Wisconsin's Emergency Human Services Response

A Disaster Mental Health, Substance Abuse, and Human Services Plan

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State of Wisconsin
Department of Health and Family Services

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Part A:

Plan Overview

Section 1: Purpose and Objectives

Purpose

In recognition of the fact that the occurrence of a biological, chemical, radiological, or natural disaster can easily overwhelm or damage the capability of local mental health, substance abuse, and human service resources to meet community human service needs, this Disaster Mental Health/Substance Abuse/Human Services Preparedness Plan has been developed.

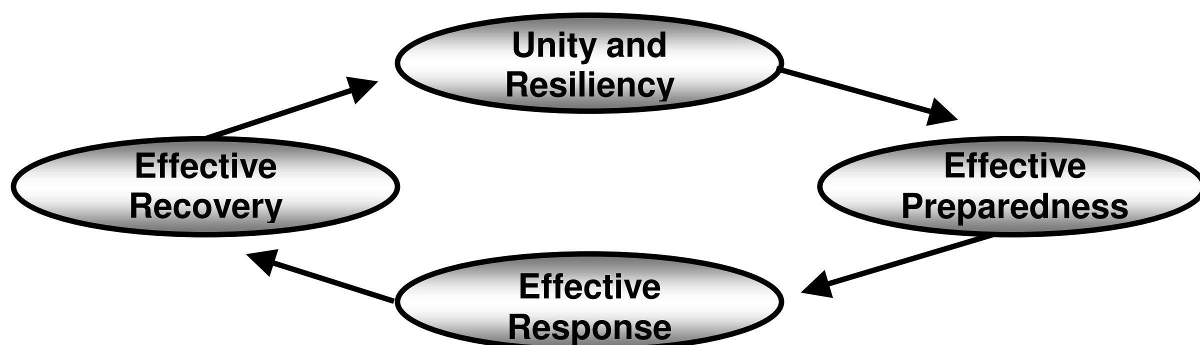
The purpose of this Plan is to create and establish the necessary structure and process to enable the Department of Health and Family Services (DHFS) to support local and regional efforts to meet community, county, and regional human service needs in a collaborative, organized, effective, and culturally and linguistically competent manner.

The Plan integrates with county, regional, state, and Federal emergency plans; other DHFS plans; CDC- and HRSA-sponsored Bioterrorism Preparedness plans within the DHFS Division of Public Health (DPH); other public health and hospital plans; institutional and organizational plans; tribal plans; other local plans; and border state plans, as appropriate.

This Plan addresses responses to Bioterrorism, Other Infectious Disease Outbreaks, Other Public Health Threats and Emergencies (BOIDOOPHTE), and natural disasters, taking an all-hazards approach that spans the full spectrum of possible causes and effects of public health threats and emergencies:

- From natural disasters to intentional (e.g., terrorist) events
- From localized to national threats and emergencies
- From short- to long-term repercussions
- From mild to severe psychosocial effects

The Plan is designed to promote community resilience, unity, and recovery, and to minimize the negative psychosocial effects of natural disasters, public health threats and emergencies on individuals, families, communities, service systems, and the emergency response as a whole.



Objectives

Part A: Plan Overview

1. Define a purpose and objectives for the Plan
2. Describe the general circumstances under which the State's emergency human service planning and response processes take place (Section 2, Situation and Assumptions)
3. Provide a general overview of the responsibilities and procedures outlined in the Plan (Section 3, Concept of Operations)
4. Name the legal authorities supporting this Plan (Section 4, Legal Basis)

Part B: Planning and Preparedness

5. Describe some of the circumstances that affect this planning process (Section 5, Planning Considerations)
6. Outline some of the training options available to DHFS and its partners (Section 6, Education and Training)

Part C: Roles, Responsibilities, and Tasks

7. Delineate lines of authority and divisions of responsibility in emergency human services provision in Wisconsin (Section 7, Authority and Responsibility)
8. Document the tasks of emergency human services staff during the warning and mobilization process (Section 8, Warning and Mobilization)
9. Document the tasks of emergency human services staff during the response phase (Section 9, Response)
10. Document the tasks of emergency human services staff during the recovery phase (Section 10, Recovery)
11. Coordinate with other governmental bodies and integrate with other related plans (Section 11, Coordination and Connectivity)
12. Identify issues for administration and details of plan maintenance and revision (Section 12, Administration and Plan Maintenance)

Part D: Guidance on Specific Issues

13. Outline communication issues that might arise in the event of a disaster or emergency, and resources identified (Section 13, Communications)
14. Describe key considerations for public information designed to promote psychosocial well being in an emergency situation (Section 14, Public Information)

15. Identify procedures for continuing Departmental operations and communicating with field institutions in the event of a disaster or other emergency (Section 15, Mobilization of Human Service Systems)
16. Outline human services considerations to be addressed in the realm of health and medical care (Section 16, Health and Medical)
17. Identify key considerations for human services planning to respond to specific types of disasters, threats, and emergencies (including terrorism) most likely to affect Wisconsin (Section 17, Hazard-Specific Risks and Effects)

Part E: Standard Operating Procedures and Checklists

18. Provide standard operating procedures for the warning and mobilization process (Section 18, SOP, Warning and Mobilization)
19. Provide standard operating procedures for the response phase (Section 19, SOP, Response)
20. Provide standard operating procedures for the recovery phase (Section 20, SOP, Recovery)

Section 2: Situation and Assumptions

Scope and Administration

A. Governments have the legal duty and ethical responsibility to provide effective and appropriate support to communities, families, and individuals affected by the stress, grief, and fatigue engendered by all forms of disasters, public health threats, and emergencies.

B. Wisconsin is a Home Rule state. Per Wisconsin State Statute (Chapter 166), Wisconsin counties have primary control and responsibility for disaster/emergency planning, response, and recovery activities. In the event of an emergency, county government has the authority to coordinate both governmental and volunteer activity. On the local level, the County Emergency Management office is the coordinating agency for the overall disaster/emergency preparedness and response effort. The County Human Services Authority is the coordinating agency for disaster mental health, substance abuse, and emergency human service (combined under the term “disaster human service”) preparedness, response, recovery, as well as evacuation and sheltering.

C. Native American tribes in Wisconsin have Sovereign Nation status. Tribes have their own laws in addition to Federal and State statutes, and their own judicial systems, police, fire, and tribal government. For a tribe, human services authority is vested in the Tribal Chair.

D. Local jurisdictions respond first to a disaster by implementing municipal plans, but can quickly exhaust resources, making outside assistance necessary. When such assistance is provided, local elected officials still retain control over the response effort.

E. The role of State government is to provide support to counties in the form of collaboration, technical assistance, and help in obtaining Federal disaster assistance funding. Wisconsin Emergency Management (WEM) is the statewide coordinating agency for overall disaster preparedness and response. The Department of Health and Family Services (DHFS), Division of Disability and Elder Services (DDES), Bureau of Mental Health and Substance Abuse Services (BMHSAS) is the statewide coordinating agency for disaster human service preparedness and response.

F. Emergency Management in Wisconsin uses an all-hazards approach that includes mitigation, preparedness, response, and recovery from major incidents. It also utilizes the Incident Command Structure (ICS) with Unified Command and Control.

G. Wisconsin’s disaster human service response is based on the same all-hazards approach and plays an essential part in the emergency management Incident Command Structure. The DHFS Emergency Human Services Coordinator occupies a station in the Emergency Operations Center (EOC) run by Wisconsin Emergency Management, DHFS runs a 24 hour/seven day per week Emergency Human Services on-call system, and county-level Human Services Authorities take part in local emergency management teams.

Wisconsin's disaster human service efforts are also an integral part of a larger all-hazards public health response to Bioterrorism, Other Infectious Disease Outbreaks, and Other Public Health Threats and Emergencies (BOIDOOPHTE). This public health response is administered by the DHFS Division of Public Health (DPH) and funded by Federal grants from the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA).

Hazards

A. Several hazards pose a threat to human lives and well being in Wisconsin. These threats include, but are not limited to:

- Natural events such as tornadoes, straight-line wind events, and other violent storms; floods, ice storms; heat waves; extreme cold; and drought
- Human-caused events such as fires; the release of hazardous materials (e.g., pesticides, nuclear radiation) into the air, ground or water at fixed locations or during transportation; and aircraft crashes
- Communicable disease outbreaks and epidemics such as hepatitis, tuberculosis, SARS, monkey pox, cryptosporidiosis, Legionnaires' disease, food-borne and water-borne diseases, rabies, and vaccine-preventable diseases (e.g., measles, smallpox)
- The subset of human-caused events defined as terrorist threats and emergencies, which might include explosions, communicable disease outbreaks (e.g., smallpox, anthrax), aircraft incidents, release of toxic chemicals, or damage to nuclear power plants within the state or in states situated upwind of Wisconsin (Minnesota) or near Wisconsin's borders (Illinois)

B. Based on past experience, hazards most likely to occur with any frequency in the state include floods, tornadoes, disease outbreaks, and the release of toxic chemicals (due to train derailments, chemical spills, etc.).

C. In terms of the Public Health and hospital response, events (disasters, epidemics, etc. that overwhelm the resources of a particular institution and require outside help) are defined in terms of varying levels of severity:

- Level 1: The closest hospital can accommodate the needs
- Level 2: Other hospitals and off-site treatment facilities in the region are required for effective response
- Level 3: Hospitals and off-site treatment facilities in other regions or states are also necessary
- Level 4: The event is national in scope, because a Level-3 disaster exists in two or more states

D. Disasters are also divided into two types:

- "Lights and Sirens" incidents: Develop rapidly and produce many casualties in a short time
- "Delayed" and/or "Biological" incidents: Develop gradually; may produce many casualties over a long period of time; and may produce significantly more people who, though not infected, have significant fear of infection and often present for testing and reassurance

E. Although Wisconsin has experienced and responded effectively to many localized disasters, it has had no experience of the kind of mass-casualty situation that a strategically executed terrorist event (e.g., smallpox epidemic, large-scale bombing incident) might produce.

Human Impact

A. The effects of natural disasters and other public health threats and emergencies can place enormous stress on the coping abilities of even the healthiest people, be they victims, survivors, family members, emergency responders, community leaders, or public officials.

B. The need for an understanding and "normalization" of ordinary human reactions to these extraordinary events is not widely understood, but it is of great importance in meeting the needs and respecting the dignity of people in crisis. Many people who need help in coping with this stress may not seek or accept help if it is presented in terms of "mental health services" or "substance abuse services," for fear of the stigma associated with the conditions that those services are traditionally designed to treat.

C. In a large-scale public health emergency, both the emergency and the response process itself can engender chaos and confusion, destabilizing survivors and crisis workers alike. Disaster situations may also leave some survivors with long-term chronic stress disorders, in numbers that the pre- and post-crisis human service systems are not equipped to address.

D. For people with pre-existing mental illness, substance use disorders, disabilities, or higher levels of vulnerability to emotional stress (e.g., children, older adults), crisis situations can bring about psychological and/or behavioral symptoms that are both painful to the individual and disruptive to the crisis response process. The medical stability, survival, and dignity of people with pre-existing mental, developmental, and substance-related illnesses and disabilities are also jeopardized when emergency conditions disrupt their patterns of care. In addition, older adults and people who require significant health care support can be greatly affected.

E. In public health threats involving the spread of communicable disease, people can experience considerable stress whether or not they have been exposed to the agents, because of the "invisible" nature of these microscopic threats. The fear that can take place in some public health emergencies (e.g., those involving infectious agents and quarantine

procedures) can also create isolation and dismantle the sense of community that is so essential to mental health and resiliency.

F. The level of skill, sensitivity, respect, disability competence, and cultural and linguistic competence with which public information about the crisis is conveyed can have a significant effect on the psychological impact of the situation and the cohesiveness of the community.

G. Most disasters, threats, and emergencies can cause two types of trauma:

- Individual trauma is sometimes described as “a blow to the psyche that breaks through one’s defenses so suddenly and with such brutal force that one cannot react to it effectively.”
- Collective trauma is sometimes described as “a blow to the basic tissue of social life that damages the bonds attaching people together and impairs the prevailing sense of community.” The loss of relationships, work, transportation, and housing are just some of the factors that can undermine people’s feelings of community.

H. The pre-incident mental health and resilience of individuals, families, and communities is perhaps the strongest factor in mitigating the psychological impact of public health threats and emergencies. Recovery of individuals in a community will not be complete until the resiliency and cohesiveness of the community itself is restored, a process that can take several years.

I. A number of factors play a significant role in mitigating the effects of disasters and other public health threats and emergencies, including:

- Planning, preparedness, and response efforts designed to promote community resilience and unity
- Normalization of disaster-related stress reactions and the presentation of programs and services in non-labeling, non-stigmatizing terms
- Disaster mental health technologies such as the Crisis Counseling model supported by the Federal Emergency Management Agency (FEMA) and the Substance Abuse and Mental Health Services Administration (SAMHSA)
- Well planned and coordinated responses to the special needs of people with mental illness, substance use disorders, disabilities (including visual and hearing impairment), age-related challenges, language or cultural barriers, etc.

Section 3: Concept of Operations

Scope of Plan

This Plan is used to coordinate State resources to respond to the human service needs caused by a disaster, bioterrorist event, or other public health threat or emergency. A qualified disaster for this Plan is an event that overwhelms the resources and staff of a local institution, community, or county. The impact of such an event would require aid from other institutions, communities, or counties, or would require regional, state, or national resources.

This Plan is designed to address responses to Bioterrorism, Other Infectious Disease Outbreaks, and Other Public Health Threats and Emergencies (BOIDOOPHTE), taking an all-hazards approach that spans the full spectrum of possible causes and effects of public health threats and emergencies.

The Plan specifically addresses the human services implications of disaster, including (but not limited to):

- Needs of people residing in publicly funded facilities
- Disaster mental health needs
- Substance abuse-related needs
- Disability-related needs
- Age-related needs (e.g., needs of older adults and children)
- Needs related to culture, language, and literacy
- Circumstances of populations with special needs

The Plan identifies roles, responsibilities, and tasks of the public-sector agencies and staff directly involved in the emergency human services response, including:

- County Human Services Authorities[1]
- County-level emergency human services response and recovery
- The Area Administrator or a Human Services Area Coordinator assigned to emergency human services responsibilities in the DHFS Regional Area Administration Office, under the Office of Strategic Finance (OSF)

[1] "County Human Services Authority" is a general term used for the purposes of this Plan. The County Human Service Authority will vary from county to county. Some of the more common examples are the County Human Services Department, Department of Health and Human Services, Department of Community Programs, Department of Social Services, Department of Health and Social Services, Human Service Center, Unified Community Services, Unified Services, Human Services and Health Department, and Social Human Department. The County Human Service Authority will coordinate human services activities, except at State and Federal facilities.

- The DHFS Emergency Human Services Coordinator, DHFS 24/7 On-Call staff, and any other designated DHFS emergency human services staff

The essential roles played by a variety of organizations—including Wisconsin Emergency Management; the American Red Cross, Salvation Army, and other voluntary agencies; the DHFS Division of Public Health; the Wisconsin Critical Incident Stress Management Network; Federal resources such as the Federal Emergency Management Agency and the Substance Abuse and Mental Health Services Administration (including the Center for Mental Health Services and its Disaster Technical Assistance Center, the Center for Substance Abuse Treatment, and the Center for Substance Abuse Prevention); and many other valuable resources—will be referenced but not described in detail in this Plan.

Overview of Approach

Government in Wisconsin is decentralized, with the counties having primary responsibility for, and control of, many local functions, including human services and emergency response. Regional and State government exists to support the counties, to provide assistance, and to help with coordination of resources. That principle forms the basis for the structure and division of responsibilities presented throughout this Plan.

Warning and Mobilization

A. When the scope of a disaster threatens to exceed local human service resources, the County Human Services Authority determines whether or not outside human services assistance is needed and appropriate. It then (in coordination with the terms of the individual local county Emergency Management Plan):
   1. Notifies the DHFS response system, to cue the State response process (Note: In some cases Wisconsin Emergency Management notifies the DHFS response system)
   2. Notifies any pre-established emergency human services resources within the community

B. DHFS 24/7 On-Call staff alert the DHFS Emergency Human Services Coordinator or DHFS Emergency Coordinator

C. The DHFS Emergency Human Services Coordinator, DHFS Emergency Coordinator, DHFS 24/7 On-Call staff, or other designated DHFS emergency human services staff first determines if any facilities under DHFS responsibility have been affected and take steps to coordinate assistance

D. The DHFS Emergency Human Services Coordinator, DHFS 24/7 On-Call staff, or other designated DHFS emergency human services staff investigates the scope, severity, and potential human impact of the disaster and, if it is warranted:

1. Notifies management personnel within the Bureau, the Division, and the Department including the DHFS Emergency Coordinator
2. Notifies appropriate personnel within the DHFS Regional Area Administration Office (OSF)
3. Activates response activities in accordance with this Plan

Response

During the response phase:

A. The County Human Services Authority, in coordination with the individual local county plan and EOC/ICS:

   1. Coordinates assistance in meeting the basic short-term needs of those affected (e.g., food, potable water, replacement medications, evacuation, shelter, monetary grants)
   2. Coordinates the disaster mental health/substance abuse/human service response
   3. Coordinates any needed response on the part of crisis intervention program staff and other available resources
   4. Provides services for special needs populations
   5. Provides staffing to the Emergency Operations Center
   6. Provides technical advice to the Incident Commander and EOC, Public Health, tribal health, and hospitals on matters related to the psychosocial needs and reactions of emergency response teams, victims, survivors, family members, vulnerable populations, and the community
   7. Requests assistance from the DHFS Emergency Human Services Coordinator, if the need for disaster-related human services exceeds local capacity
   8. In preparation for a Presidential declaration of disaster:
      - Begins assessing the need for an Immediate Services Crisis Counseling Grant from the Federal Emergency Management Agency and the Center for Mental Health Services, and collects information for the application process
      - Requests the assistance of the DHFS Emergency Human Services Coordinator in the application processes

B. In coordination with the Emergency Operations Center and Incident Command System, the County Human Services Authority:

   1. Coordinates and oversees all municipal, private, and volunteer human service organizations involved in the response effort
   2. Coordinates the resource management of invited and uninvited human service volunteers

C. During the response phase, the American Red Cross may, in coordination with the County Human Services Authority, provide support for the local emergency response through emergency aid, support, shelter, technical assistance, and a variety of disaster mental health services, including:

1. Initial crisis counseling
2. Defusing
3. Stress management
4. Problem-solving
5. Logistical support
6. Screening
7. Referral to local human service resources for ongoing assistance

D. In events associated with crime, local victims' assistance organizations and resources take the lead in the provision of some emergency mental health services. In these cases, the American Red Cross Disaster Mental Health System may play a supportive role under the direction of these resources.

E. In coordination with the County Human Services Authority, the local county emergency management plan, volunteer human services responders may collaborate in provision of the local human services response, including:

1. Disaster crisis counseling
2. Stress management
3. Problem-solving
4. Logistical support
5. Screening and referral
6. Evacuation and sheltering
7. Other forms of human service assistance, as needed and appropriate

F. The Area Administrator or a Human Services Area Coordinator Administrator assigned to emergency human services responsibilities in the DHFS Regional Area Administration Office (OSF):

1. Provides technical advice on matters related to the psychosocial needs and reactions of emergency response teams, victims, survivors, family members, vulnerable populations, and the community

2. Provides support, technical assistance, and coordination assistance to the local human services response

3. Assists county staff in obtaining any emergency Federal/State aid available through DHFS

4. Assists state and county staff in conducting CMHS needs assessment and preparation of FEMA/CMHS ISP/RSP Crisis Counseling grants

G. The DHFS Emergency Human Services Coordinator:

1. Provides support, technical assistance, and coordination assistance to local and regional emergency human services response

2. Provides advice and consultation to the Incident Commander, the Emergency Operations Center, Public Health, tribal health, and hospitals on matters related to the

psychosocial needs and reactions of emergency response teams, victims, survivors, family members, vulnerable populations, and the community

3. Coordinates with FEMA Region 5 human services staff, DHFS Regional Area Administrative staff (OSF), and the County Human Services Authority in the staffing of the FEMA Disaster Recovery Center
4. Serves as the DHFS Secretary's Emergency Human Services Liaison with WEM and the State Incident Command; advises the DHFS Secretary on disaster human service issues
5. Provides support, technical assistance, and coordination assistance to the local and regional human services response
6. In preparation for a Presidential disaster declaration, takes primary responsibility for completion and submission of a proposal for an Immediate Services Crisis Counseling Grant from the Federal Emergency Management Agency and the Center for Mental Health Services, in coordination with the County Human Service Authority, the Regional Area Administration Office, and any other designated DHFS staff

H. When their assistance has been requested, Critical Incident Stress Management (CISM) Teams provide Critical Incident Stress Debriefing, Defusing, and Stress Management services to public safety emergency response teams and their family members, as requested and appropriate.

I. A variety of other voluntary, para-professional, faith-based, service-oriented, culture-specific, and community-based organizations and individuals also provide various forms of support and assistance to the human service response effort, as offered, needed, and appropriate. Their services are coordinated by the County Human Services Authority and guided by the individual local county Emergency Operations Plan and the terms of any existing Memoranda of Understanding.

Recovery

During the recovery phase:

A. The County Human Services Authority:

- Continues to coordinate disaster human service activities with Wisconsin Voluntary Organizations Active in Disasters and other volunteer agencies, as appropriate
- Continues to provide technical advice to the Incident Commander and EOC, Public Health, tribal health, and hospitals, as needed
- Continues to provide services for special needs populations
- Continues to coordinate volunteer agency activities
- In preparation for a Presidentially declared disaster, may request the assistance of the DHFS Emergency Human Services Coordinator in application for a Regular Services Crisis Counseling Grant from the Federal Emergency Management Agency and the Center for Mental Health Services, and begin the data-collection process

B. The local County Human Services Authority provides disaster human services assistance during the recovery phase, including:

1. Disaster crisis counseling
2. Stress management
3. Problem-solving
4. Logistical support
5. Screening and referral
6. Evacuation and sheltering
7. Other services, as needed and appropriate

C. The Area Administrator or a Human Services Area Coordinator assigned to emergency human services responsibilities in the DHFS Regional Area Administration Office (OSF):

1. Continues to provide technical advice on matters related to the psychosocial needs and reactions of emergency response teams, victims, survivors, family members, vulnerable populations, and the community, as needed

2. Provides support, technical assistance, and coordination assistance to the local human services recovery activities

3. Assists county staff in obtaining any emergency Federal/State aid available through DHFS

D. The DHFS Emergency Human Services Coordinator:

1. Continues to provide technical advice to Wisconsin Emergency Management, Public Health, hospitals, and Regional and Local government on matters related to the psychosocial needs and reactions of emergency response teams, victims, survivors, family members, vulnerable populations, and the community, as needed

2. Provides support, technical assistance, and coordination assistance to the local and regional human services recovery activities

3. In the case of a Presidential disaster declaration, takes primary responsibility for completing and submitting a proposal for a Regular Services Grant from the Federal Emergency Management Agency and the Center for Mental Health Services

E. A variety of other voluntary, para-professional, faith-based, service-oriented, culture-specific, and community-based organizations and individuals also provide various forms of support and assistance to the disaster human service recovery effort, as offered, needed, and appropriate. Their services are coordinated by the County Human Services Authority.

