☐ Provide oversight for all agency emergency response activities
- ☐ Provide for financial accounting of response costs
- ☐ Assure all information needed for FEMA / CMHS Immediate Services grant is provided to grant writers

Recovery Phase

- ☐ Implement continuity of operations procedures, and reestablish interrupted consumer services
- ☐ Assure all information needed for FEMA / CMHS Regular Services grant is provided to grant writers
- ☐ Report any missing or deceased consumers to DBH
- ☐ (*Assure implementation of agency protocols for responding to employees killed or victimized by event*)
- ☐ Notify Board of Directors of agency status and recovery plans

EMERGENCY RESPONSE COORDINATOR

Pre-Disaster Phase

- ☐ Represent agency on (*local emergency planning committee (LEPC) or emergency management group*)
- ☐ Assist with logistics for staff training; assure all staff have copy of agency ERP
- ☐ Assign clinical staff to key disaster response positions & teams
- ☐ Assist with logistics for agency to participate with other organizations during emergency response exercises
- ☐ Participate in development of Mutual Aid Agreements

Emergency Disaster Phase

- ☐ Contact staff with emergency response assignments (*utilizing telephone tree, or other contact scheme*), and schedule initial briefing and planning meetings
- ☐ Deploy agency Liaison to EOC
- ☐ Assist Executive Director to assess immediate needs for staff on duty, and for consumers in agency facility(s)
- ☐ Assist with logistics of accessing and occupying alternative facility(s) as needed
- ☐ Prepare outline of initial needs assessment with information provided by EOC Liaison and other community sources as available
- ☐ Investigate safety concerns, and support needs for staff preparing to deploy for community assignments
- ☐ Arrange for procurement and distribution of supplies as indicated
- ☐ Conduct initial planning meeting with Team Leaders
- ☐ Conduct initial staff briefing meeting
- ☐ Deploy behavioral health response teams to areas of immediate need based upon safety concerns, needs assessment and existing MAA
- ☐ Coordinate with Emergency Response Administrative Support Supervisor to provide information to consumers as needed
- ☐ Provide information to EOC Liaison regarding resource needs
- ☐ Coordinate debriefing(s) for all agency staff as indicated
- ☐ Continue needs assessment and modify initial response plan as indicated
- ☐ Develop staff schedules and assignments in collaboration with Team Leaders and Program Supervisors
- ☐ Participate with DHSS / DBH representatives in preparation of FEMA / CMHS Immediate Services Grant as indicated

Recovery Phase

- ☐ Continue needs assessment; specifically identify special needs groups for outreach services
- ☐ Develop plan for long-term behavioral health recovery services and activities
- ☐ Participate with DHSS / DBH representatives in preparation of FEMA / CMHS Regular Services Grant as indicated
- ☐ Organize notes, ideas for updating agency Emergency Response Plan based on current event experiences
- ☐ Coordinate debriefing(s) for all agency staff as indicated
- ☐ Coordinate defusing and public debriefing services with (*local incident command structure*) as indicated or requested
- ☐ Continue other outreach services to community as necessary
- ☐ Assist agency and emergency response staff with transition to Crisis Counseling Program services upon award of Regular Services Grant
- ☐

EMERGENCY OPERATIONS CENTER LIAISON

Pre-Disaster Phase

- ☐ Thoroughly familiarize self with agency ERP
- ☐ Familiarize self with community ERP
- ☐ Attend training on National Incident Management System (NIMS)
- ☐ Visit EOC to familiarize self with environment, access, etc.
- ☐ Arrange introduction(s) to community responders likely to staff EOC

