

State of New Hampshire

Department of Safety Homeland Security and Emergency Management

Disaster Behavioral Health Response Plan

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I. INTRODUCTION:

The events of September 11th and the increased threat of terrorism to citizens of the United States have caused us to reevaluate our disaster planning and response efforts. No longer can we focus our attention primarily on internal situations such as fires or power outages but must expand our focus to include potential mass disasters in our community.

The state of New Hampshire has charged Homeland Security and Emergency Management with the responsibility to coordinate behavioral health preparedness and response activities integrating these efforts with state and local emergency management operations. HSEM provides leadership in addressing the behavioral health needs of disaster survivors including those with mental health, developmental disabilities and substance abuse disorders. HSEM has developed a statewide plan to respond to the behavioral health needs of the State of New Hampshire that arise as the result of a disaster. This plan describes the organization, scope and expectations for provision of disaster preparedness and response activities. This plan encourages the regional community mental health centers to have their own disaster response plans. These plans describe the local agency's responsibilities, area resources for disaster response and community coordination of disaster responses.

HSEM has developed a Disaster Behavioral Health Response Plan to provide an effective, organized system to manage the consequences of emergencies and disasters which impact consumers, staff, and area residents. The response may include immediate crisis intervention, short term and long-term support for emotional needs, community networking, assessment of the scope of disaster and support of first responders. Because a disaster is an unplanned, disruptive event, response and interventions will emphasize the utilization of local resources first such as community mental health services and agencies within the affected area.

This Plan is designed to guide the behavioral health planning, intervention and response efforts relative to disasters of any type. Disaster response will be coordinated with other agencies including the Department of Health and Human Services- Bureau of Behavioral Health, the Office of Community and Public Health, the American Red Cross and in federally declared disasters, the Federal Emergency Management Agency (FEMA) and the Substance Abuse and Mental Health Services Administration (SAMHSA).

This plan outlines preparedness and response guidelines specifying agency and staff roles. The plan also includes important phone numbers and contacts. This planning document is located in HSEM and in the Bureau of Behavioral Health and should be implemented in case of an incident. The Disaster Response Plan outlines the organization of HSEM behavioral health response to disasters, which may impact the services we provide to our citizens of New Hampshire.

Coping with an unplanned event with negative consequences requires careful pre-planning, skilled communication, collaboration and trust among many organizations. The Disaster Response Plan is designed to provide a quick and effective response to disaster situations in order to maintain quality care, safety and security for survivors, their families, disaster workers and volunteers.

II. PURPOSE

- A. To define the method in which the HSEM can support the efforts of local disaster operations by providing specific behavioral health interventions.
- B. To ensure an efficient, coordinated and effective response to the disaster behavioral health needs of the population in time of a disaster.
- C. To identify specific roles, responsibilities and relationships between local, state and federal entities during each phase of a disaster.
- D. To ensure coordination of behavioral health services among the Community Mental Health Centers, American Red Cross -Disaster Mental Health, the Granite State Critical Incident Stress Management Team, the Center for Trauma Intervention, the New Hampshire Disaster Behavioral Health Response Team and other related behavioral health organizations and individuals following a disaster.
- E. To provide disaster crisis counseling services to the citizens of New Hampshire as well as emergency responders in all federal and state declared disasters.

III. PRINCIPLES

- A. All who experience a disaster are affected, in varying degrees, individually and collectively. Witnessing massive destruction and terrible sights evokes deep feelings. Often residents of disaster-stricken communities report disturbing feelings of grief, sadness, anxiety and anger. Everyone who sees a disaster is, in some sense, a victim.
- B. The psychological effects of the disaster will be immediate but also may be long term and potentially not manifest for months or years following the disaster.
- C. Disaster response should be a local response as much as possible. It is essential that planning and response activities consider the ethnic and cultural groups in the community. In addition, programs are most effective if workers indigenous to the community and various ethnic and cultural groups are involved in service delivery.
- D. Disasters require an immediate, coordinated and effective response by multiple government and private sector organizations to meet the medical, logistical and emotional needs of the affected populations.
- E. Different segments of the population will require different levels of behavioral health services, depending on the nature of the disaster.
- F. In a disaster, most victims are normal persons who function well with the responsibilities and stresses of everyday life. However, a disaster may add stress to the lives of these individuals. The signs of stress may be physiological, cognitive/intellectual, emotional or behavioral. These stress reactions are expectable and understandable reactions to an abnormal event. Sometimes these stress reactions appear immediately following a disaster. In some cases, they are delayed for a few days, weeks or even months.
- G. People who have pre-existing stress before the disaster and/or who may have particular needs that merit special attention include: children, disabled, elderly, economically disadvantaged, multicultural and racial groups, people requiring emergency medical care, people who have experienced previous traumatic events,

- people diagnosed as mentally ill or emotionally disturbed, people who lack support networks, and disaster relief workers.
- H. The behavioral health needs of disaster workers and volunteers should be considered in both the planning and response to disasters. Support for these individuals is critical to protecting this valuable resource.
 - I. Disaster victims will be found among all populations in a disaster area. Disaster workers should provide appropriate interventions for all types of disaster victims, including counseling, public education, linkage and referral/advocacy services.
 - J. Because many people do not see themselves as needing mental health services following a disaster and will not seek out such services, a traditional, office based approach to providing services has proven ineffective. Disaster behavioral health responders must actively seek out those impacted by the disaster in community settings such as schools, shelters, hospitals, public meeting places and their homes.
 - K. Interventions must be appropriate to the phase of the disaster. Disaster behavioral health workers must recognize the varying psychological and emotional reactions to be expected during each phase of the disaster. It may be counterproductive to probe for feelings when shock and denial are shielding the survivor from intense emotion.
 - L. Support systems are crucial to recovery. The most important group for individuals is the family. Workers should attempt to keep the family together. Family members should be involved as much as possible in each other's recovery. For people with limited support systems, disaster support groups can be very helpful. Support groups help to counter isolation. Such groups not only provide emotional support, but survivors can share concrete information and recovery tips.

IV. AUTHORITY

The authority for the HSEM Disaster Behavioral Health Response Plan originates from the State of New Hampshire, Emergency Operations Plan-Emergency Support Function – Health and Medical (ESF-8).

The Director of HSEM has overall responsibility for the Plan and will coordinate with various other key local, state and federal agencies to oversee implementation, maintenance, evaluation and revisions of the plan. The Director has delegated operational responsibility for disaster behavioral health preparedness, response and recovery planning, including training and implementation to the Disaster Behavioral Health Coordinator. Other key staff may include, but are not limited to the HSEM Bioterrorism Section Chief, the Disaster Behavioral Health Liaisons and the HSEM Public Information Officer. The Disaster Behavioral Health Coordinator is responsible to ensure that the Plan is reviewed on an annual basis and updated as necessary.

V. SCOPE

The Disaster Behavioral Health Response Plan has been developed to organize the HSEM response to disaster situations ranging from small-scale emergencies to large-scale disasters requiring state wide coordinated efforts. It is based on the premise that emergency response begins and end at the local level. HSEM will collaborate with the Bureau of Behavioral Health in offering comprehensive behavioral health services to survivors of natural or technological disasters, and to those responding to the survivor's needs. This may include residents of N.H., those visiting N.H. or evacuees from other states or countries.

This plan addresses the following priorities:

- Maintenance of essential services to current behavioral health consumers in a disaster.
- Provision of services to meet the acute behavioral health needs arising from a disaster
- Management of the necessary collaboration and coordination with other disaster assistance resources before, during and after the event.
- Provision of training and support for regional disaster behavioral health response teams, first responders, emergency medical personnel and leaders in the Faith community.
- Defining the responsibilities of the HSEM in response to a declared disaster situation.

VI. RESPONSE LEVELS

- A. **Level One Disaster:** Response by local Community Mental Health Center (CMHC) on-duty staff only. Staff will be requested to provide assistance as determined by the CMHC Executive Director or his/her designee.
- B. **Level Two Disaster:** Response by all CMHC available staff, including those who are off duty through notification by the Executive Director. If the Executive Director determines that the local behavioral health resources are not sufficient to meet the needs of the community, he/she may request the assistance of the Disaster Behavioral Health Response Team by contacting the Disaster Behavioral Health Coordinator at HSEM.
- C. **Level Three Disaster:** Response by all available CMHC staff and the regional Disaster Behavioral Health Response Team with additional assistance from neighboring Community Mental Health Centers and Disaster Behavioral Health Response teams from other regions.
- D. **Level Four Disaster:** Response by all available community, State, and Federal resources, activated by an event that overwhelms local systems, and requires assistance from the State or FEMA. Requests for out-of state and federal resources will be made through the Emergency Management Assistance Compact and in the event of a Presidential declaration of disaster, the FEMA Crisis Counseling Program.

VII. PRE-DISASTER PLANNING

- A. **Training and Credentials of Staff**
 1. HSEM will arrange for and provide training for DBHRT members and community mental health center staff to prepare them for the uniqueness of disaster behavioral health approaches.
 2. Specialized training will be offered for all members of the Regional Disaster Behavioral Health Response Teams. This training will focus on the following: intervention skills necessary to respond effectively during all phases of a disaster, the roles and responsibilities of team members, the impact of disasters on individuals, disaster workers and communities, factors associated with adaptation to disaster-related trauma, operational guidelines for applying disaster behavioral

health interventions including psychological first aid, defusing, debriefing, community outreach, death notification and psychoeducational interventions, operational guidelines for disaster behavioral health worker stress management and relationship to other disaster response organizations. The training will consist of a full day of initial basic training and at least one half-day of training annually. In addition, team members are expected to participate in table top and simulated drills to test/ practice their knowledge and skills. Those who complete this training will receive appropriate CEU's and an identification card recognizing them as a member of the New Hampshire Disaster Behavioral Health Response Team. This identification will allow for access to sites in which disaster behavioral health services are being provided; it is recognized by law enforcement agencies.

3. The Disaster Behavioral Health Response Team Leaders will receive additional training relative to their roles and responsibilities.
4. CMHC staff and members of the DBHRT are also encouraged to be trained in the Incident Command System, National Incident Management System and American Red Cross disaster mental health training.
5. HSEM will provide Risk Communication training to public officials on how to communicate effectively with the general public and the media during and after a disaster/crisis. The goal of this training is to prevent fear-driven, potentially damaging public responses to disasters and to foster trust and confidence.
6. HSEM will also offer basic disaster behavioral health training to first responders regarding the psychosocial consequences of disasters and how to maintain positive mental health both during a disaster and throughout the recovery phase.
7. **ESAR VHP**-stands for the Emergency System for Advance Registration of Voluntary Health Care Professionals. This is a national initiative to expedite the registration and credentialing of a variety of healthcare professionals interested in disaster response. Most state and local public health emergency response plans envision the participation of significant numbers of medical and public health volunteers to fill surge capacity and provide necessary expertise. These state-based systems are designed to assess and register state and territorial VHPs to facilitate their interstate and intrastate activities during public health and other emergencies. An application has been developed and mailed out to DBHRT members. CMHC staff at the Board of Mental Health Practice have agreed to assist checking credentials for licensed professionals. Licensed professionals may be classified as Level 1 and may be able to participate in hospital settings. DBHRT members who are not licensed will still be able to participate but may be restricted to non-acute care settings such as shelters, family assistance centers, etc. HSEM is developing a database of behavioral health licensees interested in volunteering in the event of a disaster. This database will be the State Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program, which will be able to link to other States' systems. The database will be used to identify qualified individuals, to effectively utilize their critical skills, and to share that information with other agencies and organizations involved in a coordinated response to a disaster.

B. Orientation to Plan

1. All existing members of the DBHRT will receive an orientation of the Disaster Behavioral Health Response Plan.

2. All new members of the DBHRT will receive an orientation to the Disaster Behavioral Health Response Plan at the DBHRT Basic training.

C. Integration with local emergency management system

1. Every effort will be made to integrate this plan with local and state emergency operations plans so that the various agencies are aware operationally how they will work together during any phase of a disaster event. Planning efforts are coordinated with other disaster response entities such as the American Red Cross, local emergency planning committees, All-Health Hazard Regional Planning Regions (AHRH), local CISM teams, schools, hospitals, volunteer organizations, the faith-based community and any other organizations that have a role in disaster preparedness and response.
2. Formal memorandums of understanding, mutual aid agreements and community partnerships will be included as Appendices to this Plan once they are developed, signed and formalized.
3. Every effort will be made to include members of the DBHRT in all types of disaster drills that occur within their Region. The Disaster Behavioral Health Coordinator will rely on the assistance of the Disaster Behavioral Health Liaisons, the HSEM Exercise Coordinator, hospital emergency preparation representatives, AHRH Point of Contacts and the HSEM Field Representatives in this integration effort.

D. Drills/Exercises

1. Whenever members of the DBHRT are involved in a drill/exercise, a written after action report will be drafted by the Disaster Behavioral Health Coordinator. The report will be reviewed by the HSEM BT Section Chief and presented to the Disaster Behavioral Health Advisory Committee for the purpose of identifying deficiencies and recommending opportunities for improvement based on lessons learned. *Drill Review Report Forms* can be found in **Appendix C**.
2. The Regional Disaster Behavioral Health Response Team will participate in local and statewide disaster drills. Working side by side with traditional disaster response agencies will increase the knowledge of the team members regarding the roles of other disaster responders. In addition, it will increase the knowledge of other disaster agencies regarding the psychological consequences of disasters as well as the roles and capabilities of behavioral health in disaster situations. Furthermore, this involvement will help to establish behavioral health as a regular and essential part of the overall response effort.

E. Maintenance of CMHC Services-Each CMHC should have as a component of their Disaster Response Plan, a provision for the continuation of critical services to current consumers in a disaster. The plan addresses records, medications, and staffing, alternate locations of essential operations and which services could be curtailed or cut back temporarily so that resources may be redirected to areas of urgency. The Plan should be reviewed on an annual basis and forwarded to the Bureau of Behavioral Health. The Disaster Behavioral Health Coordinator and the Disaster Behavioral Health Liaisons are available to consult with the community mental health centers around the development, evaluation and revision of their disaster response plans

F. Disaster-Related Services to be Provided-The following behavioral health services can be rapidly made available to victims of disaster, their families, the general public,

disaster workers and volunteers utilizing resources from the DBHRT, CMHC and other behavioral health providers. Specific services include: 24-hour response capacity, crisis intervention, psychological first aid, outreach, individual and community assessment, screening and referral, CISD/CISM debriefings, crisis counseling, community education, stress management, brief supportive counseling, case management/advocacy, training, and support groups. Services will be appropriate to the phases and needs of each specific disaster.

H. Potential Service Delivery Sites-Disaster behavioral health services may be provided at any of the following sites: Emergency Operations Center, staging areas, morgues, death notification centers, hospitals, disaster affected areas, Red Cross shelters, family assistance centers, mass prophylaxis sites and various community locations conducive to the above mentioned services.

I. Culturally Competent Disaster Behavioral Health Services-Culture refers to the patterns of behavior and belief common to members of a society. It is the rules for understanding and generating customary behavior. Culture includes beliefs, norms, values, assumptions, expectations and plans of action. It is the framework within which people see the world around them, interpret events and behavior and react to their perceived reality. Culturally competent disaster behavioral health services should be designed to respect the uniqueness of cultural influences. These services will work best if provided within the disaster victim's cultural framework. Nine principles govern the development of culturally competent programs:

1. The family, however defined, is critical and usually the focus of treatment and services.
2. Americans with diverse racial/ethnic backgrounds are often bicultural or multicultural. As a result, they may have a unique set of issues that must be recognized and addressed.
3. Families make choices based on their cultural backgrounds. DBHRT members must respect and build on their own cultural knowledge as well as their families' strengths.
4. Cross-cultural relationships may include major differences in worldviews. These differences must be acknowledged and addressed.
5. Cultural knowledge and sensitivity must be incorporated into disaster behavioral health programs, policy-making, administration and services.
6. Natural helping networks such as neighborhood organizations, community leaders and natural healers can be a vital source of support.
7. In culturally competent systems of care, the community as well as the family, determine the direction and goals.
8. Programs must do more than offer equal, nondiscriminatory services; they must tailor services to the populations being served.
9. When services include responders that share the cultural background of disaster victims, the services tend to be more effective.

J. Coordination with Community Mental Health Center Regions. Upon learning of a potential or actual event, or upon being requested to provide disaster behavioral health services, the Disaster Behavioral Health Coordinator will contact the Executive Director of the affected CMHC in an effort to coordinate the behavioral health response. All ten CMHC have collaborated in the development of this statewide plan and have entered into a Mutual Aid Agreement. This agreement states that in the

event of a disaster that impacts the operational capabilities of any Community Mental Health Center or that the extent of the disaster is greater than the “home” CMHC resources to manage the event, the affected CMHC may request assistance from other CMHC. Such request should be made through the Administrator of the Bureau of Behavioral Health.

K. Disaster Behavioral Health Response Teams-The teams are established in five regions throughout the state. The teams are comprised of CMHC staff, public/private mental health counselors, substance abuse providers, human service professionals, clergy, employee assistance program professionals, student assistance program professionals, psychologists, social workers and others who have specific skills and or experience in emergency services, trauma or disaster response. The Disaster Behavioral Health Response Teams have received basic training in disaster behavioral health. Those who complete this initial training will receive an identification card recognizing them as a member of the New Hampshire Disaster Behavioral Health Response Team. The ID card will be recognized by law enforcement personnel and will provide access to the specific sites where behavioral health services will be delivered. Each team’s activities will be coordinated by the Disaster Behavioral Health Coordinator, the assigned Disaster Behavioral Health Liaison and Regional Team Leaders.

L. Roles and Responsibilities

1. BIOTERRORISM SECTION CHIEF

The HSEM Bioterrorism (BT) Section Chief supervises the Disaster Behavioral Health Coordinator (DBHC). They are responsible for reviewing all plans, policies, forms, reports, MOU’s, mutual aid agreements, contracts, etc., prior to implementation. During the disaster response the HSEM BT Section Chief will collaborate with the Disaster Behavioral Health Coordinator to plan the behavioral health response. The HSEM BT Section Chief will determine if the DBHC will be located at the State EOC or in the community affected by the disaster. After the disaster response, the HSEM BT Section Chief will review the After Action Report and Corrective Action Plan. The HSEM BT Section Chief serves as a member of the Disaster Behavioral Health Advisory Committee.