Section 4: Legal Basis

Purpose

This Section documents the legal authority behind the responsibilities and actions outlined in this Plan.

Wisconsin Statutes

Chapter 46, “Social Services”
Chapter 48, “Children’s Code”
Chapter 49, “Public Assistance”
Chapter 51, “State Alcohol, Drug Abuse, Developmental Disabilities and Mental Health Act”
Chapter 59, “Counties” (Home Rule)
Chapter 250, “Health, Administration and Supervision”
Chapter 251, “Local Health Officials”
Chapter 252, “Communicable Diseases”
Chapter 254, “Environmental Health Concerns”
Chapter 146, “Miscellaneous Health Provisions”
Chapter 150, “Regulation of Health Care Services”
Chapter 166, “Emergency Government”

Wisconsin Administrative Codes

HFS 124, “Hospitals”
HFS 132, “Nursing Homes”
HFS 133, “Home Health Agencies”
HFS 134, “Facilities for the Developmentally Disabled”

Department of Health and Family Services Administrative Directive 38.2, “Assignment of Emergency Management Services Responsibilities of Division and Department Personnel”

Federal Authorities

Federal Legislation:

Federal Disaster Relief and Emergency Assistance Act (Stafford Act) (PL 100-707)
Disaster Mitigation Action of 2000 (PL 106-390)
Health Insurance Portability and Accountability Act of 1996 (HIPAA) (PL 104-191)

Federal Emergency Management Agency Emergency Support Functions:

Emergency Support Function #6, Mass Care Annex
Emergency Support Function #8, Health and Medical Services Annex

And all current applicable authorities.

Part B:

Planning and Preparedness

Section 5: Planning Considerations

In the past two years the Division of Disability and Elder Services has begun a formal process of planning for effective and culturally competent responses to the disaster mental health, substance abuse, and other human service needs that arise in the event of disasters, bioterrorist attacks, and other public health threats and emergencies.

This section briefly outlines five considerations that have contributed to the shaping of this Plan and will be important to address in the ongoing revision and execution of the Plan. They are:

- Availability of Resources
- Inclusion and Support
- Need for Closer Coordination With Hospitals
- Need for Assessment of Needs and Resources
- Multiple Planning Processes

Availability of Resources

Like other State governments, Wisconsin is operating in a state of severe financial constraint. In response to current need and threat, the Department applied to the Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA) for funds to support and enhance its capacity to plan for and respond to bioterrorist events.

The CDC grant ("2000 Supplementary Funds for Public Health Preparedness and Response for Bioterrorism") is designed to provide:

- Assistance in developing department-wide preparedness and response plans
- Assistance to local communities in enhancement of planning, preparedness, and response capacity
- Training and technical assistance
- Assistance in the development and execution of full-scale and table-top exercises
- Support for the evaluation of exercise responses
- Revision of State and local plans
- Increased staff capacity to carry out these tasks (including three contract staff in the mental health portion of the grant)

In order to complete the objectives of the CDC grant, DHFS/DDES convened the Statewide DMH/SA/HS Advisory Committee. That Committee conducted two extensive, multidisciplinary needs assessment focus groups in 2002. Each focus group was composed of key stakeholders

active in mental health, human services, and disaster relief efforts. Information from those focus groups was used to direct disaster mental health planning for the Wisconsin CDC bioterrorism work plan.

In addition to the CDC and HRSA grants, the Department has also been successful in obtaining a State Emergency Response Capacity Grant from the Substance Abuse and Mental Health Services Administration. That grant will fund a two-year half-time contract employee to coordinate all-hazards emergency human services planning efforts in a 10-county area in Western Wisconsin that mirrors Public Health Consortium #2.

These efforts are, in great measure, based on the leadership of the DHFS Secretary and the Administrators of the Divisions of Disability and Elder Services and Public Health.

Inclusion and Support

In contrast to the scarcity of available resources has been the abundance of inclusion and support that Wisconsin's emergency human services effort has received from a wide variety of state, local, and national partners.

Wisconsin is among the strongest states in the nation in its recognition of the importance of disaster human services and the integration of disaster mental health/substance abuse/human services into planning, training, exercise, response, and recovery processes. A few examples:

- The collaboration of the Wisconsin Emergency Management Director and DHFS Secretary as co-chairs of the Governor's Task Force on Terrorism
- Participation of the Division of Disability and Elder Services (DDES), Bureau of Mental Health and Substance Abuse Services (BMHSAS) in the DPH's planning process for the CDC Bioterrorism Preparedness Grant
- Inclusion of BMHSAS on committees and coalitions sponsored by the DPH under the CDC Bioterrorism Preparedness Grant, including the Statewide Community Coalition for Special Populations
- Inclusion of BMHSAS staff in a wide variety of full-scale and table-top exercises sponsored by Wisconsin Emergency Management

Along with the funds committed to disaster human services in Wisconsin in the CDC and SAMHSA grants, Wisconsin has also received a wealth of technical assistance from a number of State and Federal sources, including the SAMHSA/CMHS Disaster Technical Assistance Center.

Need for Closer Coordination With Hospitals

Traditionally, disaster planning processes for human services, public health, and hospitals have often moved in parallel but separate tracks. However, the Division of Public Health's CDC- and HRSA-funded bioterrorism initiative is creating many opportunities for collaboration and coordination of planning and service provision.

Importance of Coordination With Population-Specific Networks and Resources

One of the Department's most important missions is the promotion of, respect for, and care of, vulnerable populations, including but not limited to:

- Older adults
- Children
- People with disabilities (e.g., physical, developmental, visual, hearing, speech)
- People with mental disorders
- People with substance use disorders

Nowhere is this mission more critical than in the emergency planning and response processes. Many circumstances of people's lives can complicate a number of emergency-related processes, including:

- Preparation
- Mitigation
- Warning and notification
- Risk communication and public information
- Mass vaccination
- Rescue
- Mass care
- Evacuation and sheltering
- Decontamination
- Recovery

Although DHFS has access to an abundance of information and expertise through its staff, consultants, resource materials, and programs (including the Community Coalition of the CDC Bioterrorism Preparedness Program), it is equally essential to involve a wide variety of population-specific networks and resources in planning, response, and recovery efforts.

These networks include members of these populations, family members, friends, advocates, volunteers, and helping professionals. They have the depth and breadth of perspective that come only from living or working with special circumstances from day to day and situation to situation.

In many places throughout this document and others appear the terms “special needs” and “more vulnerable populations.” While these terms adequately refer to the many sets of complicating circumstances that must be considered in the planning, response, and recovery processes, they fail to capture the many resources associated with these populations. Two examples among many:

- Many planners are well aware of the difficulties that many older adults face in emergency situations (e.g., physical and logistical difficulties, fear, confusion, and disorientation), but equally important are the wisdom and inner strength that many older adults have earned through their many years’ hard experience, and the large numbers of volunteers available through aging resource networks. It is essential for planning efforts to involve and link with these networks in ways that will allow local government to tap into these resources if they are needed and appropriate to the situation.
- Planners who understand substance use disorders know that some people with these disorders will face special challenges in an emergency situation (e.g., people in residential treatment facilities who are displaced by evacuation, people in early recovery whose emotional stability is still fragile, people receiving methadone treatment whose medication supplies are threatened). However, it is equally important to remember that the addiction recovery community in Wisconsin holds thousands of members with stable sobriety who have extensive experience and a strong personal and organizational commitment toward helping others. This community can be mobilized, both to provide stability to its own more vulnerable members, and to perform needed acts of community service.

Need for Assessment of Needs and Resources

To-date, Wisconsin’s only formal assessments of disaster human services needs and resources have been the qualitative processes conducted at the two full-day meetings of the Statewide DMH/SA/HS Advisory Committee. Under the DPH’s CDC-funded bioterrorism initiative, a portion of the contract employees’ time will be available to assist the Department in an assessment process.

Appendix C (Assessment Considerations) provides a comprehensive list of needs and resources that might be considered in an emergency human services assessment process. State, regional, and local entities embarking on assessment processes might choose from these elements in designing their assessment tools, depending on the characteristics of this state, regions, counties, and communities.

Multiple Planning Processes

At a recent meeting of the Statewide DMH/SA/HS Advisory Committee, a committee member reported that, within her five-county area, she is aware of 130 separate planning groups related to disasters and other public health threats and emergencies. There are many valid reasons for the large number of planning processes dedicated to this subject, including the following:

- Wisconsin government is decentralized, with each county responsible for completing its own locally customized plan, based on the FEMA template issued by Wisconsin Emergency Management
- Tribes in Wisconsin have Sovereign Nation status, and so are not under the jurisdiction of State, regional, or local entities
- Disasters and other public health threats and emergencies affect many areas of functioning, and so inspire planning efforts in many fields, including emergency management, public health, tribal health departments, human services, criminal justice, law enforcement, fire and rescue, agriculture, parks and recreation, animal care and control, victims' services, social services, and education
- A number of regional and statewide planning efforts have begun as part of the CDC Bioterrorism Preparedness Program administered by the DPH
- Even within the realm of human services, a wide variety of public and private, professional and volunteer agencies and organizations are involved in disaster planning, response, and recovery activities
- Disaster plans are also required of each institution funded by the Division of Disability and Elder Services (e.g., facilities for people with mental illness, substance use disorders, developmental disabilities)
- In the era that began on September 11, 2001, the nation's consciousness of our vulnerability has been greatly enhanced. Many organizations and agencies responsible for the care and functioning of society have been forced to consider this aspect of their charge.

Although some planning efforts are multi-disciplinary and collaborative, many others are specific and conducted in isolation from other planning processes. At this point no one has collected their products or attempted to integrate them.

One valuable planning exercise would be to collect all the existing plans that have (or should have) provisions for disaster human services, and to integrate their contents—to see how they all fit together. Whether or not this exercise would be feasible, many planners have felt the need to encompass the full scope of planning that has taken place. This analysis might reveal a number of things, including:

- Strengths that can be replicated from plan to plan
- Duplications of effort
- Gaps in the overall planning process
- Gaps in specific plans
- Confusion about responsibilities

Section 6: Education and Training

Purpose

To ensure that emergency human service responders are well informed, well educated, and well trained in:

A. Anticipation of the range of potential psychosocial effects that might occur in the response and recovery phases of disasters, terrorist events, and other public health threats and emergencies

B. Recognition of the signs and symptoms of mental illness; substance use disorders; and the full range of disaster-related sequelae, including shock, panic, trauma, grief, depression, and acute and chronic post-traumatic stress disorder

C. Delivery of the most effective research-based disaster human service technologies

D. Effective outreach to communities, families, and individuals, including the use of non-stigmatizing terminology and the normalization of common reactions to disaster, threat, and emergency conditions

E. Understanding, supporting, and coordinating/collaborating with the full range of emergency response systems, including Emergency Management, Public Health, hospitals, the Coroner's Office, public safety, voluntary organizations, community organizations, faith-based organizations, and individual volunteers

F. Functioning effectively under pressure, exercising appropriate self-care, and recognizing their own physical and emotional limits

Situation and Assumptions

A. When a disaster, terrorist event, or other public health threat or emergency occurs, there will be little or no time for education and training.

B. Even the best-intentioned human service responders can fail to accomplish their mission—and can even inflict harm—if they are not prepared to deliver appropriate services effectively.

Criteria for Effectiveness

A. The most effective disaster human service training is:

- Based on research-supported technologies and positively evaluated training materials
- Culturally and linguistically competent for the regions/communities served by trainees
- Disability competent
- Delivered in small groups
- Coordinated and delivered in regional venues
- Focused on skill building, using effective tools
- Designed to promote ongoing regional teams and collaborative networks and relationships among trainees
- Delivered by people who have coordinated effective disaster human service response and recovery programs
- Reinforced through participation in full-scale and table-top exercises that reflect the human services implications of a wide range of events

B. The most effective State emergency human service response system:

- Trains its emergency human service staff in all aspects of effective disaster human services
- Informs human service responders throughout the state about training opportunities that exist
- Forms collaborative relationships with sources of appropriate training, to make training more accessible to human service responders throughout the state
- Participates in all aspects of multi-disciplinary (e.g., Emergency Management, Public Health) full-scale and table-top exercises, including:
  - Development of exercise scenarios
  - Full participation in exercises
  - Evaluation of the success and implications of exercises
  - Use of new learning to inform and revise training and planning efforts
- Promotes the earning and maintenance of credentials (e.g., certification, licensure) in appropriate disaster human service technologies, and maintains easily accessible records of trained and credentialed service providers
- Promotes system-wide training in and adoption of effective emergency human service response and recovery technologies, so that the effectiveness of the response is not dependent on the availability of specific individuals

Response/Recovery Technologies and Credentials

Appropriate technologies for training and credentialing include, but are not limited to:

A. American Red Cross Disaster Mental Health Certification

B. FEMA Crisis Counseling Training

C. Training in Incident Command Systems

D. CISM training and certification from the International Critical Incident Stress Foundation

E. Training from the National Organization for Victims Assistance

F. Specialized training in hazard-specific areas of response, including hazards of high frequency in Wisconsin (e.g., tornadoes), terrorism, and outbreaks of infectious disease

G. Trauma-related training from organizations such as the National Center for Post-Traumatic Stress Disorder, American Academy of Experts in Traumatic Stress, and the Association of Traumatic Stress Specialists

H. Loss and grief counseling training

I. Training on death notification

J. Training in cultural/linguistic/disability competence

K. Incident-specific training (e.g., training on psychosocial effects of terrorism)

L. Training on the range of disaster-related counseling (e.g., crisis counseling, mental health, substance use, peer support) services available within local communities

M. Training in media relations and emergency public information, including risk communication

N. Training on human service programs (Federal, State, regional, or local) that provide material or financial assistance to people affected by disaster, including assistance with:

- Housing
- Personal property
- Food
- Clothing
- Unemployment compensation
- Business loans
- Farm assistance
- Tax assistance
- Insurance information
- Legal services
- Social Security benefits

- Veterans' benefits
- Consumer information
- Aging services

Training and Education Focus Area of CDC Bioterrorism Project

This focus area is responsible for ensuring that planners and responders have the knowledge and skills they will need to address public health emergencies. This includes the provision of education and training, testing of knowledge and skills, and ongoing evaluation and improvement of training. Activities for this focus area include:

- Assessing the education and training needs of public, community, and private partners
- Working with traditional and non-traditional partners to identify and/or develop curricula
- Providing training in information technology, epidemiology, and risk communication
- Implementing "table-top" emergency exercises at local, regional, and state levels
- Sending select public health staff to FEMA's Training
- Providing periodic refresher training for environmental response teams
- Helping the various disciplines define their core competencies

Resources for Training and Training Information

State and national resources for training, training materials, and information include, but are not limited to:

A. Technical assistance, materials (including a CD), and training available from the SAMHSA/CMHS Disaster Technical Assistance Center (DTAC) (www.mentalhealth.samhsa.gov/dtac)

B. Materials available from the Substance Abuse and Mental Health Services Administration, including:

   - SAMHSA's Training Manual for Mental Health and Human Services Workers in Major Disasters (second edition) (www.mentalhealth.org/publications/allpubs/ADM90-538/Default.asp)
   - Communicating in a Crisis: Risk Communication Guidelines for Public Officials
   - Disaster Mental Health: Crisis Counseling Programs for the Rural Community
   - Field Manual for Mental Health and Human Service Workers in Major Disasters

C. Wisconsin Health Alert Network

D. Wisconsin DHFS Division of Public Health (www.dhfs.state.wi.us/programs/publichealth.htm?nav=mo)

E. Wisconsin Emergency Management (www.emergencymanagement.wi.gov)

F. Federal Emergency Management Agency Library (www.fema.gov/library)

G. Emergency Management Institute (http://training.fema.gov/EMIWeb/)

H. Centers for Disease Control and Prevention (www.bt.cdc.gov)

I. National Mental Health Association (www.nmha.org)

J. American Red Cross (www.redcross.org)

K. National Voluntary Organizations Active in Disaster (www.nvoad.org)

L. International Critical Incident Stress Foundation (www.icisf.org)

M. The Trauma Center (www.traumacenter.org)

N. International Society for Traumatic Stress Studies (www.istss.org)

O. Center for the Study of Traumatic Stress Disaster/Terrorism Care Resources (www.usuhs.mil/psy/disasteresources.html)

P. National Center for Post-Traumatic Stress Disorder (www.ncptsd.org)

Q. Trauma Information Pages (www.trauma-pages.com)

R. American Academy of Experts in Traumatic Stress (www.atss-hq.com)

S. Association of Traumatic Stress Specialists (www.atss-hq.com)

T. National Organization for Victims Assistance (www.try-nova.org)

U. Office for Victims of Crime (www.ojp.usdoj.gov/ovc)

V. Connect for Kids (www.connectforkids.org/homepage1535/index.htm)

W. International Center to Heal Our Children (www.dcchildrens.com/about/abt5a_mn.asp)

X. New York University Child Study Center (www.nyuchildstudycenter.org)

Y. National Organization on Disability (www.nod.org/content.cfm?id=787)

Z. Disaster Preparedness Resources for People With Disabilities (www.jik.com/disaster.html)

AA. AOA: Disaster Assistance Resources (www.aoa.dhhs.gov/disaster/default.htm)

BB. A Practical Guide for Crisis Response In Our Schools (www.crisisinfo.org/schoolcrisisresponse)

CC. American Psychological Association (www.APAhelpcenter.org)

DD. David Baldwin's Trauma Information Pages (www.trauma-pages.com)

EE. Department of Homeland Security (www.dhs.gov/dhspublic/)

FF. Executive Session on Domestic Preparedness (www.esdp.org)

GG. National Business & Disability Council (www.business-disability.com)

HH. National Governor's Association Center for Best Practices (www.nga.org)

II. Disaster Help (www.disasterhelp.gov)

Part C:

Roles, Responsibilities, and Tasks

Section 7: Authority and Responsibility

Objective

To delineate clearly the division of authority and responsibility for management and coordination of disaster mental health/substance abuse/human services in Wisconsin.

Situation

In the event of a disaster, bioterrorist event, or other public health threat or emergency that exceeds local capacity to respond, the Department will provide support, technical assistance, and departmental emergency human services resources to assist local government in its response

Delegation of Responsibilities

A. Department of Health and Family Services

1. The Department of Health and Family Services (DHFS) will provide management and coordination of disaster mental health/substance abuse/human services in support of local communities' or regions' need or request for assistance.

2. The Office of the Secretary will direct all emergency management responsibilities, functions, and services of the Department, and all operations on behalf of the Department during emergencies. For policy matters, decision making remains with the Secretary.

3. The Office of the Secretary has designated a DHFS Emergency Management Coordinator, to be the central liaison for all issues related to emergency planning and operations.

4. The DHFS Emergency Management Coordinator will serve as the Department's principal liaison with Wisconsin Emergency Management (WEM) and other Federal, State, and local units of government on all issues relating to emergency planning and operations for which DHFS has responsibility. In consultation with the Office of the Secretary and Division Administrators, the Coordinator will direct, supervise, coordinate, and approve all emergency planning, training, and operational activities. The Coordinator will advise the Office of the Secretary on any recommended changes in emergency management activities, conduct an annual review of the operating plans and

procedures of the Department, represent the Department in the State Emergency Operations Center (along with emergency staff from DPH and DDES), and facilitate the development and operational readiness of an intra- and inter-agency emergency communication system.

B. Division of Disability and Elder Services

1. DHFS management and provision of disaster human services will be coordinated by the Division of Disability and Elder Services (DDES) DHFS Emergency Human Services Coordinator, in concert with the DHFS Emergency Management Coordinator, Wisconsin Emergency Management (WEM) staff, the Federal Emergency Management Agency, other DHFS Division emergency management staff, DHFS management, the American Red Cross, the Salvation Army, County Human Service Authority, Voluntary Organizations Active in Disasters (VOAD), and other non-governmental organizations.

2. The DHFS Emergency Human Services Coordinator will ensure that the Departmental Human Services Emergency Plans are complete, current, and operational; serve on, or participate in, any advisory committees, interagency work groups, or task forces assigned by the Department.

3. The management and provision of disaster human services will be guided by this Plan and by the WEM State Emergency Operations Plan, DHFS Administrative Directive AD 38.2, DHFS Emergency Operations Policy, the DHFS DMH/SA/HS Emergency Operations Plan, and the CDC/HRSA Bioterrorism Preparedness Plan.

4. The DDES maintains Madison-based 24/7 on-call personnel for emergency human services issues. These staff members may be contacted and notified through the emergency 800 number operated by Wisconsin Emergency Management or DHFS 24-hour answering service phone number.

5. The DDES will ensure that current plans for state mental health institutes, centers for people with developmental disabilities, the Wisconsin Resource Center, and the Sand Ridge Secure Treatment Center are developed, maintained, and periodically tested to prepare for the care, safety, and possible evacuation of patients, residents, inmates, and staff.

6. The DDES will provide any needed assistance in the relocation of vulnerable citizens, as requested and appropriate. See Administrative Directive 38.2

7. The DDES may provide post-emergency assistance and counseling to disaster victims by using Central Office, Regional, or institution staff.

8. *The DDES will develop and maintain a database of trained professionals and volunteers throughout the state who can be called on to help with emergency human services. These staff members and external resources may be contacted and notified by the DHFS Emergency Human Services Coordinator or designee.*

9. The DDES is responsible for coordinating and applying for FEMA/CMHS Immediate and Regular Services Crisis Counseling Grants (for Presidentially declared disasters) and other federal grants associated with disaster response.

10. The DDES will administer, in coordination with appropriate state and local entities, federal grants awarded to the Department.

11. As appropriate, the DDES will assist the Office of Strategic Finance in its efforts to help counties and other local entities develop local crisis response and emergency human services plans.

12. The DDES will update and disseminate this Plan for use in emergency human services planning.

13. The DDES will provide support and technical assistance to the Division of Public Health in times of public health threats and emergencies.

C. DHFS Regional Area Administration Office (OSF*)*

1. In each DHFS Regional Area Administration Office (OSF), the Area Administrator or a Human Services Area Coordinator will have emergency management responsibilities. The Office will assist in the planning and development of emergency human services carried out through counties and municipalities.