Emergency Disaster Phase

- ☐ Attend briefing with agency Emergency Response Coordinator
- ☐ Deploy to EOC as directed
- ☐ Provide information to Incident Command Staff regarding behavioral health resources availability, capability and needs
- ☐ Receive information from Incident Command Staff regarding community need for behavioral health support
- ☐ Relay continuous information from EOC to agency Emergency Response Coordinator to assist with needs assessment and resource management
- ☐ Provide continuous informal assessment of EOC environment and submit suggestions to Incident Command Staff for improving comfort, and wellbeing of EOC participants
- ☐ Provide behavioral health support for all EOC participants as indicated
- ☐ Maintain presence at EOC for as long as requested or necessary to coordinate behavioral health support

Recovery Phase

- ☐ Continue Emergency Disaster Phase tasks as necessary or requested
- ☐ Provide information and ideas to agency Emergency Response Coordinator for update of agency ERP
- ☐ Assist with other agency behavioral health emergency response tasks and activities as assigned

EMERGENCY ADMINISTRATIVE SUPPORT SUPERVISOR

Pre-Disaster Phase

- ☐ Thoroughly familiarize self with agency ERP
- ☐ Coordinate development of agency emergency supply list(s)
- ☐ Coordinate updates of agency staff emergency contact list(s)
- ☐ Coordinate development of "Permission List" of agency employee friends and family who may receive information about employee whereabouts, wellbeing, and contact information
- ☐ Develop emergency service contact data forms
- ☐ Coordinate development of protocols for protecting and salvaging agency documents / files, including priority order in which items are rescued and recovered
- ☐ Participate in development of continuity of operations protocols
- ☐ Provide for training for administrative staff regarding agency emergency protocols, policies and procedures, and admin emergency support roles and responsibilities
- ☐ Act as agency custodian of all (*evacuation plans, facility diagrams/blueprints, emergency key-sets, etc.*)

Emergency Disaster Phase

- ☐ Test telephone and computer systems for operability
- ☐ Lead agency response in protecting and salvaging agency documents / files
- ☐ Collaborate with Executive Director and Emergency Response Coordinator for provision of administrative support needs
- ☐ Assign admin resources as indicated to support agency emergency response efforts
- ☐ Coordinate consumer notifications regarding availability of agency services
- ☐ Provide for assistance with collation of contact service data, and preparation of grant information

Recovery Phase

- ☐ Continue to coordinate Emergency Disaster Phase tasks as necessary
- ☐ Participate as indicated in continuity of operations protocols
- ☐ Provide information and ideas to agency Emergency Response Coordinator for update of agency ERP

ANNEX B

Description of Agency Organization, Programs & Services
Organization Chart
List of Employee Positions & Corresponding Emergency Service Positions

NOTE: The following chart is only a suggested arrangement for CMHC. Position names will vary between different organizations. Some positions and responsibilities can obviously be combined, which will be common to smaller CMHC. Behavioral Health Emergency Response Teams will differ in composition and size depending upon the number of available employees, the event, and victim needs. The corresponding Responsibility Checklists in Annex A do not reflect all the positions noted here. Annex A includes only a few primary positions as example. It is recommended that checklists be developed for every emergency assignment.

Agency Position	Emergency Service Position
Executive Director	Executive Director
Clinical Director	Emergency Response Coordinator
Program Supervisor	EOC Liaison
Administration Mgr.	Emg. Response Admin. Supervisor
Administration Staff:	Emergency Admin Team:
1. Receptionist	1. Phones & Public Contact
2. Records Clerk	2. Records Protection/ Salvage
3. Executive Asst.	3. Data Collection & Forms
Chief Financial Officer	Emergency Comptroller
Finance Staff:	Finance / Payroll Team:
1. Payroll Clerk	1.Asst. Comptroller / Payroll
2. Claims Clerk	2. Insurances / Injury Claim
Case Manager Supervisor	Volunteer Coordinator
Program Supervisors (2)	Team Leaders (2)
Clinical Staff	Beh. Hlth. Emg Responders (6)
Psychologists	
MH/SA Clinicians	
Case Managers	
Beh. Hlth. Aids	
Maintenance Manager	Facilities / Vehicles & Emg. Supplies

ANNEX C

Evacuation Plans

ANNEX D

(Optional)

Procedures for Responding to Employee Death or Victimization

ANNEX E

(Optional)

Continuity of Operations Protocols / Plan

NOTE: The following list represents some of the issues that should be considered when developing a business continuity plan. The list is not all inclusive, and it is not intended as a plan outline or template. The list is intended to alert not-for-profit management of the potential interests that may need to be addressed for an organization to open its doors again for business following a disaster.