2. DISASTER BEHAVIORAL HEALTH COORDINATOR

Responsible for the overall planning, policy development, management and evaluation of the Disaster Behavioral Health Program. Develops and supervises initiatives to recommend and implement a wide variety of policies and procedures that support program operations and agency goals. Coordinates with the Department of Health and Human Services and Bureau of Emergency Management and other stakeholders as to the need for behavioral health intervention in the disaster events, and the planning and coordinating for provision of behavioral health services to the community, the department’s vulnerable populations, and first responders in the case of a disaster.

Coordinates with the Community Mental Health system and other providers as to provision of care as needed. Evaluates the need for behavioral health related training among DBHRT members, other behavioral health providers, other responders and

coordinates and implements this training as needed. Regularly reviews literature and resources for additional technical information, provides this information to other emergency preparedness agencies and CMHC's and other providers of mental health disaster response, and organizes this information in a reference library available to all. Works with the Office of Public Information and other sources to implement public information projects and mailings, TV and other media announcements, etc. Provides technical assistance to the statewide community mental health centers and other providers as to disaster planning and readiness. Coordinates periodic drills and tests of the preparedness and readiness plans in coordination with other emergency preparedness agencies when appropriate, or independently as needed. In the response phase of disasters, coordinates all response activities from the State Emergency Operations Center (if activated) in conjunction with the Disaster Behavioral Health Liaisons and Team Leaders.

3. DISASTER BEHAVIORAL HEALTH LIAISONS (DBHL)

Non-disaster Status:

Act as liaison to local public health and emergency management systems; attend meetings relative to the public health network and emergency management, planning sessions and table-top exercises as the regional disaster behavioral health representative;

Promote the awareness of behavioral health's role in disaster emergency response by actively networking with volunteer agencies, state agencies, local emergency planning committees, hospitals, etc.

Integrate disaster behavioral health planning efforts with those of public health, public safety and emergency medical entities. Assure integration and coordination of Disaster Behavioral Health Response Plan with State and Local Emergency Operations Plans.

Assist in the development of resources for the general public that will promote resiliency to terrorism, foster coping strategies and assist in understanding the dynamics of disaster preparedness and response.

Create a resource directory of local behavioral health professionals who are willing to provide acute crisis, intermediate and long term behavioral health support to victims, families, vulnerable populations, first responders and the general public.

Advise Disaster Behavioral Health Coordinator of emergency management issues, local needs and planning issues.

Participate in recruitment, development and ongoing training of DBHRT members.

Maintain, stabilize and continue relationship with regional DBHRT members.

Support Team Leaders in their preparedness, mitigation and response efforts.

Participate in planning and operation of disaster drills/simulations.

Disaster Status:

Oversee implementation of Disaster Behavioral Health Disaster Plan at the time of a disaster through liaison with Disaster Behavioral Health Coordinator, Disaster Behavioral Health Response Team Leaders, Community Mental Health Centers and local emergency management officials.

Conduct a needs assessment survey to determine local behavioral health needs;

Assist in the coordination of response and recovery efforts.

Coordinate orientation/pre-deployment briefings for DBHRT members.

Provide leadership in local planning, coordination and collaboration of behavioral health services to disaster victims, as appropriate and necessary.

4. TEAM LEADERS

Non-Disaster Status:

Network with peer agencies/departments to promote awareness of behavioral health's role in disaster response.

Assists DBHL in conducting regional meetings of the DBHRT.

Participate in local disaster drills/simulations.

Maintain contact with State Disaster Behavioral Health Coordinator (DBHC) and Disaster Behavioral Health Liaison.

Disaster Status:

Coordinate orientation/pre-deployment briefings for DBHRT members.

Coordinate field triage for disaster behavioral health services.

Work with State Disaster Behavioral Health Coordinator and DBHL to:

- Conduct an initial community needs assessment.
- Track activity and services provided by team and report to DBHC.
- Schedule post-deployment check-in of team members.

5. DBHRT SQUAD BOSS

Non-Disaster Status: none; this position is used only during deployment.

Disaster Status: In order to avoid exceeding the ICS principle of span-of-control requirements (no more than 5-7 people reporting to one person), the Team Leader may assign Team Members to serve as Squad Bosses to serve as the point persons for a team of 5-7 DBHRT members assigned to a particular site. These subgroups will be termed "squads" and their assigned leader will become the "squad boss." The squad boss will report regularly to the Team Leader as to the current status of the teams efforts, needs (if any) and problems that may arise.

6. DBHRT MEMBERS

The experience, training and qualities that DBHRT members possess make them uniquely qualified to provide counseling and supportive services immediately after disaster events. The roles of DBHRT members as well as the location and types of services that will be offered after a disaster event are defined by the type and impact of the event. The behavioral health response to disasters is community-based. The roles and responsibilities of DBHRT members are diverse. Team members may be asked to provide a variety of behavioral health services in a disaster response.

During the response phase, providing support is often what is most needed. Team members may be asked to do rapid needs assessments, provide immediate counseling services and outreach, or even assist the medical examiner's office in death notification. Team members will be assigned based on need and skills. Skills most

needed for mass casualty disaster work include training and experience in PTSD, trauma, bereavement and Critical Incident Stress Management.

Team members with skills in grief and bereavement may be assigned to assist with death notification, follow-up and community outreach to churches and schools. Team members with skills in crisis intervention and Post Traumatic Stress Disorder (PTSD) are best assisting those injured as well as witnesses and those who assisted with the initial rescue attempts. They can also be a vital support to those too overwhelmed to seek counseling services and those who are fearful about the health and welfare of those still missing, by providing support to crisis hot lines set up in the immediate aftermath of such disasters.

Team members with backgrounds and experience in family counseling are often best suited to support those waiting for information about missing family members, staffing the perimeter area where mourners are frequently drawn, and working in shelters and family assistance centers. Those with training and experience in CISM can be used in a variety of settings, debriefing or defusing emergency workers volunteers at the disaster site, family assistance centers, temporary morgues, hospitals churches and schools.

Members of the faith-based community may be paired with the medical examiner and behavioral health response team members to serve on death notification teams.

Whenever possible, team members will be assigned to work in teams of two. If there are enough team members to allow this arrangement, team members may work with other members of their team or with emergency medical personnel, Red Cross workers or other human service-type disaster responders. This ensures a system by which team members can serve as a check-and-balance for each other in assessing needs, making decisions, setting priorities, etc. in the chaotic disaster environment.

DBHRT Incident Command System Roles

DBHRT Leader-Interfaces with the Incident Commander and other behavioral responders such as the Red Cross, American Psychological Association, etc. Is the primary contact for members of the DBHRT who are being deployed to a disaster site(s). Ensures Disaster Behavioral Health Liaisons and Disaster Behavioral Health Coordinator are informed of community needs, status of operations, services being provided and additional support required.

Logistics Section Chief-Responsible for providing or arranging for facilities, services, supplies, materials and personnel necessary for an effective response. Coordinates the assembling and distribution of all support resources. Manages issues such as transporting teams to disaster sites, maintaining communications, identifying facilities in which services will be provided and ensuring that team members are fed, etc.

Planning/Intelligence Section Chief-Responsible for collecting, evaluating and disseminating tactical information. Obtains situation status reports. Identifies status of current resources available. Assists Team Leader(s) in establishing goals of response effort and strategizes how to meet them. Assists in the development of incident action plans for long-term events. Involved in the demobilization process and after action critique.

Operations Section Chief- Directs and coordinates (how to get it done) behavioral health activities targeted toward reducing the immediate psychosocial threats to the community and in restoring the community to normal mental health. Ensures safety of team members. Keeps Team Leader apprised of the ongoing situation

Finance Section Chief-Established typically for long-term events. Tracks costs and arranges for procurement of materials. Is primarily responsible to ensure that documentation is completed thoroughly and in a timely fashion. (This is especially important if it is a Presidentially declared disaster and there will be an application for federal funds.) Compiles information for reimbursement. Orients team members regarding completion of time sheet and other forms as required.

VIII. DISASTER RESPONSE

- A. **Disaster Declaration**-Emergencies generally fall into three categories. The categories indicate the severity of the disaster, offer guidance about the level of involvement that can be expected from HSEM– Disaster Behavioral Health services and provide information regarding the likelihood that Regional Disaster Behavioral Health Response Teams will be mobilized to address community needs.
1. **Local Disaster**-A local disaster is any event, real or perceived, that threatens the well being of citizens in one municipality. It is confined geographically to a small area and primarily has impact only on persons living in that area. A local disaster is manageable by local officials without a need for outside resources. Local government such as police, fire, ems, health and municipal officials handle the response. The decision to involve the Disaster Behavioral Health Response Team is made on a case-by-case basis in concert with local officials. There is no set time for response to a local disaster. Costs associated with response to this type of disaster are not reimbursable by state or federal sources.
 2. **State Declared Disaster**-A state disaster is any event, real or perceived, that threatens the well being of citizens in multiple towns, cities, or regions or overwhelms a local jurisdiction's ability to respond, or affects state owned property or interests. Only the Governor, or their designee, can declare a state of emergency in New Hampshire. Response and recovery is the responsibility of HSEM. A response by the Disaster Behavioral Health Response Team may be required depending on the magnitude, nature and duration of the emergency. HSEM may supplement local resources with state employees and/or call upon Disaster Behavioral Health Response Teams from the other regions to assist. The duration of response is generally limited to the duration of the event, or until it is

determined by the Governor's Office and HSEM that a response is no longer necessary. Costs associated with response to this type of disaster are not reimbursable by federal sources.

3. **Federally Declared Disaster**-A federally declared disaster is any event, real or perceived, that threatens the well being of citizens in multiple locales throughout the state and overwhelms the local and state ability to respond and recover, or the event affects federally owned property or interests. In addition, a federal disaster may be declared in response to a catastrophic event that threatens an entire region of the country or the entire nation. Only the President of the United States can declare a federal disaster. A response will be required in accordance with the actual or perceived need. If the disaster is of sufficient severity, HSEM may deploy state employees and/or Disaster Behavioral Health Response Teams from other regions to assist in meeting local or statewide needs. The duration of the response will encompass the duration of the event or until it is jointly determined by the Governor's Office and HSEM that a response is no longer needed. The duration of behavioral health activities supported by federal funds will be determined by the terms of a Federal Crisis Counseling Program Grant, if such funds are sought by the State Authority, and subsequently awarded by federal authorities.

B. Procedures for Activating the Plan

The following are general guidelines. In all instances, the magnitude of the disaster shall be the determining factor regarding the response by the HSEM. Local emergency management entities and HSEM are expected to be proactive in assessing whether they need to respond to a local incident and in determining the need for outside assistance.

1. **Disaster Notification**-HSEM may receive notification of an actual/potential disaster from a variety of sources, including but not limited to local hospitals, schools, public safety agencies or federal agencies such as FEMA. The Disaster Behavioral Health Coordinator is available 24/7 to receive notification of a disaster and the request for DBHRT activation from any of the above sources. In the absence of the Disaster Behavioral Health Coordinator, the Disaster Behavioral Health Liaison shall serve as back up. When such notification is received, the Disaster Behavioral Health Coordinator (or Liaison) will immediately notify the HSEM BT Section Chief, the Administrator of the BBH, the Executive Director of the affected regions Community Mental Health Center and the Disaster Behavioral Health Liaison assigned to the region in which the disaster is occurring. The essential information to be obtained from the notification source includes: the type and cause of the disaster incident, the approximate time and place the disaster occurred or is expected to occur, the number and condition of person(s) involved, the current response plan (if any), the location of the EOC (if established), the source for obtaining continued information, the name/title of caller and return phone number to verify information. This information will immediately be given to the Director of the HSEM by the BT Coordinator. The HSEM Director, or their designee, is the only one authorized to activate the HSEM Disaster Behavioral Health Response Plan.

2. Requesting DBHRT Support/Services

- A. HSEM is the single point of contact to request the assessment of behavioral health needs following a critical incident or large-scale event that requires activation of the DBHRT.
 - B. If a locality determines that their existing resources are either insufficient or have become exhausted in response to an incident, they should call HSEM at 271-2231 or 1-800-852-3792 to request assistance. This request can originate from a community mental health center (CMHC), school, Red Cross Chapter, hospital, Incident Commander, etc. The HSEM Duty Officer is available 24/7 to then contact the Disaster Behavioral Health Coordinator (DBHC). The DBHC will then contact a Disaster Behavioral Health Liaison (DBHL) and/or Team Leader(s) and request that they report to the incident site and meet with local officials to begin information gathering for the incident.
 - C. The DBHL or Team Leader will work closely with local community mental health centers and other local officials to determine the scope of the disaster, local behavioral health resources and needs for continued behavioral health services. The *Initial Community Needs Assessment*-(see Appendix C) form may be used for this purpose.
3. **Coordination with other Behavioral Health Responders**-Upon receipt of the initial information, the Disaster Behavioral Health Coordinator in concert with the Disaster Behavioral Health Liaison, Team Leader and local officials will assess the situation and make a preliminary determination as to the nature and scope of the response. Depending on the scope, the DBHC will collaborate with other key personnel such as the HSEM BT Section Chief, the Disaster Behavioral Health Liaison, the Administrator of the Bureau of Behavioral Health and the CMHC Executive Directors to assist in coordinating a response. The local community mental health center will always be contacted by the Disaster Behavioral Health Coordinator or the Disaster Behavioral Health Liaison to coordinate efforts and plan for a response. Typically, other behavioral health related resources might also respond to an event. These may include the Red Cross, Community Mental Health Centers, the Granite State CISD team or other local debriefing teams. All behavioral health assets should report to the local Incident Commander for the disaster incident. The Incident Commander will determine how best to use all available resources.

(Does this really need to be in here – it’s the IC’s decision on what to do – doesn’t really belong in the DBHRT Plan. It may be that the Granite State CISD team will focus on the needs of the first responders while DBHRT addresses the needs of victims and families. Coordinating resources is a key logistical function under the Incident Command System.)

The Disaster Behavioral Health Coordinator will determine, based on need, the number of DBHRT members and/or the number of DBHRT to activate. The Disaster Behavioral Health Coordinator will contact the Disaster Behavioral Health Response Team Leader(s) to alert him/her that their DBHRT may be mobilized.

4. **Activation/Deployment of DBHRT**-The DBHRT is a state resource comprised of volunteer behavioral health professionals who either work or live in the affected area that can be requested when, in the opinion of local officials, existing resources are not sufficient to meet the needs of the affected population. There may be instances in which DBHRT learns of an event and contacts the local authorities to make them aware of DBHRT services. DBHRT will not “show up” until requested by local authorities or assigned by the Governor. It is imperative that team members not report to an event site until they are officially activated by the DBHC. There may be instances in which a Regional DBHRT is placed on **ALERT** status. This may occur when there is advance notice of a potential disaster for which the DBHRT may be activated. If a disaster is currently underway, a neighboring Regional DBHRT may be activated to relieve the Regional DBHRT currently involved in a response. Depending on the scope and magnitude of the event, the DBHRT Regional team in which the event is occurring will be activated first. Additional Regional teams may be placed on **ALERT** status for relief, to provide debriefing services to DBHRT members from another region or if the scope/magnitude of the event increases.

In large-scale event, the **Health Alert Network (HAN)** shall be employed to notify DBHRT members of:

- ❖ The nature of the event;
- ❖ Where to report (location of behavioral health staging area);
- ❖ Whom to report to (in most cases this will be the Team Leader or the Disaster Behavioral Health Liaison) ;
- ❖ What to bring (DBHRT ID badge, clothing, flashlight, personal meds, etc).

In smaller scale events, the DBHC/DBHL, or their designee, shall contact DBHRT members by phone, pager or e-mail to request their services. The following information will be communicated to those DBHRT members who are able to respond:

- ❖ The nature of the event;
- ❖ Where to report (location of behavioral health staging area);
- ❖ Whom to report to (in most cases this will be the Team Leader or the Disaster Behavioral Health Liaison);
- ❖ What to bring (DBHRT ID badge, clothing, flashlight, personal meds, etc).

It is imperative that DBHRT members inform the DBHC of any changes in their contact information (e.g. e-mail, phone, pager, etc).

Team members are encouraged to develop their own personal “go kits” that may include a change of clothes, flashlight, personal medications, eyeglasses, etc., that is readily accessible if they are activated.

The DBHRT member should give an estimated time of arrival at the BH Reporting Area or indicate if they are able to report for a second shift, if one is necessary.

5. **Incident Command System (ICS)**-All parties involved in disaster behavioral health response will utilize the ICS for centralized decision-making and coordination of information. ICS is organized into five functions: command, operations, planning, logistics and finance/administration. Once the ICS is initiated, an Incident Commander (IC) has the overall responsibility for the

effective site management of the incident and must ensure that an adequate organization is in place to carry out all emergency functions. In minor incidents, depending on the severity, any or all functions may be managed directly by the IC. Larger incidents usually require that one or more of the functions be set up as separate sections or functional roles under the ICS. The DBHL and the Team Leader will discuss whether or not the event requires assignment of team members to Incident Command System roles. If the event requires ICS roles for DBHRT members, they will determine which DBHRT members are best suited to these roles to support the efforts of the Team Leader and the DBHRT response effort. (See DBHRT ICS Roles in Section VII-L.).