2. Regionally based Area Administration teams will assist Wisconsin counties and municipalities in the planning and development of emergency human services response. This will include, but not be limited to, discussing emergency plans with assigned agencies and being familiar with State and Department emergency plans.

3. The Office will also assist county staff in the coordination of emergency human service response to disasters, and in obtaining any emergency Federal/State aid available through DHFS.

D. County Human Service Authorities

The county supports municipal government in meeting human service needs (e.g., evacuation, sheltering, congregate care, food coupons, monetary grants, crisis counseling), by providing staff and administering assistance programs. The County Human Service Authority will vary from county to county. Some of the more common examples are the County Human Services Department, Department of Health and Human Services, Department of Community Programs, Department of Social Services, Department of Health and Social Services, Human Service Center, Unified Community Services, Unified Services, Human Services and Health Department, and Social Human Department. The County Human Service Authority will coordinate human services activities, except at State and Federal facilities.

Note: For information about coordination with other DHFS resources, coordination with other governmental units, and connectivity with local, State, and Federal plans, Section 11, "Coordination and Connectivity."

Section 8: Warning and Mobilization

Objective

To activate the Disaster Mental Health/Substance Abuse Human Services Plan and mobilize all appropriate components of the DHFS emergency human services response quickly, effectively, and in an orderly fashion.

Situation and Assumptions

A. In the event of a disaster or other public health threat or emergency that threatens to exceed local capacity, support, technical assistance, and assistance with coordination will be required from the Region and from the State. DHFS is organized to receive, investigate, and provide emergency human service assistance 24 hours a day in response to notification received.

B. County authorities follow the responsibilities, procedures, delineation of authority, and lines of succession set forth in their county-level Emergency Management Plans. Their responsibilities and procedures will be coordinated with the individual local county plan and with the local Emergency Operations Center/Incident Command System established during a disaster.

Plan of Action

A. Notification

1. Initial awareness of a disaster or other public health threat or emergency generally originates with county-level Emergency Management authorities. Emergency Management staff will notify the following:
   - Wisconsin Emergency Management
   - The county-level Human Service Authority
   - The Local Public Health Agency
   - Tribal Health Department
   - The American Red Cross

2. If the human service impact of the event has the potential to exceed local human service capacities, either the Wisconsin Emergency Management Duty Officer or the county-level Human Services Authority will notify DHFS emergency human services on-call staff, in coordination with the individual local Emergency Management Plan.

3. DHFS emergency human services 24/7 On-Call staff receive notification through direct calls during normal working hours, or through the WEM Duty Officer and/or DHFS 24-hour answering service during working and non-working hours.

4. During normal work hours, the WEM Duty Officer or DHFS Answering Service will contact emergency human services 24/7 On-Call staff first by telephone and then, if necessary, by pager. The DHFS staff member who is scheduled to be on call at the time will be the first person contacted. In the event of failure to reach the designated staff member, other staff on the on-call list will be contacted. Staff on 24-hour on-call status are listed in the Emergency Alert List. Copies of the Alert List and current schedules are distributed to WEM, the DHFS Answering Service, DHFS senior managers, and on-call staff.

5. In the event that on-call staff are victims of the disaster, those staff are responsible to notify the DHFS Emergency Human Services Coordinator as to their status and ability to respond.

6. *In coordination with the local Emergency Management Plan and EOP/ICS, the County Human Service Authority will estimate or determine the need for additional emergency human services and may request such assistance from the DHFS Emergency Human Services Coordinator (See Administrative Directive 38.2)*.

B. Investigation

1. Any necessary decisions concerning the level and intensity of the DHFS emergency human services response will be discussed with the DHFS Emergency Management Coordinator, the DDES Administrator, and the Office of the Secretary.

2. The first determination to be made is whether or not a State- or county-operated facility has been affected. The Emergency Human Services Coordinator will determine the perimeters of the affected area, obtain maps and regional documents showing the locations of DHFS facilities, and interview local human services staff to make that determination.

3. The Emergency Human Services Coordinator will, in conjunction with the County Human Services Authority, active voluntary agencies, and BQA staff, determine the status of hospital capacity in the affected area, the need for off-site mass care, the need for evacuation or emergency shelter, and the presence of mass casualties.

4. The DHFS 24/7 On-Call staff member receiving notification will record all information available from the duty officer or other reporting source. If investigation of the reported incident warrants notification and involvement of other DDES or DHFS staff, the on-call staff is responsible for contacting and briefing those staff members.

5. The appropriate staff will then be responsible for completing the preliminary investigation. An activities log of the incident investigation will be initiated and will serve as a written record. This log will include: time/date of calls or contacts, people/agencies contacted, issues discussed, actions taken, required follow-up, etc. The appropriate staff will then contact the on-site person/agency to obtain as much information as is

available. It may be necessary to contact a number of people/agencies at the local level to obtain additional or more complete information. The staff member conducting the investigation will utilize all DHFS resources available to complete a preliminary investigation. It is essential that every notification be investigated thoroughly to determine the immediate or potential human services impact.

6. The staff member conducting the preliminary investigation will, in consultation with the DHFS Emergency Human Service Coordinator or DHFS Emergency Coordinator, determine the necessity of contacting and briefing other technical and administrative staff in DHFS. If necessary, other DHFS 24/7 On-Call staff will be contacted to assist or facilitate these efforts.

7. If disaster human services response assistance is requested or needed on-site, the on-call staff member will provide such information as it is available, to prevent or minimize any negative effects. If the notification is made during off-hours, the staff person will use all resources available (e.g., home-based computer and modem). Off-hours investigation and response may require the review of additional resources or the use of equipment available through key access to the building housing DDES offices at 1 W. Wilson (e.g., computers, specific hard-copy references).

C. Alerting of DHFS/DDES/BMHSAS Management Personnel

1. If warranted, the on-call staff will immediately report the incident to the DHFS Emergency Human Services Coordinator or DHFS Emergency Coordinator who will discuss it with the responsible member of DDES management staff, which may include the appropriate Section Chief(s), Business Area Director(s), and the Administrator's Office.

2. DDES Administration will determine if the incident will be reported to the Secretary's Office. In the event that DDES Administration cannot be contacted, DHFS Emergency Human Services Coordinator, in coordination with the DHFS Emergency Management Coordinator, will ensure that the Secretary's Office is contacted and briefed.

3. On-call staff, in coordination with the DHFS Emergency Human Service Coordinator or DHFS Emergency Coordinator, will be responsible for obtaining any information that may be necessary to provide reports to the Business Area Directors' Office, Division Administrator's Office, or Secretary's Office. Media contacts will be addressed according to current departmental guidelines, unless specified otherwise.

D. Response Actions

1. *After receiving recommendations from the DHFS Emergency Human Services Coordinator or DHFS Emergency Coordinator, DDES management staff will if the magnitude or specific nature of the event requires additional DDES technical personnel. If so, the DHFS Emergency Human Services Coordinator may request the involvement of other DHFS staff with the appropriate technical skills consistent with the Administrative Directive 38.2.*

2. The function of DHFS Emergency Human Services Coordinator is to coordinate all DHFS activities in response to the emergency. The Emergency Human Services Coordinator is responsible for ensuring communication with and updating of the DDES Administrator's Office.

3. Where written protocols are established, staff are expected to follow the protocols. Deviation from the protocols requires supervisory/management concurrence.

Note: For information about coordination with other DHFS resources, coordination with other governmental units, and connectivity with local, State, and Federal plans, see Section 11, “Coordination and Connectivity.”

Section 9: Response

Objective

To anticipate and respond promptly and effectively to the range of disaster mental health/substance abuse/human service needs and circumstances that arise in the wake of a disaster, during an outbreak of infectious disease, or in the event of any other public health threat or emergency. To provide this response in a collaborative manner that acknowledges and respects the essential roles, responsibilities, and authority of each entity involved in the disaster response. Emergency human services are directed toward reestablishing the lifestyles of people affected by disaster at the earliest practical time.

Situation and Assumptions

A. In the event of a disaster or other public health threat or emergency that threatens to overwhelm local capacity, support, technical assistance, and assistance with coordination will be required from the Region and from the State. DHFS is responsible for providing support and technical assistance, and for helping local and regional entities coordinate the emergency human services response.

B. County authorities follow the responsibilities, procedures, delineation of authority, and lines of succession set forth in their county-level Emergency Management plans. Their responsibilities and procedures will be coordinated with the individual local county plan and with the local Emergency Operations Center/Incident Command System established during a disaster.

Delegation of Responsibilities

A. Emergency Management Response

1. The **County Emergency Management Director** will coordinate the County Emergency Operations Center/Incident Command System; and will coordinate the response and recovery activities of mutual aid, county, local, and volunteer agencies, as well as the private sector, through the EOC and/or the Incident Command Post.

2. The **Wisconsin Emergency Management Regional Director** will coordinate the regional emergency response; and will provide direction, support, and technical assistance to the local emergency response.

3. The **Wisconsin Emergency Management Director** will coordinate the statewide emergency response; and will provide direction, support, and technical assistance to the regional and local emergency response.

B. Human Services Response

1. The **County Human Services Authority**, in coordination with the county Emergency Management Plan and EOC/ICS; will coordinate assistance in meeting the basic short-term needs of those affected (e.g., food, potable water, replacement medications, evacuations, shelter, monetary grants); will coordinate the disaster mental health/substance abuse/human service response; will coordinate any needed response from crisis intervention program staff and other available resources; will provide services for special needs populations; will provide staff to the EOC; will provide technical advice to Incident Commander, EOC, Local Public Health Agency, Tribal Health, and hospitals on matters related to the psychosocial needs and reactions of emergency response teams, victims, survivors, family members, vulnerable populations, and the community; and will begin assessment of the need for a FEMA/CMHS Immediate Services crisis counseling grant, and will report that assessment to the DHFS Emergency Human Services Coordinator. In close coordination with the individual county Emergency Management Plan and EOC/ICS, will coordinate and oversee all municipal, private, and volunteer human service organizations involved in the response effort; and will coordinate the resource management of invited and uninvited human service volunteers.

2. The **American Red Cross** will support the local emergency response through the provision of emergency aid, support, shelter, technical assistance, and a variety of disaster mental health services (e.g., initial crisis counseling, defusing, stress management, problem-solving, logistical support, screening, and referral to local human service resources for ongoing assistance).

3. In events associated with crime or terrorism, **county/federal victims' assistance agencies** will take the lead in the provision of some emergency mental health services. In these cases, the American Red Cross Disaster Mental Health System may play a supportive role.

4. In coordination with the individual local county plan, **Human Services Responders** may collaborate in provision of the local human services response, including disaster crisis counseling, stress management, problem-solving, logistical support, screening and referral, and other forms of human service assistance, as needed and appropriate.

5. The **Area Administrator or a Human Services Area Coordinator** assigned to emergency human services responsibilities in the DHFS Regional Area Administration Office (OSF) *will provide technical advice on matters related to the psychosocial needs and reactions of emergency response teams, victims, survivors, family members, vulnerable populations, and the community; will provide support, technical assistance,*

and coordination assistance to the local human services response; will assist county staff in obtaining any emergency Federal/State aid available through DHFS; and will coordinate with State and Federal staff to conduct a Preliminary Damage Assessment (PDA).

6. The **DHFS Emergency Human Services Coordinator** will provide technical advice to Wisconsin Emergency Management on matters related to the psychosocial needs and reactions of emergency response teams, victims, survivors, family members, vulnerable populations, and the community; will provide support, technical assistance, and coordination assistance to the local and regional human services response; will coordinate with FEMA Region 5 Human Services staff, the OSF Regional Area Administration staff, and the County Human Services Authority the staffing of the FEMA Disaster Recovery Center; will serve as the DHFS Secretary's emergency human services liaison with Wisconsin Emergency Management and State EOC, advising the Secretary on disaster human services issues; will provide support, technical assistance, and coordination assistance to the local and regional human services response; and will, in preparation for a Federal disaster declaration, take primary responsibility for completing and submitting a proposal for an Immediate Services Crisis Counseling Grant from the Federal Emergency Management Agency and the Center for Mental Health Services, in coordination with the County Human Services Authority, the Regional Area Administration Office (OFS), and any other designated DHFS staff.

7. When their assistance has been requested, **Critical Incident Stress Management (CISM) Teams** may provide Critical Incident Stress Debriefing, Defusing, and Stress Management services to public safety emergency response teams and their family members, as requested and appropriate. (Note: Human Service Respondents to the incident should not also be members of the CISM debriefing team.)

8. A variety of other **voluntary, para-professional, faith-based, service-oriented, culture-specific, and community-based organizations and individuals** will also provide various forms of support and assistance to the human service response effort, as offered, needed, and appropriate. Their services will be coordinated by the County Human Services Authority, in coordination with the individual local county plan and any existing Memoranda of Understanding.

General Plan of Action

Note: Plans and procedures for emergency human service response and recovery are developed at the local level by County Human Services Authorities, based on templates provided by Wisconsin Emergency Management (primarily in Annexes E and F). Some counties have expanded and customized these procedures, and have added steps that their training and experiences have revealed as effective.

The action plans presented below represent a combination of steps outlined in the WEM templates with steps that have been added in several counties' customized versions of Annexes E and F. They are meant to represent an Emergency Operations Plan and are examples of procedures to consider including in local plans.

A. **County Human Services Authority** (in coordination with the county Emergency Management Plan and EOC/ICS)

1. If necessary, implement the Continuity of Operations Plan.
2. Advise the Incident Commander of the presence of emergency human services workers.
3. Conduct an initial needs assessment to determine who has been affected and who needs help immediately.
4. Establish a base of operations in coordination with other human services entities (e.g., American Red Cross, Wisconsin VOAD, victims' assistance organizations, Salvation Army, clergy, interfaith groups, social services, Area Agencies on Aging) and advise the Incident Commander of the location.
5. Establish a check-in function for emergency human service responders to establish on-scene staffing, congregate/service center staffing, and staffing at hospitals and morgues.
6. Verify the credentials of all psychosocial support personnel reporting to the scene.
7. Brief human service responders regarding the scope of the disaster, existing community resources, locations being staffed, communications, travel, contact persons with other organizations, process to receive pay (if applicable), record-keeping procedures, schedule of work times, and other policies and procedures.
8. Assign one or more human service responders to Team leadership roles at each location being staffed.
9. Assign human service responders to:
   - Provide crisis intervention and mediate the impact of the event.
   - Assist other disaster response personnel in addressing the needs of people directly involved in or affected by the disaster, and in rerouting or addressing the concerns of people not directly involved or affected.
   - Give victims and survivors specific information about sources of follow-up disaster mental health and other human services.
10. Distribute supplies to human service responders and deploy them, preferably in pairs, to their respective assignments. Instruct them to report to Command personnel or human services leadership when they arrive at the location.
11. Arrange for coverage of second and subsequent shifts.

12. If additional mental health resources are needed:
    - Call local emergency mental health responders according to the County Emergency Management Plan
    - Coordinate any necessary disaster mental health training for staff and volunteers
    - Coordinate responses from crisis intervention program staff and other resources
    - If appropriate, request the CISM Team for support of public safety emergency response teams

13. If a Presidential disaster declaration has been made or is imminent, conduct a needs assessment process according to guidelines from FEMA/CMHS, to apply for crisis counseling funds under the Immediate Services Program (final application must be received by FEMA/CMHS within 14 calendar days after the Declaration). (See Appendix D, “ISP and RSP Recording Forms.”) Collect information from a wide variety of sources, including the FEMA/State briefings, local media, the American Red Cross, Salvation Army, local human service agencies, Local Public Health Agencies, tribal health departments, law enforcement, civic organizations, voluntary organizations, hospitals, the faith community, interfaith groups, and Wisconsin Emergency Management Preliminary Damage Assessments.

14. Keep accurate records of hours worked, activities, numbers of people participating, and any other measures required (e.g., psychosocial data required for FEMA/CMHS Regular Services Crisis Counseling Grant applications) (See Appendix D, “ISP and RSP Recording Forms”).

15. If it is ever necessary to record the name of someone receiving services (e.g., for follow-up purposes), ensure that this information is kept strictly confidential, stored in a locked file, and destroyed when it is no longer needed.

16. Ensure that any necessary forms (e.g., FEMA/CMHS ISP and RSP recording forms) are available at the disaster site and/or the human services base of operations.

17. Provide for demobilization and defusing of human service responders as they return from their assignments.

18. Serve as an advisor and consultant to the Incident Commander, the Emergency Operations Center, Public Health, tribal health, and hospitals on matters related to the psychosocial needs and reactions of emergency response teams, victims, survivors, family members, vulnerable populations, and the community.

19. Provide support, technical assistance, and human services resources to the Local Public Health Agency and Regional Public Health Consortium, as requested and appropriate, in coordination with the individual local county plan and with the local EOC/ICS.

20. Give appropriate local community service agency representatives progress reports and details regarding the potential long-term needs of the individuals, families, and communities affected.

21. Maintain communication and coordination with the American Red Cross Disaster Mental Health System.

22. Continue to coordinate the resource management of other municipal, private, and volunteer human service organizations.

23. Continue to coordinate the resource management of invited and uninvited human service volunteers.

24. Maintain contact with human service responders to notify them of changing needs and potential problems.

25. Continue to debrief members of human service responders and other emergency responders on a routine basis.

26. Conduct ongoing reassessments of the disaster human service needs of victims, relatives, responders, and others affected by the event.

27. Conduct ongoing evaluations of services provided by human service responders, and make recommendations for improvement, as needed. Monitor:
    - The course of events
    - Problems encountered
    - Strengths/weaknesses of services, and opportunities for improvement
    - Any other information that might be useful

28. Monitor human service responders for any signs of stress reactions that might endanger them or impair their ability to provide effective services. In such cases, arrange for crisis counseling, reassignment, hiatus, or cessation of participation in the response effort.

29. Continue to coordinate response efforts with those of other organizations.

30. If appropriate, conduct a needs assessment process according to guidelines from FEMA/CMHS, to apply for crisis counseling funds under the Regular Services Program.

31. As emergency facilities are closed, coordinate the withdrawal of emergency human services responders from those facilities, and (as appropriate) the reassignment of responders to open facilities.

32. As the end of the Response phase approaches, plan for and coordinate transition to the Recovery phase.

B. Human Services Responders[2] (in coordination with the county Emergency Management Plan and EOC/ICS)

[2] These responders may include trained and credentialed staff of the County Human Services Authority, local mental health providers, volunteers, or DHFS staff.

1. Meet with County Human Services Authority staff at the designated site to be briefed on the scope of the disaster, existing community resources, communications, travel, pay process (if applicable), record keeping procedures, schedule of work times, location.

2. Gain access to the work site and contact the person(s) coordinating on-site disaster human services.

3. Determine if any victims or families do not speak English, or who are deaf, and find translators, if needed.

4. Assess and triage those in need of disaster human services intervention.

5. Provide crisis counseling services through outreach to victims, their families, and other community members.

6. Wherever appropriate, link disaster victims with appropriate human service agencies that provide support services.

7. Respond to and stabilize psychiatric emergencies.

8. As needed, provide referrals to local mental health providers and to other health and human service organizations.

9. As needed and appropriate, provide support and stress-management assistance to emergency responders.

10. As needed and appropriate, provide non-traditional services such as distributing food at feeding sites, helping with relocation efforts, supplementing the staffing of shelters by staying in them at night, providing child care at disaster response centers, removing debris, etc.

11. Provide consultation to community agencies.

12. Keep records of hours, activities, numbers of people participating, etc.

13. If it is ever necessary to record the name of someone receiving services (e.g., for follow-up purposes), keep that record completely confidential and destroy it as soon as you no longer need it.

14. Return to the volunteer registration center upon completion of each shift, for refreshment and debriefing.

15. As the end of the Response phase approaches, reassess needs, evaluate services to-date, and plan for transition to the Recovery phase.

C. The Area Administrator or a Human Services Area Coordinator assigned to emergency management responsibilities in the DHFS Regional Area Administration Office (OSF)

1. Provides support, technical assistance, and coordination assistance to the local human services response.

2. Serves as an advisor and consultant on matters related to the psychosocial needs and reactions of emergency response teams, victims, survivors, family members, vulnerable populations, and the community.

3. Assists county staff in the coordination of the emergency human services response to disaster and in obtaining any emergency Federal/State aid available through DHFS.

D. DHFS Emergency Human Services Coordinator

1. Provides support, technical assistance, and coordination assistance to the local and regional emergency human services response.

2. Serves as an advisor and consultant to the Incident Commander, the Emergency Operations Center, Public Health, tribal health, and hospitals on matters related to the psychosocial needs and reactions of emergency response teams, victims, survivors, family members, vulnerable populations, and the community.

3. *As needed, generates lists of appropriate credentialed and paraprofessional emergency human service responders from the emergency human services database.*

4. Coordinates with FEMA Region 5 Human Services staff, the OSF Regional Area Administration staff, and the County Human Services Authority the staffing of the FEMA Disaster Recovery Center.

5. Assists in requesting the services of designated Critical Incident Stress Management (CISM) Teams to support public safety emergency response personnel.

6. As needed, coordinates the preparation of proposals for FEMA/CMHS Immediate and Regular Services Crisis Counseling Grants with the County Human Services Authority, the DHFS Regional Area Administration Office (OSF), and any other designated DHFS staff.

Supplements to Plan of Action

In cases of Evacuation and Shelter, Mass Casualty, or Quarantine, the County Emergency Human Services Authority will take the following steps in addition to the responsibilities described above, in coordination with the county Emergency Management Plan, EOC/ICS, and the American Red Cross.

A. Evacuation and Shelter

1. Coordinate with the Red Cross and the local Emergency Management Plan the general activities of local and private sector, not-for-profit and public service/volunteer organizations regarding shelter operations.

2. Identify and request special resources needed for evacuation and sheltering operations.

3. With the help of the Red Cross, coordinate with the local Emergency Management Plan the requirements of short- and long-term sheltering.

4. Work with other agencies to coordinate and administer food distribution programs, as needed.

5. Coordinate the provision of special services (e.g., transportation, special means or styles of communication, assistance with the psychosocial effects of transition) to people with special needs.

6. Coordinate the evacuation of residents of government-sponsored facilities (e.g., mental health facilities, substance abuse treatment facilities, facilities for people with developmental disabilities).

7. In cases of evacuation, serve as an advisor and consultant to the Incident Commander, the Emergency Operations Center, Public Health, tribal health, and hospitals on matters related to the psychosocial needs and reactions of the community, its residents, people with special needs, and other vulnerable populations to the evacuation process.