Business Continuity Concerns for Non-Profit Organizations

- Business impact analysis / risk analysis
- Identification of critical business processes
- Access to emergency power source(s)
- Electronic Data back-up procedures / storage off-site
- Records salvage
- Access to alternative facilities
- Communications needs
- Insurance claim procedures
- Prioritizing clinical services
  - Psychiatric / medication
  - Support for consumers in addictions recovery
  - Case management services
- Need for "cash" operations
- Personnel assignments, and role responsibilities / succession line back-up assignments
- Procedures for temporary workforce reduction
- Procedures for rapidly increasing workforce to assist with disaster recovery operations
- Alternative Record Keeping procedures (when electronic data capability is compromised / interrupted)
- Services, policies and practices to promote well being and psychological recovery of employees

ANNEX F

Mutual Aid Agreements

ANNEX G

Acronyms & Glossary of Terms

ANNEX F

"Acronyms & Abbreviations"

Acronyms and Abbreviations

ARC American Red Cross

CBRNE Chemical, Biological, Radiological, Nuclear, High-yield Explosive

CCP Crisis Counseling Program

CISM Critical Incident Stress Management

CMHC Community Mental Health Center

CMHS / SAMHSA Center for Mental Health Services / Substance Abuse and Mental Health Services Administration

DBH Division of Behavioral Health

DHSS Department of Health and Social Services

DPH Division of Public Health

EOC Emergency Operations Center

EOP Emergency Operations Plan

ERP Emergency Response Plan

ESF Emergency Support Function (#1 – 12; see Federal ERP)

FEMA Federal Emergency Management Administration

IHS Indian Health Services

IMT Incident Management Team

LEPC Local Emergency Planning Committee

MAC Group Multi-Agency Coordination Group

MHRT Mental Health Response Team

MAA Mutual Aid Agreement

NIMS/ICS National Incident Management System / Incident Command System

OVC Office for Victims of Crime

PDD Presidential Declared Disaster

SECC State Emergency Coordination Center

SOA State of Alaska

VCCB Victims of Crime Compensation Board

WMD Weapons of Mass Destruction

ANNEX G

"Glossary"

Glossary

All-hazards

The concept of a matrix of planning, mitigation and response and recovery tasks and activities that addresses all forms of emergencies or disasters whether naturally occurring (e.g. earthquake) or human induced (e.g. arson; terrorist attack)

Behavioral Health Responder / Staff

A behavioral health responder is a person trained to provide specific behavioral health emergency and disaster response services and activities. All CMHC employees engaged in direct behavioral health service provision to consumers are eligible to receive training and to provide disaster response and recovery services, regardless of [college] degree, license or certification. Behavioral health professionals, para-professionals, and lay citizens may be trained as temporary CMHC employees to provide these services through the Crisis Counseling Program in a Presidential Declared Disaster. NOTE: The American Red Cross utilizes only licensed mental health professionals for their Disaster Mental Health program services.

Catchment area

The area assigned by the State for a Community Mental Health Center that defines the geographical boundaries for the delivery of agency services.