6. **Disaster Behavioral Health Reporting Area** will be established in concert with local officials. The Behavioral Health Reporting area is the location where team members report for briefing/orientation, breaks, maintain contact with their families, hold team meetings, provide confidential services and receive post deployment check-ins prior to leaving their shift. This reporting area will be the coordination area for the local disaster behavioral health response activities. The disaster behavioral health reporting area will be staffed for as long as necessary and shall serve as the focal point of contact between state level coordination and local needs, including gathering information about resource needs. The location, phone numbers and fax number of the Reporting Area will be communicated to the State EOC at HSEM, DHHS, the local CMHC, the American Red Cross and the local emergency management authority. Upon arrival at the behavioral health reporting area, the DBHRT member should seek out the contact person (most likely the Team Leader or the DBHL) and inform them of their arrival for deployment. As team members arrive at the behavioral health reporting area, the following information must be recorded in the ***DBHRT Activation/Check-In/Deployment Form***: date/time of arrival, name, cell phone # (if any) and special skills they may have. The Team Leader will record where team members will be deployed, when they check out and if they have been debriefed at the end of the shift. Team Members will be reminded to wear their DBHRT I.D. badge in a visible place as it provides access to locations that are inaccessible to the general public. The location of the Disaster Behavioral Health Coordinator will be situation dependent. They may be located in the Disaster Behavioral Health Reporting area or at the State EOC to assist to coordinate the behavioral health response between the state and the local area(s) affected.
7. **CMHC Employee Emergency Notification**In the event of a disaster, CMHC employees may need to be recalled to provide coverage for essential services or disaster response. The Emergency Services Directors of the CMHC will utilize their emergency notification call list to contact staff at home and notify their respective employees of the disaster declaration and staffing needs. This call list will be updated as needed, or at least semi-annually, by the Emergency Services Director. When notified, staff will be informed of the site to report to for orientation and deployment.
8. **Emergency Contact Information**-An up-to-date call list including HSEM BT Section Chief, Administrator of the BBH, Disaster Behavioral Health Coordinator, CMHC Executive Directors, CMHC Emergency Services Directors, Disaster Behavioral Health Liaisons and Disaster Behavioral Health Response

Team Leaders will be maintained and updated on a regular basis. This list (*Appendix D*) will include the home phone number, work phone number, cell phone number, pager number, fax number and home address.

C. Assessment of Community Need

1. An initial community needs assessment will be conducted by the Disaster Behavioral Health Liaison and/or the Regional Team Leader utilizing the *Initial Needs Assessment Form. (Appendix C)*. The assessment shall evaluate: the nature of the event, the location where survivors are being assisted, the estimated number of survivors, the magnitude of the disaster with regard to casualties and damage incurred, response entities on the scene, if local behavioral health resources have been requested or are on the scene, the behavioral health status and needs of the community including special needs issues, the capacity of staff/team members from the affected area to respond and the needs of community leaders/general public in the affected area.
2. The assessment should address the needs of survivors, their families, bystanders, witnesses, first responders and the community at large. An assessment of the scope and magnitude of the event and the number of people affected directly and indirectly should be carried out as quickly as possible. Psychological first aid, crisis counseling, and public education will be made available immediately for people in the community directly impacted by the disaster.
3. Once completed, the Disaster Behavioral Health Liaison shall contact the Disaster Behavioral Health Coordinator to report the initial findings of needs and recommendations for behavioral health response. The DBHL will maintain contact with the DBHC, providing reports as necessary.
4. HSEM will activate the State Emergency Operations Plan when there may be the threat of a disaster or if one occurs without warning. At the request of the local emergency management authority, the Disaster Behavioral Health Liaison and/or the Regional Team Leader will work with the local officials to determine the full impact of the event and needs resulting from it. The needs assessment will form the basis for determining the resources and support needs of the affected area. The Disaster Behavioral Health Coordinator will coordinate the activation and deployment of Disaster Behavioral Health Response Team members.
5. The Team Leader will utilize information obtained from the initial needs assessment to orient arriving DBHRT members of the scope/nature of the event, potential services to be delivered, sites and potential problems that may be encountered.

D. Mobilizing the Disaster Behavioral Health Response Team

1. Once the disaster has been declared, locally, statewide or federally, the Disaster Behavioral Health Coordinator upon receiving instruction from the HSEM BT Section Chief, will begin to activate the Disaster Behavioral Health Response Team and instruct them to assemble at a designated site(s). The composition and size of the DBHRT will be determined by the type of disaster, the number and composition of those potentially requiring support and the location of the response sites.

2. The team will be briefed by the Team Leader or the Disaster Behavioral Health Liaison before being deployed to the field (see ***Briefing/Orientation Checklist, Appendix C***) regarding the scope of the disaster, potential problems that may be encountered, special needs clients, the locations where survivors are being assisted, the services that they will be providing, safety issues, existing community resources, communications, travel, contact persons with other organizations, reporting requirements/documentation, schedule of work times, work sites, specific roles and responsibilities, the frequency of meetings that will be expected of the response team and the frequency of periodic update meetings. In addition to addressing the logistical issues, the briefing should also prepare team members emotionally for their disaster experience as much as possible.
3. At this time, the team will also receive special instructions regarding safety issues, reporting, maintaining contact with the Team Leader at the Behavioral Health Reporting Area, work sites and other disaster specific information.
4. Team members will then be given their assignments and deployed with necessary supplies from the “Go Kits”. The Team Leaders will distribute materials from the “Go Kits”, forms, hand-held radios (if necessary) and key contact numbers to team members before they are deployed to the field. In most cases, team members will be issued a red, reflective vest with the term, “DBHRT” on the back. The purpose of the vest is to ensure team members are easily identifiable to each other and other responders. Team Leaders may organize their members into smaller teams (squads) for purposes of carrying out specific functions like debriefing responders, providing outreach to shelters and congregate sites, etc.
5. Documentation- Team members should record significant actions they have taken on the ***Disaster Action Log (Appendix C)***, such as key people, phone numbers, actions taken, things to follow up and issues to bring up at a team meeting. Other forms may be used to record types of services provided and general estimates of people served.
6. The Disaster Behavioral Health Response Team Leader will ensure that a post deployment check-in plan is in place for members of the Disaster Behavioral Health Response Team prior to their leaving their shift.
7. The Disaster Behavioral Health Leadership (Coordinator, Liaisons and Team Leaders) will meet daily, if possible, to review the status of the response, emerging needs/ requirements, assign tasks and areas of responsibility.

E. Deactivation of DBHRT Members

1. Team Leaders will check in regularly with their team members to process the day’s work, discuss challenges and potential solutions. The Team Leader will collect team member’s reports prior to their release and determine the availability of each team member for subsequent rotations if necessary. The departing DBHRT member will check with the Team leader prior to departure. The Team Leader will collect all materials such as radios, vests, go kit materials, etc. and record the time out and whether or not the team member participated in a post deployment check in on the ***DBHRT Activation Check In and Deployment***

Form. (Appendix C)

2. **Post-Deployment Check-In:** This is an opportunity for all team members involved in the disaster to deal with the emotional effects of the experience and to exchange information for purposes of planning and coordinating services. The purpose of the post deployment check-in is for the team to share their impressions of the disaster event, address their emotional responses, discuss their specific roles and their evaluate their effectiveness in providing services. All team members are encouraged, but not mandatory, to attend a post-deployment check-in at the end of every shift. It is important to provide an opportunity for team members to talk about any emotional reactions they may have experienced in the course of the day's work. Having fellow team members share their experience can be beneficial and will give the Team Leader an objective monitor of team's level of stress. The provision of disaster behavioral health services is stressful and challenging work. Staff may be exposed to significant traumatic situations. Provisions will be made for a post deployment check-in for all members of the Disaster Behavioral Health Response Team as well as any support staff who require it. This may occur individually or in a group format. Post Deployment Check-In is a specific skill and will only be provided by the Team Leader or a qualified designated member of the Disaster Behavioral Health Response Team.
3. A more formal debriefing to DBHRT members may be offered at a later time, as needed. Debriefings will also be made available by trained members of the Disaster Behavioral Health Response Team to any of the following disaster workers: law enforcement, Red Cross, fire department, public works, National Guard, emergency medical, public health, volunteers and other disaster workers as appropriate.
4. After an assignment, DBHRT members are encouraged to express their gratitude to those who have covered their usual responsibilities at home and at work after an assignment. Members are expected to feel "out of sorts" for a while, they may experience an adjustment period, mild depression and possibly a physical letdown. If, however, these feelings continue for more than two weeks, they are encouraged to contact their Team Leader, the Disaster Behavioral Health Coordinator or a mental health professional for additional assistance.

F. Communication Plan

1. The purpose of the communications plan is to provide: immediate, accurate information necessary to initiate proper response, ongoing information necessary to meet emerging needs and reliable information necessary to dispel rumors.
2. Disaster Behavioral Health Liaisons, Team Leaders and members of the Disaster Behavioral Health Response Teams will be notified of a disaster according to the procedures outlined in the "*Procedures for activating the plan*" section VIII-B.
3. The CMHC Executive Director or his/her designee should contact the Disaster Behavioral Health Coordinator at the State Emergency Operations Center to inform him/her about actions being taken and provide him/her with contact names and information.
4. The BBH should be kept informed as to what is being done by the local CMHC and DBHRT.

5. All communication with the media regarding any disaster situation must be coordinated through the HSEM Public Information Officer to ensure that information is given in a consistent and appropriate manner. All media requests should be referred to the HSEM Public Information Officer, who will maintain communications with the media and preserve confidentiality of survivors and their families.
6. HSEM will respond to inquiries from the media through the public information office delivering information to the public through broadcast, print and web-based media. Public meetings at schools and other community sites may be held when appropriate.
7. HSEM has prepared educational materials for public dissemination that address the psychological impact of terrorist attacks and how individuals and families can cope with such treats or events. These materials will be available in several languages, in special formats for non-readers and for persons with other communication needs. These materials are located in the Go Kit Contents (**Appendix G**).
8. Regular updates to the HSEM website will be provided regarding disaster response and recovery activities. The website section for Disaster Behavioral Health can be visited at .
<http://www.nh.gov/safety/divisions/HSEM/behavhealth/index.html>. In the Library section of this page there are articles, the Disaster Behavioral Health Resource Directory and a list of disaster behavioral health related materials, which can be accessed through the NH State Library.

IX. POST DISASTER SERVICES AND ACTIVITIES

A. Recovery Services

1. Brief Supportive Counseling-Brief supportive counseling will be provided to survivors and their families, as well as, other community members affected by the crisis.
2. Psychological First Aid-This intervention is typically used in the immediate aftermath of a disaster and seeks to promote safety, create calm, orient survivors, connect them to social supports, support positive coping and instill hope.
3. Crisis Counseling-The Disaster Behavioral Health Response Team, clinical staff of the local CMHC and other behavioral health providers will provide short-term intervention with individuals and groups experiencing psychological reactions to a major disaster and its aftermath. Crisis counseling assists people in understanding their current situation and reactions, reviewing their options, addressing their emotional support and linking with other individuals/agencies who may assist the disaster survivor. FEMA funded crisis counselors will be professionals indigenous to the affected area.
4. Case Management and Advocacy-The Disaster Behavioral Health Response Team will link survivors and their family members to appropriate behavioral health services. Special emphasis will be placed on assisting those individuals and families when it is apparent that short term counseling is not sufficient to address significant issues related to trauma and bereavement.
5. Community Outreach and Public Education-The Disaster Behavioral Health

Response Team will provide outreach and public education to affected groups in the community. These activities will be targeted to broad segments of the community and will focus on enhancing naturally occurring supports in order to minimize the impact of the disaster.

6. Information Dissemination-The DBHRT and the local CMHC will work in collaboration to provide general information to the public for the dissemination of crisis and disaster information to schools, churches, disaster relief centers, community groups, hospitals, government offices, etc.
7. Screening and Assessment-Community based services for screening, assessment and referral in the initial phase of the disaster will be expanded to include ongoing assessment, service planning /coordination and outcome evaluation.
8. Support Groups-The DBHRT and the local CMHC will sponsor the development of a network of support groups that address the needs of several of various populations.
9. Grief Counseling and Death Notification Support-The DBHRT and CMHC staff will provide grief counseling and support during the death notification process at morgues, mortuary facilities and any other site in which disaster behavioral health services are being provided. A mental health professional who specializes in grief counseling should be present at all times to supervise the provision of this service. Team members and CMHC staff may also be required to assist in notifying the victim's immediate family of his or her death.

B. Evaluation of Effectiveness of Response and Revision of Plan

1. After an incident or disaster event a meeting should be convened as soon as possible to review the response and performance of the DBHRT and the overall disaster behavioral health response.
2. The meeting may include the Disaster Behavioral Health Coordinator, HSEM BT Section Chief, the BBH, the Disaster Behavioral Health Liaisons, Team Leaders and others who may have played a significant role in the behavioral health response. The meeting should result in an assessment of how well the disaster plan, policies and procedures assisted or impeded the response and delivery of services.
3. Once problems have been identified, the Disaster Behavioral Health Coordinator will develop a Corrective Action Plan with recommendations to improve the preparedness, response and recovery activities. This Plan will be forwarded to the HSEM Director, BBH Administrator and Disaster Behavioral Health Advisory Committee for review.
4. The Disaster Behavioral Health Response Plan will be revised based on these recommendations and lessons learned.
5. The Disaster Behavioral Health Response Plan will be reviewed on an annual basis by the Disaster Behavioral Health Advisory Committee. The Disaster Behavioral Health Coordinator will ensure that appropriate changes are made to the Plan, dates of revision recorded and distributed to the proper authorities.

C. Application Process for Federal Assistance

1. In the event of a major disaster, it may become necessary to seek federal assistance to support the efforts of the Community Mental Health Centers and the Regional Disaster Behavioral Health Response Teams. The President is authorized to provide professional counseling services, including financial assistance to state or local agencies or private mental health organizations, to

provide such services or training of disaster workers and to victims of major disasters in order to relieve mental health problems caused by or aggravated by such major disasters or its aftermath. The President must declare a disaster in New Hampshire in order for the state to apply for Crisis Counseling Assistance and Training (CCP) Program grant(s), which would provide for emergency behavioral health services to disaster victims who live and/or work in the affected area. These programs are funded through the Center for Mental Health Services (CMHS) in collaboration with the Federal Emergency Management Agency (FEMA), as mandated by the Robert T. Stafford Disaster Relief and Recovery Act. New Hampshire may apply for one or both of the following grants: Immediate Services Grant and Regular Services Grant. Both grants provide support for a range of emergency behavioral health services to an area impacted by disaster if the state's resources are not sufficient to meet the need. These grants can support services such as crisis intervention, outreach, consultation, brief supportive counseling and community education.

2. The crisis-counseling program for survivors of major disasters provides support for direct services to disaster survivors. Disaster survivors are eligible for crisis counseling services if they are residents of the designated major disaster area or were located in the area at the time of the disaster. In addition, they must 1. have a mental health problem that was either caused or aggravated by the disaster or its aftermath or 2. they may benefit from preventative care techniques. This program has been developed in cooperation with FEMA and the CMHS within the Substance Abuse and Mental Health Services Administration (SAMHSA).
3. Assistance under this program is limited to Presidentially declared disasters. Moreover, the program is designed to supplement the available resources and services of state and local government. Thus support for crisis counseling services to disaster victims may be granted if these services cannot be provided.
4. The Office of the Governor will determine whether FEMA Crisis Counseling funding will be requested. The Governor will appoint a Governor's Authorized Representative (GAR) to make all requests for federal disaster assistance. Requests for funds under both the Immediate and Regular Services Program must be made by the GAR. The recipient of support may be a state agency or its designee such as a Community Mental Health Center. The Bureau of Behavioral Health in collaboration with HSEM will be responsible for developing the grant application; the support is not automatically provided.
5. An assessment of need for crisis counseling must be initiated by the state within 10 days of the presidential disaster declaration. The needs assessment must demonstrate that disaster-precipitated mental health needs are significant enough that a special mental health program is warranted which cannot be provided without federal assistance. There are two types of support: Immediate Services Grants and Regular Services Grants; funds for both types of support come from FEMA. When applying for either type of federal assistance, the following concerns need to be addressed: attention to high risk groups such as children, elderly and the disadvantaged and maximum use of available local resources and personnel. Programs should be adapted to meet local needs, including cultural, geographic and/or political constraints.
6. Support for Immediate Services must be requested in the form of a "Letter of Request" within 14 days of the date of disaster declaration by the GAR to the FEMA Disaster Recovery Manager (DRM). The application for Immediate Services must include the state's assessment of need, initiated within 10 days of

the disaster declaration. An estimate of the size and cost of the proposed program is required. HSEM in collaboration with the Bureau of Behavioral Health will address each of the following issues for each jurisdiction that is requesting funds: extent of need, state resources and program plan. Support may be provided for up to 60 days after the date of the presidential disaster declaration. When the Immediate Services Grant is exhausted, the state may apply for the FEMA Regular Services Grant, which, if approved, extends the federally funded emergency services for an additional nine months.

7. Regular Services Grant funding must be requested within 60 days of the date of the presidential disaster declaration. The GAR must submit the application to the FEMA Assistant Associate Director, through the FEMA Regional Director and simultaneously to the Emergency Services and Disaster Relief Branch, CMHS. The application for Regular Services must include: a disaster description needs assessment, program plan, staffing and training, and resource needs and budget. The Regular Program is limited to nine months except in extenuating circumstances when an extension of up to three months may be requested.
8. The grant application will include a description of proposed services, budget, description of the organizational structure, staffing and training requirements, job descriptions, facility and equipment requirements, and the process of record keeping and program evaluation.

D. Reporting Requirements/Documentation

1. HSEM and the affected local CMHC will work together to collect data on the demographics of the disaster affected areas, services provided, staff deployed, populations served etc for the purpose of completing FEMA or other grant applications. Reimbursement may depend on the thoroughness and accuracy of documentation. **Appendix C** has copies of several forms that can be used to capture this information.
2. Training sessions for members of the Disaster Behavioral Health Response Teams and CMHC staff will describe the instructions for completing forms. Also, during the initial briefing/orientation for DBHRT members reporting to the Behavioral Health Reporting Area, a quick review of reporting requirements/documentation will be conducted
3. The following types of information should be retrieved and recorded:
 - Daily record of services provided such as individual counseling sessions, group counseling sessions, educational presentations, support groups, etc.
 - # of participants/recipients
 - Situation reports
 - Materials distributed
 - Staff utilized/allocated
 - Expenditures
 - Initial community needs assessment
 - Daily needs assessment
 - Follow up, if required
4. The type of and frequency of reports will be determined by the Disaster Behavioral Health Coordinator.