8. Coordinate the assessment and accommodation of the needs of all special-needs populations involved in the evacuation and sheltering process.

9. Oversee the provision of information and support to families, loved ones, etc. regarding people involved in the evacuation and sheltering process and people whom they cannot locate.

B. Mass Casualty

Note: A mass casualty scene is automatically considered a crime scene until it is determined that no crime has occurred. Requirements relevant to that consideration may affect some of the steps outlined below.

1. As requested and appropriate, oversee the assignment of human services personnel to hospitals, off-site care facilities, morgues, and facilities for families of victims.
2. Obtain full briefing on any medical safety procedures to be followed, and brief all assigned staff on these procedures.
3. Serve as an advisor and consultant to Public Health, tribal health, hospital administration, the Incident Commander, the Emergency Operations Center, and the Coroner's Office on matters related to the psychosocial needs and reactions of the community, its residents, people with special needs, and other vulnerable populations to the mass care process.
4. In coordination with the local Emergency Management Plan, coordinate and oversee the understanding and compliance of human service responders with medical policies and procedures.
5. Coordinate the assessment and accommodation of the special needs of all special needs populations being treated at hospitals and mass-care facilities.
6. Oversee the provision of information and support to families, loved ones, etc. regarding people being treated at hospitals and mass-care facilities, people whom they cannot locate, and people who have died.

C. Quarantine (in coordination with Local Public Health Authorities)

1. Serve as an advisor and consultant to Public Health, tribal health, hospitals, the Incident Commander, and the Emergency Operations Center on matters related to the psychosocial needs and reactions of the community, its residents, people with special needs, and other vulnerable populations to the quarantine process.
2. Obtain full briefing on any medical safety procedures to be followed, and brief all assigned staff on these procedures.
3. Coordinate and oversee the understanding and compliance of human service responders with medical policies and procedures.
4. Coordinate the human service component of quarantine processes affecting residents of government-sponsored facilities (e.g., mental health facilities, substance abuse treatment facilities, facilities for people with developmental disabilities).
5. In conjunction with the local Emergency Management Plan and Public Health, coordinate the assessment and accommodation of the needs of all special needs

populations affected by the quarantine (e.g., people who are under quarantine, people whose caregivers or loved ones are under quarantine).

6. Oversee the provision of information and support to families, loved ones, etc. regarding people under quarantine and people whom they cannot locate.

Note: For information about coordination with other DHFS resources, coordination with other governmental units, and connectivity with local, State, and Federal plans, see Section 11, "Coordination and Connectivity."

Section 10: Recovery

Objective

A. To anticipate and respond promptly and effectively to the range of disaster mental health/substance abuse/human service needs and circumstances that arise in the recovery phase following a disaster, bioterrorist event, outbreak of infectious disease, or any other public health threat or emergency. To provide this response in a collaborative manner that acknowledges and respects the essential roles, responsibilities, and authority of each entity involved in the disaster response.

B. County authorities follow the responsibilities, procedures, delineation of authority, and lines of succession set forth in their county-level Emergency Management plans. All of their responsibilities and procedures would be coordinated with local plans, and with the local Emergency Operations Center/Incident Command System.

Situation

After a disaster, bioterrorist event, or other public health threat or emergency that has overwhelmed local capacity, ongoing support, technical assistance, and assistance with coordination will be required from the Region and from the State. DHFS is responsible for providing support and technical assistance, and for helping local and regional entities coordinate emergency human services during the recovery phase.

Delegation of Responsibilities

A. Emergency Management

1. The **County Emergency Management Director** will continue to manage the EOC and support the Incident Commander as necessary; will activate and deactivate resources and personnel, as needed; will collect, record, and disseminate information; will

coordinate with state and municipal governments; will compile and update disaster assessment information for the State; and will support continuing recovery operations.

2. The **Wisconsin Emergency Management Regional Coordinator** will coordinate the regional recovery effort; and will provide direction, support, and technical assistance to the local recovery effort.

3. The **Wisconsin Emergency Management Director** will coordinate the statewide recovery effort; and will provide direction, support, and technical assistance to regional and local recovery efforts.

B. Human Services

1. The **County Human Services Authority**, in coordination with the County Emergency Management Plan and EOC/ICS, will continue to coordinate disaster human service activities; will continue to provide technical advice to Incident Command, the Emergency Operations Center, Public Health, tribal health, and hospitals, as needed; will continue to provide services for special needs populations; and will continue to coordinate volunteer agency activities.

2. *The **Human Service Responders** will provide disaster human services assistance during the recovery phase, including disaster crisis counseling, stress management, problem-solving, logistical support, screening and referral, and other services, as needed and appropriate.*

3. The **Area Administrator or a Human Services Area Coordinator assigned to emergency human services responsibilities in the DHFS Regional Area Administration Office (OSF)** will continue to provide technical advice on matters related to the psychosocial needs and reactions of emergency responders, victims, survivors, family members, vulnerable populations, and the community, as needed; will provide support, technical assistance, and coordination assistance to the local human services recovery activities; and will assist county staff in obtaining any emergency Federal/State aid available through DHFS.

4. The **DHFS Emergency Human Services Coordinator** will continue to coordinate preparation of proposal for FEMA/CMHS Regular Services grant; will continue to provide technical advice to State, Regional, and local Emergency Management and Public Health, tribal health, hospitals, and the County Human Service Authority on matters related to the psychosocial needs and reactions of emergency response teams, victims, survivors, family members, vulnerable populations, and the community, as needed; will provide support, technical assistance, and coordination assistance to the local and regional human services recovery activities; and if the FEMA Regular Services Grant is awarded, will administer the grant.

5. A variety of other **voluntary, para-professional, faith-based, service-oriented, culture-specific, and community-based organizations and individuals** may also provide various forms of support and assistance to the community and the disaster human service recovery effort, as offered, needed, and appropriate. Their services will be provided in coordination and collaboration with the County Human Services Authority

and coordinated with the individual local county plan and with the local Emergency Operations Center/Incident Command System.

Plan of Action

Note: Plans and procedures for emergency human service response and recovery are developed at the local level by County Human Services Authorities, based on templates provided by Wisconsin Emergency Management (primarily in Annexes E and F). Some counties have expanded and customized these procedures, and have added steps that their training and experiences have revealed as effective.

The action plans presented below represent a combination of steps outlined in the WEM templates with steps that have been added in several counties' customized versions of Annexes E and F. They are meant to represent the Emergency Operations Plan and are examples of what procedures to consider including in local plans.

A. County Human Services Authority (in coordination with the county Emergency Management Plan and EOC/ICS)

1. Conduct ongoing reassessments of the disaster mental health needs of victims, relatives, responders, and others affected by the event.

2. If necessary, implement the Continuity of Operations Plan.

3. Develop a phase-appropriate disaster recovery program that matches the needs of the community and its individuals.

4. Request and coordinate additional assistance from other counties, Regional resources, or State resources, as needed and appropriate.

5. Assess the extent of damage and determine the recovery activities necessary to return to normal operations.

6. If appropriate, conduct a needs assessment process according to guidelines from FEMA/CMHS, to apply for crisis counseling funds under the Regular Services Program. Communicate the results of this assessment to the DHFS Emergency Human Services Coordinator.

7. Establish liaison with Wisconsin Emergency Management and Wisconsin VOAD recovery projects.

8. Train human service staff in recovery issues and activities, including the recognition of post-disaster stress-related behavior and the referral of clients to the appropriate mental health, substance abuse, and other human services.

9. Continue to coordinate the provision of outreach and clinical services to people in the affected area. Wherever possible, provide for the delivery of services in home or community settings.

10. Provide consultation to community organizations and agencies that will be in contact with disaster victims, survivors, families, and community members during the recovery phase.

11. Obtain community-appropriate materials and information on the effects of a disaster on mental health and substance use patterns, symptoms of post-disaster stress, and the locations of counseling services. (These types of materials might be available from DHFS, from the Risk Communication Focus Area of the statewide CDC bioterrorism initiative, and from the CMHS Disaster Technical Assistance Center.) Provide these materials to local public information officers, radio stations, and television stations.

12. Liaison with the Joint Public Information Center (JPIC) and other entities providing public information, and coordinate all public information with the JPIC. (The JPIC is established by the county and the Emergency Operations Center to ensure that all public information disseminated is consistent and appropriate.)

13. Provide information to the public on the locations of disaster mental health and substance abuse services. Wherever possible, use non-stigmatizing terms (e.g., "disaster stress support services" rather than "mental health services," or "help with alcohol or drug problems" rather than "substance abuse services").

14. Provide regular support sessions for staff involved in the recovery phase.

15. Keep accurate records of hours spent, activities engaged in, numbers of people participating, and any other measures required (e.g., psychosocial data required for FEMA/CMHS Regular Services Crisis Counseling Grant applications).

16. If it is ever necessary to record the name of someone receiving services (e.g., for follow-up purposes), ensure that this information is kept strictly confidential, stored in a locked file, and destroyed when it is no longer needed.

17. Continue to serve as an advisor and consultant to the Incident Commander, the Emergency Operations Center, Public Health, tribal health, and hospitals on matters related to the psychosocial needs and reactions of emergency response teams, victims, survivors, family members, vulnerable populations, and the community.

18. Assist in identifying appropriate studies and implementing protective actions to address the long-term psychosocial effects of the event.

19. Continue to coordinate recovery efforts with those of other organizations.

20. Continue to give appropriate local community service agency representatives progress reports and details regarding the long-term needs of the individuals, families, and communities affected.

21. Collaborate with human service recovery teams, local community organizations, volunteer organizations, Wisconsin VOAD, interfaith groups, cultural groups, and other concerned individuals and organizations in the planning of phase-appropriate commemorative events and other community support events (e.g., community dinners, memorial services, anniversary events, transition events).

22. As the end of the Recovery phase approaches, plan for and coordinate transition to community self-sufficiency.

23. Evaluate the effectiveness and cultural/linguistic competence of disaster human services, using feedback from members of response and recovery organizations, victims, human service response/recovery team members, and program staff. Participate in any interagency reviews of the integrated emergency response. Use this information to make recommendations to improve disaster mental health planning, response, and recovery activities on the local, Regional, and State levels.

24. Update and enhance the local disaster human services plan, as needed. Submit recommendations for improvements and enhancements to the State-level Plan, as needed.

B. Human Services Responders[3]

1. *Provide phase-appropriate disaster mental health/substance abuse/human services through outreach to victims, their families, and other community members. As often as possible, provide these services in home or community settings.*

2. *As needed and appropriate, continue to refer victims to disaster service agencies, mental health providers, substance abuse treatment providers, or other appropriate human service agencies.*

3. *As needed and appropriate, continue to provide support to emergency responders.*

4. *As needed and appropriate, continue to provide consultation to other community agencies.*

5. *As needed and appropriate, continue to maintain confidential records of services provided.*

C. Area Administrator or a Human Services Area Coordinator assigned to emergency management responsibilities in the DHFS Regional Area Administration Office (OSF):

1. Provide support, technical assistance, and coordination assistance to the local human services recovery effort.

[3] They may include trained and credentialed staff of the County Human Services Authority, local mental health providers, or full-time temporary crisis counselors and volunteers. In a Presidentially declared disaster, these counselors will be hired with funds from FEMA, administered through the Center for Mental Health Services. These counselors are generally indigenous to the affected area and supervised by trained clinical staff.

2. As needed, continue to serve as an advisor and consultant on matters related to the psychosocial needs and reactions of emergency response teams, victims, survivors, family members, vulnerable populations, and the community

3. Assist county staff in obtaining any emergency Federal/State aid available through DHFS

D. DHFS Emergency Human Services Coordinator

1. As needed, coordinate the preparation of the proposal for FEMA/CMHS Regular Services Grant.

2. *Continue to provide support, technical assistance, and coordination assistance to the local and regional human services response.*

3. As needed, continue to serve as an advisor and consultant to State, Regional, and local Emergency Management, Public Health, tribal health, and hospitals on matters related to the psychosocial needs and reactions of emergency response teams, victims, survivors, family members, vulnerable populations, and the community.

4. If the FEMA/CMHS Regular Services Crisis Counseling Grant has been awarded, administer the grant.

Note: For information about coordination with other DHFS resources, coordination with other governmental units, and connectivity with local, State, and Federal plans, see Section 11, "Coordination and Connectivity."

Section 11: Coordination and Connectivity

This Section

This Section applies to all other Sections within Part C: Roles, Responsibilities, and Tasks:

- The first subsection ("Resources Within DHFS") addresses separately the planning considerations of the first three sections of Part C ("Authority and Responsibility," "Warning and Mobilization," and "Response").
- The remaining two subsections ("Coordination With Other Governmental Units" and "Connectivity With Local, State, and Federal Plans") apply to all four of the previous sections.

Assumption

County authorities follow the responsibilities, procedures, delineation of authority, and lines of succession set forth in their county-level Emergency Management plans. All of their responsibilities and procedures would be coordinated with local plans, and with the local Emergency Operations Center/Incident Command System.

Coordination With Other DHFS Resources

1. **Authority and Responsibility**

   Emergency human services personnel within the Department of Health and Family Services will coordinate their emergency planning and response functions with those of Wisconsin Emergency Management, the Division of Public Health, Regional Public Health staff, the American Red Cross, the Salvation Army, Great Lakes Inter-Tribal Council, Local Public Health Agencies, local tribal health departments, local social service agencies, local mental health agencies, Area Agencies on Aging, WI VOAD, and other agencies, as appropriate.

A number of resources that exist within DDES and DHFS have provisions for involvement as the result of emergencies. DDES or DHFS personnel, through contact with local and other involved state agencies, will contact staff in these areas when their services may be required to respond to an emergency or disaster. These areas include:

- Division of Public Health
  - Bureau of Health Information and Policy (BHIP)
- Division of Disability and Elder Services (DDES)
  - Bureau of Quality Assurance (BQA)
  - Population-Specific DDES Bureaus and Offices
  - DHFS Emergency Human Services Coordinator
- Division of Health Care Financing (DHCF)
  - Bureau of Health Information (BHI)
- DHFS Affirmative Action/Civil Rights Compliance (AA/CRC) Officer

These Divisions, Business Areas, and Offices are described in greater detail below.

B. Warning and Notification

1. Notification of Local and Regional Authorities

- In incidents in which the County Human Services Authorities (CHSA) have not been notified, Emergency Human Services staff should contact and brief the CHSA(s) on the nature of the incident and the response provided or required. If the event is of such importance or magnitude as to warrant immediate response, CHSAs will be contacted during off hours. CHSAs will be requested by the DHFS Regional Offices to supply the Area Administrators with the appropriate emergency telephone numbers of their designated emergency response personnel. (Those numbers will be given to DHFS.) As appropriate, CHSAs will supply updates of their emergency contacts. CHSAs will maintain contact information within the County Emergency Management Plan, according to Plan provisions.

- DHFS will notify the Regional Offices of Strategic Finance (OSF) Offices about emergency responses. DDES maintains a list of emergency response contacts for Regional Office staff. They may be asked by DDES to provide available staff or resources if incident-specific emergency responses require their help. DHFS Regional Offices will also supply updates of their emergency contacts, as appropriate.

- Regional staff receiving requests for assistance will report these immediately to DHFS Emergency Human Services on-call staff. These requests are investigated, and appropriate personnel are contacted, in the same manner specified above.

2. Response

A number of resources that exist within DDES and DHFS have provisions for involvement as the result of emergencies. DDES or DHFS personnel, through contact with local and other involved state agencies, can contact staff in these areas when their services may be required to respond to an emergency or disaster.

- **Division of Public Health (DPH)**: The DPH is responsible for overseeing all public health concerns in the state, including responses to public health threats and emergencies. It has Regional Offices and provides technical assistance, support, and coordination assistance to Local Public Health Agencies. The DPH administers both the CDC and HRSA Bioterrorism Preparedness Grants. Included in that program are Statewide Coalitions of stakeholders and Regional Consortia that advise the preparedness process. Focus Areas within the program of particular interest to human services include Preparedness Planning and Readiness Assessment, the Health Alert Network, Risk Communication, and Training and Education.

  - **Bureau of Health Information and Policy(BHIP):** The portion of the State Emergency Operations Plan that contains the BHIP role is Annex H (Health and Medical Services). BHIP has several functions related to emergencies or disasters. At the time of a disaster, one objective is to ensure the quality of the records filed and to expedite filing processes and copy services to families affected by the tragedy.

  - **Wisconsin Hospital Association (WHA):** The WHA, under contract with DPH, collects in-patient data from all Wisconsin hospitals on a quarterly and annual basis. WHA can also produce information on some of the health and medical care resources available in a disaster area. This may include the staffing, services and size of specific hospitals, the number and specialties of physicians in an area, and resources needed to care for patients receiving special hospital services in the event of hospital evacuations.

- **The Division of Disability and Elder Services (DDES)**: The DDES operates a number of institutions in the State of Wisconsin. These institutions maintain the staff and services required to meet the needs of their patients. Service providers in the form of multi-lingual interpreters, crisis counselors, etc. are available if necessary. DHFS emergency staff in these areas will be identified by geographic area of the state and specialty area served. DHFS staff will contact these personnel through DHFS Emergency Human Services Coordinator or DHFS Emergency Coordinator. Other resources within the DDES include the following:

  - **The Bureau of Quality Assurance (BQA)**: The BQA is responsible for licensing, certifying, or regulating many health care facilities and services in the state. These include hospitals, nursing homes, public and private institutions for people with developmental disabilities, and home health agencies. BQA management, engineering, and health care staff (e.g., nurses, other health care professionals) may be contacted for information or requested to provide

assistance in the event of a disaster or emergency. BQA maintains an emergency response phone list for notification of its personnel, which can be accessed by DHFS Emergency Human Services 24/7 On-Call staff and DHFS Emergency Human Services Coordinator.

- **Population-Specific DDES Business Areas**: Within the DDES, a number of Bureaus and Offices are responsible for coordination of services to vulnerable populations, including (but not limited to) older adults, children, people with mental disorders, people with substance use disorders, people with physical disabilities, people with hearing impairment, and people with visual impairment. Resources within these Business Areas and Offices can provide information, technical assistance, guidance, and support to disaster human services efforts.

- **DHFS Emergency Human Services Coordinator (EHSC):** The EHSC is responsible for coordinating with County Human Service Authorities and other human service organizations (such as the American Red Cross and the Salvation Army) that work to meet the human and social service needs of the affected population.

- **DHFS Affirmative Action/Civil Rights Compliance (AA/CRC) Officer:** The DHFS AA/CRC Officer has identified resources (e.g., interpreters) that may be of assistance to DHFS, DDES, and DPH in time of crisis. Contact and identification of such staff will be initiated through DHFS Emergency Human Services Coordinator.

Coordination With Other Governmental Units

A number of local, Regional, State, and Federal governmental units are involved in disaster planning, mitigation, response, and recovery. Emergency human service representatives responsible for coordinating the human service response with those of other branches of government include:

- The County Human Services Authority, in coordination with local Emergency Management
- The emergency human services representative from the DHFS Regional Office
- The DHFS Emergency Human Services Coordinator, in coordination with Wisconsin Emergency Management

At their respective levels of government, these three people will:

1. Assess the situation concerning the involvement of additional State and Federal governmental units. If such involvement is needed and/or in progress, coordinate warning, response, and recovery efforts with these agencies, including:
    - Criminal justice
    - Law enforcement
    - Fire and rescue
    - Agriculture (including extension service and veterinary services)

- Parks and recreation
- Animal care and control
- Victims' service agencies
- Social services agencies
- Education
- VOAD

2. In coordination with these entities, determine if they require the assistance of emergency human service responders.

3. Determine the need for involvement by additional local governmental units, and contact the appropriate agency representatives.

4. Include representatives of all appropriate agencies in state-level human service preparedness, response-, and recovery- related committees, coalitions, and other bodies.

5. Coordinate the state-level human service response with the activities of all other involved governmental units.

Connectivity With Local, State, and Federal Plans

Throughout the ongoing process of developing this Plan, care has been taken to reflect related provisions in Local, State, and Federal emergency response and recovery plans (e.g., County EOP Plans, Wisconsin Emergency Operations Plans, State of Wisconsin Public Health Bioterrorism Preparedness Plan, Federal guidance documents on all-hazards planning).

Persons involved in the preparedness, response, and recovery processes will carry on this work by:

A. Coordinating closely with emergency management responders

B. Monitoring the ways in which provisions of this Plan do and do not match provisions of emergency operations plans and local emergency human services plans

C. Recommending alterations to this plan to bring it into closer connection with other relevant local, State, and Federal plans

Section 12: Administration and Plan Maintenance

This Section touches on four aspects of program administration in disaster human service planning and response:

- Recording and reporting functions
- Self-sufficiency of human services responders at disaster locations
- Access and credentialing issues
- Plan development and maintenance

Recording and Reporting Functions

State recording and reporting functions fall into two categories:

1. Recording and reporting needs connected with FEMA/CMHS Immediate and Regular Services Crisis Counseling Grants
2. Recording and reporting needs connected with the human services portion of the CDC-funded Bioterrorism Preparedness Program

Reporting for Immediate and Regular Services Crisis Counseling Grants

In the event of a disaster or other public health emergency, it is the responsibility of the local Human Service Authority to collect, record, and report the information required for preparation of FEMA/CMHS Immediate Services Crisis Counseling grant application. Once the grant is in place, it is the responsibility of the local Project Recovery Director to collect data on the crisis counseling project. This information falls in the following categories:

1. Needs estimates
   - Estimated numbers of people to be served in each designated area
   - Estimated numbers of people in each loss category
   - Detailed needs assessment data

2. Provider/staffing information:
   - Agency information and service area
   - Staffing plan

3. Financial information:
   - Budgets for each participating agency/organization
   - Costs associated with each consultant and trainer

4. Service provision information:
   - Crisis counseling contacts in each demographic group
   - Observed and reported reactions (behavioral, emotional, physical, and cognitive)
   - Individual referrals
   - Group contacts made
   - Materials distributed

Copies of these reporting forms are included in Appendix D, "ISP and RSP Reporting Forms."

Self-Sufficiency of Human Service Responders at Disaster Locations

Depending on the scope and severity of a disaster, responders may need to bring with them enough provisions to sustain them during the acute phase of the response. Like other emergency responders, human services staff might need to operate on site without exhausting any of the already-scarce survival resources that exist there.

DDES will, within resources available:

A. Determine the volume of supplies necessary to allow staff in the field to operate independently for at least 72 hours.