Chemicals of Opportunity

Term that refers to chemicals and materials commonly manufactured for general industrial use which are openly stored and transported in extremely large quantities and which may be easily accessible by criminal or terrorist factions for use as a weapon of mass destruction. Often referred by the acronyms: TIC (toxic industrial chemicals), and TIM (toxic industrial materials). Exposure may occur through inhalation, ingestion, or absorption. (See Appendix D, Chart 1)

Category A Biological Agents

Specific micro-organisms or toxins derived from living organisms which cause illness and death in humans, animals and birds and which have been identified by the Center for Disease Control as a <u>High Priority Risk</u> for use by terrorist and criminal factions as a weapon of mass destruction. Category A Biological Agents include: *anthrax, botulism, plague, smallpox, tularemia, viral hemorrhagic fevers.*

Category B Biological Agents

Specific micro-organisms or toxins derived from living organisms which cause illness and death in humans, animals and birds and which have been identified by the Center for Disease Control as a Second Highest Priority Risk for use by terrorist or criminal factions as a weapon of mass destruction. Category B Biological Agents include: *typhoid fever, cholera, salmonella, brucellosis, Q Fever, Ricin.*

Competency Level 1 Training

Disaster training developed by DBH specifically for CMHC behavioral health professionals at all levels of service provision. Competency Level 1 provides an overview of disaster response, disaster management concepts and the general introduction to behavioral health disaster response and recovery roles and responsibilities.

Competency Level 2 Training

The second in a series of three competency based disaster trainings developed by DBH specifically for CMHC behavioral health professionals at all levels of service provision. Competency Level 2 provides detailed instruction on the skills and interventions utilized in disaster behavioral health response and long-term recovery according to the phases and type of disaster.

Competency Level 3 Training

The third in a series of three competency based disaster trainings developed by DBH specifically for CMHC. Competency Level 3 is designed specifically for CMHC supervisory or management staff who will be responsible for conducting behavioral health emergency operations during a major emergency or disaster. Competency Level 3 training provides detailed instruction on writing a CMHC Emergency Operations Plan; writing, submitting and managing Crisis Counseling Program grants from Federal Emergency Management Administration (FEMA) and Center for Mental Health Services (CMHS); managing behavioral health response and recovery efforts in cooperation with local, state and federal emergency management organizations.

Community Mental Health Center (CMHC)

A behavioral health treatment center which provides community based comprehensive mental health and / or substance abuse services to populations of need, in a defined catchment area and organized according to Alaska Statutes, Title 47 and Alaska Administrative Code, Title 7. The State has identified CMHC as the provider of emergency and disaster behavioral health services for all local incidents.

Center for Mental Health Services / Substance Abuse and Mental Health Services Administration (CMHS / SAMHSA)

The Substance Abuse and Mental Health Services Administration (SAMHSA) is an agency of the U.S. Department of Health and Human Services. SAMHSA mission is to improve the lives of people with or at risk for mental health and substance abuse disorders through programs, funding, and technical assistance. The Center for Mental Health Services (CMHS) is a branch department of SAMHSA. CMHS mission is to improve the availability and accessibility of community based services for people with or at risk for mental illness. CMHS supports the Community Mental Health Services Block Grant, and through an interagency agreement with FEMA provides technical assistance, consultation, training, grant administration and program oversight for the Crisis Counseling Program.

Crisis Counseling Program (CCP)

The CCP is one of the services authorized by the Robert T. Stafford Disaster Assistance and Emergency Relief Act (P.L. 93-288 as amended) and available under the Individual Assistance category following an event designated as a Presidential Declared Disaster. CCP services and assistance are provided through funding from FEMA and CMHS / SAMHSA. Funding is provided to state mental health authorities through two separate programs: the Immediate Services Program, (60 days of services) and the Regular Services Program (an additional nine months of services).

Critical Incident Stress Management (CISM)

A comprehensive, systematic, integrated, multi-component and strategic program of crisis intervention services provided to first responder groups, and other groups who have experienced traumatic events. Services are typically provided by a multi-disciplinary team which usually includes personnel familiar with the culture of the groups being served. Services are flexibly utilized according to situation and need and may include debriefing, defusing, crisis management and stress management interventions.

Department

In this plan, "Department" refers to the State of Alaska, Department of Health and Social Services (DHSS).