E. Equipment and Supplies

1. Logistical planning and support for transportation and deployment of supplies, equipment and personnel shall be arranged by the Disaster Behavioral Health

Coordinator. A member of the DBHRT may be assigned to manage the behavioral health resource needs during the disaster.

2. The Operations and Logistics Sections of the SEOC will ensure provision of food, supplies and equipment to support the DBHRT operations.
3. The Information & Planning and Logistics sections of the SEOC will coordinate the provision of hardware, software and communication equipment needed by the DBHRT.
4. Each Disaster Behavioral Health Liaison will have “Go Kits” stored at their primary offices that include forms, pens, screening instruments, coping tip handouts, fact sheets, A.A. meeting lists, educational materials and referral directories. A quantity of “Go Kit” materials is stored at HSEM and can be delivered to any site in which behavioral health services are being provided in a timely fashion. A list of *Go Kit Contents* can be found in **Appendix G**.

APPENDIX A
DEFINITIONS

DEFINITIONS

- A. Crisis Counseling**-A short-term intervention with individuals and groups experiencing psychological reactions to a major disaster and its aftermath. Crisis counseling assists people in understanding their current situation and reactions, reviewing their options, addressing their emotional support and linking with other individuals/ agencies that may assist the disaster survivor. It is assumed that, unless there are contrary indications, the disaster survivor is capable of resuming a productive and fulfilling life following the disaster experience if given support, assistance, and information in a manner appropriate to the person's experience, education, developmental stage and ethnicity. Crisis counseling does not include treatment or medication for people with severe and persistent mental illnesses, substance abuse problems or developmental disabilities.
- B. Crisis Counseling Program (CCP)**-Funded by FEMA through the Robert t. Stafford Disaster Relief and Emergency Assistance Act (P.L. 93-288 as amended by P.L. 100-707), it is formally known as the Crisis Counseling Assistance and Training Program. The CCP involves direct interventions as well as crisis counseling to individuals and groups impacted by a major disaster or its aftermath. Educational activities and public information on disaster mental health issues are another component of the CCP. In addition, disaster mental health consultation and training are also provided.
- C. American Red Cross (ARC)** - A humanitarian organization led by volunteers and guided by its Congressional Charter and the Fundamental Principles of the International Red Cross Movement that provides relief t survivors of disasters and or relief workers within 48 hours of the disaster event. CISD has three goals: 1) to reduce or prevent Post Traumatic Stress Disorder (PTSD) by helping victims tell their story, unload their emotions and access their coping skills; 2) to offer support with the healing process; 3) to reduce costs to the employer for lost productivity and health and human costs due to untreated trauma. Only professionals trained in CISD should perform this process. This specialized technique is not crisis counseling.
- D. Critical Incident Stress Management (CISM)**-An integrated "system" of interventions which are designed to prevent and/or mitigate the adverse psychological reactions that so often accompany emergency services and disaster workers.
- E. Debriefing**-Usually, a formal meeting between a trained clinician and a disaster/crisis responder or a disaster/crisis survivor, generally conducted within 72 hours of exposure to the disaster/crisis. The purpose of the meeting is to allow the person who was exposed to a disaster/crisis to communicate his/her cognitive and emotional reactions to a highly stressful event to a clinician who will provide therapeutic assistance to that person in the recovery process.
- F. Disaster Application Center**-Facility established by FEMA to accept and process applications for federally funded disaster relief assistance following a Presidential declaration.
- G. Disaster Behavioral Health Advisory Committee**-A group of behavioral health professionals and interested citizens in New Hampshire who oversee the development and maintenance of an enhanced behavioral health system designed to prepare for and respond to disasters. The Committee meets monthly to review plans, provide direction, establish relationships with emergency management entities, and promote disaster related initiatives of the Department of Safety.

- H. Disaster Behavioral Health Coordinator-A** fulltime position funded through the Centers for Disease Control Public Health Emergency Preparedness Grant, assigned to the Department of Safety Homeland Security and Emergency Management. This person administers agency objectives by assessing needs, coordinating operations, planning and managing the statewide behavioral health disaster response system within the Department of Safety. He/she works closely with the Division of Behavioral Health, the Office of Community and Public Health, Community Mental Health Centers, other behavioral health providers, emergency management planners and other community stakeholders as necessary.
- G. Disaster Behavioral Health Staging Area-**The local coordination site for disaster behavioral health response activities. The staging area will be established as needed and determined by the Incident Commander, the Executive Director of the local community mental health center and the Disaster Behavioral Health Coordinator. The location of the staging area may be at one of the agency's sites, a public safety facility or at a local hospital. The staging area is the focal point of contact between state level coordination and local needs.
- H. Disaster Behavioral Health Response Teams-** Five regionally based teams comprised of behavioral health professionals and paraprofessionals who reside in or near the affected communities that are available for rapid deployment and immediate response to disasters and emergencies. All team members are expected to complete the initial Disaster Behavioral Health training prior to deployment.
- I. Disaster Behavioral Health Response Team Leader-**Leader of the regional Disaster Behavioral Health Response Team. They participate in the development of the regional Disaster Behavioral Health Response Team and assures that team members are appropriately trained and oriented to the Plan. Coordinates the disaster response in collaboration with the Disaster Behavioral Health Coordinator, the Director of the Division of Behavioral Health, the Executive Directors of the Community Mental Health Centers and local emergency management officials. Manages the day-to-day activities of the team during a disaster, maintaining rotation schedules and tracking service activity of the team. The team leader(s) will also participate in community disaster drills/simulations and provides the linkage to state and local responders during the pre-disaster, response and post-disaster phases.
- K. Disaster (FEMA definition)-**An occurrence of a severity and magnitude that normally results in deaths, injuries and property damage and that cannot be managed through the routine procedures and resources of government. It requires immediate, coordinated, and effective response by multiple government and private sector organizations to meet human needs and speed recovery.
- **Local Disaster-**A local disaster is any event, real and/or perceived, which threatens the well being of citizens in one municipality. A local disaster is manageable by local officials without a need for outside resources.
 - **State Declared Disaster-**A state declared disaster is any event, real and/or perceived, which threatens the well-being of citizens in multiple cities, counties, regions, and/or overwhelms a local jurisdiction's ability to respond, or affects a state-owned property or interest.
 - **Federally Declared Disaster-**A federally declared disaster is any event, real and/or perceived, which threatens the well being of citizens, overwhelms the local and state ability to respond and/or recover, or the event affects federally owned property or interests.

- J. Emergency Operations Center (EOC)**--A protected site, from which government officials and emergency response personnel exercise direction and control in an emergency; this is the nerve center of disaster response operation. New Hampshire's EOC is located on state owned property just off Route 106 in Concord. The State EOC is designed to be self-sufficient for a reasonable amount of time with provisions for electricity, water, sewage disposal, ventilation and security. The major functions of the State EOC are information management, situation assessment and resource allocation.
- K. Immediate Services Program**-A 60 day crisis counseling program funded by FEMA.
- L. Essential Services Personnel**-Those positions providing a service that must be maintained regardless of the emergency situation to ensure quality of care. These positions include direct care in 24-hour, 7 day a week programs such as residential services, emergency services medication delivery to clients, medical personnel and maintenance/transportation personnel.
- M. Federal Coordinating Officer (FCO)**-The person appointed by the Director of FEMA on behalf of the President whose responsibility it is to coordinate the timely delivery of disaster assistance to affected state and local governments and disaster victims. In many cases, the FCO is also the disaster recovery manager, whose responsibility it is to administer financial assistance as designated under the Stafford Act.
- N. Federal Emergency Management Agency (FEMA)**-An independent agency of the federal government, which reports to the President. It is the lead Federal agency in disaster response and recovery. The agency's mission is to "reduce loss of life and property and protect our nation's critical infrastructure from all types of hazards through a comprehensive, risk-based, emergency management program of mitigation, preparedness, response and recovery". Provides funding for crisis counseling grants to State mental health authorities following Presidential declared disasters.
- O. Governor's Authorized Representative (GAR)**The person appointed by the Governor who has the authority to execute all necessary documents for disaster assistance on behalf of the state. Often the GAR and the State Coordinating Officer (SCO) are the same person.
- P. Incident Command System**-A standardized system used by emergency response agencies to manage emergency operations.
- Q. Special Needs Population**-In a disaster, those people who are more vulnerable to physical or emotional harm than most people. They may be physically and/or emotionally handicapped.
- R. Mass Care**-Mass Care consists of activities to provide shelter, feeding, first aid and distribution of supplies to disaster survivors, following a catastrophic event.
- S. Memorandum of Understanding**-A document that is negotiated between organizations or legal jurisdictions, to provide mutual aid and assistance in times of need. A MOU usually contains information on organizational structure and responsibility, assigned or delegated authority, financial considerations (who pays for the expense of operations), liability (who is liable for personal property or personal injury or destruction during response operations), and commercial considerations (appropriate statements of non-competition of government resources with private enterprise).
- T. Mutual Aid Agreement**-A formal or informal understanding between jurisdictions

- that pledge exchange of emergency or disaster assistance.
- U. Outreach**-A method for delivering crisis-counseling services to disaster survivors and victims. It consists primarily of face-to-face contact with survivors in their natural environments in order to provide disaster-related crisis counseling services. Outreach is the means by which such services are made available to people.
 - V. Post Traumatic Stress Disorder (PTSD)**-A disorder caused by experiencing traumatic events that result in prolonged anxiety and emotional distress.
 - W. Psychological First Aid**-Pragmatically oriented interventions with survivors or emergency responders targeting acute stress reactions and immediate needs. The goals of psychological first aid include the establishment of safety, stress-related symptom reduction, restoration of rest and sleep, linkage to critical resources and connection to social support.
 - X. Regular Services Program**-A nine month crisis counseling program that is federally funded through CMHS.

APPENDIX B
MEMORANDUMS OF UNDERSTANDING
MUTUAL AID AGREEMENTS

Community Mental Health Center
MUTUAL AID NETWORK
MEMORANDUM OF UNDERSTANDING

The below listed Participants, by affixing their signature to this memorandum of understanding, agree in principle to voluntarily coordinate mutual aid services with each of the signatories in a good faith effort to minimize risk to client care and agency operations.

I. SCOPE AND APPLICABILITY

The Participants agree that in the event of a declared or undeclared event affecting community mental health services as a result of natural, man-made or technological causes or a mass casualty incident (hereinafter “Disaster”) which impacts the operational capabilities of any other Participant, the affected Participant may request assistance from the other Participants as is more generally set forth herein.

In the event of a Disaster, an affected Participant should contact the Bureau of Behavioral Health. If during an initial needs assessment it is determined that the mental health needs of the affected community are greater than what the Participant can manage, the Bureau of Behavioral Health will contact other Participants to request assistance. The Participants will use the guidelines established herein to coordinate the care and services necessary to deal with the Disaster.

Each participant shall agree to take all appropriate actions during a Disaster without regard to race, color, creed, national origin, age, sex, religion, or handicap of any individual involved and to assist all Participants as necessary. No Participant shall be required to provide treatment, care, supplies, equipment, services or personnel over and above that which is necessary to meet its own needs, existing or anticipated, or beyond its own resources.

In the event that the affected Participant is unable to continue client care for some or all of its clients, the Participants agree to act as receiving facilities for these clients. Each Participant agrees to follow the guidelines set forth herein to the extent possible. There shall be no cause of action or basis of liability for breach of this Memorandum of Understanding by any Participant(s) against any other Participant(s).

This Memorandum of Understanding is not intended to replace each agency’s Disaster Response Plan, but is intended to support those plans and agreements. Each Participant shall incorporate this Memorandum of Understanding into its disaster response plan consistent with the principles agreed to herein.

II. GUIDELINES:

EMERGENCY CARE

Each Participant agrees to provide assistance, as available within its reasonable capabilities, including:

- Accepting as many transfers for residential services as resources permit.
- Providing emergency care within the capabilities of the agency.

Providing emergency behavioral health services including crisis intervention, outreach, crisis counseling, critical incident stress management debriefings for CMHC staff and first responders, community education, stress management, and brief supportive counseling.
Providing diagnostic, assessment and referral services.
Notifying the Participants when referrals can no longer be accepted.
Providing a copy of the treatment record for client who is transferred to a residential facility.
Providing other behavioral health services that may be necessary and requested.

EMERGENCY SUPPLIES AND EQUIPMENT:

A Participant shall provide emergency supplies and equipment within reasonable resource capabilities.

COST OF SERVICES, EQUIPMENT AND PERSONNEL:

A Participant receiving services, equipment and personnel, will replace or reimburse the cost of same to the Participant providing services, equipment and personnel.

ADMINISTRATIVE SERVICES:

A Participant will provide the following administrative services for themselves and will assist other Participants by:

Maintaining a current listing of all transfers made to and from the Participant's facility.
Maintaining a current listing of all discharges, their assigned areas and location.
Notifying the other Participants when clients or personnel can be returned to their agency.
Furnishing other information or record keeping, as may be requested or deemed necessary by the Participant.

III. EFFECTIVE DATE, FUTURE AMENDMENT AND CONSTRUCTION

This Memorandum of Understanding shall become effective on _____. A Participant may terminate its participation in this Memorandum of Understanding by giving a sixty (60) day written notice to the other Participants of its intentions to terminate.

This Memorandum of Understanding shall be reviewed periodically by the Participants to ensure that it meets the requirements of the Participants.

This Memorandum of Understanding is in no way meant to affect any of the Participants' rights, privileges, titles, claims, or defenses provided under federal or state law or common law.

IN WITNESS WHEREOF, we have set our hands and seals as written below:

Community Mental Health Center

Executive Director

Date

Attest:

APPENDIX C - FORMS

INDIVIDUAL SERVICES TALLY SHEET FOR DEMOGRAPHIC DATA

Team Member: _____ Date: _____ Region: _____

	SUN	MON	TUE	WED	THU	FRI	SAT	TOTAL
I. AGE								
0-5 YEARS								
6-11 YEARS								
12-17 YEARS								
ADULTS								
OLDER ADULT								
II. ETHNICITY								
III. WHITE								
IV. HISPANIC ORIGIN								
V. BLACK								
VI. AMERICAN INDIAN (ALASKAN NATIVE)								
VII. ASIAN & PACIFIC ISLANDER								
VIII. OTHER								
IX. DON'T KNOW								
X. LANGUAGE								
XI. ENGLISH								
XII. SPANISH								
XIII. ASL								
XIV. OTHER								
XV. SEX								
XVI. MALE								
XVII. FEMALE								
XVIII. CONTACTS								
XIX. 1 st								
XX. 2 nd								
XXI. 3 rd								
XXII. 4 th or More								
XXIII. Yes to more contacts								
XXIV. No to more contacts								

XXV.

EDUCATIONAL SERVICES FORM

Team Member: _____ Date: _____ Region: _____

Location: _____

MATERIAL DISTRIBUTION

TYPE OF MATERIAL DISTRIBUTION	XXVI. NUMBER DISTRIBUTED							
	SUN	MON	TUE	WED	THU	FRI	SAT	TOTAL
Material left in public places								
Material handed to people with no further interaction								
Material handed to people followed by a brief discussion of the material								

INDIVIDUAL EDUCATIONAL SERVICES

XXVII. TYPE OF CONTACT	XXVIII. NUMBER OF CONTACTS							
	SUN	MON	TUE	WED	THU	FRI	SAT	TOTAL
In-person brief contact								
Telephone contact								

1. GROUP EDUCATIONAL SERVICES

DATE	NAME/TYPE OF GROUP	FOCUS OF PRESENTATION	NUMBER OF PARTICIPANTS
Number of Groups:		Total Number of Participants:	

GROUP CRISIS COUNSELING SERVICES FORM

Team Member: _____ Date: _____ Region: _____

Location: _____

TYPE OF GROUP PARTICIPANTS	NUMBER OF
FOCUS OF GROUP SESSION:	
PLAN FOR FUTURE SESSIONS:	
NOTES:	

GROUP SERVICES TALLY SHEET

Team Member: _____ Date: _____ Region: _____

NUMBER OF PARTICIPANTS								
	SUN	MON	TUE	WED	THU	FRI	SAT	TOTAL
NUMBER OF GROUPS								

INDIVIDUAL CRISIS COUNSELING SERVICES

Team Member: _____ Date: _____ Region: _____

Location: _____

NAME AND ADDRESS, IF NEEDED:

2. DEMOGRAPHIC INFORMATION

AGE (CHECK ONE) <input type="checkbox"/> PRESCHOOL (0-5) <input type="checkbox"/> CHILDHOOD (6-11) <input type="checkbox"/> PREADOLESCENT <input type="checkbox"/> ADOLESCENT (12-17) <input type="checkbox"/> ADULT <input type="checkbox"/> OLDER ADULT	XXIX. ETHNICITY <input type="checkbox"/> WHITE <input type="checkbox"/> HISPANIC ORIGIN <input type="checkbox"/> BLACK <input type="checkbox"/> AMERICAN INDIAN/ALASKA NATIVE <input type="checkbox"/> ASIAN & PACIFIC ISLANDER <input type="checkbox"/> MIDDLE EASTERN <input type="checkbox"/> OTHER _____ <input type="checkbox"/> DON'T KNOW	XXX. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE XXXI. PREFERRED LANGUAGE <input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> AMERICAN SIGN LANGUAGE <input type="checkbox"/> OTHER _____
--	---	---