B. Purchase and/or solicit donations of supplies, including:
   - Meals Ready to Eat (possibly obtainable from the Wisconsin National Guard)
   - Bottled drinking water in easily carried containers
   - Portable tents
   - Bed-rolls or sleeping bags
   - Any forms that might be needed in the field
   - Paper, pens, stationery, masking tape
   - Alternative communications equipment (e.g., hand-held FM radios, two-way radios that avoid frequencies used by other response systems)
   - Flashlights and batteries
   - Uniform garments (e.g., caps, nylon jackets) that team members, other emergency responders, and the public can use to identify members of the emergency human service team
   - Keys, credit cards, building passes, and building and room keys

C. Arrange for the immediate use of reliable vehicles (preferably vans or other vehicles that would easily accommodate sleep) in the event of a disaster or other emergency.

D. Arrange for immediate access to gasoline in the event of a disaster or other emergency.

Access and Credentialing Issues

In the response phase of a disaster, the local human service infrastructure is often overwhelmed by the level of need that exists. Fortunately, many human service professionals are willing to travel to the affected area to help. However, differences in credentialing and gaps in information—across geographic boundaries and among the various disaster response fields and authorities—can create barriers that waste precious time and energy in a crisis.

When Emergency Human Services personnel reach the disaster areas, their ability to gain access to those areas and to be recognized by emergency services personnel is crucial to the effectiveness of the human service response. Each entity involved in the planning and response process needs a procedure for identifying the necessary credentials, verifying the credentials of responders who arrive on the scene, and (if appropriate) "on-the-spot" credentialing processes.

Plan Development and Maintenance

This Plan was developed by the Bureau of Mental Health and Substance Abuse Services, based on the State's:

- Experience participating in numerous disaster response and recovery processes
- Information gained in literature reviews and training courses
- Experience gained in numerous full-scale and table-top exercises
- Information gained from several full-day meetings of the multi-disciplinary, multi-agency Statewide DMH/SA/HS Advisory Committee
- Consultation with CMHS DTAC and review of other States' Disaster Mental Health plans.

This Plan was reviewed and approved by the Statewide DMH/SA/HS Advisory Committee. The Plan has been reviewed at multiple levels of authority within the Department, including administration of the Bureau of Mental Health and Substance Abuse Services, the Division of Disability and Elder Services, the Division of Public Health, and the Office of the Secretary.

The Plan will be reviewed periodically by the DHFS Emergency Human Services Coordinator. Whenever major revisions are recommended, the Statewide DMH/SA/HS Advisory Committee will also be asked to review and make recommendations.

This Plan is designed to complement other existing plans, and facilitate integration among the many plans that seek to protect Wisconsin's citizens in the event of disaster, bioterrorism, and other public health threats and emergencies.

Part D:

Guidance on Specific Issues

Section 13: Communications

Purpose

To ensure that emergency human service responders:

A. Have access to the information they need in order to fulfill their mission

B. Are able to communicate with one another and with their support and supervision networks

Situation and Assumptions

A. It is in the nature of a disaster to disrupt the status quo, including normal means of communication and mass communication. Land telephone/fax lines, cell towers, radio and television transmitters, electricity, computer networks, roads, and vehicles are all vulnerable to destruction, disruption, or a flood of demand that renders systems inaccessible to those who need them for the response effort.

B. Some situations may occur (e.g., severe ice storm) in which all normal means of communication fail.

C. In the event of a disaster, terrorist event, or other public health threat or emergency, communication about the situation and the associated needs will be critical to the effectiveness of the human service response.

D. It is essential for the emergency human response system to have:

- Redundant communication systems, including systems that are able to operate independently
- The ingenuity to plan for, and respond to events with ideas for, additional alternative systems (including communications systems considered outmoded), if circumstances necessitate
- Policies and procedures for the establishment, maintenance, and smooth operation of communication systems

Communications Equipment

A. DHFS has in its possession a small quantity of laptop computers that can be diverted to the response process if they are needed. DHFS equipment is locked in a secure site with access limited to designated staff. Point of contact is DHFS Emergency Human Services Coordinator.

B. As resources permit, DHFS will purchase, solicit as donations, or arrange for rapid loan (on an as-needed basis) of a variety of alternative communication devices, including:

- Satellite phones
- Hand-held two-way radios that avoid frequencies needed by other emergency responders
- Battery-powered FM radios
- Batteries
- Flashlights
- Electrical generators
- Extra batteries for laptops
- Cellular phones that accommodate Internet access
- Hand-operated duplicating machines

C. WEM has some communications equipment that can be loaned (with permission of the WEM Regional Director). This equipment includes:

- Mobile radio network (VHF repeaters, control stations, and mobile and portable radios)
- Hand-held radios, including 70 5-watt radios (30 State EOC, 18 Emergency Police Service Director, 5 each regional office, except for Southwest Region)
- Portable repeaters: Two 165-lb. GE Master II. Each has either the WEM statewide or the Mutual Aid Radio Channel (MARC) frequency pair. They can be used with WEM's portable tower or at the pre-positioned WEM antenna sites in Seneca (Crawford County) or Wheeler (Dunn County).
- Separate, trailer-mounted, thirty-foot tower that may be used with either of WEM's transportable repeaters to set up a localized communications center.
- Two 6.5-KW generators, self-contained in a stand-alone trailer
- Mobile Command Center, including:
  - Forty-foot trailer towed by a pickup truck
  - Mobile data terminal (no print, not a computer)
  - Radios (UHF and VHF)
  - Two facsimile machines (cellular and land-line)
  - Telephone service (cellular and land-line)
  - Copy machine
  - TV/VCR/Satellite Dish

- 10-KW generator
- Tripod halogen lighting device
- Computers (desktop and laptop, with printer)

Health Alert Network (HAN)

An essential source of public health information for the human service response is the Health Alert Network (HAN), a web-based computer network that gives people throughout the emergency response system immediate access to the information they will need to plan for, identify, and respond to public health threats. This information will include minutes of planning meetings, background information on specific public health threats, current surveillance and epidemiological data, laboratory results, contact information for and credentials of responders, training schedules, and training materials.

The Health Alert Network will carry a variety of event-related information, including:

- Information for the medical community from the hospital liaison group (re: hospitals, medical providers, supply, staffing, etc.).
- Information regarding treatment recommendations and guidelines for health care providers.
- Recommendations regarding quarantine or shelter-in-place advisories

The Health Alert Network will use a variety of communication venues, including the Internet, broadcast fax, emails, etc.

HAN staff have developed a number of elements to help users adapt to the HAN technology, including a user-friendly format, education and support, a best-practices guide, information about free software for compatibility, and desk-top networking and security. Users of the network will be assigned different access levels (including different layers of security for transmission, storage, and access to data) according to their needs. Some types of information—meeting minutes or educational materials, for example—will be available to all users. Others, such as confidential patient data, will be guarded carefully.

Section 14: Public Information

Purpose

To ensure that emergency public information is conveyed in ways that will reach all vulnerable populations, promote public safety, and minimize the potential negative psychosocial effects of these messages.

Situation and Assumptions

A. If a public health threat arises, people will need accurate, up-to-date, and useful risk and safety information, presented in ways they can understand, by people they can trust. The Division of Public Health described some of the central challenges in a fact sheet about its Risk Communication and Public Information Focus Area:

> *As a crisis unfolds, information is often contradictory, if it exists at all, but then expands to an overwhelming avalanche of complex messages. Inaccurate and poor information sharing can quickly create confusion and undue concerns, resulting in over-reactions by the public that inundate the response system. However, withholding information and understating risks can irreparably damage credibility and undermine public confidence* (Division of Public Health, 2002).

B. Any of these common conditions can have serious implications for the psychosocial well being of the public—and the psychosocial issues that arise can have serious disruptive effects on the overall response system. For these reasons, emergency public information is a vital emergency human services issue.

Criteria for Effective Emergency Public Information

Public information must be:

- Provided in multiple languages, to reach all affected populations

- Provided in disability-appropriate ways, to reach people with special communication needs (e.g., visual or hearing impairment, mental disorders, developmental disabilities). A volunteer network may be activated to inform people with special communication needs.
- Complete enough to give people all available information about what they can do to seek help, remain safe, find their loved ones, etc.
- Provided in terms designed to stabilize and reassure people, rather than alarm or anger them.

The Joint Information Center

In the event of a disaster, threat, or emergency, and activation of the State Emergency Operations Center (EOC), a Joint Public Information Center (JPIC) will be established at the State level as part of the State EOC. Public Information Officers will report to the Joint Information Center, and all media communications will be conducted through that Center. The JPIC will issue all press releases and conduct all news conferences. Cities and counties also have the option to open local EOCs and JPICs.

The JPIC will also coordinate communication with hospitals, and relay all appropriate hospital and public health information to the media, so that the public will receive clear and specific information about where and how to seek appropriate levels of care. (If the JPIC has not yet been developed, the EOC will disseminate this information, in conjunction with the Governor's Office.)

Guidelines for Effective Public Information

Note: Most of these guidelines were distilled from a booklet entitled **Communicating in a Crisis: Risk Communication Guidelines for Public Officials**. This 83-page pocket-sized booklet is available from the Substance Abuse and Mental Health Services Administration.

A. If you are communicating with the media, be aware of their deadlines and ways in which those deadlines might affect your ability to convey your information (e.g., communicate messages briefly, starting with the ones it is most important to convey).

B. If you are producing materials to be given to the public, ensure that they will be translated into all of the most common languages, and that they will be produced in disability-appropriate versions (e.g., large print, audio, Braille).

C. Remember to balance people's need for clear and accurate information with their need for reassurance and a sense of hope and order.

D. Wherever possible, choose less dramatic words (e.g., find substitutes for words such as "crisis" or "life-threatening," discuss the "event" rather than the "disaster").

E. Use simpler language and explanations, avoiding jargon and technical terms, so that more people will understand your message. However, avoid being simplistic or sounding condescending.

F. Provide definitions in advance, rather than assuming people will know your terminology.

G. If you lack the information or confidence to answer a question effectively, you can always say something like "I'd like to answer that question later" or "I don't have that information yet."

H. Help people understand that uncertainty is part of the still-developing process, and that the answers available now may not be the final answers.

I. Provide whatever reassuring information you have (e.g., "the illness is treatable"). When people are afraid, their ability to concentrate is often impaired. So repeat your reassuring information at appropriate intervals throughout your message.

J. Provide all available information on what people can do, including:f

- Precautions they can take
- What to do if they may have been exposed to infection
- How to recognize symptoms
- What to do if they develop symptoms
- Where to go for medical care, emergency shelter, quarantine, etc.
- Whom to contact for crisis counseling

K. Remember that people facing the effects of disasters, epidemics, terrorist events, etc. feel acutely the loss of control that these events bring about. Helping people find out what to do will help them define the areas in which they still have some control.

L. Normalize the common reactions to crisis.

M. Encourage parents to limit their children's exposure to news coverage of the event and its effects.

N. If there is no clear link between the event and terrorist activity, do not suggest the possibility of a link. If it appears that no link exists, volunteer this information, and let people know that investigators are following up to make sure that this is the case.

O. Focus on unity, rather than divisiveness.

Section 15: Mobilization of Human Service Systems

Purpose

This Section outlines the Department of Health and Family Services (DHFS) plan for mobilizing the disaster mental health response, both within the Department and with public and private sector mental health resources. Its purpose is to ensure:

- Prompt and thorough notification of the Department
- Effective mobilization of resources within the Department
- Effective notification of external mental health, substance abuse, and other human services resources serving people with special needs
- Effective notification of the larger mental health, substance abuse, and other human service systems
- Effective notification of private sector resources

Situation and Assumptions

Many people with special needs may be more vulnerable to the psychosocial effects of natural disasters, terrorist events, and other public health threats and emergencies. Many people in DHFS-operated facilities are dependent upon medication, the supply of which might be disrupted in an emergency. Life in an institutional setting can also in some cases contribute to feelings of isolation, helplessness, hopelessness, entrapment, fear, anger, and loss. These feelings can be exacerbated by the effects of disasters and other emergencies, and terrorist actions are often followed by even higher levels of fear and anger.

The Department of Health and Family Services has a responsibility for the well being of Wisconsin's most vulnerable citizens. Though the Department is not itself invulnerable to the effects of natural disasters, terrorist events, or other public health threats and emergencies, it has a duty to do everything in its power to continue functioning and provide the protective services that fall within its mission.

Warning and Notification

DHFS receives rapid notification of disasters and other public health threats and emergencies through several avenues:

A. Rapid notification of public health threats and emergencies is transmitted through the Wisconsin Health Alert Network, administered by staff of the focus area of the Division of Public Health's CDC Bioterrorism Preparedness Program.

B. The DHFS Emergency Coordinator receives direct notification from Wisconsin Emergency Management and/or from local Emergency Management authorities.

C. The DHFS Emergency Human Services 24/7 On-Call staff member receives direct notification from Wisconsin Emergency Management and/or from local Human Service authorities.

D. The DHFS Emergency Coordinator notifies the Emergency Human Services Coordinator of any event that may have human service effects. The Emergency Human Services Coordinator notifies the Emergency Coordinator of all threats or emergencies.

E. When the Emergency Human Services Coordinator receives notification of a threat or emergency, the first determination to be made is whether or not a State- or county-operated facility has been affected. The emergency human services coordinator will determine the perimeters of the affected area, obtain maps and regional documents showing the locations of DHFS facilities, and interview local Institution and human services staff to make that determination.

F. The Emergency Human Services Coordinator will notify any institution affected by the threat or emergency.

G. If warranted, the 24/7 On-Call staff will immediately report the incident to the DHFS Emergency Human Services Coordinator or the DHFS Emergency Coordinator who will discuss it with the responsible member of DDES management staff, which may include the appropriate Section Chief(s), Business Area Director(s), and the Administrator's Office.

H. DDES Administration will determine if the incident should be reported to the Secretary's Office. In the event that DDES Administration cannot be contacted, DHFS Emergency Human Services Coordinator, in coordination with the DHFS Emergency Management Coordinator, will ensure that the Secretary's Office is contacted and briefed.

I. On-call staff, in coordination with appropriate DHFS staff, will be responsible for obtaining any information that may be necessary to provide reports to the Bureau Directors' Office, Division Administrator's Office, or Secretary's Office. Media contacts will be addressed according to current departmental guidelines, unless specified otherwise.

Identification of Vulnerable Populations

A. As resources permit, DDES will use its existing Business Area-specific databases, supplemented by databases compiled by the Community Coalition of the DPH CDC/HRSA-funded Bioterrorism Preparedness program, to establish contact information for:

1. State-operated, county-operated, private, and community-based residential facilities for:
    - People with mental illness (e.g., psychiatric facilities, community-based mental health centers)
    - People with substance use disorders (e.g., residential treatment facilities, methadone clinics)
    - People with physical disabilities (e.g., rehabilitation facilities, assisted living centers)
    - People with developmental disabilities (e.g., group homes, residential facilities)
    - Older adults (e.g., nursing homes, assisted living centers)
    - Children (e.g., child care institutions, day care facilities)
2. Hospitals and state-operated public health facilities
3. In-home caregivers and people receiving in-home care
4. Other vulnerable populations

B. In the event that DHFS operations must be moved and/or modified due to the effects of a disaster or other emergency, Departmental staff will be assigned to contact facilities, caregivers, and human service agencies, to:

1. Notify them of the status of DHFS operations
2. Determine their need for assistance
3. Activate the appropriate procedures to ensure that assistance is delivered

Section 16: Health and Medical

Purpose

This Section is intended to:

A. Promote effective collaboration and coordination between health and medical resources (e.g., Public Health, and hospitals) and human services responders

B. Prepare human service responders to provide effective support to public health and hospital staff, and to their response efforts

C. Identify some of the psychosocial considerations inherent in Public Health and hospital responses to threats and emergencies, for special-needs populations and for the population in general

D. Help Public Health and hospitals consider their options concerning the use of community mental health and human service responders to support their efforts

Situation and Assumptions

A. In the event of a large-scale disaster or epidemic, public health systems and hospitals may have to implement a variety of extreme measures (e.g., steps to increase inpatient bed capacity, quarantine, decontamination). Even carried out in humane ways, these measures may have unintended negative psychosocial consequences for patients and their loved ones. These consequences may compound or aggravate the psychosocial effects of the event itself.

B. These effects may be even stronger in more vulnerable populations (e.g., children, older adults, people with mental disorders, people with developmental disabilities, people with visual or hearing impairment, people who experience language barriers, people who live in isolation from the community as a whole).

C. For a number of vulnerable populations, the medications they receive for their mental disorders, substance use disorders, age-related disorders, or other disabilities are crucial to their physical and psychological stability, even in stable environments. When disasters disrupt normal pharmaceutical supply lines, those medications may become unavailable. This medical instability may severely compound or aggravate the psychosocial effects of the event itself.

D. In a large-scale event, it is possible that hospitals and public health teams will be operating below normal staffing levels (e.g., if staff are injured or taking care of their own families, if staff are assigned to off-site mass care facilities). This may create significantly increased burdens on the staff who are present. The increase in stress that these new burdens bring about may be further increased by health care providers' own experience of the event and concern for their families and friends.

E. Even with normal staffing patterns, the experience of multiple patient fatalities in a medical care setting can lead to rapid (e.g., two hours) development of burnout among medical staff. With the exponential increase in fatalities that might accompany a mass-casualty event, the psychosocial effects on medical providers might also rise to dangerous levels.

F. Depending on the availability of personnel in the various response disciplines, emergency mental health providers might be available to assist the medical care systems, and might be needed in that capacity. The Public Health and hospital planning process includes consideration of the various ways in which they might make use of mental health resources that exist outside the medical setting.

CDC- and HRSA-Funded Planning Processes

Wisconsin's CDC- and HRSA-funded bioterrorism planning processes have defined three broad populations potentially in need of disaster mental health services:

A. Hospital and public health staff and their families

B. Victims and their families

C. The general public

Among the mental health factors under consideration in those planning processes are the most effective ways to provide emergency support to those three populations. The subject has been under discussion in the CDC-funded Regional Consortia and the HRSA-funded Hospital Regions.

Representatives of the CDC- and HRSA-funded planning processes serve on the DHFS Disaster Mental Health/Substance Abuse/Human Services Advisory Committee.

Assistance From Community Mental Health

An essential part of the medical planning process will be a discussion of the ways in which community-based mental health providers should be brought in to help the hospital effort, if such providers are available. Population-specific options include:

A. Use of community-based providers for crisis counseling services to medical personnel (e.g., FEMA crisis counseling model). If this option is chosen, then the mental health personnel providing services to staff should not also be part of the response effort at medical facilities, in order to maintain an important boundary in the service-provision process.

B. Use of community-based providers to assist with patients and their families. (A number of circumstances in which such assistance might be needed are outlined in the following subsection.)

C. The current use of community-based mental health personnel, provision of services to the general public. These services can significantly reduce the burden on hospitals and other health care resources, by reducing the anxiety that otherwise often drives some people to seek medical attention despite the fact that they have not been injured or infected.

Community-based providers who might want to participate in the hospital response effort should contact their local hospitals' social work departments during the planning process, rather than waiting for an event to occur. The sharing of information and ideas will be far more fruitful if it occurs in a planning atmosphere, with time to investigate challenges and develop appropriate solutions. It will also provide time for the orientation to hospital flow patterns and procedures, an essential element of preparing volunteers that may be difficult to achieve under emergency circumstances.

The Hospital Culture

Community-based mental health providers who do enter the hospital culture to provide services will find several ways in which this culture differs from their own. Chief among this is the difference in pace.

Hospital staff are used to having very little time for assessment of patients' circumstances and needs. Rather than the comprehensive, in-depth assessments that community-based providers may be used to giving, they will need to provide rapid, brief, and succinct observations and assessments, particularly in emergency room settings.

Psychosocial Effects of Medical Circumstances

A number of procedures that may become necessary in large-scale events may have serious psychosocial effects on patients and families, including:

- Methods of Increasing Hospital Bed Capacity
- Quarantine
- Decontamination

Some circumstances that are common or unavoidable in these procedures, and some of their possible effects (particularly among more vulnerable populations), are outlined below.

Increasing Hospital Bed Capacity

Many hospitals are already filled to capacity. To accommodate even a moderate influx of patients, an equal number of patients will have to be displaced. Patients may have to be discharged early, with or without the need for continuing in-home care; transferred to nursing homes or to other hospitals; transferred within the hospital; or diverted to other hospitals or clinics before they are admitted. Patients who are scheduled for surgery may be reviewed for possible postponement of surgery.

Even under normal circumstances, many patients in hospitals feel helpless, confused, and frightened, even with the most competent and caring medical staff. For many people, illness itself is frightening, as is the helplessness inherent in letting other people take control of one's body and one's physical well being. In addition, in the age of managed care, many people are already dismissed earlier than their medical providers would choose if coverage were not an issue. Being dismissed even earlier can lead to increased feelings of fear and helplessness, and loss of trust in the medical system. Patients who need continuing care but have limited resources will face additional fears and frustrations.

In mass-casualty situations, these circumstances are multiplied many times over. Hospital staff may be left with painful decisions concerning their patients' care, and more vulnerable patients may feel discarded or abandoned by the health care providers on whom their lives depend. Nursing homes and in-home caregivers may be stretched past their limits. Large numbers of people may be experiencing very real concerns, aggravated by the experience of living in close proximity to a large-scale event.

Appropriate disaster mental health services can help people gain reassurance, maintain their confidence, find alternative resources, and break the feelings of abandonment and isolation that might otherwise accompany these circumstances.

Quarantine

In the event of a bioterrorist incident or a naturally occurring outbreak of infectious disease, Wisconsin's hospitals and public health system may have to implement quarantine procedures. Depending on the incident, its scope, and its boundaries, people may be quarantined in hospitals or off-site care settings, or they may be quarantined in their homes.

The greatest concerns surround more vulnerable populations, particularly people who depend on in-home caregivers. Those caregivers may well be infected, killed by the epidemic, quarantined in their own homes, or needed to care for their own families. Their patients may not know where their caregivers are, and may not be able to find information about their caregivers. Health care provision systems may not know about the circumstances or needs of the in-home patients.

Even among people whose pre-outbreak health and level of ability was normal, the isolation of living in quarantine can have severe psychosocial effects. This isolation can exacerbate a number of difficult emotions, including fear for their own health, fear for their loved ones' health,

feelings of guilt and helplessness at not being able to be with loved ones during the crisis, and fear and anger over being trapped and constrained.

Appropriate disaster mental health services can help people find alternate care, learn the status of their loved ones, break the isolation (even if only over the telephone), understand their risks, learn about the precautions they must take, and understand the quarantine process.