Emergency Operations Plan

The document that describes how people and property will be protected in disasters and disaster threat situations; details who is responsible for carrying out specific actions; identifies personnel, equipment, facilities, supplies and other resources to be used in a disaster; and outlines how all actions will be coordinated.

Faith-based services

Practical disaster related counseling, crisis intervention and support services provided to affected groups and individuals by clergy or staff of religious organizations. The distinction between general behavioral health services and faith-based services is that the latter focuses on acknowledging and intervening with people based upon their spiritual beliefs and preferences.

Immediate Services Program

A Federal grant awarded through FEMA (Federal Emergency Management Administration) in response to a Presidential Declared Disaster to cover costs of crisis counseling and outreach services provided to populations in the affected community. The grant provides training for the Crisis Counseling Program and covers all related expenses for the first 60 days post-impact. Application is made by the State Mental Health Authority and is due within 14 days of Presidential disaster declaration.

Incident Command System (ICS)

The ICS is a nationally recognized management system used for command, span of control, and coordination of response for emergencies. It provides a standardized means of breaking an incident into its component parts and then assigning one or more people to each part. The ICS establishes an orderly means to coordinate the efforts of multiple individual agencies for the common goal of stabilizing an incident and protecting life, property and the environment.

Incident Management Team (IMT)

The Incident Commander and appropriate Command and General Staff personnel assigned to plan and direct response and recovery activities to an emergency incident.

Local Emergency Planning Committee (LEPC)

Local Emergency Planning Committees were established by Congress under the Emergency Planning and Community Right-to-Know Act (EPCRA). Minimally funded, but developed in most large communities nation wide, the LEPC were designed to provide planning and response for hazardous toxic spills that could occur within their community. The LEPC membership originally consisted of people who held specific political and business positions within each community. Most LEPC though still minimally funded have expanded both scope of mission and membership to provide “all-hazards” planning and response for their respective communities. There are twenty active LEPC in Alaska.

MAC Group (Multi-agency Coordination Group)

The group of representatives of involved agencies and/or jurisdictions who come together to make decisions regarding the prioritizing of incidents, and the sharing and use of critical resources. The MAC organization is not part of the on-scene ICS and is not involved in developing incident strategy or tactics.

Mental Health Response Teams (MHRT)

MHRT are multi-disciplinary teams of behavioral health professionals from local CMHC and other treatment providers including substance abuse programs, which provide initial behavioral health disaster response services in an affected community.

Mutual Aid Agreements (MAA)

A formal, written agreement between a CMHC and other local or nearby community organizations developed for the express purpose of providing coordinated services or resources following an emergency or disaster. These agreements usually outline what services or resources other behavioral health organizations, including substance abuse programs will provide following a disaster, or how these organizations will operate within the community or catchment area in cooperation with the local CMHC. These agreements may also be entered into between the CMHC and recipient organizations such as hospitals, schools, or the local chapter of the American Red Cross which will receive or utilize CMHC services and resources during and following a disaster.

National Incident Management System (NIMS)

A management system which collectively provides a total system approach to all-risk incident management. The system consists of the incident command system, training, qualifications and certifications, support technologies, and publications management

Nerve Agents

Extremely disabling or deadly chemical compounds purposely engineered for chemical warfare. Similar in structure to organophosphate pesticides they exert their biological effects (Appendix D, Chart 1) by inhibiting acetylcholinesterase enzymes. These toxins are difficult to obtain or produce and include: *Sarin, Tabun, Soman, VX.*

Population Exposure Model

A macro-view concept of identifying disaster victims for behavioral health outreach based on gradations of effects and needs across population groups. See Appendix E.

Psychological first aid

Practical interpersonal interventions that target acute stress reactions and immediate needs. The purposes of psychological first aid is to establish safety and physical well-being, reduce stress related symptoms, promote self-efficacy, link to critical resources, and connect to social support.

Regional Coordinator

The DBH staff who is responsible for grant oversight, and for representing the DHSS / DBH Mission with all grantee programs within an assigned region. The Regional Coordinator provides clinical consultation, advocacy, and technical assistance for program design, community planning, and emergency response services to all regional grantee programs.