1. EVENT REACTIONS

XXXII. BEHAVIORAL <input type="checkbox"/> Extreme changes in activity level <input type="checkbox"/> Excessive drug alcohol or prescription use <input type="checkbox"/> Isolation/withdrawal <input type="checkbox"/> Hyper-vigilance <input type="checkbox"/> Reluctant to leave home <input type="checkbox"/> Violent behavior <input type="checkbox"/> Other _____	XXXIII. EMOTIONAL <input type="checkbox"/> Sadness tearful <input type="checkbox"/> Irritability anger <input type="checkbox"/> Feeling anxious fearful <input type="checkbox"/> Despair, hopeless <input type="checkbox"/> Feelings of guilt or shame <input type="checkbox"/> Feeling emotionally numb disconnected <input type="checkbox"/> Other _____	XXXIV. PHYSICAL <input type="checkbox"/> Headaches <input type="checkbox"/> Stomach problems <input type="checkbox"/> Difficulty falling or staying asleep <input type="checkbox"/> Difficulty eating <input type="checkbox"/> Worsening of chronic health conditions <input type="checkbox"/> Fatigue/exhaustion <input type="checkbox"/> Chronic agitation <input type="checkbox"/> Other _____	XXXV. COGNITIVE <input type="checkbox"/> Inability to accept/cope with death or loved one(s) <input type="checkbox"/> Distressing dreams or nightmares <input type="checkbox"/> Intrusive thoughts or images <input type="checkbox"/> Difficulty concentrating <input type="checkbox"/> Difficulty remembering things <input type="checkbox"/> Difficulty making decisions <input type="checkbox"/> Preoccupation with death/destruction <input type="checkbox"/> Suicidal thoughts or feelings <input type="checkbox"/> Other _____
---	--	--	--

XXXVI. REFERRAL <input type="checkbox"/> Professional mental health services <input type="checkbox"/> Substance abuse <input type="checkbox"/> Other _____ Was the referral accepted by the individual? <input type="checkbox"/> Yes <input type="checkbox"/> No	XXXVII. OTHER KEY CHARACTERISTICS/EXPERIENCES <input type="checkbox"/> Past or preexisting trauma or psychological problems or substance abuse problems <input type="checkbox"/> Injured as a result of event <input type="checkbox"/> At risk of losing life during event <input type="checkbox"/> Loved one (s) missing or dead <input type="checkbox"/> Coworker/friend(s) missing or dead <input type="checkbox"/> Witnessed death or injury of others <input type="checkbox"/> Displaced from home <input type="checkbox"/> Displaced from or lost job <input type="checkbox"/> Assisted with rescue/recovery <input type="checkbox"/> Has physical disability that limits mobility independence
---	--

NOTES:

Permission given to be contacted again
 Declined to be contacted again

1st Contact
 2nd Contact
 3rd Contact
 4th or more contact

BRIEFING AND ORIENTATION CHECKLIST

___ **Status of the Disaster** (nature of damage and losses, predicted weather or condition reports, boundaries of impacted area, hazards, response agencies involved)

___ **Orientation to the Impacted Community** (demographics, ethnicity, socioeconomic makeup, history of previous disasters, language requirements, etc.)

___ **Local Community and Disaster-Related Resources** (handouts with brief descriptions and phone numbers of local human services and disaster-related resources. Review resource lists and other materials from Go Kits. Distribute vests.

___ **Logistics** (describe arrangements for team members to be fed, housed (if necessary), receive medical care, receive messages, contact family members, etc)

___ **Communication** (how, when and what to report to Team Leader; orientation to use of two-way radios.

___ **Transportation** (clarify the mode of transportation to field assignment. If team members are using personal vehicles, provide maps, delineate open and closed routes, indicate hazard areas. Remind team members to wear DBHRT badge.

___ **Health and Safety in Disaster Area** (outline potential hazards and safety strategies. Discuss possible sources of injury and injury prevention. Discuss pertinent health issues such as safety of food and drinking water, personal hygiene, communicable disease control and exposure to the elements. Inform of first aid/medical resources in the field.)

___ **Field Assignments** (outline sites where team members will be deployed. Provide description of the setup and organization of the site and name of the person to report to. Provide brief review of appropriate interventions at the site)

___ **Policies and Procedures** (briefly outline policies regarding length of shifts, breaks, staff meetings, required reporting of statistics, etc., Give team members necessary forms and inform them when/ where to return forms)

___ **Self-care and Stress Management** (require the use of the “buddy system” to monitor each other’s stress and needs. Remind team members of the importance of regular breaks, good nutrition, positive communication and appropriate use of humor. Inform team members of the post deployment check-in to be provided at the end of each tour of duty in the field.

DRILL REVIEW REPORT

Date of Drill/Simulation:

Participating Agencies:

Location of Drill/Simulation:

Name of Person(s) completing Report:

Overall Effectiveness: In what areas did your agency excel in its response to the emergency?

Deficiencies: In what areas was your agency's response to the emergency deficient?

What are the lessons learned and implications for revisions of your Disaster Response Plan?

INDIVIDUAL ASSESSMENT FORM

Location: _____ Date: ____ / ____ / ____

REASONS FOR ASSESSMENT: (check all that apply)

- Re-experiencing the recent traumatic event
- Avoidance/emotional numbing
- Hypervigilance/increased arousal
- Substance-related issue/disorder
- Mood problem/disorder, including depression
- Anxiety problem/disorder, e.g. panic, phobia
- Somatic complaints, e.g., pain, abnormal sensations

Other specified problem not listed above: _____

Please describe your personal involvement in this event, and describe the effects that you have experienced :

	yes	no	unsure
Did you actually have a family member or close friend who was killed, injured or missing?			
Did you fear that a family member or friend who was in or around the site of the event might be killed, injured or missing?			
As a result of your exposure to the event did you feel that you were at risk of being injured or killed?			
Did you witness death or serious injury?			
Were you displaced from your home?			
Have you been the victim of traumatic events in the past?			

Which best describes your personal exposure _____ You were in or around the event and saw some of this happen.

_____ You were in or around the event but did not see it happen

_____ You were not in or around any of any of the event

How would you rate the intensity of the impact of the event upon you?

1 Not intense 2 Somewhat intense 3 Very Intense (circle one)

Length of time exposed to the event: _____

Which of the following symptoms/signs have you experienced?

<input type="checkbox"/> fatigue	<input type="checkbox"/> Exhaustion	<input type="checkbox"/> sleep disturbances	<input type="checkbox"/> appetite changes
<input type="checkbox"/> stomach problems	<input type="checkbox"/> worsening of chronic health conditions	<input type="checkbox"/> feeling restless	
<input type="checkbox"/> anxiety	<input type="checkbox"/> panic attacks	<input type="checkbox"/> fears	<input type="checkbox"/> grief
<input type="checkbox"/> mood swings	<input type="checkbox"/> helplessness		
<input type="checkbox"/> difficulty making decisions	<input type="checkbox"/> sadness, depression, crying	<input type="checkbox"/> irritability, anger, rage	
<input type="checkbox"/> thoughts of taking your life	<input type="checkbox"/> preoccupation with disaster	<input type="checkbox"/> survivor guilt	
<input type="checkbox"/> excessive or reduced activity level	<input type="checkbox"/> reluctant to leave home	<input type="checkbox"/> hopelessness	
<input type="checkbox"/> decline in performance in responsibilities at home/work/school	<input type="checkbox"/> emotionally numb		
<input type="checkbox"/> increased conflicts with authority/city/state/federal government	<input type="checkbox"/> loss of interest		
<input type="checkbox"/> confusion, disorientation, memory problems	<input type="checkbox"/> withdrawal and isolation		
<input type="checkbox"/> how many drinks did you have on a typical day since the event			
<input type="checkbox"/> how often did you have 6 or more drinks on one occasion since the event			

Have you had previous mental health treatment? Yes No

Since this event occurred have you re-experienced any of the symptoms that cause you to seek treatment? Yes No

Are you taking any medication for mental health issues? Yes No
If yes, what medication(s)?

Recommendations and Referrals

--

Completed By: _____

DBHRT TEAM LEADER REPORT

Date of incident:	Location:	Description:

Services Available: Assessment, Psychological First Aid, Crisis Intervention, Outreach, Public Education, Consultation, Screening, Referral & Support Groups.

Date /Type of Service Provided	Location of Service Provided	Numbers Served	Number of DBHRT members	Time Spent Providing Service

Follow –up/ recommendations:

Did DBHRT members receive post deployment check-in? Yes ___ No ___

Summarize:

Team Leader (print) _____

Signature and Date _____

TEAM LEADER CHECKLIST

SET UP

- ___ Report to local Incident Command and inform them who you are and what assets you bring to the response effort.
- ___ Secure space (private if possible) with a table, some chairs.
- ___ Hang up DBHRT sign.
- ___ Establish communication with Disaster Behavioral Health Coordinator. I.D. land phone. Contact key personnel and inform them how to reach you.
- ___ Organize “*Go-Kits*” (clipboards, vests, referral guides, educational materials, forms) for team members.
- ___ Coordinate the mobilization of team members. Determine what team members skills/experience is needed immediately.
- ___ Begin to keep a *Disaster Activity Log* of actions taken.

PERSONNEL

- ___ Log in team members using *DBHRT Activation/Check in/Deployment* form as they begin to arrive.
- ___ Ensure that team members have “Disaster Behavioral Health Response Team” I.D.
- ___ Provide an orientation to team members utilizing the *Briefing/Orientation Checklist* before deploying team members to field.
- ___ Distribute appropriate forms, key contact phone numbers and Go Kit materials to team members.
- ___ Discuss team member strengths, experience, familiarity with potential service sites, work tasks and assign team members to work locations.
- ___ Assign Incident Command System Roles to team members (if deemed necessary)
- ___ Create a written work schedule (4-6 hour shifts recommended).
- ___ Arrange for 24-hour coverage or on-call availability.

DAILY ACTIVITIES

- ___ Continue documenting in the *Disaster Activity Log*.
- ___ Refer inquiries from the press to the Incident Command Public Information Officer.

- ___ Attend local incident command center briefings (if invited)
- ___ Conduct a daily team member meeting to review current status, needs and plan.
- ___ Meet with each team member individually if possible to: ensure that data is being collected appropriately, review work, monitor stress level and offer support.
- ___ Contact the Disaster Behavioral Health Coordinator to give a status report.
- ___ Request additional supplies, if needed.
- ___ Ensure that team members receive a post deployment check-in at the end of shift.
- ___ Complete *Team Leader Report*
- ___ If a Team Leader is relieving you, provide a verbal status report.

NETWORKING

- ___ Notify helping organizations of potential needs. Learn who their “key” people are.
- ___ Utilize the community’s “natural helpers” to assist in spreading the word about disaster-related stress. This group may include pastors, local officials, heads of volunteer groups, etc. You may want to hold a brief educational session with them as to what to look for and how to refer their clients/customers for professional help.
- ___ Update any incorrect referral information and circulate corrections. Announce any changes at the start of team meetings.
- ___ Attend community/”town” meetings where relief and recovery plans are being made.
- ___ Encourage the development of support groups.

CLOSE OF OPERATION

- ___ Collect team member’s final paperwork and statistics.
- ___ Collect DBHRT sign, vests and “Go Kit” materials.
- ___ Ensure that all team members receive post deployment check-in.

DBHRT Activation, Check-In & Deployment

Date	Time In	DBHRT Member	Special Skills	Deployed To	Time Out	Post Deployment Check In?	Cell Phone

NH Disaster Behavioral Health
Initial Community Needs Assessment

1. **What is the nature of the event? (Location, type of event, time of occurrence, and number of people involved in the event, criminal behavior suspected?)**

2. **What is the estimated number in each category affected by the event?**
___ Victims
___ Family Members
___ Responders
___ Witnesses

3. **Provide the following information (as available):**
Incident Commanders:
Command Post Location:
Local EOC Location and Phone #

4. **Entities on scene:**
___ Police ___ Fire ___ Granite State CISD ___ CMHC
___ EMS ___ Red Cross ___ Salvation Army
List Others:

5. **Are there special needs/vulnerable populations that need to be addressed? If yes, what are the issues and/or concerns?**

6. **Are there existing BH programs that may have to be relocated? (Ie. residential programs, methadone services).**

7. **Does the affected community have a recent history of traumatic events? If yes, what are the specifics?**

8. **Where have shelters been opened?**

Locations:

9. **Where have family assistance centers been opened?**

Locations:

10. **What other locations are survivors being assisted?**

Locations:

11. **Who contacted DBHRT? What specific services were requested?**

12. **What local BH resources have been requested?**

13. **Which BH resources are on the scene and available now?**

14. **Have any BH interventions been provided to-date? If yes, by whom and when?**

15. **Are the BH needs anticipated to be beyond the capacity of local resources? If yes, what services or resources are anticipated?**

Preliminary Findings:

- 1.
- 2.
- 3.
- 4.

Recommendations for behavioral health response (in order of priority):

- 1.
- 2.
- 3.
- 4.
- 5.

Completed By:

Title:

Date:

This assessment was shared with:

Disaster Action Log

date/time of Action request	<u>specific action or request</u> (include names of individuals or agencies who initiated the request, as well as the DBHRT team member logging the request)	<u>result and/or follow-up</u> (include names of individuals or agencies who are responsible for handling the request, and the final disposition)	date/time of completion

AFTER ACTION REVIEW

1. **Identify your role in responding to this incident**

2. **What disaster behavioral health services were provided?**

3. **What went right? What worked?**

4. **What may have not worked? What could have been improved?**

5. **Did the DBHRT policies and procedures assist or impede the response and delivery of services?**

6. **What did you learn from your participation in this event?**

Name:
Event:

Date:

APPENDIX D

LOCAL, STATE & FEDERAL EMERGENCY MANAGEMENT RESOURCES/PHONE NUMBERS

EMERGENCY CONTACT INFORMATION

Jennifer Harper, HSEM, Bioterrorism Coordinator

Home address: 33 Mulberry Street Unit #3, Concord, N.H. 03301

Jennifer.Harper@hsem.nh.gov

work phone: 223-3615

work fax: 223-3609

cell phone: 419-9179

pager: 639-6960

home phone: 219-0965

Paul Deignan, HSEM, Disaster Behavioral Health Coordinator

Home address: 12 Jefferson Dr., Londonderry, N.H.

Paul.Deignan@hsem.nh.gov or repauldeg@aol.com

work phone: 223-3621

work fax: 223-3609

cell phone: 419-0074

pager: 639-6958

home phone: 425-2306

Steve Tomajczyk, DHHS, ESF-8 Coordinator

stomajczyk@dhhs.state.nh.us

work phone: 271-4462

work fax: 271-4332

cell phone: 419-0242

pager: 564-8054

home phone:

Ann Bliss, Center for Trauma Intervention, Director

Work address: 426 State St. Portsmouth, NH 03801

Abliss426@aol.com

Work phone: 431-1191

Work fax: 559-9085

Cell phone: 781-4058

Pager: 240-7329

Home phone: 436-3415

Mark Lindberg, Disaster Behavioral Health Liaison

Home address: 93 Nason Rd. Sugar Hill, NH 03586

mlindberg@nnhmdhs.org

Work phone: 444-5358

Work fax: 444-0145

Cell phone: 991-3366
Home phone: 823-9822
Pager: 549-2240

Joan Haskell, Disaster Behavioral Health Liaison

Home address: 6 Colman Path, Merrimack, NH 03054
Work phone: 889-6147
Work fax: 883-1568
Cell phone: 566-3523
Home phone: 424-7681
Pager: 639-6947

Fr. Angelo Pappas

Home Address:
Pappasfr@cityofportsmouth.com
Work Phone: 436-2733
Cell Phone: 235-0537
Pager: 517-9921
Home Phone: 436-6242

Donna Hastings

Home Address:
DMHPSYD@aol.com
Work Phone: 429-1190
Work fax: 424-4722
Cell Phone:
Pager:
Home Phone:

Community Mental Health Centers

Region I-Northern N. H. Mental Health & Developmental Services-447-3347
Region II-West Central Behavioral Health Services-448-0126
Region III-Genesis Behavioral Health-524-1100
Region IV- Riverbend Community Mental Health, Inc.- 228-1551
Region V- Monadnock Family Services- 357-6878
Region VI- Community Council of Nashua- 889-6147
Region VII- The Mental Health Center of Greater Manchester- 668-4111
Region VIII- Seacoast Mental Health Center, Inc. -431-6703
Region IX- Behavioral Health & Developmental Services of Strafford County- 332-6635
Region X- CLM Behavioral Health Systems- 893-3548

American Red Cross Chapters

Greater White Mountain Chapter, Laconia, N.H. 524-5414
Mount Washington Valley Chapter, North Conway, N.H. 356-2726
Central Vermont/New Hampshire Valley Chapter, Rutland, Vt. (802) 773-9159
Concord Area Chapter, Concord, N.H. 225-6697

New Hampshire West Chapter, Keene, N.H. 352-3210
Greater Manchester Chapter, Manchester, N.H. 624-4307
Strafford County Chapter, Dover, N.H. 742-3349
Greater Nashua & Souhegan Valley Chapter, Nashua, N.H. 889-6664
Merrimack Valley Chapter, Ward Hill, Ma. (978) 683-2465
Seacoast Area Chapter, Portsmouth, N.H. 436-2600
Durham Chapter, Durham, N.H. 868-9692

Local Hospitals

24 hour Emergency Contacts (administrator on-call or Nursing Supervisor)

Alice Peck Day Memorial Hospital- 448-3121
Androscoggin Valley Hospital- 752-2200
Catholic Medical Center- 668-3545
Cheshire Medical Center- 354-5400
Concord Hospital- 225-2711
Cottage Hospital- 747-9000
Elliot Hospital- 669-5300
Exeter Hospital- 778-7311
Franklin Regional Hospital- 934-2060
Frisbee Memorial Hospital- 332-5211
Huggins Hospital- 569-7500
Lakes Region General Hospital- 524-3211
Littleton Hospital- 444-9000
Mary Hitchcock Memorial Hospital- 650-5340
Memorial Hospital- 356-5461
Monadnock Community Hospital- 924-7191
New London Hospital- 526-2911
Parkland Medical Center- 432-1500
Portsmouth Regional Hospital- 436-5110
So. N.H. Medical Center- 577-2000
Speare Memorial Hospital- 536-1120
St. Joseph's Hospital- 882-3000
Upper Connecticut Valley Hospital- 237-4971
Valley Regional Hospital- 542-7771
Weeks Memorial Hospital- 788-4911
Wentworth-Douglass Hospital- 742-5252
New Hampshire Hospital- 271-5300
VA Medical Center- 624-4366 x 6263