Decontamination

In the event of chemical or nuclear contamination, hospitals and Local Public Health Agencies will have to use decontamination facilities and procedures. Depending on the volume of patients and the available resources, decontamination might involve:

A. Long periods of waiting for decontamination procedures, often in buses full of people also waiting to be decontaminated or in an area assigned for that purpose

B. Walking through a large plastic tube to the decontamination area

C. Being processed by personnel in full protective gear (“moon suits”) or partial protective gear (face masks, gloves, and aprons)

D. The removal of all clothing and personal effects (which might be unavailable to patients temporarily or permanently)

E. Decontamination showers, with or without privacy or segregation of the genders

F. Provision of a pair of slippers and hospital scrubs

G. Lack of information about where their relatives are, how they will be transported home, and what they can expect next

Even people with high reserves of emotional strength and resilience may experience difficulty under any or all of these circumstances. For people with added points of vulnerability, the psychosocial effects will often be much higher.

Appropriate disaster mental health services can help humanize the decontamination process, by reassuring people, helping them contact their friends and relatives and make arrangements for transportation home, moving them through the system, and giving them information about what to do and what signs to look for in the future. These services may be more difficult to provide in protective gear, but their benefits might still be significant.

Section 17: Hazard-Specific Risks and Effects

Purpose

To increase the hazard-specificity of planning processes by examining some of the disaster human services implications of the hazard-analysis information prepared by Wisconsin Emergency Management (WEM) (Wisconsin Emergency Management, 2002).

About This Section

The following pages briefly summarize:

- WEM hazard analysis information regarding Wisconsin's vulnerability to a variety of types of incidents
- Some of the more common psychosocial effects of these events

This information has been combined to allow planners to compare the risk of occurrence each type of event with the psychosocial risks associated with it.

Air Transportation Incidents

Situation and Assumptions

A. Wisconsin has 726 aircraft landing areas (136 open to the public, 430 for private use, 126 heliports, 27 seaplane bases, and 7 military/police fields).

B. Commercial airline accidents involving large aircraft have been rare in Wisconsin. Most incidents in the state have involved small privately owned airplanes or small commercial air taxis. Wisconsin's worst air crash killed 31 people in 1985, and its second worst killed 13 people in 1972. Between 1996 and 2002, all but two of the aircraft involved in fatal accidents in Wisconsin were private aircraft, and the remaining two were chartered air taxis.

C. Only two airplane hijacking incidents have originated in Wisconsin: one in 1971, when a Northwest flight to Detroit was redirected to Cuba; and a 1978 flight from Madison to Milwaukee, in which passengers overpowered the lone hijacker.

D. No matter what size the craft might be, the effects of a crash in a heavily populated area can be devastating. The risk of an accidental airplane crash is usually greatest during takeoff and landing, making the communities closest to airports more vulnerable.

Psychosocial Risks

A. In its large and small cities, Wisconsin has much potential to suffer heavy damage and casualties. Depending on the size of the craft and the concentration of people in the affected area, the need for emergency human services might be significant.

B. Psychosocial effects might be heightened by:

- the unpredictable nature of crashes
- the fear and pain that accompany exposure to and memory of explosion and fire
- the association with 9/11.

C. People might also lose their homes and workplaces, with more devastating effects on economically stressed communities.

D. Even in sparsely populated areas, the crash of a large aircraft might forever change the affected community, with the memory of the crash, the sight of the bodies, and the influx of news media and relatives of the victims into an insular rural culture.

Coastal Hazards

Situation and Assumptions

A. Three types of natural hazards affect the state's shoreline along Lakes Superior and Michigan:

- Erosion of coastal bluffs, banks, beaches, and near-shore lake beds
- Flooding from upland runoff, high lake levels, and storm-induced surges
- Damage to shoreline structures from storm waves.

B. All 15 coastal counties are vulnerable to these three types of hazards, particularly during major storms, after unusually high snowfalls, and during high seasonal summer lake levels.

C. The areas most vulnerable to bluff erosion lie on the Michigan shoreline between the Illinois state line and the Sturgeon Bay Canal in Door County, and in the northeastern area of Brown County on Green Bay. Coastal flooding is a serious issue along two low-lying sections of the Michigan shore: southern Kenosha County and the western shore of Green Bay from the City of Green Bay to the Michigan state line.

D. Approximately 37 percent of the state's population lives in the 15 coastal counties. Except for Milwaukee County, their population has grown significantly in the past 10 years.

Psychosocial Risks

A. Most of the effects of coastal hazards are financial in nature, often resulting in the fear, anger, and anxiety that often accompany financial loss. In the many cases in which insurance does not cover the losses, feelings of anger and betrayal are also common. In a difficult economy and times of high unemployment, these problems are often exacerbated.

B. Any hazard that damages people's homes also adds a strong element of personal and family instability and disruption. For more vulnerable populations, this disruption can have farther-reaching effects.

Drought

Situation and Assumptions

A. Of the two types of droughts—agricultural (with markedly reduced crop yields) and hydrological (with duration sufficient to affect lake, stream, and water table levels)—Wisconsin is most vulnerable to agricultural droughts.

B. The state has approximately 16,400,000 acres of farmland on 78,000 farms, and was ranked 10th in the country in overall farm receipts in 1998.

C. Even small, relatively brief droughts can have significant effects on crop growth and yields. Larger droughts can have severe effects on the farm economy and increase the risk of forest fires and wildfires.

D. Both agricultural and hydrologic droughts are relatively common in Wisconsin.

Psychosocial Risks

A. In a state as heavily agricultural as Wisconsin, a significant portion of the population is at risk of severe financial loss from drought.

B. The widespread nature of drought conditions and effects can easily overwhelm local emergency human service resources.

C. The fierce pride and independence that characterize many rural farm cultures can make it harder for people to admit that they need emotional support and accept the help they need.

D. Any event that threatens or damages the beauty of the scenery or the viability of the land for recreation also tends to have a depressing effect on the people who live there, the local culture, and the local economy, particularly in areas that depend on tourism. The drying of waterways, the lack of nourishment to trees and wildlife, and the increased risk of fire give drought an added dimension of psychosocial risk.

Earthquakes

Situation and Assumptions

A. The level of earthquake threat to Wisconsin is considered low. Of the 24 recorded earthquakes originating in Wisconsin since 1900 (thought to be due to the rebound of the Earth's crust after the last ice age), none has caused significant damage.

B. The closest major active fault is the New Madrid Fault, which runs along the central Mississippi River Valley in Missouri. Its seismic zone reaches as far north as southern Illinois.

C. If a catastrophic earthquake occurred along the New Madrid Fault (such as the four experienced there in 1811 and 1812), buildings in Milwaukee, Waukesha, Walworth, Racine, Kenosha, and Rock Counties might experience damage (with varying severity, depending on structural soundness), and Wisconsin might lose natural gas or oil supplies due to damage to pipelines that run through or near the fault zone.

Psychosocial Risks

A. Although the likelihood of severe damage and heavy injury is low, Wisconsin's situation in relatively close proximity to a major fault line does make earthquake planning a legitimate task for emergency human service providers.

B. The risk of losing fuel supplies also has many implications for people's psychological and economic well being. Widespread loss of heat in winter would bring significant emotional hardship, as would loss or reduction in fuel for transportation.

C. In addition, if a major earthquake struck along the New Madrid fault, Wisconsin's emergency human service responders would be among those needed in that area.

D. Floods and Flash Floods

Situation and Assumptions

A. Between 1971 and 2001, flooding has been a principal cause of damage in 16 out of 24 Presidential Disaster Declarations in Wisconsin.

B. Effects of flooding can include:

- Extensive damage to property, dams, levees, crops, and agricultural economies
- Danger of injury and loss of life (in flash floods)
- Long-term health hazards from water-borne diseases, mold, mildew, insect infestation (possibly including mosquitoes carrying West Nile virus), and contaminated drinking water.

C. Areas of highest flood risk include the low-lying areas that border the Mississippi and Wisconsin Rivers. Periodic floods have also occurred in the Chippewa River in Eau Claire and Dunn Counties, the Kickapoo River in Crawford and Vernon Counties, the Pecatonia River and its tributaries in Green and Lafayette Counties, the Bad River in Ashland County, the Wolf River in Waupaca and Menominee Counties, and the Milwaukee River.

D. The demand for housing along Wisconsin's waterfronts has been increasing dramatically (e.g., a 216-percent increase in lakefront homes since the 1960s).

E. In addition, as development moves into agricultural areas, the loss of stormwater runoff areas is likely to increase flooding on farmlands (e.g., flooding increases in rapidly developing Waukesha County).

F. Wisconsin has approximately 3,700 dams, many of which were constructed before 1900. (An additional 700 dams were built but were later washed out and no longer exist.) Approximately 5 percent of the existing dams produce hydroelectricity. Approximately 1,200 of the state's dams are large; the remainder are small and are not stringently regulated for safety purposes.

G. Among the 3,700 dams there is a wide variance in the potential to cause damage if they fail. 262 dams have been signified (by the Wisconsin Department of Natural Resources) as "high hazard" (indicating that failure would probably result in loss of life), and 252 have been signified as "significant hazard" (failure would probably lead to significant property damage).

Psychosocial Risks

A. The abundance of waterways, the high concentration of people along those waterways, and Wisconsin's heavy history of flooding make flood risk an important planning area for emergency human services in the state.

B. Like many other events, floods can damage or destroy people's homes, property, cherished keepsakes, workplaces—even their sense of being rooted and belonging in their communities, their families, and their own life histories.

C. Injury and loss of life during flash floods make those events particularly damaging to people's psychosocial well being, adding higher levels of anger, loss, grief, guilt, and other difficult experiences.

D. Slow-building floods are also often slow to recede, leaving people displaced for longer periods of time, staying in shelters or with friends or relatives. This can increase both individual and family stress.

E. Also, any event that leaves long-term health risks can complicate recovery and add new problems (e.g., the emotional burdens of debilitation from chronic toxic mold infection or other diseases).

Forest Fires and Wildfires

Situation and Assumptions

A. Although the common causes of these events (lightning, human carelessness, and arson) are usually impossible to predict (apart from the connection between increased development in recreational areas and increased risk of fire), there are several predictable forces that increase vulnerability to these events, including:

- Peak fire season, generally running from March through November in Wisconsin
- Low humidity and lack of precipitation (with drought conditions posing the highest risk)
- Increases in combustible materials: For example, in the Washburn District (straddling Douglas and Bayfield Counties), 12,000 acres of trees were downed by strong winds in 1999, resulting in a three- to six-fold increase in fuel load in that district; areas such as Burnett, Washburn, and Rusk Counties that suffered significant tornado tree damage in 2001 and 2002 may also face increased risk.

Psychosocial Risks

B. In part because of the extreme pain that can be associated with exposure to fire and healing from burns, fire inspires a high degree of fear in many people.

C. Fire can also lead to disfigurement, with all its social and psychological sequelae (e.g., shame, stigmatization, problems with self-concept).

D. For people who were directly exposed, the experience of trauma may be severe. For the families and friends of people who died or suffered serious injuries (often firefighters and other emergency responders) the grieving process is often extremely difficult.

E. The loss of homes and cherished belongings can also cause long-term grief and instability, and the loss of entire communities can either strengthen or erode the sense of community that people need for recovery.

F. Because so many fires are caused by human carelessness or arson, people's experience of anger and rage can also be significant.

G. Many people and communities also have strong emotional and aesthetic connection with the trees, wild animals, flowers, and other forms of wildlife that surround them. These losses can bring depression, grief, bitterness, and feelings of hopelessness.

Hailstorms

Situation and Assumptions

A. Hailstorms are most frequent (85 percent of the total) from May through September, peak crop-growing months.

B. Hail tends to fall in swaths, or series of hail strikes produced by individual thunderstorm clouds. The swaths may be 20-115 miles long and 5-30 miles wide.

C. Their damage to crops, and the impossibility of protecting the crops, can result in significant agricultural losses.

Psychosocial Risks

A. Although injury due to hailstorms is relatively rare, the financial effects of a widespread hailstorm on a farming community can be significant.

B. As discussed in earlier subsections, people in many rural cultures have difficulty accepting outside help or admitting that they need emotional support.

Hazardous Materials

Situation and Assumptions

A. Given the increases in use and variety of chemicals in a number of fixed sites (e.g., business, industry, agriculture, universities, hospitals, utilities, and other facilities) in the past several decades, no area of the state is considered exempt from a possible hazardous material incident.

B. Of the 6,778 facilities in Wisconsin reporting in 2002, 3,112 indicated that they had a significant amount of at least one extremely hazardous substance.

C. Wisconsin has had several significant fixed-site hazardous material incidents. However, the majority of hazardous material releases come from transportation accidents.

D. Most products being transported are petroleum products (gasoline, diesel fuel, jet fuel, fuel oil, asphalt, creosote, and propane), chemicals used in industry and manufacturing (anhydrous ammonia, sulfuric acid, and chlorine), and waste products (industrial waste, food waste, medical waste, and animal waste). Other materials often transported in smaller quantities include pesticides, herbicides, and specialized industrial chemicals.

E. Nuclear materials are transported in Wisconsin. This will increase as the state's nuclear power plans begin shipping spent fuel to fuel storage facilities, with some shipping beginning as early as 2004.

F. Every major roadway and railway is a potential route for hazardous material transport.

G. Potential impacts include long- and short-term health hazards to people exposed, explosions, fires, and environmental contamination. When these events necessitate evacuation, results can also include disruption in social and economic functioning.

Psychosocial Risks

A. The response phase of a hazardous materials release can cause intense confusion in the affected area.

B. Depending on the size of the area, the density of population, and barriers to communication (e.g., hearing loss, language barriers), notification may be difficult.

C. If people are asked to shelter in place, uncertainty about the possible effects and the procedures they are to follow can bring anxiety, and isolation can exacerbate their fears. For people with mental disorders, disabilities, and age-related vulnerabilities, sheltering at home raises an additional set of challenges and fears (e.g., whether or not caregivers are available).

D. Evacuation can also result in a great deal of psychosocial stress, due to:

- Displacement from homes and workplaces

- Uncertainty about the well being and location of loved ones (particularly those who are more vulnerable, physically and/or emotionally)
- Uncertainty about where one is being taken
- The discomfort associated with mass evacuation procedures.

E. People who depend on psychiatric medications for emotional stability may be caught up in the panic of the evacuation process and forget to bring their medications.

F. If decontamination is necessary, that process can also carry many forms of fear, discomfort, indignity, and confusion.

G. If there is loss of life, serious injury, or long-term environmental contamination, people can suffer significant loss and grief.

Heat Waves

Situation and Assumptions

A. Excessive heat has become the most deadly hazard in Wisconsin in recent years.

B. Between 1982 and 2001, 109 people died as a direct result of heat waves (primarily due to heat stroke), more than 4 times higher than the mortality rate for the next most deadly hazards, tornadoes (25 deaths) and cold waves (24 deaths).

C. Older adults and people with disabilities and debilitating conditions are the most susceptible to heat stroke, the most common cause of heat wave-related death.

D. Other effects include sunburn, heat cramps, and heat exhaustion.

E. Large and highly urbanized cities are the most vulnerable areas, creating "islands" of heat that can raise temperatures from 3 to 5 degrees Fahrenheit.

Psychosocial Risks

A. With by far the highest mortality rate of the events that Wisconsin has experienced thus far, this is an important issue for emergency human service planners.

B. Because their primary victims are particularly vulnerable populations (older adults and people with disabilities and debilitating conditions), heat waves often add stress to lives that are already marked by exceptional stress.

C. Lack of mobility and access to information can also add to isolation, fear, and feelings of helplessness.

Nuclear Power Plant Incidents

Situation and Assumptions

A. Two nuclear power plants (in Two Creeks and Carlton) produce 25 percent of Wisconsin's electricity, and two nuclear power plants are located close-by in Illinois (Byron) and Minnesota (Red Wing).

B. Thus far no commercial nuclear power plant incidents have occurred that have affected Wisconsin.

C. Damage from contamination by radioactive materials (from the plant or from transportation routes) would depend on the type and amount of radioactivity and the existing weather conditions.

D. Counties in the "possible ingestion pathway" include Brown, Buffalo, Calumet, Door, Dunn, Fond du Lac, Green, Kewaunee, Lafayette, Manitowoc, Marinette, Oconto, Outagamie, Pepin, Pierce, Polk, Rock, Shawano, Sheboygan, St. Croix, Walworth, and Winnebago.

Psychosocial Risks

A. Until America's recent growing awareness of the threat of chemical and biological weapons, many people's strongest disaster-related fears centered on nuclear power plant explosions or radiation leaks. For anyone who lived through the 1950s and 1960s, the nuclear explosion has long been a significant symbol of fear—as many agents of destruction have become for the individuals who lived through 9/11.

B. One powerful element of fear in the threat or event radiation contamination is the fact that people cannot see, hear, or smell radiation. The possible presence of an "invisible threat" increases the sense of all-pervasive fear, and leads people to question their feelings of safety.

C. Given the possible scope and severity of the physical effects of a nuclear power plant incident, emergency human services response resources might very well be stretched far past their capacity.

D. The chronic and/or fatal nature of some illnesses caused by exposure to radiation also indicates that several psychosocial issues (e.g., isolation, feelings of worthlessness at loss of livelihood, anger, grief) might arise during an extended period of recovery or decline.

Terrorism

Situation and Assumptions

A. Terrorism can be defined as the unlawful use of force or violence against persons or property to intimidate or coerce a government, the civilian population, or any segment of either, in the furthering of political or social objectives.

B. Terrorist acts are divided into domestic (involving only United States citizens) and international (involving nationals of other countries).

C. Although state-specific risks and hazards are difficult to pinpoint, strong national possibilities include:

- Bombing (most terrorist incidents in the U.S. have involved bombs or incendiary devices)
- Airline attack, including hijacking, sabotage, tampering with navigation and control systems, and airport bombings or shootings
- Chemical/biological/nuclear attack (e.g., introduction of smallpox, or a sarin gas attack like that on the Tokyo subway system in March, 1995)
- Weapons of Mass Destruction (WMB), including chemical, biological, and nuclear materials dispersed through weapons and highly explosive devices, with high potential for widespread dissemination, destruction, injury, illness, and loss of life
- Hostage taking, to gain publicity for political or social objectives
- Infrastructure attacks, against utilities, water supply, electric power generation or transmission, telephone service, or computer resources (e.g., databanks, communications, and software), through viruses, Trojan horses, and worms (through email or hacking)

D. In the past 30 years Wisconsin has been the target of several violent acts that might be classified as terrorism or potential terrorism, e.g.:

- A bomb blast at the University of Wisconsin – Madison in 1970
- An individual in Rock County making deadly ricin and nicotine sulfate toxins in his home in 1997
- Incendiary devices with timers placed on a propane tank in Vernon County in 2000

E. Wisconsin was also the site of several anthrax hoax letters in 2000.

Psychosocial Risks

A. Acts of terrorism can bring on all the psychosocial sequelae associated with the agent (e.g., an explosion and fire, chemical, a disease, radiation) and its short- or long-term physical and economic effects, along with many sequelae often associated with the terrorism, including:

- Fear and anxiety due to the highly unpredictable nature of the attack
- Fear, confusion, anxiety, and anger at the realization that someone wants to harm oneself, one's neighbors, one's community, and/or one's country, for reasons that one may or may not understand.
- For people with experiences of war, oppression, abuse, or crime victimization, terrorist events can bring back associated memories and feelings; for people with persistent post-traumatic stress disorder (PTSD), these events can trigger PTSD symptoms.
- Emotional stress at repeated exposure to information about the event through the media, particularly the "24/7" news channels. In children and other people with greater psychological vulnerability, even this kind of exposure can be traumatizing.
- Loss of community cohesion, if some community members are treated as potential terrorists because of their race, culture, or religion.
- Since 9/11, the danger of terrorism has become an emotion-charged symbol to public officials, the media, and many Americans. Any event might invoke this store of emotion.

B. The scope and magnitude of an effective terrorist event are far beyond the state's experience, and might easily overwhelm response systems, with resulting chaos and fear. At that scale, even preventive measures (such as mass vaccination if smallpox is found or suspected) are likely to produce

Tornadoes and Severe Thunderstorms

Situation and Assumptions

A. Wisconsin lies along the northern edge of the nation's maximum frequency belt for tornadoes—called "tornado alley" by some—reaching northeastward from Oklahoma into Iowa, then across Wisconsin to Michigan and Ohio.

B. Although each Wisconsin county recorded at least two tornadoes between 1844 and 2001, several counties (Barron, Clark, Chippewa, Dane, Dodge, Fond du Lac, Grant, Marathon, Polk, Rock, and Waukesha) each recorded 30 or more tornadoes. Dane (52), Dodge (51), and Grant (50) Counties recorded the highest numbers.

C. Average winds in a tornado are estimated between 100 and 200 mph, but some may have winds higher than 300 mph.

D. Even in the absence of tornadoes, in the past 30 years Wisconsin has experienced hurricane-force winds (75 mph or higher) on 120 days, and winds in excess of 100 mph on 17 days.

E. One of the nation's worst thunderstorms occurred in 1977 in northern Wisconsin, with a 150-mile-long swath of winds reaching more than 115 mph and flattening hundreds of thousands of acres of forest. In 1998, south central and southeast Wisconsin experienced an unprecedented widespread downburst wind event known as a "derecho," with hurricane-force straight-line winds with peak gusts of 100 to 128 mph.

F. Peak periods for these events run from May through September, with peak hours between noon and 10 p.m.

Psychosocial Risks

A. The extremely violent and unpredictable nature of tornadoes often increases people's experience of fear, helplessness, and trauma. Other effects, such as the darkness and loud noise that often accompany tornadoes, can exacerbate people's feelings of fear and fear-laden memories.

B. As in the case of many destructive events, populations whose members may have greater physical or emotional vulnerability in general (e.g., older adults, children, people with mental disorders, people with developmental disabilities, and people with visual and hearing impairment) may also have impaired access to warning and shelter.

C. Long-term psychosocial effects can include PTSD, loss and grief, anger, isolation, depression, disorientation from the changes in the environment, substance abuse, increases in domestic violence, and the emotional effects of financial loss.

D. After tornadoes and other severe storms, the loss of trees and other natural forms of beauty and comfort can also be a source of significant grief.

Winter Storms

Situation and Assumptions

A. These can include heavy snowstorms, blizzards, freezing rain, sleet, ice storms, and blowing and drifting snow.

B. Winter storms can paralyze communities:

- Sheets of ice can cover large areas, making roads impassable
- Sleet, ice storms, and freezing rain can damage property and down electric and telephone lines
- Extremely cold temperatures with strong winds can cause wind chills that lead to bodily injury and death.

C. The winter storm season in Wisconsin generally runs from October through March, with variations depending on timing, type of storm, and area of the state (e.g., greater incidence of sleet and ice storms in southern Wisconsin, snowfall averaging more than 100 inches a year in the extreme northwestern counties).