Regular Services Program

A Federal grant awarded through FEMA and CMHS / SAMHSA in response to a Presidential Declared Disaster to cover long range costs of crisis counseling and outreach services provided to populations in the affected community. The grant provides continuing training for the Crisis Counseling Program, funds positions for outreach counselors and covers all related expenses for six to nine months of services following the termination of the [FEMA] Immediate Services Program (see above). Application is made by the State Mental Health Authority and is due within 60 days of Presidential disaster declaration.

Sociogenic casualties

A sub-population of non-exposed victims of a chemical or biological incident who none-the-less present for medical treatment with somatic complaints that are similar to the symptoms of victims actually exposed to the released agent. This phenomenon occurs in all mass casualty events, and is probably the result of anxiety, uncertainty and the need for reassurance and support. The ratio of this population to actual medical patients is most often greater than 4:1. Often referred to as “worried-well”. (See Appendix D, Chart 1 for details regarding symptom comparison)

Special [Needs] Populations

These are groups of people who, because of age or physical, medical or mental handicaps, require specialized assistance immediately following the impact of a disaster, and possibly for longer periods of time to assure stabilization and healthy recovery. These groups usually include children, some elderly - especially those who may be isolated or who are non-ambulatory, the physically handicapped, the developmentally disabled, seriously mentally ill, and those who are in the initial stages of recovery from alcohol or drug addiction. The Homeless and people who do not speak English as their primary language may also require additional support.

ANNEX H

"Mutual Aid Agreements"

ANNEX I

"Authorities & Plans"

AUTHORITIES and PLANS

Authorities

State

Alaska Statues:

Title 47, Welfare, Social Services and Institutions

Chapter 30 Mental Health

Section(s) 520 – 590

AS 26.23.050 (a). It is the intent of the legislature, and declared to be a policy of the state, that funds to meet disaster emergencies will always be available.

Alaska Administrative Code:

Title 7, Health and Social Services

Chapter 71, Community Mental Health Services

Section 135, "Types of Services and Populations to be Served"

Section 140, "Availability and Accessibility of Services"

Section 145, "Coordination and Continuation of Services"

Changes to Regulations, Effective June 24, 2004

Register 170

In part, provided for change of wording in Title 7, Chapter 71 of Alaska Administrative Code to reflect that the "Department" (DHSS) is the primary administrative state agency for all procedures related to community mental health.

Alaska Administrative Orders (AO):

AO#170, dated January 17, 1997, directed adoption of the National Interagency Incident Management System, Incident Command System (NIIMS/ICS) as the State command and control system for emergency response and recovery operations, and that the NIIMS/ICS be incorporated in all State agency emergency plans. AO#170 also directed that the State establish State Interagency Incident Management Teams (IMT).

AO#202, dated December 2, 2002, directed Office of Management and Budget to conduct internal performance audits of all principal departments. The scope of these audits included: 2. a review of the economy and efficiency with which a department's resources are employed; 6. recommendations for consolidation and reorganization of departments, divisions, and duties and any other recommendation to promote sound and efficient administration.

Alaska Executive Orders (EO):

EO#108, effective July 1, 2003 provided for the transfer of function to the Department of Health and Social Services (DHSS) "for efficient administration and closer coordination of program planning, implementation, and delivery for each affected program".

Memorandum

Dated July 1, 2003 and signed by Governor Frank Murkowski (7/2/03), and DHSS Commissioner Joel Gilbertson (7/1/03), sets forth the new organizational structure for the Department, which in part officially establishes the Division of Behavioral Health.

Plans

Federal:

National Response Plan, December 2004

State:

State of Alaska Emergency Response Plan, 2004

State of Alaska Hazard Mitigation Plan, 2004

DHSS Disaster Response and Recovery Guide, July 2004

Alaska Mass Casualty Plan (Draft), DHSS/DPH, 2004