STATE RESOURCES

Bureau of Behavioral Health-271-5300
Employee Assistance Program- 271-4336
New Hampshire Disaster Behavioral Health Coordinator-223-3621
New Hampshire National Guard- 225-1200
New Hampshire Bureau of Emergency Management-1-800-852-3792
New Hampshire State Police-1-800-525-5555
New Hampshire Fish and Game- 271-3421
New Hampshire Poison Control Center-1-800-562-8236

APPENDIX E-LANGUAGE BANK

LANGUAGE	NAME	M-Medical Training L-Legal Training M&L-Both	CONTACT INFORMATION	TIME AVAILABLE
	FIRST/LAST			
ALBANIAN & KOSOVO	ADRIAN TRESKA	Social Services and Legal Experience working for U.S. Department of Defense	644-8424	any time
ARABIC	LAMIA BOSLI	M	298-6724 OR 668-0982	varies
ARABIC	FATEN ALHASSUN	ML	647-7595	any time
ARABIC	MOWHAMED ALI ESSA	M	647-7595	any time
ARABIC	WAFI JABER	ML	483-4030	Mon-Fri 9am – 4pm
ARABIC	AHMED TAHUN	L	647-6888	NEEDS 2h NOTICE
ARABIC	MAGDA TAHUN	L	485- 2471	NEEDS 24h NOTICE
ARABIC	FATIMA DEEK	ML	626-0253	any time
ARABIC	HANI DURZY	ML	673-0217 durzy@ adelphia.net	varies
ARABIC & BOSNIAN/ SERBO/ CROATIAN	SAIFELDIN ABDELRAHIM	M (experienced in social services and more)	624-5427 Tabbaldy@msn	Please Call
BOSNIAN/ SERBO/ CROATIAN	AIDA CATOVIC	M (Very experienced in social services also)	Cell: 867-4220 Or 625-0434	Please call
BOSNIAN/S/C	ELDIN MEDIC	M	321-8168	AM
BOSNIAN/S/C	VERDINA MEKIC	M	647-6026	Please call
BOSNIAN/S/C	FAHIRA ZLOTRG	ML	785-4043 OR 625-0375	Please call
BOSNIAN/S/C	EMIN MUKANOVIC	L	647-6970	PREFERS AM, (any time)
BOSNIAN/S/C	MEJREMA RASTODER	L	645-7610	8AM-2PM
CHINESE/ Cantonese	STELLA LOUI	M	H.624-0570 OR W. 695-2663	SAT./SUN./MON.
CHINESE/ Mandarin	WENJUAN JIANG	M	882-5035	Weekdays-daytime
CHINESE/ Mandarin	GUANGXIONG FANG	M	882-5035	Please call to find out
CHINESE/ Mandarin	AMMIE LONG	M	289-1624 OR HAPPYAMMIE @YAHOO.COM	varies
CILUBA (African tribal language)	BEN KABAMBA	M	668-2704/ 512-1994	any time
FRENCH	AUGUSTIN MUHIZI	M	934-4781 or	Tues, Thurs after 2pm

(African)			934-2060	
FRENCH (European)	CORA DER KOORKANIAN	ML (trained at UN)	625-2689	any time
FRENCH (African)	BEN KABAMBA	M	668-2704/ 512-1994	any time
FRENCH (Algerian)	LAMIA BOSLI	M	298-6724 OR 668-0982	varies
HEBREW	CORA DER KOORKANIAN	ML (trained by UN)	625-2689	any time
LATVIAN	JURIS DRILINS (did not graduate from training, use only if you have no other resource)	M	978-256-7371 OR JURIS17@YAH OO.COM,	varies
LINGALA African tribal language)	BEN KABAMBA	M	668-2704 / 512-1994	any time
PERSIAN (FARSI) &: DARI, TURKISH, UZBALS, TAJK.	BEHRUZ LASHGARLOU (Did not graduate from training, call only if you have no other resource)	M	629-9543	any time
PORTUGUESE	CORA DER KOORKANIAN	ML (trained at UN)	625-2689	any time
PORTUGUESE	NORMA V. CERIATTI	M	539-1686	any time
PORTUGUESE	PAT A. ALVES	M	594-3704	varies
PORTUGUESE	MONICA HOEFLE	M	437-8967	varies
PORTUGUESE	LILIAN WOJCICKI	M	595-9432/ 557-6545	Please call
PORTUGUES	PATRICIA MUSCELLI	M	883-5658 889-8899	Please call
PORTUGUESE	FERNANDA SANTANNA	M	595-8069/ 978-664-5694	Please call
PORTUGUES E:	CLAUDIA FERNANDEZ	M	598-1704	AFTER 5PM
PORTUGUES E:	LUCI DE BIAGIO	M	595-9915	Please call
PORTUGUES E:	FATIMA PEREIRA	M	595-9915	Please call
PORTUGUES E:	SILVIA MENDONCA	M	897-0408	Please call
ROMANIAN	CORA DER KOORKANIAN	ML (trained at UN)	625-2689	any time
RUSSIAN	INNA VOZLINSKI	M (L experienced)	742-1967	any time
RUSSIAN	LILIYA MAYEVSKY	M	587-0033	after 5pm
RUSSIAN	OLGA GLOTOVA	M	512-2004	Thurs, Fri evenings
RUSSIAN	TAYA BELOUS	M	661-0621	AFTER 2:30PM
RUSSIAN	NADIA GAPONOVA	M	464-6506	Varies
SWAHILI	AUGUSTIN MUHIZI	M	934-4781 or 934-2060	Tues, Thurs after 2pm

SWAHILI	BEN KABAMBA	M	668-2704/512-1994	any time
UKRAINIAN	LILIYA MAYEVSKY	M	587-0033	after 5pm
UKRAINIAN	TAYA BELOUS	M	661-0621	AFTER 2:30PM
UKRANIAN	NADIA GAPONOVA	M	464-6506	Varies

XXXVIII. SPANISH LANGUAGE

NAME FIRST	NAME LAST	M-Medical Training L-Legal Training M&L-Both	CONTACT INFORMATIO N	TIME AVAILABLE
ELIUD	ALMODOVAR	M	470-6084/ 625-4011	Varies
PAT A.	ALVEZ	M	594-3704	Varies
GIOVANNY	ARGUELLO	M	647-8967	Varies
MERCEDES	BERBERIAN	M	MERBERICH@ COMCAST.NET	Varies
CARMEN (Spain)	BERTRAN	ML	669-5661	Varies - Please call
SUSAN E.	CASTELLANOS- BILODEAU	ML	225-7786 / 738-7772	Varies
EVA	CASTILO	ML	669-5661 / 634- 5155	Varies
NOHORA P.	CIOPPA	M	624-1835	Please call
DAISY	CRUZ	M	232-2939	ON CALL BASIS
ROSEMARY W.	DANN	L	432-5578	Varies
MADLINE	DELGADO	M	882-6333 mdelgado@ region6.com	Please call
WANDA	DIAZ	M	627-7703 x 42	Varies
ALEJANDRO	ECHAVARRIA	M (Colombian- Spanish),	628-1730	Varies
ROSA	ESCALERA (did not finish training)	M	315-1142 / 622- 9546	any time
PETE	ESCALERA	M	867-9546 / 622- 9546	any time
ROSA I.	ESCOBAR	M	626-0962	Evenings 5:00 or Sat.
MARIA	ESTRADA	M	891-2014/ 930-8553	Varies
JANICE	FELICIANO	M	623-5166	Evenings 5:00 or Sat.
CLAUDIA	FERNANDEZ	M	598-1704	AFTER 5PM
MARGARITA	FERNANDEZ- LETKOWSKI	M	644-3742	Varies - Please call
MAURICIO	GALVIS	M	644-1588 / 628-4400	VARIES
JEFFRE	GARATE	M	880-7863	Mon-Fri 9am – 4pm

MARIA	GRIGGS	M	881-1128	Varies
CORNELIA	HOLT	ML	879-9380	VARIES
WENDY	JONES	M	557-5781	Tues, Thurs, Fri after 3pm
CORA DER	KOORKANIAN	ML (trained at UN)	625-2689	any time
FATIMA	LAPERLE	M	647-8960	AFTER 6PM
DANIEL	MARADIAGA	M	264-6439	Evenings
KARINA	MERA	L	595-0417	Varies
SUSANA	MIDDLETON	ML	888-5233	During summer
MARIA	OSTROVSKI	L	622-6781	PM
CARMEN S.	PEREZ	M	883-8845/ 930-0950	Evening after 4
NANCY	PEREZ	L	644-5027	AFTER 4:30
TONA	PEREIRA	M	577-8751 bobyhora@ hotmail.com	Please call
LUIS	PORES	M	627-7703	Varies
MARLENE	RAMOS	M	264-9632	Evenings 5:00 or Sat.
ANNIE	RODRIGUEZ	M	668-4213	AFTER 3PM
MOISE	RODRIGUEZ	M	668-4213	Varies
ELIZABETH	RODRIGUEZ	M	470-6084/ 625-4011	Please Call
ANAYS	RODRIGUEZ	M	749-5785	Varies
ELAINE	ROMANO	L	731-3959	Varies
LINA	RUIZ	M	578-1393	Varies - Please call
THERESE	SARGEANT	M	770-1322/642- 3341	Please call
GANDY	TERRERO	M	540-1937	Varies
MIA	VELASQUEZ	M (Colombian-Spanish)	628-1730	Varies
RUBY	VELASQUEZ	M	644-1310	Please call
VIVIAN	VELEZ	M	886-2744	Mon-Fri after 5, Sat & Sun anytime

NATIONALLY CERTIFIED INTERPRETERS

SPECIALIST CERTIFICATE: LEGAL (SC:L)

Barb Walker, CSC and SC:L
Spinster Hill
RD 2, Box 291
St. Johnsbury, VT 05819
Home: 802-748-8905 (TTY/Voice)
Education: MA

Jane Hecker-Cain, CSC, CI/CT, SC:L
18 Lockwood Drive
Kennebunk, ME 04043-2245
Home: 207-967-8601 (Voice)
Beeper: 1-800-914-4971
Fax: 207-967-8730
Education: BS + 24 graduate credits

Amy Cara Williamson-Loga, CI/CT,
SC:L
8 Derby Drive
Montpelier, VT 05602
Home: 802-229-9876 (Voice)
Email: williamson_loga@hotmail.com
Education: BA
Licensed

CERTIFICATE OF INTERPRETATION (CI) AND CERTIFICATE OF TRANSLITERATION (CT)

Diane Aseltine-Grzyb, CI/CT
28 Cleveland Hill Road
Brookline, NH 03033
Home: 603-672-3656 (Voice)
603-672-3755 (TTY)
Beeper: 599-8243 numeric
Fax: 603-673-0612
Education: Interpreter Training
Program
Licensed

Luce Aubry, CI/CT
101 Wibird Street
Portsmouth, NH 03801
Home: 603-430-2061 (TTY/Voice)
Email: luce.aubry@verizon.net
Education: BA and MA

Licensed

Ellen Boda, CI/CT
81 Shepard Home Road
Chester, NH 03036
Home: 603-887-2363 (Voice)
Fax: 603-887-2363
Email: bodafam@aol.com
Education: AA Degree

Licensed

Julie Bornstein, CI/CT
1375 Bodwell Road Unit #27
Manchester, NH 03109
Pager: julieb@wyndtell.com
Email: joolyb@aol.com
Cell Phone: 603-826-0266
Education: MSW
Licensed

Exeter, NH 03833
Home: 603-778-0037 (Voice)
Email: maura@mfay.net
Education: B.S.
Licensed

Melody Chicoine, CI/CT
R3 Box 85
Claremont, NH 03743
Home: 603-543-0607 (TTY/Voice)
Cell Phone: 603-381-4341
Fax: 603-542-2847
Email: mchicoine@juno.com
Education: AA, Interpreter Training
Program
Licensed

Cynthia Cohen-Salter, CI/CT
25 Old Cathedral Road
Rindge, NH 03461
Home: 603-899-9557 (Voice)
Work: 978-632-7110 ext. 237 (Voice)
Cell: 508-207-8296
Email: aslsvm@yahoo.com
Education: DVM
Licensed

Reed B. Marmy Cotton, CI/CT
46 Eastman Street
Concord, NH 03301-5409
Home: 603-225-4849 (TTY/Voice)
Work: 603-624-6378 (TTY/Voice)
Fax: 603-226-4025
Email: rcotton@usadatanet.net
Education: MA and M.Ed.
Licensed

Kathleen Eifler, CI/CT
2719 Jericho Street
White River Jct., VT 05001
Cell: 612-978-0122
Work: 603-646-1564
Education: BA
Licensed

Maura Fay, CI/CT
23 Woodlawn Circle

Erin E. Thompson-Foote, CI/CT, ACCI
III
68 Denny Hill Road
Warner, NH 03278-4505
Home: 603-456-3726 (TTY/Voice)
Email: etnd91@tds.net
Pager: etnd91@vzw.blackberry.net
Education: BA
Licensed

Jack Hoza, CI/CT
9 Moulton Street
Newburyport, MA 01950
Home: 978-465-1596 (TTY/Voice)
Email: jack.hoza@unh.edu
Education: MA and Ph.D.

Virginia Husted, CI/CT
16 Main Street
Gilsum, NH 03448
Home: 603-355-2242 (TTY/Voice)
Beeper: 603-655-0175 enter # to call
after beep
Education: 2 years college
Licensed

Tim Kinsella, CSC, CI/CT
PO Box 6944
Portsmouth, NH 03802-6944
Home: 603-512-3005
Email: tkinsella2@hotmail.com
Education: BA +
Licensed

Jodi Lefort, CI/CT
138 Anthony Street
Manchester, NH 03103
Home: 603-622-3894 (TTY/Voice)
Email: mom61098@comcast.net
Education: BS
Licensed

Terry Linehan, CI/CT
436 Boston Post Road
Amherst, NH 03031
Home: 603-673-6175 (TTY/Voice)
Email: terrynewf@adelphia.net
Education: BA
Licensed

Denise Martinez, CI/CT
158E Portsmouth Avenue

PO Box 636
New Castle, NH 03854
Home: 603-431-4927 (TTY/Voice)
Email: denisem95@earthlink.net
Education: AA
Licensed
Laurie Meyer, CSC, CI/CT
Box 69
Dublin, NH 03444
Cell Phone: 603-313-0108
Email: lmnh@aol.com
Education: MA
Licensed
Lianne Moccia, CI/CT
128 Stoney Brook Road
Lebanon, NH 03766
Home: 603-448-1411 (TTY/Voice) Beeper for
emergencies only: 443-5729
Email: lianne.moccia@valley.net
Education: M.Ed.
Licensed

Richard Pope, CI/CT
PO Box 76
Nashua, NH 03061
Home: 603-882-6707
Email: rick@iit-inc.net
Education: HS
Licensed

Ann-Marie Pucillo, CI/CT
41 Alder Road
Norton, MA 02766
Email: ampucillo@yahoo.com
Licensed

Jolanta Sudbay, CI/CT
334 North Broadway #106
Salem, NH 03079
Home: 603-890-3401
Email: Jolanta@tmail.com
Education: AA Interpreting
Licensed

Cindy Wallace, CI/CT
8 Woodside Drive
Londonderry, NH 03053
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Licensed

Lori A. Whynot, CI/CT

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Arlington, MA 02476
Home: 781-316-8612 (TTY/Voice)
Email: lawhynot@hotmail.com

James Wiggins, CI/CT
PO Box 272
Medford, MA 02155
Home: 617-448-8264 (Voice)
617-629-2132 (TTY)
Email: athmysts@aol.com

**COMPREHENSIVE SKILLS
CERTIFICATE (CSC)**

Douglas L. Newton, CSC
HCR 75, Box 570
East Sebago, ME 04029
Home: 207-787-3218 (TTY/Voice)
Work: 207-885-0536 (TTY/Voice)
Education: BA

Joan T. Pellerin, CSC
290 Lakeview Terrace
Waterbury Center, VT 05677
Home: 802-244-6117 (TTY/Voice)
Beeper: 802-283-2574
Fax: 802-244-1409 *call first*
Education: MA

Home: 617-267-5188 (TTY)
Work: 617-373-5135 (TTY)
Pager: Jlipsky@wyndtell.com
Email: JSL567@aol.com
Education: BS and MA

CERTIFIED DEAF INTERPRETER (CDI)

Arkady Belozovsky, CDI-P
University of NH at Manchester
400 Commercial Street
Manchester, NH 03101
Work: 6-3-641-4310 (TTY)
Email pager: arkady@wyndtell.com
Email: Arkadyb@cisunix.unh.edu
Education: MS

Georgette "Gigi" Doran, CDI-P, CLIP-
R
28 McCuster Drive, Apt. 7
Braintree, MA 02184
Home: 781-356-9772 (TTY)
Work: 617-695-7600 (TTY)
Or direct line 617-695-7678 (TTY)
Beeper: GIGI49@Wyndtell.com
FAX: 508-588-8420
Email: Gigidoran@aol.com
Education: BA + ITP

Nancy Fuller, CDI-P
12 Eva Street
Providence, RI 02908-2430
Home: 401-861-7679 (TTY)
Work: 401-222-3525 (TTY/Voice)
Beeper: 401-563-4040
Fax: 401-222-6998
Email: CWFuller@aol.com and/or
Nfuller@juno.com
Education: ITP for Deaf Persons

Jazmine K. Gabriel, CDI
Fax: 603-478-1222
Email: serenehaven@gsinet.net
Education: M.Ed.
Licensed

Jim S. Lipsky, CDI
Boston, MA

CERTIFICATE OF INTERPRETATION
(CI)

Caroline Davis-Hines, CI
NH Rte 3A, Box 269
Hill, NH 03243
Home: 603-934-4491 (TTY/Voice)
Beeper: 603-572-2494 numeric & voice
mail
Education: AAS Degree +
Licensed