Psychosocial Risks

A. In many winter storms, one of the greatest human service challenges is the fact that these storms can paralyze so many systems (e.g., electricity, heating, telecommunications, transportation) at once.

B. When extreme cold is combined with loss of communication, transportation, and heating capacity, the physical dangers are often compounded by isolation, confusion, and the pain and grief that accompany injury and death.

C. In hard-to-reach rural areas, the damage can be widespread and relief and support systems can remain powerless over the elements for long periods of time.

D. As they so often do, more vulnerable populations tend to suffer more from all of these conditions.

Part E:

Standard Operating Procedures

Section 18: SOP, Warning and Mobilization—County Emergency Management

Notification

1. In coordination with the County Emergency Management Plan, notify:
    - Wisconsin Emergency Management
    - County-level Human Service Authority
    - Local Public Health Agency
    - Tribal Health Department
    - American Red Cross

SOP, Warning and Mobilization—Co. Human Services

In coordination with the county Emergency Management Plan and EOC/ICS:

1. If disaster scope is beyond county capacity, notify DHFS Emergency Human Services 24/7 On-Call staff.

2. If you do not reach the person on duty, contact the others on the on-call staff list.

SOP, Warning and Mobilization—DHFS 24/7 On-Call Staff

1. If you are a victim of the disaster, contact the DHFS Emergency Human Services Coordinator. Tell them your status and let them know if you're able to respond.

2. Share information previously reported to you or observed by you.

3. The DHFS Emergency Human Services Coordinator will communicate with DHFS Emergency Coordinator to report staff availability.

4. The DHFS Emergency Human Services Coordinator will make recommendations to the DHFS Emergency Coordinator as to what, if any, additional staff are required to respond to the event.

SOP, Warning and Mobilization—DHFS Emergency HSC

Note: This SOP is for the **DHFS Emergency Human Services Coordinator.**

Investigation

1. For decisions on level of response, consult:
   - DHFS Emergency Management Coordinator
   - DDES Administrator
   - Office of the Secretary
2. Keep an activities log, including:
   - Time of calls or contacts
   - People/agencies contacted
   - Issues discussed
   - Actions taken
   - Required follow-up, etc.
3. Find out if a State-or County-operated facility has been affected:
   - Determine perimeters of the affected area
   - Get maps and regional documents with locations
   - Interview local Human Services
   - If it has been affected, call the Director of the Business Area
4. Discuss with local human services and active voluntary organizations:
   - Possibility of mass casualties
   - Status of hospital capacity
   - Need for off-site mass care
   - Need for evacuation
   - Need for emergency shelter
   - Any technical information they might need

Continued on the next page

5. If needed, call the Area Administrator or a Human Services Area Coordinator assigned to emergency human service responsibilities in the DHFS Regional Area Administration Office (OSF).

6. Brief any other technical and administrative DHFS staff, if needed.

Alerting DHFS/DDES/BMHSAS Management

A. Alerting DHFS/ DDES/BMHSAS Management Personnel

1. If warranted, talk to responsible DDES management staff, which may include Section Chief(s), Business Area Director(s), the Administrator's Office.

2. If warranted and if Business Area and DDES Administrator's Office are not available, contact the Secretary's Office.

3. Refer media contacts per current Departmental guidelines.

B. Response Actions

1. Contact any DDES technical staff needed for assistance.

2. Coordinate all DDES response activities according to SOP: Response.

3. Contact and update DDES Administrator's Office, as appropriate.

4. Follow any written protocols, unless you have authorization from supervision/management to deviate from them.

Section 19: SOP, Response—County Human Services Authority

General Response to Disaster or Other Emergency

(In coordination with the County Emergency Management Plan and EOC/ICS)

A. Set-Up and Check-In

1. Tell the Incident Commander that emergency human services workers are on the scene.
2. Do quick needs assessment (Who was affected? Who needs help immediately?).
3. Set up base of operations with other human services; tell the Incident Commander where it is.
4. Begin coordination with American Red Cross Team and other voluntary groups.
5. Set up a check-in function for emergency human service responders, to establish:
   - On-scene staffing
   - Congregate/service center staffing
   - Staffing at hospitals and morgues
6. Verify credentials of all psychosocial support personnel.
7. Set up process for managing/verifying credentials of unsolicited volunteers/professionals.

B. Briefing and Assignments

1. Brief human service responders on:
   - Scope of the disaster
   - Existing community resources
   - Locations being staffed
   - Communications
   - Travel
   - Contacts with other organizations
   - Process to receive pay (if applicable)
   - Record-keeping procedures
   - Schedule of work times
   - Any other policies and procedures

Continued on the next page

2. Assign one or more to Team leadership at each location.
3. Assign human service responders to:
   - Do crisis intervention and problem solving
   - Help other disaster response personnel with:
     - Needs of people directly involved or affected
     - Concerns of people not directly involved or affected
4. Give information about follow-up mental health/human services, if appropriate.

C. Deployment

1. Distribute supplies.
2. Send human service responders to assignments:
   - If possible, send them in pairs
   - Tell them to report to Command personnel or human services leadership

D. Getting More Help

1. Arrange coverage of second and subsequent shifts.
2. If more mental health resources are needed, you can:
   - Call local emergency mental health responders, according to the individual local county Emergency Management Plan
   - Coordinate any necessary disaster mental health training for staff and volunteers
   - *Contact the DHFS Emergency Human Services Coordinator to identify additional resources consistent with DHFS Administrative Directive 38.2*
   - Coordinate response from crisis intervention program staff
3. If appropriate, ask the DHFS Emergency Human Services Coordinator to assist in requesting a CISM Team (to support public safety emergency responders).
4. If there is or if a Presidential declaration is expected, conduct a needs assessment for an Immediate Services Crisis Counseling Grant, with information from:
   - FEMA/State briefings and WEM assessments
   - Local media
   - American Red Cross
   - Salvation Army
   - Local human service agencies
   - Public health, tribal health, and hospitals
   - Law enforcement
   - Civic and voluntary organizations
   - Faith community & interfaith groups
   - Wisconsin Emergency Management assessments
5. Give needs information to DHFS Emergency Human Services Coordinator.

Continued on the next page

E. Continuing Operations

1. Keep records of hours, activities, numbers of people participating, etc.

2. If you have to write down the name of someone receiving services (e.g., for follow-up), make sure it is kept completely confidential, stored in a locked file, and destroy it as soon as you no longer need it.

3. Provide for demobilization and defusing as people return from assignments
   - If any responders are also CISM team members, direct them to be on one team or the other (not both) for the rest of the response effort.

4. Serve as consultant to the Incident Commander, the Emergency Operations Center, Public Health, tribal health, and hospitals:
   - Tell them about any general psychosocial implications of emergency procedures
   - Tell them about any implications for special needs populations
   - Make suggestions, as appropriate

5. Provide support, technical assistance, and human services resources to the Local Public Health Authority and the Regional Public Health Consortium as requested and appropriate, in coordination with the individual local county plan and local EOC/ICS.

6. Conduct ongoing reassessments of existing and projected needs, and give information to DHFS Emergency Human Services Coordinator, as appropriate.

7. Report to community service agencies on possible long-term needs.

8. Evaluate services, and recommend improvements as needed.

9. Monitor human service responders for signs of stress reactions. (Arrange for crisis counseling, reassignment, break, or stopping.)

F. Transition

1. If appropriate, conduct a needs assessment for a FEMA/CMHS Regular Services Grant.

2. As emergency facilities close, coordinate withdrawal/reassignment of responders.

3. As end of phase approaches, coordinate transition to Recovery.

Continued on the next page

Evacuation and Shelter

(In coordination with the County Emergency Management Plan and EOC/ICS)

1. Identify/request any special resources needed.
2. Coordinate the requirements of short- and long-term sheltering.
3. Work with agencies to coordinate and administer food distribution.
4. Coordinate services for special-needs populations, including:
   - Transportation
   - Special means or styles of communication
   - Help with psychosocial effects of transition
5. Serve as consultant to the Incident Commander, the Emergency Operations Center, Public Health, tribal health, and hospitals:
   - Tell them about any general psychosocial implications of evacuation or sheltering procedures
   - Tell them about any implications for special needs populations
   - Make suggestions, as appropriate
6. Coordinate meeting the needs of all special-needs populations.
7. Oversee information and support to families, loved ones, etc.

Continued on the next page

Mass Casualty

(In coordination with the County Emergency Management Plan and EOC/ICS)

Note: The scene of a mass casualty event is treated as a crime scene until it is determined otherwise. Make sure you know and follow the appropriate regulations, in coordination with the County Emergency Management Plan and EOC/ICS.

1. Oversee assignment of human services responders to hospitals/off-site care.
2. Get briefing on medical safety procedures, and brief all staff.
3. Coordinate meeting the needs of all special needs populations.
4. Serve as consultant to Public Health, tribal health, hospitals, the Incident Commander, and the Emergency Operations Center:
   - Tell them about any general psychosocial implications of mass care procedures
   - Tell them about any implications for special needs populations
   - Make suggestions, as appropriate
5. Coordinate/oversee human service responders' compliance with medical policies and procedures.
6. Oversee information and support to families, loved ones, etc.

Continued on the next page

Quarantine

(In coordination with the County Emergency Management Plan and EOC/ICS)

1. Get briefing on medical safety procedures, and brief all staff.
2. Coordinate meeting the needs of all special needs populations, including:
   - People who are under quarantine
   - People whose caregivers or loved ones are under quarantine
3. Serve as consultant to Public Health, tribal health, hospitals, the Incident Commander, Emergency Operations Center:
   - Tell them about any general psychosocial implications of quarantine procedures
   - Tell them about any implications for special needs populations
   - Make suggestions, as appropriate
4. Coordinate/oversee human service responders' compliance with medical policies and procedures.
5. Oversee information and support to families, loved ones, etc.

SOP, Response—Emergency Human Service Responders

Responding to a Disaster or Other Emergency

(In coordination with the County Emergency Management Plan and EOC/ICS)

1. Report to the scene and locate the base of operations for human services.
2. Be briefed by County Human Services Authority on:
    - Scope of the disaster
    - Existing community resources
    - Where you'll be working
    - Who you'll report to when you get there
    - Schedule of work times
    - Communications
    - Travel
    - Pay process (if applicable)
    - Record keeping procedures
3. Go to your assignment and find your contact.
4. Find out if any victims or families do not speak English, or are deaf, and find translators.
5. Assess and triage people who need disaster mental health intervention.
6. Provide services to victims, families, other community members, including:
    - Crisis counseling
    - Problem solving
    - Stress management
    - Meeting basic needs
7. Where appropriate, link victims with human service agencies.
8. Respond to and stabilize psychiatric emergencies.
9. As needed, refer to local mental health providers/other providers.

Continued on the next page

10. As needed and appropriate, provide support to emergency responders.

11. As needed and appropriate, provide non-traditional services, including:
    - Distributing food at feeding sites
    - Helping with relocation
    - Staying overnight at shelters
    - Providing child care at response centers
    - Removing debris

12. Provide consultation to other community agencies.

13. Keep records of hours, activities, numbers of people participating, etc.

14. If you have to write down the name of someone receiving services (e.g., for follow-up), make sure it is kept completely confidential and destroyed as soon as you no longer need it.

15. Return to the human services base of operations at the end of each shift, for refreshment and debriefing.

16. Even if you're also qualified to be a debriefer on the CISM Team (that team debriefs public safety responders), if you are already part of the human service response, don't also try to be on the CISM Team. It's important to keep those two roles separate.

17. When Response phase is near its end:
    - Reassess needs
    - Evaluate services to-date
    - Plan for transition to Recovery phase

SOP, Response—Regional Area Administration Office (OSF)

Note: This SOP is for the **Area Administrator** or a **Human Services Area Coordinator** assigned to emergency human services responsibilities in the DHFS Regional Area Administration Office (OSF).

Responding to a Disaster or Other Emergency

1. Provide support, technical assistance, and coordination assistance to the local human services response.
2. As needed, serve as a consultant to Emergency Management or Public Health:
   - Tell them about any general psychosocial implications of emergency procedures
   - Tell them about any implications for special needs populations
   - Make suggestions, as appropriate
3. Help county staff apply for any emergency Federal/State aid available through DHFS.

SOP, Response—DHFS Emergency Human Services

Note: *This SOP is for the* ***DHFS Emergency Human Services Coordinator****.*

Responding to a Disaster or Other Emergency

1. Provide support, technical assistance, and coordination assistance to the local and regional human services response.
2. As needed, serve as consultant to the Incident Commander, the Emergency Operations Center, Public Health, Tribal Health, or hospitals:
   - Give information about any general psychosocial implications of emergency procedures
   - Give information about any implications for special needs populations
   - Make suggestions, as appropriate
3. *As needed, run lists of emergency human service responders from database.*
4. Coordinate staffing of the FEMA Disaster Recovery Center (with FEMA Region 5 Human Services, OSF Regional Area Administration staff, and County Human Services Authority).
5. As needed, coordinate proposals for FEMA/CMHS ISP and RSP Grants with the County Human Services Authority, the Regional Area Administration Office (OSF), and any other designated DHFS staff.
6. Coordinate emergency human service response for licensed/certified facilities, including:
   - Mental health facilities
   - Substance abuse treatment facilities
   - Facilities for people with developmental disabilities

Section 20: SOP, Recovery—County Human Services Authority

Recovery Phase of Disaster or Other Emergency

(In coordination with the county Emergency Management Plan and EOC/ICS)

A. Setting Up the Recovery Program

1. Continue to reassess disaster mental health needs of victims, relatives, responders, and others affected.
2. Develop a phase-appropriate disaster recovery program that matches the needs of community and individuals.
3. Request and coordinate any appropriate assistance from other counties, Regional resources, or State resources.
4. If appropriate, conduct a needs assessment for the FEMA/CMHS RSP Grant. Give results to DHFS Emergency Human Services Coordinator, as appropriate.
5. Establish liaison with Wisconsin Emergency Management and Wisconsin VOAD recovery projects.
6. Train human service workers in recovery functions, including:
   - recognition of post-disaster stress-related behavior
   - referral of clients to appropriate mental health, substance abuse, other human services.

Continued on the next page

B. Coordinating the Recovery Program

1. Coordinate outreach/clinical services (wherever possible, in home or community settings).
2. Continue to coordinate recovery efforts with those of other organizations.
3. Provide regular support sessions for staff involved in the recovery phase.
4. Coordinate records of the types of services provided, the numbers of people receiving services, and any other records required (e.g., data for FEMA/CMHS Regular Services Grant).
5. If any records contain the names of people receiving services, keep them completely confidential in a locked place and destroy them as soon as you no longer need them.
6. Help identify studies and implement protective actions to address the long-term health effects.
7. As needed, continue to serve as consultant to Emergency Management:
   - Tell them about any general psychosocial implications of disaster-related procedures
   - Tell them about any implications for special needs populations
   - Make suggestions, as appropriate

Continued on the next page

C. Liaison and Public Information Functions

1. Provide consultation to community organizations and agencies.

2. Continue to report to community service agencies on possible long-term needs.

3. Provide advice to the Incident Commander, the Emergency Operations Center, Public Health, Tribal Health, and hospitals regarding psychosocial needs and circumstances.

4. Liaison with the Joint Public Information Center (JPIC)* and other entities providing public information, and coordinate all public information with the JPIC.

5. Find non-stigmatizing, community-appropriate materials/information on:
   - Effects of a disaster on mental health and substance use patterns
   - Symptoms of post-disaster stress
   - Locations of counseling services

6. Possible sources of materials:
   - DHFS
   - Risk Communication Focus Area, statewide CDC bioterrorism initiative (Division of Public Health)

7. Provide materials to local:
   - Community groups
   - Public information officers
   - Radio stations
   - Television stations
   - Individuals

***Note:** The JPIC is an emergency information center established by the County and the County EOC to make sure that all information given out is consistent and appropriate.

Continued on the next page

D. Community Healing

1. Collaborate in planning phase-appropriate community support events, including
    - commemorative events
    - community dinners
    - memorial services
    - anniversary events
    - transition events

2. Involve:
    - human service responders
    - local community organizations
    - volunteer organizations
    - Wisconsin VOAD
    - interfaith groups
    - cultural groups
    - other concerned individuals and organizations

Continued on the next page

E. Transition

1. As the end of Recovery approaches, plan for and coordinate transition to community self-sufficiency.

2. Evaluate service effectiveness and cultural/linguistic competence, using feedback from:
   - Members of response and recovery organizations
   - Victims and families
   - Human service response/recovery staff
   - Program staff

3. Participate in interagency reviews of emergency response. Use information to recommend improvements.

4. Update and enhance local disaster human services plan, as needed.

5. Recommend improvements to State-level Plan, as needed.

SOP, Recovery—Disaster Human Responders

Recovery Phase of Disaster or Other Emergency

(In coordination with the county Emergency Management Plan and EOC/ICS)

1. Provide phase-appropriate disaster mental health/substance abuse/human services:
   - Provide outreach to victims, their families, and other community members
   - As often as possible, provide services in home or community settings
2. Continue to refer victims to:
   - Disaster service agencies
   - Mental health providers
   - Substance abuse treatment providers
   - Other appropriate human service agencies
3. As needed and appropriate, continue to provide:
   - Support to emergency responders
   - Consultation to other community agencies
4. As needed and appropriate:
   - Continue to keep records of the types of services provided, the numbers of people served, etc.
   - If you have to write down the name of someone receiving services (e.g., for follow-up), make sure it is kept completely confidential and destroyed as soon as you no longer need it

SOP, Recovery—Regional Office

Note: This SOP is for the **Area Administrator** or a **Human Services Area Coordinator** assigned to emergency human services responsibilities in the DHFS Regional Area Administration Office (OSF).

Recovery Phase of Disaster or Other Emergency

Area Administrator or a Human Services Area Coordinator assigned to emergency management responsibilities in the DHFS Regional Area Administration Office (OSF):

1. Provide support, technical assistance, and coordination assistance to the local human services recovery effort.
2. As needed, continue to serve as consultant and advisor in the recovery effort:
   - Give information about any general psychosocial implications of disaster-related procedures
   - Give information about any implications for special needs populations
   - Make suggestions, as appropriate
3. Help county staff apply for any emergency Federal/State aid available through DHFS

SOP, Recovery—DHFS Emergency Human Services

Note: This SOP is for the **DHFS Emergency Human Services Coordinator**.

Recovery Phase of Disaster or Other Emergency

1. As needed, coordinate preparation and submission of FEMA/CMHS RSP Grant.
2. Continue to provide support, technical assistance, and coordination assistance to the local and regional human services response.
3. As needed, continue to serve as consultant to Emergency Management:
    - Tell them about any general psychosocial implications of disaster-related procedures
    - Tell them about any implications for special needs populations
    - Make suggestions, as appropriate
4. If the FEMA/CMHS Regular Services Grant is awarded, administer the grant.

Appendices

Appendix A: Glossary of Terms

Continuity of Operations Plan (COOP): A plan that provides for the continued functioning of an agency, organization, or facility in spite of an event that would otherwise disrupt functioning. COOP plans based on the Federal Emergency Management Agency model provide detailed inventory of resources and personnel needed to continue operations, along with a plan for restoration and maintenance of operations.

County Emergency Operations Plan: In Wisconsin, the primary source of direction and coordination for county-level emergency responders is the locally customized Emergency Operations Plan based on templates provided by Wisconsin Emergency Management. The Plan contains a Basic Plan section and several Annexes that provide guidance on specific issues.

Crisis Counseling Program (CCP): FEMA-funded grant program to provide crisis counseling to survivors of a disaster, within either a 60 day period or a 9 month period following the disaster occurrence.

Crisis Counseling Team: A team of paraprofessionals, including one or more mental health professionals, who provide mental health counseling to survivors, immediately after or in the months following natural or human-caused disasters.

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 who 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.

Critical Incident Stress Debriefing (CISD): This technique is provided to survivors 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 individuals trained in CISD should perform this process. This specialized technique is not crisis counseling.

Critical Incident Stress Management (CISM): An integrated system of interventions designed to prevent and/or mitigate the adverse psychological reactions that so often accompany emergency services, public safety and disaster response functions.

Debriefing: Usually, a formal meeting between a trained individual 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 the highly stressful event to a clinician who will provide therapeutic assistance to that person in the recovery process.

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.

Disaster Field Office (DFO): The office that is established in or near the designated area to support Federal and State response operations.

Disaster Recovery Center (DRC): A centralized location where individuals affected by a disaster can go to obtain information on disaster recovery assistance programs from various Federal, State, and local agencies, as well as volunteer organizations. Trained staff are also on hand to provide counseling and advice.

Disaster/Emergency: A disaster and an emergency can both be described as any natural or human-caused event, which threatens or causes excessive morbidity, mortality, and/or loss of property. Disaster and emergency are used interchangeably whenever a situation calls for a crisis response. However, emergencies can be handled with resources that are routinely available to the community. A disaster calls for a response and resources that exceed local capabilities.

Emergency Management (EM): The organized analysis, planning, decision-making, and assigning and coordinating of available resources, for the purpose of preparing for, responding to, or recovering from major community-wide emergencies and disasters.

Emergency Medical Services (EMS): Local medical response teams, usually rescue squads or local ambulance services that provide medical services during a disaster.

Emergency Operations Center (EOC): This is the nerve center of disaster response operation. The 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 EOC are information management, situation assessment, and resource allocation. A protected site, from which government officials and emergency response personnel exercise direction and control in an emergency. The Emergency Communications Center is usually an essential part of the EOC.

Essential Services Personnel: Positions providing service that must be maintained regardless of the emergency situation to ensure quality 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.

Federal Emergency Management Agency (FEMA): Lead Federal agency in disaster response and recovery. Provides funding for crisis counseling grants to State mental health authorities following Presidential declared disasters through the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS).

Federally Declared Disasters: There are varying levels of disaster declaration. Federally declared disasters represent the highest level, and can be established only by formal declaration of the President of the United States. An event, real and/or perceived, receives Federal declaration when it is deemed to threaten the well being of citizens, overwhelm the local and state ability to respond and/or recover, or affect Federally owned property or interests.

Home Rule: Wisconsin Chapter 59 establishes responsibilities of county government.

Immediate Services Program (ISP): A grant award, from FEMA/CMHS to a state, to provide crisis counseling to survivors of a disaster within a 60 day period following the disaster occurrence.

Incident Command System (ICS): An organized system of roles, responsibilities, and suggested operational guidelines used to manage and direct emergency operations at the scene of an incident. The Incident Commander (IC) is located on scene at an Incident Command Post (ICP).