Julia Barnwell Emley, RSC, IC/TC and
CI
23 Dwinell Drive
Concord, NH 03301
Home: 603-226-0699 (TTY/Voice)
Education: BA
Licensed

Kathleen Fraini, CI
1114 Winn High Drive
Danville, VT 05828
Home: 802-748-4047 (TTY/Voice)
Email: KATHLEEN@kingcon.com
Education: BS

Cheryle Giberson, CI
1114 Winn High Drive
Danville, VT 05828
Home: 802-748-4047 (TTY/Voice)
Email: cheryle_g@yahoo.com
Education: BA's (2)

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Education: Interpreter Training
Program
Licensed

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Cell: 978-852-8617
Email: amyjean30@aol.com
Pager: amyjean37@tmail.com

Education: ASL Deaf Studies: Sign
Language Interpreting
Licensed

Karen G. Paget, CI
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Ipswich, MA 01938
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Email: kgpaget@comcast.net
Licensed

Dena M. Riccio, CI
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Email: denariccio@gowebway.com
Education: Associates
Licensed

Toni L. Robbins, CI
16 Ballard Road
Derry, NH 03038
Home: 603-437-8621 (TTY/Voice)
Fax: 603-437-8621
Education: Interpreter Training Prog.
Licensed

Bethany Roffman, CI
634 Borough Road
Pembroke, NH 03275
Home: 603-226-2486 (Voice)
Email: ASLBethany@comcast.net
Education: BA
Licensed

Damon Timm, CI
310 East Ricker Road
Chichester, NH 03261
Home: 603-608-7589 (Voice)
Email: damontimm@yahoo.com
Education: BS
Licensed

Janice Lynn Wightman, CI
43 Church Street
Lebanon, NH 03766
Home: 603-443-6107 (TTY/Voice)
Work: 603-646-1564 (Voice)
Email:
Janice.Wightman@Dartmouth.edu
Education: Interpreter Training
Program;
BA + 2
Licensed

**CERTIFICATE OF
TRANSLITERATION (CT)**

Stephanie Rosa Harlan, CT
99 Dartmouth Street, Apt. #2F
Manchester, NH 03102

Home: 603-641-6683 (Voice)
Email: stephanierosa714@yahoo.com
Education: High School diploma
Licensed

Marcia Huston, CT
6 Garfield Lane West
Andover, MA 01810
Home: 978-475-3868 (TTY/Voice)
Beeper: 1-800-225-0256 ID# 255543
Email: m-huston@comcast.net
Education: BS

Sally Plows, CT
135 Brookside Drive
New London, NH 03257
Home: 603-526-7335 (TTY/Voice)
Education: BA

Licensed

**XXXIX. INTERPRETATION
CERTIFICATE AND
TRANSLITERATION CERTIFICATE
(IC/TC)**

Jean A. Brennan, IC/TC
23 Duane Road
North Reading, MA 01864
Home: 978-664-2128 (TTY/Voice)
Education: M.Ed.

Jennifer Raney, IC/TC
RD 2, Box 291
St. Johnsbury, VT 05819
Home: 802-748-8799 (Voice)
Education: MA

**AMERICAN CONSORTIUM OF
CERTIFIED INTERPRETERS LEVEL V**

Lesley Garey, ACCI V
24 Wallace Road
Rindge, NH 03461
Home: 603-899-6309 (Voice)
Email: LesleyGarey@hotmail.com
Licensed

Laurie Gilbert, ACCI V
18 Merrimack Drive
Merrimack, NH 03054-4825
Home: 603-886-3807 (Voice)
Licensed

**AMERICAN CONSORTIUM OF
CERTIFIED INTERPRETERS LEVEL III**

Sirena S. Lemieux, ACCI III
785 Valley Street
Manchester, NH 03103
Home: 603-669-5736 (Voice)
Email: sirena2076@comcast.net
Education: BS
Licensed

Amanda Reynolds McClure, ACCI III
111 Lockehaven Road
Enfield, NH 03748
Home: 603-632-9649 (Voice/TTY)
Fax: 603-632-9649
Email: awr001amanda@netscape.net
Education: Associates Degrees - Liberal Arts
and Interpreter Training Program
Licensed

Claudia Nixon, ACI III
13 Perkins Street
Concord, NH 03301
Home: 603-226-3981 (Voice/TTY)
Cell Phone: 603-759-8282
Work: 800-826-3700 (Voice)
888-396-3459 (TTY)
Pager: claudia_nixon@tmail.com
Education:
Licensed

**Oral Certificate from Clarke School for the
Deaf**

* Shannon Kruger
1 Clearview Drive
Bow, NH 03304
Home: 228-5938 (Voice)
Email: krugersnh@cs.com
Education: BA, M.Ed.

* This individual may be paid at the rate of
\$20.00 per hour.

STATE SCREENED INTERPRETERS

Elizabeth Anne Adler
Tyngsboro, MA 01879
Home: 978-649-0262 (Voice)
Cell: 508-572-6878
Email: b_adler@hotmail.com
Licensed

Christine Berube
PO Box 524
Putney, VT 05346
Home: 802-387-4831 (Voice)
Email: Chrisbruby@aol.com
Education: Bachelor's Degree in Sign Language Interpreting

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APPENDIX F

DBHRT Description and Regions by Cities and Towns

New Hampshire Disaster Behavioral Health Response Teams

Overview

The New Hampshire Department of Safety, Homeland Security and Emergency Management (HSEM) has developed an organized team of behavioral health providers to respond to the mental health needs of New Hampshire residents following disasters (e.g., bioterrorism, manmade or natural disasters). Five regional disaster behavioral health response teams (DBHRT) can be deployed immediately anywhere in the state. These teams would respond to disasters or critical incidents when local behavioral health resources have been depleted or are overwhelmed. The goal of the disaster behavioral health response teams is to provide an organized response to individual victims, family members, survivors, or the community affected by critical incidents or disasters.

Team Composition

Teams include individuals with experience in human services, psychology, mental health, substance abuse, social work, psychiatry, education or spirituality. Over 500 Behavioral Health Response Team members have completed specialized training. Team members operate under the supervision of HSEM's Disaster Behavioral Health Coordinator, receive ongoing training and participate in community wide drills.

Interventions

The DBHRTs provide interventions in three distinct phases that may be delivered at a disaster site, in an affected community, or statewide. The phases and interventions include:

Immediate Response

- Behavioral Health Needs Assessment
- Psychological First Aid
- Crisis Intervention
- Community Outreach
- Public Information
- Behavioral Health Consultation

Transition to Recovery

- Brief Supportive Counseling
- Information Dissemination
- Screening and Referral
- Support Groups
- Public Education

Preparedness and Mitigation

- Disaster Behavioral Health Planning and Networking

- Prevention Services Designed to Strengthen Community Resiliency
- Specialized Training Initiatives for Team Members and Community Partners
- Research

Activation

The Governor, or their designee at the Bureau of Emergency Management, would activate these teams during federal or state emergencies. If an emergency is not declared, local municipalities or emergency response systems may request assistance in order to meet the behavioral health needs of communities in local crises by contacting the Disaster Behavioral Health Coordinator at 800-852-3792 or 603-271-2231.

For additional information about the role these teams can play in assisting your community, please contact Paul Deignan, Disaster Behavioral Health Coordinator, at the Bureau of Emergency Management via email pdeignan@nhoem.state.nh.us or by calling 800-852-3792 or 603-271-2231.

DISASTER BEHAVIORAL HEALTH RESPONSE TEAM MEMBER QUALITIES

- **Energetic**- have the capacity and stamina to deal with large numbers of survivors with a broad range of problems and remain active in the face of stress.
- **Tolerant** of others with different values and/or from different cultures and be able to work with a diverse clientele
- **Mature**- able to maintain their own identity and values while working with others.
- **Flexible**- has the capacity to deal with changing situations, which cannot, at least be temporarily fixed.
- **Focused**- able to figure out with the survivor what is most important at that moment and effectively address it.
- **Empathetic**- has the ability to listen and to convey caring.
- **Creative**- have the capacity to think on their feet, problem solve sometimes in an improvisational manner and mobilize environmental resources.
- **Positive**- a sense of confidence, able to help survivors celebrate the small victories on the long road to recovery and possess an optimistic yet realistic view of life.
- **Non-traditional**- able to work in a variety of environments when and where needed.
- **Available**- able to give of one's time and energy sufficiently to do the job.
- A **team player**- has the capacity to become part of a synergistic team, including other community emergency response partners and work within the incident command structure.
- A **self-starter**-shows initiative and able to work independently while staying within the overall guidelines of the Plan.
- **Sensitive** to the needs of others and able to monitor/manage their own stress.
- Able to **function** in confusing and often chaotic environments.
- **Comfortable** initiating a conversation in any community setting and able to "be with" survivors who may be suffering tragedy and enormous loss.
- **Committed** to respect the privacy and confidentiality of survivors, not inclined to gossip.

**DISASTER BEHAVIORAL HEALTH RESPONSE TEAM
CITIES & TOWNS BY REGIONS**

Region I	Region II	Region III	Region IV	Region V
Albany	Acworth	Alexandria	Amherst	Atkinson
Bartlett	Alstead	Allenstown	Auburn	Barrington
Bath	Antrim	Alton	Bedford	Brentwood
Benton	Bennington	Andover	Brookline	Chester
Berlin	Canaan	Ashland	Candia	Danville
Bethlehem	Charlestown	Barnstead	Goffstown	Deerfield
Brookfield	Chesterfield	Belmont	Hollis	Derry
Carroll	Claremont	Boscawen	Hooksett	Dover
Chatham	Cornish	Bow	Hudson	Durham
Clarksville	Croydon	Bradford	Litchfield	East Kingston
Colebrook	Dorchester	Bridgewater	Londonderry	Epping
Columbia	Dublin	Bristol	Manchester	Exeter
Conway	Enfield	Campton	Mason	Farmington
Dalton	Fitzwilliam	Canterbury	Merrimack	Fremont
Dixville	Francestown	Center Harbor	Milford	Greenland
Dummer	Gilsum	Chichester	Mont Vernon	Hampstead
Easton	Goshen	Concord	Nashua	Hampton
Eaton	Grafton	Danbury	New Boston	Hampton Falls
Effingham	Grantham	Deering		Kensington
Errol	Greenville	Dunbarton		Kingston
Franconia	Hancock	Ellsworth		Lee
Freedom	Hanover	Epsom		Madbury
Gorham	Harrisville	Franklin		Middleton
Hart's Location	Hinsdale	Gilford		Milton
Haverhill	Jaffrey	Gilmanton		New Castle
Jackson	Keene	Groton		New Durham
Jefferson	Langdon	Hebron		Newfields
Lancaster	Lebanon	Henniker		Newington
Landaff	Lempster	Hill		Newmarket
Lincoln	Lyme	Hillsboro		Newton
Lisbon	Lyndeborough	Holderness		North Hampton
Littleton	Marlborough	Hopkinton		Northwood
Lyman	Marlow	Laconia		Nottingham
Madison	Nelson	Loudon		Pelham
Milan	New Ipswich	Meredith		Plaistow
Monroe	Newport	New Hampton		Portsmouth
Moultonborough	Orange	New London		Raymond
Northumberland	Orford	Newbury		Rochester
Ossipee	Peterborough	Northfield		Rollinsford
Piermont	Plainfield	Pembroke		Rye
Pittsburg	Richmond	Pittsfield		Salem
Randolph	Rindge	Plymouth		Sandown
Sandwich	Roxbury	Rumney		Seabrook
Shelburne	Sharon	Salisbury		Somersworth
Stark	Springfield	Sanbornton		South Hampton
Stewartstown	Stoddard	Sutton		Strafford
Stratford	Sullivan	Thornton		Stratham

Sugar Hill	Sunapee	Tilton		Windham
Tamworth	Surry	Warner		
Tuftonboro	Swanzey	Weare		
Wakefield	Temple	Webster		
Warren	Troy	Wentworth		
Waterville	Unity	Wilmot		
Wentworth Location	Walpole	Windsor		
Whitefield	Washington			
Wolfboro	Westmoreland			
Woodstock	Wilton			
	Winchester			

DBHRT TEAM MEMBERSHIP AGREEMENT

The provisions below represent the requirements for membership with the New Hampshire Bureau of Emergency Management Disaster Behavioral Health Response Team (DBHRT). Please read the Agreement and Attachment thoroughly, complete and sign where indicated. Signature on this form denotes that you agree to each of the following:

- I shall maintain and abide by the ethics and standards of my profession, including licensure, certification and/ or training requirements relevant to my Team Membership role.
- I shall serve for a minimum of two years in a voluntary capacity as a DBHRT member. Membership may be renewed. If I become unable to provide further services, I will submit a written resignation to that effect at least 30 days in advance. I also agree to return my I.D. badge and any other team property.
- I understand that in order to renew membership status I must attend a minimum of eight (8) hours of DBH approved continuing education in each 2-year service cycle. These hours may include DBH approved Core Competencies in the following areas:

Crisis Intervention (Acute/Post/Ongoing)	Pastoral Crisis Intervention
Psychological First Aid	Death Notification
Field Assessment	Secondary Traumatization (Self/Team Care)
Community Outreach	Stress Management
Incident Command System	Substance Abuse Risks, Prevention and Treatment
Individual & Group Interventions	Suicide Prevention/Intervention

- I understand that in order to retain membership status I must be available for responses. My membership may be revoked if I am not available to respond on three or more occasions to a crisis within my area. Exceptions, in cases of illness or conflict of interest, may be made upon request.
- I agree to maintain strict confidentiality regarding statements made by participants during crisis debriefings /interventions except under those circumstances such as duty to warn and abuse or neglect. I am aware that any violation of confidentiality may result in dismissal from the DBHRT.
- I have read and shall follow the DBHRT Operational Procedures.
- I agree to participate in at least one tabletop or other simulated drills each year.
- I shall not act in the capacity of a responder, nor present myself as a DBHRT member, at any given site without prior authorization from the DBH staff.
- I shall not solicit clients or conduct other personal business while acting in the capacity of a DBHRT member.
- I understand that only authorized travel expenses associated with responding as a DBHRT member will be reimbursed based on state rates for mileage, tolls and parking, food and lodging.

Name (printed) _____

Home Address _____

Work Address _____

Telephone: (home) _____ (Work) _____

(Pager) _____ (Cell) _____

E-mail (H) _____ (w) _____

Signature _____ Date _____

APPENDIX G - GO KIT

Coping Tip Handouts

(* materials are available in French, Arabic, Bosnian, Spanish and Vietnamese)

GO-KIT CONTENTS

INFORMATIONAL HANDOUTS

After Disaster- Guide for Parents
After the disaster
Children's Reactions to Disaster
Common Stress Reactions
Coping with Disaster - Tips for Adults
Coping with the Aftermath of
Witnessing a Major Disaster
DBHRT Description
Families Can Help Children Cope
Handling Disaster Related Stress
Helping Children Cope w/Trauma
How to Deal with Grief
How to Help Children After Disaster
Learning to Say Goodbye
Managing Anxiety in Times of Crisis
Self-care Tips for Dealing w/ Stress
Self-care Tips for Disaster Workers
Special Concerns of Older Adults
Warning Signs of Trauma

FORMS

Disaster Activity Log
Initial Community Needs Assessment
Intake Form

REFERRAL GUIDES

A.A. /N/A. meeting lists
Behavioral Health Resource Directory
Local, State and Federal Emergency Management/Resources Phone Numbers
DBHRT Field Guides
Community Profiles

MISCELLANEOUS

Clipboards
Paper, markers, pencils
Vests
DBHRT Banner
Stapler

AFTER THE DISASTER*

After experiencing the shock and pain of the disaster, you will be very busy for the next few days or weeks. Caring for your immediate needs, perhaps finding a new place to stay, planning for cleanup and repairs, and filing claim forms may occupy the majority of your time. As the immediate shock wears off, you will start to put your life back together. Most people experience normal reactions as a result of the disaster. Generally, these feelings don't last long, but it is common to feel let down and resentful many months after the event. Some feelings or responses may not appear until weeks or even months after the disaster.

Some common responses are:

- Irritability/Anger
- Fatigue
- Loss of appetite
- Inability to sleep
- Nightmares
- Sadness
- Headaches or nausea
- Hyperactivity
- Lack of concentration
- Increased alcohol or drug consumption

Many victims of disaster will have at least one of the above responses. Acknowledging your feelings and stresses is the first step to feeling better. Other helpful actions include:

- Talk about your disaster experiences. Sharing your feelings rather than holding them in will help you feel better about the experience.
- Take time off from cares, worries, and home repairs. Engage in recreation, relaxation, or a favorite hobby. Getting away from home for a day or a few hours with close friends also can help.
- Pay attention to your health, a good diet, and adequate sleep. Relaxation exercises may help if you have difficulty sleeping.
- Prepare for possible future emergencies to help lessen feelings of helplessness and to achieve peace of mind.
- Rebuild personal relationships in addition to repairing other aspects of your life. Couples should make time to be alone together, to talk, and to have fun.

If stress, anxiety, depression, or physical problems continue, you may wish to contact the post-disaster services provided by your local mental health disaster recovery program.

Please take this sheet with you today and reread it over the next few weeks and months. Being aware of your feelings and sharing them with others is an important part of your recovery.

CHILDREN'S REACTIONS TO DISASTER*

A disaster, whether community wide or involving only a single family, may leave children especially frightened, insecure, or upset about what happened. They may display a variety of emotional responses after a disaster, and it is important to recognize that these responses are normal.

How a parent reacts will make a great difference in the child's understanding and recovery after the disaster. Parents should make every effort to keep the children informed about what is happening and to explain it in terms they can understand.

The following list includes some of the reactions parents may see in their children:

Crying/Depression	Inability to concentrate
Bedwetting	Withdrawal and isolation
Thumb sucking	Not wanting to attend school
Nightmares	Headaches
Clinging/fear of being left alone	Changes in eating and sleeping habits
Regression to previous behaviors	Excessive fear of darkness
Fighting	Increase in physical complaints

Some things that will help your child recover are to:

- Hug and touch your child often.
- Reassure the child frequently that you are safe and together.
- Talk with your child about his/her feelings about the disaster. Share your feelings too. Provide information the child can understand.
- Talk about what happened.
- Spend extra time with your child at bedtime.
- Allow children to grieve about their lost treasures: a toy, a blanket, and a lost home.
- Talk with your child about what you will do if another disaster strikes. Let your child help in preparing and planning for future disasters.
- Try to spend extra time together in family activities to begin replacing fears with pleasant memories.
- If your child is having problems at school, talk to the teacher so that you can work together to help your child.

Usually a child's emotional response to a disaster does not last long. Be aware that some problems may not appear immediately or may recur months after the disaster. Talking openly with your children help them to recover more quickly from the loss. If you feel your child may need additional help to recover from the disaster, contact your Community Mental Health Agency. Call 1-800- to obtain the phone # of the agency closest to you.

COMMON STRESS REACTIONS FOLLOWING EXPOSURE TO TRAUMA

Psychological and Emotional

- Initial euphoria, relief
- Guilt about surviving or not having suffered as much as others
- Anxiety, fear, insecurity, worry
- Pervasive concern about well-being of loved ones
- Feelings of helplessness, inadequacy, being overwhelmed
- Vulnerability
- Loss of sense of power, control, well-being, self-confidence, trust
- Shame, anger over vulnerability
- Irritability, restlessness, hyperexcitability, impatience, agitation, anger, blaming (anger at source, anger at those exempted, anger at those trying to help, anger “for no apparent reason”)
- Outrage, resentment
- Frustration
- Cynicism, negativity
- Mood swings
- Despair, grief, sadness
- Periods of crying, emotional “attacks” or “pangs”
- Feelings of emptiness, loss, hopelessness, depression
- Regression
- Reawakening of past trauma, painful experiences
- Apathy, diminished interest in usual activities
- Feelings of isolation, detachment, estrangement, “no one else can understand”
- Denial or constriction of feelings; numbness
- “Flashbacks,” intrusive memories of the event, illusions, pseudo-hallucinations
- Recurrent dreams of the event or other traumas

Cognitive

- Poor concentration
- Mental confusion, slowness of thinking
- Forgetfulness
- Amnesia (complete or partial)
- Inability to make judgments and decisions
- Inability to appreciate importance or meaning of stimuli
- Poor judgment
- Loss of appropriate sense of reality (denial of reality, fantasies to counteract reality)
- Preoccupation with the event
- Repetitive, obsessive thoughts and ruminations
- Over-generalization, over-association with the event
- Loss of objectivity
- Rigidity
- Confusion regarding religious beliefs/value systems; breakdown of meaning and faith
- Self-criticism over things done/not done during trauma
- Awareness of own and loved ones’ mortality

SPECIAL CONCERNS OF OLDER ADULTS FOLLOWING A DISASTER*

Each age group is vulnerable in unique ways to the stresses of a disaster. Different issues and concerns become relevant during the emotional recovery. In older adults some disaster stress reactions may be experienced immediately, while others may appear months later. Here are some of the symptoms you or a loved one may be having.

BEHAVIORAL SYMPTOMS

Withdrawal and isolation
Reluctance to leave home
Mobility limitations
Relocation adjustment problems

PHYSICAL SYMPTOMS

Worsening of chronic illness
Sleep disorders
Somatic symptoms
Physical or sensory limitations
Embarrassment about receiving "handouts"

EMOTIONAL SYMPTOMS

Depression
Despair about losses
Apathy
Confusion - Disorientation
Suspicion
Agitation - Anger
Fears of institutionalization
Anxiety with unfamiliar surroundings

Many who survive a disaster experience a strong desire to withdraw from others. They may withdraw even from those to whom they are the closest. Overcoming the tendency to isolate themselves takes real strength and discipline. A few ways to break the isolation barrier are to:

TALK: It takes courage to reveal what you are thinking and feeling to someone else. Talking can be very comforting and healing. Talking is worth it.

ASK FOR HELP: Research shows that people who ask for help come through disasters stronger and healthier than those who view seeking help as a weakness.

BE WITH PEOPLE: Life does not return to normal overnight. You have survived a disaster. That doesn't mean your life is over or that you don't deserve to be happy again. Do something good for yourself. Now is the time to do it!

HANDLING DISASTER-RELATED STRESS

Tips for Coping with Disaster

Disasters affect our lives like no other phenomena. For those of us affected directly, they generate a sense of anxiety that can destroy our peace of mind. They can create fears that wake us in the night and intrude on our thoughts during the day. They can break our ability to concentrate and turn small problems into huge issues. And even for those of us not affected, disasters have profound impact on our lives by robbing us of our personal sense of control and security.

In short, disasters create a tremendous amount of stress. If this stress goes unrecognized and unmanaged, it can severely damage a person's mental and physical health. It can increase until it is impossible to cope mentally with everyday problems or to resist stress-related physical illnesses such as high blood pressure, ulcers, and heart disease.

If you recognize and handle stress properly, however, it can become something healthy that gets you through the challenges of each day and the trauma of another disaster. This fact sheet should give you the information needed to adjust.

What is stress?

Stress is a unique and personal response from our bodies and minds to meet the demands of different situations. These situations trigger an instinctive "fight or flight" response that increases blood pressure, heart rate, respiration, and blood flow to muscles. Mentally, we focus our attention and intellect on the matters at hand. Originally, these reactions helped people prepare for a physical conflict, or to escape from one. Now, they usually serve to direct our mental and physical resources to a particularly difficult or trying situation with positive results. Sometimes, though, these events last longer than our ability to cope with them, as when disaster strikes.

When disasters happen, we experience feelings of *distress*, or negative stress. If this negative stress is left unmanaged, the risk for stress-related health problems, interpersonal conflicts, and even domestic violence becomes much more likely. To counter such responses, you must learn how to recognize negative stress, and then learn how to help it work for you.

How do I know if I'm experiencing negative stress?

Stress affects everyone differently. What might indicate negative stress in one person might be a personality trait in another. In most cases, though, there are warning signs that indicate a need for active stress management.

These signs include:

- persistent fatigue
- inability to concentrate
- flashes of anger, lashing out at friends and family
- changes in eating and sleeping habits
- prolonged tension headaches, lower backaches, stomachaches, or other physical ailments
- prolonged feelings of depression, anxiety, or helplessness

How do I manage stress?

Just as stress affects everyone differently, each person finds different ways to cope. Some approaches that help you manage negative stress in your life are to:

Talk it out. You're not in this alone. Your family, friends, and neighbors are feeling some of the same anxieties you're experiencing. Share your feelings and listen to what they share. Other sources of support can be found in your community mental health center or in your church.

Try physical activity. Release the tension of stress by developing a regular exercise routine. Try walking in the evenings or some stretching exercise. If you have a physical disability, consult a physician to determine what kind of exercise is right for you.

Know your limits and make time for relaxation. Sometimes exercising or talking about your feelings only work briefly before something reminds you of the disaster and again creates anxiety. It's important to remember that disasters are beyond your control. Try to reduce the amount of time you spend worrying about the things you cannot change. Cut down or eliminate the activities that cause you stress. If coverage of the disaster on the evening news or in the morning paper leaves you stressed or anxious, simply reduce the amount of time you spend reading or watching the news. Use that time to involve yourself in activities you find enjoyable and relaxing, such as reading a book, visiting with friends, or helping others that are affected. Take control. You can't control disasters or the damage caused by them. Admit that certain things are beyond your control and then regularly remind yourself of your strengths and abilities. It is important to remember that you can control your reactions.

If you feel your problem is more serious or if you're experiencing hopelessness or extreme anger, you may want to consider professional help from a counselor, social worker, psychologist, or psychiatrist.

After a Disaster Guide for Parents and Teachers

Natural disasters such as tornados, or man-made tragedies such as bombings, can leave children feeling frightened, confused, and insecure.

Whether a child has personally experienced trauma or has merely seen the event on television or heard it discussed by adults, it is important for parents and teachers to be informed and ready to help if reactions to stress begin to occur.

Children respond to trauma in many different ways. Some may have reactions very soon after the event; others may seem to be doing fine for weeks or months, and then begin to show worrisome behavior. Knowing the signs that are common at different ages can help parents and teachers to recognize problems and respond appropriately.

Preschool Age

Children from one to five years in age find it particularly hard to adjust to change and loss. In addition, these youngsters have not yet developed their own coping skills, so they must depend on parents, family members, and teachers to help them through difficult times.

Very young children may regress to an earlier behavioral stage after a traumatic event. For example, preschoolers may resume thumb sucking or bedwetting or may become afraid of strangers, animals, darkness, or "monsters." They may cling to a parent or teacher or become very attached to a place where they feel safe.

Changes in eating and sleeping habits are common, as are unexplainable aches and pains. Other symptoms to watch for are disobedience, hyperactivity, speech difficulties, and aggressive or withdrawn behavior. Preschoolers may tell exaggerated stories about the traumatic event or may speak of it over and over.

Early Childhood

Children aged five to eleven may have some of the same reactions as younger boys and girls. In addition, they may withdraw from play groups and friends, compete more for the attention of parents, fear going to school, allow school performance to drop, become aggressive, or find it hard to concentrate. These children may also return to "more childish" behaviors; for example, they may ask to be fed or dressed.

Adolescence

Children twelve to fourteen are likely to have vague physical complaints when under stress and may abandon chores, schoolwork, and other responsibilities they previously handled. While on the one hand they may compete vigorously for attention from parents and teachers, they may also withdraw, resist authority, become disruptive at home or in the classroom, or even begin to experiment with high-risk behaviors such as drinking or drug abuse. These young people are at a developmental stage in which the opinions of others are very important. They need to be thought of as "normal" by their friends and are less concerned about relating well with adults or participating in recreation or family activities they once enjoyed.

In later adolescence, teens may experience feelings of helplessness and guilt because they are unable to assume full adult responsibilities as the community responds to the disaster. Older teens may also deny the extent of their emotional reactions to the traumatic event.

How to Help

Reassurance is the key to helping children through a traumatic time. Very young children need a lot of cuddling, as well as verbal support. Answer questions about the disaster honestly, but don't dwell on frightening details or allow the subject to dominate family or classroom time indefinitely. Encourage children of all ages to express emotions through conversation, drawing, or painting and to find a way to help others who were affected by the disaster.

Try to maintain a normal household or classroom routine and encourage children to participate in recreational activity. Reduce your expectations temporarily about performance in school or at home, perhaps by substituting less demanding responsibilities for normal chores.

Finally, acknowledge that you, too, may have reactions associated with the traumatic event, and take steps to promote your own physical and emotional healing.

Note: Information based on brochure developed by Project Heartland -- A Project of the Oklahoma Department of Mental Health and Substance Abuse Services in response to the 1995 bombing of the Murrah Federal Building in Oklahoma City. Project Heartland was developed with funds from the Federal Emergency Management Agency in consultation with the Federal Center for Mental Health Services.

How to Deal With Grief

What is grief?

Grief is the normal response of sorrow, emotion, and confusion that comes from losing someone or something important to you. It is a natural part of life. Grief is a typical reaction to death, divorce, job loss, a move away from family and friends, or loss of good health due to illness.

How does grief feel?

Just after a death or loss, you may feel empty and numb, as if you are in shock. You may notice physical changes such as trembling, nausea, trouble breathing, muscle weakness, dry mouth, or trouble sleeping and eating.

You may become angry - at a situation, a particular person, or just angry in general. Almost everyone in grief also experiences guilt. Guilt is often expressed as "I could have, I should have, and I wish I would have" statements.

People in grief may have strange dreams or nightmares, be absent-minded, withdraw socially, or lack the desire to return to work. While these feelings and behaviors are normal during grief, they will pass.

How long does grief last?

Grief lasts as long as it takes you to accept and learn to live with your loss. For some people, grief lasts a few months. For others, grieving may take years.

The length of time spent grieving is different for each person. There are many reasons for the differences, including personality, health, coping style, culture, family background, and life experiences. The time spent grieving also depends on your relationship with the person lost and how prepared you were for the loss.

How will I know when I'm done grieving?

Every person who experiences a death or other loss must complete a four-step grieving process:

- (1) Accept the loss;
- (2) Work through and feel the physical and emotional pain of grief;
- (3) Adjust to living in a world without the person or item lost; and
- (4) Move on with life.

The grieving process is over only when a person completes the four steps.

How does grief differ from depression?

Depression is more than a feeling of grief after losing someone or something you love. Clinical depression is a whole body disorder. It can take over the way you think and feel. Symptoms of depression include:

- A sad, anxious, or "empty" mood that won't go away;
- Loss of interest in what you used to enjoy;
- Low energy, fatigue, feeling "slowed down;"
- Changes in sleep patterns;

- Loss of appetite, weight loss, or weight gain;
- Trouble concentrating, remembering, or making decisions;
- Feeling hopeless or gloomy;
- Feeling guilty, worthless, or helpless;
- Thoughts of death or suicide or a suicide attempt; and
- Recurring aches and pains that don't respond to treatment.

If you recently experienced a death or other loss, these feelings may be part of a normal grief reaction. But if these feelings persist with no lifting mood, ask for help.

Where can I find help?

The following list of organizations and web sites provides information and support for coping with grief:

The Compassionate Friends (national office)

P.O. Box 3696

Oak Brook, IL 60522-3696

630-990-0010; Toll Free 877-9690010

<http://www.compassionatefriends.org>

A national, self-help support organization for those grieving the loss of a child or sibling.

Online Resources

GriefNet

<http://www.griefnet.org/>

A web site that provides information and resources related to death, dying, bereavement, and major emotional and physical losses.

Growth House, Inc.

<http://www.growthhouse.org>

A source of quality information and resources on death and dying issues,

Transformations

<http://www.transformations.com>

A web site about self-help, support, and recovery issues.

Managing Anxiety in Times of Crisis

Recognizing and Reducing Anxiety in Times of Crisis

Americans need ways to cope with the anxiety produced by senseless tragedies such as terrorist attacks. No one who sees or hears about a tragedy of this kind is untouched by it - and in an era of instant mass communications, the numbers of people exposed to such violence in one way or another is significant. Most of us will experience some related anxiety and stress that will fade over time. For some, however, such feelings may not go away on their own. We need to recognize the difference and understand that, if needed, help is available and effective.

What are Common Reactions?

Mass tragedies can affect us in many ways: physically, emotionally and mentally. They can make people feel angry, enraged, confused, sad, or even guilty. When those feelings don't go away over a few weeks, or when they seem to get worse, it may be appropriate to seek help for yourself or the person in your life who is experiencing these difficulties. Among the signs to look for over time are:

- Feeling tense and nervous
- Being tired all the time
- Having sleep problems
- Crying often or easily
- Wanting to be alone most of the time
- Drinking alcohol or taking drugs more often or excessively
- Feeling numb
- Being angry or irritable
- Having problems concentrating and remembering things

What Can You Do to Help?

Everyone can take one simple step: get in touch with your emotions and how you are feeling and how your family and loved ones are doing as well. If you think there may be a problem, get advice from someone trained to recognize signs and symptoms of post-traumatic stress. Pay special attention to children's needs and talk with them in a calm, supportive way about their fears. Don't neglect or let anyone you know neglect his or her other health care needs at this time. You should get immediate help from a trained mental health professional if you or a loved one is experiencing any one or more of these problems: inability to return to normal routine; feeling extremely helpless; having thoughts of hurting one's self or others; using alcohol and drugs excessively; thinking about or being abusive or violent; or having noticeable symptoms of mental illness.

Warning Signs of Trauma-Related Stress

Individuals who have experienced a traumatic event oftentimes suffer psychological stress related to the incident. In most instances, these are normal reactions to abnormal situations. Individuals, who feel they are unable to regain control of their lives, or who experience the following symptoms for more than a month, should consider seeking outside professional mental health assistance. The American Red Cross is now working with mental health professionals trained in trauma. For information or referral, contact the local American Red Cross chapter or the American Psychological Association at 202/336-5800.

- Recurring thoughts or nightmares about the event.
- Having trouble sleeping or changes in appetite.
- Experiencing anxiety and fear, especially when exposed to events or situations reminiscent of the trauma.
- Being on edge, being easily startled or becoming overly alert.
- Feeling depressed, sad and having low energy.
- Experiencing memory problems including difficulty in remembering aspects of the trauma.
- Feeling "scattered" and unable to focus on work or daily activities. Having difficulty making decisions.
- Feeling irritable, easily agitated, or angry and resentful.
- Feeling emotionally "numb," withdrawn, disconnected or different from others.
- Spontaneously crying, feeling a sense of despair and hopelessness.
- Feeling extremely protective of, or fearful for, the safety of loved ones.
- Not being able to face certain aspects of the trauma, and avoiding activities, places, or even people that remind you of the event.

by the American Psychological Association

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State of New Hampshire
Department of Safety Homeland Security and
Emergency Management
Disaster Behavioral Health Response Plan

Signatories to the State of New Hampshire Disaster Behavioral Health Response Plan

Department of Health & Human Services
Bureau of Behavioral Health

Date

Department of Safety
Homeland Security & Emergency Management

Date

American Red Cross

Date

Salvation Army

Date

Volunteer Organizations
Active in Disaster (VOAD)

Date

To: New Hampshire Homeland Security and Emergency Management
Disaster Behavioral Health Coordinator
33 Hazen Drive Concord, NH. 03305

Proposal for Changes, Corrections, Additions and Deletions to the Disaster Behavioral Health Response Plan

Any user of this plan is encouraged to recommend changes that the user feels might enhance or clarify a particular portion of the area being addressed. Suggested changes should be submitted to Homeland Security and Emergency Management, at the above address, for coordination, comment, concurrence and approval. The format of suggested changes should be by Section, Paragraph/Subparagraph and page number.

CHANGE:

SHOULD READ:

Submitted by:

Name

Date

Phone Number