Joint Public Information Center (JPIC): In the event of a disaster, threat, or emergency, a Joint Information Center (JPIC) are established at the State level as part of the State Emergency Operations Center. Cities and counties also have the option to open local EOCs and JPICs. Public Information Officers report to the Joint Information Center, and all media communications are conducted through that Center. The JPIC issues all press releases and conducts all news conferences.

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.

Major Disaster: As defined under P.L. 93-288, a major disaster is any natural catastrophe, (including any hurricane, tornado, storm, flood, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mud slide, snowstorm, or drought), or regardless of cause, any fire, flood, or explosion, in any part of the United States, which in the determination of the President, causes damage of sufficient severity and magnitude to warrant major disaster assistance under this Act, that serves to supplement the efforts and available resources of States, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby.

Mass Care: Mass Care consists of activities to provide shelter, feeding, first aid and distribution of relief supplies to disaster survivors, following a natural disaster or other event.

Memorandum of Understanding (MOU): A document that is negotiated between organizations or legal jurisdictions, for mutual aid and assistance in times of need. An 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 or property injury or destruction during response operations), and commercial considerations (appropriate statements of non-competition of government resources with private enterprise).

Mental Health Treatment: Includes professionally conducted assessment, therapies, and treatment that are provided to persons who usually qualify for or already have a mental health diagnosis.

Mitigation: Actions and activities directed toward eliminating or reducing the risk of disaster occurrence or sequelae. Mitigation may include changes in land use management; safety and rules and regulations; building codes/specifications; flood proofing; and disseminating information to the public.

Mutual Aid Agreement: A formal or informal understanding between jurisdictions that pledge exchange of emergency or disaster assistance.

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 crisis counseling services are made available to people.

Paraprofessional: People who have strong intuitive skills about people and how to relate to others. They possess good judgment, common sense and are good listeners. Paraprofessionals may or may not be indigenous workers. Paraprofessionals will do outreach, counseling, education, provide information and referral services and work with individuals, families and groups. Paraprofessionals who serve as members of the regional Disaster Response teams will receive training in human response to disasters, basic interviewing skills, functional assessment skills, basic group process skills, and methods for guiding people in problem solving and in setting priorities and ethical conduct.

Post Traumatic Stress Disorder (PTSD): An acute or chronic disorder stemming from the neurological and psychological effects of exposure to traumatic experiences. Common symptoms of chronic PTSD include anxiety, depression, hypervigilence, anger, substance abuse, and “kindling” (rapid production of high amounts of adrenaline in response to ordinary stimuli).

Preparedness: Pre-event activities that facilitate disaster response to save lives and minimize damage. These include the development of shelter and evacuation plans; the establishment of warning and communication systems; the training of emergency response personnel; and the conducting of tests and exercises.

Recovery: Assistance provided to return a community to normal or near-normal conditions. Short-term recovery returns vital life-support systems to minimum operating standards. Long-term recovery may continue for a number of years after a disaster and seeks to return life to normal or improved levels. Recovery activities include temporary housing, loans or grants, disaster unemployment insurance, reconstruction, and counseling programs.

Regular Services Grant (RSG): A grant award, from FEMA/CMHS to a state, to provide crisis counseling to survivors of a disaster within a nine-month period following the termination of an Immediate Services Project.

Response: Activities that occur immediately before, during, or directly after an emergency or disaster. This includes lifesaving actions, such as the activation of warning systems, staffing the

EOCs, implementation of shelter or evacuation plans, search and rescue, and provision of emergency medical services.

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 disabled, or isolated from the community as a whole.

State-Declared Disasters: 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.

Substance Abuse Treatment: Includes professionally conducted assessment, therapies, and treatment provided to people who suffer from substance use disorders (e.g., substance dependence or substance abuse).

Trauma: An experience of extreme fear, pain, and/or stress. Individual trauma is described as "a blow to the psyche that breaks through one's defenses so suddenly and with such brutal force that one cannot react to it effectively." Collective trauma is described as "a blow to the basic tissue of social life that damages the bonds attaching people together and impairs the prevailing sense of community."

Unified Command: An application of Incident Command System used when there is more than one agency with incident jurisdiction. Agencies work together through their designated Incident Commanders at a single Incident Command Post to establish a common set of objectives and strategies, and a single Incident Action Plan.

Appendix B: Common Acronyms

AA/CRC	Affirmative Action/Civil Rights Compliance
APA	American Psychological Association
ARC	American Red Cross
BHIP	Bureau of Health Information and Policy
BMHSAS	Bureau of Mental Health and Substance Abuse Services
BOIDOOPHTE	Bioterrorism, Other Infectious Disease Outbreaks, and Other Public Health Threats and Emergencies
BQA	Bureau of Quality Assurance
CDC	Centers for Disease Control and Prevention
CISD	Critical Incident Stress Debriefing
CISM	Critical Incident Stress Management
CMHS	Center for Mental Health Services
COOP	Continuity of Operations Plan
CSAP	Center for Substance Abuse Prevention (SAMHSA)
CSAT	Center for Substance Abuse Treatment (SAMHSA)
DDES	Division of Disability and Elder Services
DFO	Disaster Field Office
DHFS	Department of Health and Family Services
DMH	Disaster Mental Health
DMH/SA/HS	Disaster Mental Health/Substance Abuse/Human Services
DOT	Department of Transportation
DPH	Division of Public Health
DRC	Disaster Recovery Center
DTAC	Disaster Technical Assistance Center
EHCS	Emergency Human Services Coordinator
EM	Emergency Management
EMS	Emergency Medical Services
EMT	Emergency Management Technicians
EOC	Emergency Operations Center
FEMA	Federal Emergency Management Agency
HAN	Health Alert Network
HIPAA	Health Insurance Portability and Accountability Act
HRSA	Health Resource and Services Administration
ICS	Incident Command Systems
ICISF	International Critical Incident Stress Foundation
ISP	Immediate Services Program (FEMA/CMHS Crisis Counseling Grant)
JPIC	Joint Public Information Center
KW	Kilowatt
LSSI	Lutheran Social Services, Inc.
MHA	Mental Health Association
MOU	Memorandum of Understanding
NAMI	National Alliance for the Mentally Ill
NASW	National Association of Social Workers

NIMS	National Incident Management System
NOVA	National Organization for Victims Assistance
PTSD	Post-Traumatic Stress Disorder
RSP	Regular Services Program (FEMA/CMHS Crisis Counseling Grant)
SAMHSA	Substance Abuse and Mental Health Services Administration
TA	Technical Assistance
VOAD	Voluntary Organizations Active in Disasters
WAAODA	Wisconsin Association on Alcohol and Other Drug Abuse
WCA	Wisconsin Counties Association
WCHSA	Wisconsin County Human Services Association
WEM	Wisconsin Emergency Management
WHA	Wisconsin Hospital Association

Appendix C: Assessment Considerations

Purpose

This Appendix provides a comprehensive list of elements that might be considered in an assessment of the needs and resources related to emergency human services, so that regions, counties, municipalities, and organizations might choose from these elements in designing assessment tools and processes that are appropriate for their responsibilities.

The Information-Gathering Process

Information for the assessment would be gathered from all levels, including Federal, State, regional, and local experts and professionals who serve vulnerable individuals and communities whose needs must be considered, as well as the individuals and communities themselves.

Need and resource data would be recorded in a manner that allowed planners to sort them by a number of criteria, including county and region. The assessment would also be integrated with hazard and risk analyses conducted by Wisconsin Emergency Management (WEM). The process as a whole would include provisions for review, revision, and update.

Needs

The statewide inventory of needs would include a comprehensive assessment of the needs of more vulnerable populations; administrative, logistical, and legal needs; continuity of operations needs; hazard-specific needs; training, technical assistance, and exercise needs; credentialing needs; research needs; and evaluation needs.

Needs of More Vulnerable Populations

The needs of people in a number of circumstances would be assessed, including but not limited to:

- People in mental health facilities
- People in treatment facilities for substance use disorders
- People in facilities for people with developmental disabilities
- People in elder-care facilities

- People receiving in-home health and/or custodial care
- People in hospitals
- Children living in child care institutions
- People with disabilities (including physical, visual and hearing impairment) living in the community
- People with mental disorders living in the community
- People with substance use disorders living in the community
- People with special communication challenges (e.g., language, literacy, religious rules against the use of telephones or televisions)
- People who are isolated from the predominant culture of the community

The needs of these populations would also be assessed for a number of factors, including:

- Input into plan development
- Need for specialized format, content, or delivery of information about disaster preparedness, warnings, response efforts, mass care, evacuation, etc.
- Need for specialized communication devices
- Special needs in evacuation or mass care situations
- Medical and pharmaceutical services and supplies that might be disrupted
- Special hazard-specific needs that might arise

One tool that would help Wisconsin in the identification of vulnerable populations is a database being developed by the Community Coalition that is part of the CDC-funded Bioterrorism Preparedness effort led by the Division of Public Health (DPH). Local Public Health Agencies, tribal health, mental health, and human service resources are also excellent sources of information. One of many possible assessment process might be a survey that gathered data on the types of incidents people have experienced, the most helpful responses they have experienced, the least helpful responses they have experienced, and suggestions for improved response efforts.

Administrative, Logistical, and Legal Needs

Planners would consult many governmental entities to determine the range of factors they must consider in the event of a large-scale disaster, particularly if that disaster were to impair government's ability to continue its own functions. These factors might include:

- Record-keeping needs related to the disaster
- Issues related to human resource utilization
- Data and situation reports that would be needed
- Legal issues that might arise

Self-Sufficiency and Continuity of Operations Needs

If State-level disaster human services staff were dispatched to the site of a large-scale disaster, they would need to operate at that site without exhausting any of the already-scarce survival resources that exist there. Should State government's functioning be threatened or disrupted, a number of continuity of operations needs would arise. Needs in these situations might include:

- Transportation needs
- Supplies (e.g., food, water, hygiene supplies)
- Housing needs for staff in the field
- Program activities that would have to be maintained
- Maps and regional documents showing the locations of all DHFS facilities
- Records and data to be stored (e.g., disaster plans, staff rosters)
- Need for temporary space to house operations
- Purchasing authority that circumvents the normal channels

Hazard-Specific Needs

All of the categories of need assessed would be examined in light of specific events of medium or high probability in the state. These events would vary from state to state and region to region. In Wisconsin, hazards analyzed in the Wisconsin Emergency Management Hazard Analysis include:

- Air transportation incidents
- Coastal hazards
- Drought
- Earthquakes
- Floods and flash floods
- Forest fires and wildfires
- Hailstorms
- Hazardous materials
- Heat waves
- Nuclear power plant incidents
- Terrorism
- Tornadoes and severe thunderstorms
- Winter storms

Categories of need would be examined in light of less probable but potentially more catastrophic events, such as the effects of bioterrorism or nuclear attack.

Training, Technical Assistance, and Exercise Needs

Among the resource assessment considerations described in the next subsection is a thorough inventory of professional and paraprofessional resources available to provide human service assistance in the event of a natural disaster, public health threat or emergency. The assessment of these helpers' current levels of training, education, certification, and experience would be analyzed to identify areas in which training, technical assistance, and full-scale or table-top exercises are needed.

This information would be used to target:

- Training resources available through the Education and Training Focus Area of the CDC Bioterrorism preparedness grant
- Technical assistance to be provided by local, regional, and State resources

- Full-scale and table-top exercises conducted on local, regional, and statewide levels, with collaborative development and participation by emergency management, public health, tribal health departments, human services, and other key players

Credentialing Needs

When emergency human service professionals are dispatched to disaster areas, their ability to gain access to those areas and to be recognized by emergency services personnel is crucial to the effectiveness of the human service response. Differences in credentialing and gaps in information among the various disaster response fields can create barriers that waste precious time and energy in a crisis. The needs assessment process would include an analysis of credentialing differences and information gaps, and a proposal for credentialing procedures that would ensure smooth and rapid access for, and recognition of, legitimate human service responders.

Research Needs

Resource assessment elements described below would include an inventory and review of existing research related to mental health, substance use disorders, disabilities, age, family disruption, and other human service issues in the event of a disaster or other public health threat or emergency. Gaps in the existing research would be noted, particularly gaps in information about:

- Disaster human service needs and experience
- Human service implications of hazards of high probability
- Disaster-related needs and circumstances of more vulnerable populations
- Disaster-related needs and circumstances of cultures that are represented in significant numbers in Wisconsin (e.g., African Americans, Native Americans, rural agricultural cultures, Latinos, and Hmong people)

A number of resources, including Federal disaster-related research agencies and institutions of higher learning, would be given this information and encouraged to engage in studies that would help fill these gaps.

Evaluation Needs

The development and execution of even the best plan requires a solid evaluation component built in from the beginning. Construction of the evaluation component would be most effective if it were based on input from a comprehensive needs assessment process, including information on:

- Support and coordination needs and expectations articulated by:
  - Local community residents and organizations
  - Voluntary organizations
  - Culture-specific organizations
  - County and regional human service, public health, tribal health, and emergency management authorities

  - In a state such as Wisconsin, the Great Lakes Inter-Tribal Council

- Evaluation criteria for effective State human services support, as defined by:
  - Local community residents and organizations
  - Populations with special needs
  - Voluntary organizations
  - VOAD (Voluntary Organizations Active in Disaster)
  - Culture-specific organizations
  - County and regional human service, public health, tribal health, and emergency management authorities
  - In Wisconsin, the Great Lakes Inter-Tribal Council
  - Research in the fields of disaster human services, public health, and emergency management
  - Identified experts in the fields of disaster human services, public health, and emergency management
  - Federal guidelines such as the Mental Health All-Hazards Disaster Planning Guidance and the CDC and HRSA Bioterrorism Preparedness program guidelines
- A baseline qualitative assessment of the effectiveness of support provided by the Department or organization developing the Plan
- Ongoing assessment of the effectiveness of this Plan, and of its connectivity with other local, institutional, Regional, State, and national plans

Resources

Wisconsin's planning initiative is taking place in an environment that is rich in a number of resources, including:

- Staff and volunteers at the local, regional, State, and national levels who are willing to dedicate their time, effort, expertise, and creativity to the well being of individuals and communities affected by disasters
- A wealth of information about the effects of disaster, disaster human services technologies, and related topics
- Leadership, vision, and support from the Office of the Governor and the leadership of the Department of Health and Family Services, the Division of Disability and Elder Services, and the Bureau of Mental Health and Substance Abuse Services
- Support, guidance, and collaboration from Wisconsin Emergency Management and the DHFS Division of Public Health (both CDC and HRSA Bioterrorism Preparedness processes)
- Support and guidance from the US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, including support from the CMHS Disaster Technical Assistance Center (DTAC)
- Funds from the Centers for Disease Control and Prevention, through the DHFS Division of Public Health's Bioterrorism Preparedness Program

- Disaster crisis counseling funds from the Federal Emergency Management Agency and the Center for Mental Health Services
- Guidance and support from a number of other Federal agencies, including the Department of Justice and the US Department of Agriculture

An important complement to an assessment of needs would be an inventory of human, informational, and physical resources. These resources would include personnel, mutual aid agreements, pharmaceutical resources, resources for communication, resources for self-sufficiency, resources for training and education, and resources for public information.

Personnel

Disaster Mental Health Professionals

The first category of human resources that might be inventoried includes licensed, credentialed, or trained disaster mental health, substance abuse, and other counseling personnel who have specialized education, training, experience, and expertise in disaster human services.

Although the American Red Cross provides credentialed disaster mental health workers during the initial response phase, their presence is meant to be temporary, and one of their goals is the smooth transfer of need to local resources, as those resources become capable of addressing that need.

An important planning step is the identification and support of a number of networks of disaster mental health professionals, FEMA crisis counseling trained individuals to meet whatever needs might arise. States, regions, or local entities might construct database of these resources, to be integrated with other related resource databases.

Sources of information about licensed and credentialed counseling personnel who may have disaster mental health expertise would include:

- County human service and mental health departments and tribal health departments
- Treatment agencies and organizations
- Great Lakes Inter-Tribal Council
- Divisions and Bureaus within the Department, including the Bureau of Mental Health and Substance Abuse Services, and the Division of Children and Family Services
- Critical Incident Stress Management (CISM) teams in the state
- Professional associations such as the National Association of Social Workers, the American Psychological Association, the Wisconsin Association on Alcohol and Other Drug Abuse, and Wisconsin chapters of the Employee Assistance Program Association
- Credentialing bodies such as the Wisconsin Certification Board, Department of Regulation and Licensing
- A database of personnel working with special populations, under development by the Community Coalition of the DPH Bioterrorism Preparedness Program
- Hospitals (for resources in social service departments, psychiatry, pastoral counseling, etc.)
- Schools, colleges, and universities (for social service and Student Assistance Program staff)
- Businesses (for Employee Assistance Program staff)
- Any other databases of human service professionals

Licensed and credentialed personnel would be surveyed to determine who has training and certification in disaster human services, including:

- American Red Cross Disaster Mental Health Certification
- FEMA Crisis Counseling Training
- Training in Incident Command Systems
- CISM Certification from the International Critical Incident Stress Foundation
- Training from the National Organization for Victims Assistance
- Specialized training in hazard-specific areas of response, including hazards of high frequency in Wisconsin (e.g., tornadoes), terrorism, and outbreaks of infectious disease
- Trauma-related training from organizations such as the American Academy of Experts in Traumatic Stress or the Association of Traumatic Stress Specialists

Paraprofessionals and Volunteers

Paraprofessionals and Volunteers with disaster human services skills also represent a vital and valuable part of the response and recovery process. An important assessment consideration is information about:

- FEMA Crisis Counseling Training
- Members of Voluntary Organizations Active in Disasters (VOAD)
- Faith leaders and interfaith organizations
- Members of victims' assistance organizations
- Non-counseling resources within State, regional, and local human service agencies
- Non-counseling resources within hospitals (e.g., nurses, volunteers)
- Natural helpers within the community, particularly in communities whose cultures, languages, or geographic circumstances set them apart, or whose experience has left them mistrustful of authorities
- Business leaders concerned about potential effects on their employees
- Educators (including school guidance counselors) concerned about potential effects on their students

Paraprofessionals and Volunteers would also be surveyed, to assess their experience, education, training, and certification in disaster-related human service issues and techniques.

The results of these personnel assessments would be used to inform the needs assessment process, identifying areas of need for personnel, education, training, exercises, and certification.

Mutual Aid Agreements

An agreement entered into by counties, municipalities, townships, political subdivisions, federally recognized Tribal Nations and public agencies of the state of Wisconsin based upon the determination that it is in the best interests of themselves and their citizens to create a plan

to foster communications and the sharing of responses, personnel and equipment in the event of an emergency.

Pharmaceutical Resources

For a number of vulnerable populations, the medications they receive for their mental disorders, substance use disorders, age-related disorders, or other disabilities are crucial to their physical and psychological stability, even in stable environments. When disasters disrupt normal pharmaceutical supply lines, those medications become unavailable.

An important resource assessment step would be to identify sources of needed medications and distribution systems that can take over when normal distribution systems fail.

Resources for Communication

Experience has shown that a wide variety of large- and small-scale disasters can disrupt:

- Essential means of everyday communication, including land phones and faxes, cell phones, computers and computer networks, and radio and television transmission
- The electrical power necessary to run many means of information transmission (e.g., computer servers, radio stations, and television stations) and reception (e.g., computers, radios, and televisions)

An important needs and resource assessment process would be a survey of alternative communication devices already available to human service entities at local, regional, and State levels. These devices include:

- Satellite phones
- Hand-held two-way radios that avoid frequencies needed by other emergency responders
- Battery-powered FM radios
- Batteries
- Electrical generators

In Wisconsin, another assessment consideration would be local human services and mental health agencies' ability to connect with and use the Health Alert Network (HAN). This network has become the central repository for disaster-related health information in Wisconsin, including information about available resources.

The communication needs of some special populations would also be a major concern in the event of a threat or emergency. An important assessment consideration would be identification of the alternative communication technology that exists to assist these populations, and its availability to the people who need it.

Resources for Self-Sufficiency

A standard goal in the emergency response field is for responders to have enough physical resources to sustain them for 72 hours without drawing on local resources. An important

assessment consideration would be the availability of a number or resources to emergency human service response personnel, including:

- Transportation, particularly vehicles that can provide overnight shelter
- Portable tents and other portable sleeping accommodations
- Food (e.g., Meals Ready to Eat, Heater Meals)
- Drinking water
- Hygiene supplies
- Flashlights and batteries

Where these resources are not available, it would be important to identify likely sources and assess costs, ordering procedures, etc.

Resources for Training and Education

Assessment of training and educational resources would include inventories of:

- Resources available through the Education and Training Focus Area of the State's CDC bioterrorism planning effort
- In Wisconsin, training and technical assistance on the HAN network available through the Health Alert Network Focus Area of the CDC bioterrorism planning effort
- Materials and training opportunities available through the Center for Mental Health Services Disaster Technical Assistance Center
- Training available through State's Emergency Management authority (e.g., training on incident command system)
- Training available through the American Red Cross
- Educational opportunities offered by institutions of higher learning
- Self-study and distance-learning resources available through institutions of higher learning, Federal and State agencies, and national disaster human service-related organizations

Resources for Public Information

The content, language, format, tone, and delivery source of public information about threats, emergencies, and disasters can have profound effects on the psychological well-being—and behavioral responses—of individuals and communities. Those behavioral responses can in turn influence the course and success of the entire disaster response effort. Disaster mental health should play a vital role in guiding and advising the public information process.

An important assessment task would be an inventory of disaster human service-competent resources that already exist in Wisconsin, in other states, or at the Federal level, including:

- Templates for press releases and newspaper articles
- Human service-competent, event-specific footage to be inserted into television newscasts and public service announcements

- Human service-competent, event-specific sound recordings to be inserted into radio newscasts and public service announcements
- Fact sheets for individual, family, and community preparedness
- Materials in the many languages used by Wisconsin residents
- Materials written in easy-to-read language
- Visually-based materials for people with language or literacy challenges
- Large-print and sound-based forms of communication for people with visual impairment
- Alternative (non-written) means of disseminating information
- Materials and other forms of communication for people with special communication needs
- Guidelines and training for public information officers
- Media guidelines and training for human service officials
- Public information officers and human service officials already knowledgeable about and skilled in human service-competent delivery of threat- and disaster-related information
- Guidelines and training for community leaders, particularly in communities whose experience has left them mistrustful of authorities
- Community leaders already knowledgeable about and skilled in human service-competent delivery of threat- and disaster-related information
- Training for the media in human service-competent delivery of threat- and disaster-related information
- Media personnel already knowledgeable about and skilled in human service-competent delivery of threat- and disaster-related information
- Mechanisms for distribution and delivery of public information

Appendix D: ISP and RSP Reporting Forms

Immediate Services Program

A. Geographic Areas and Estimated Need. In the table provided below, list the areas within the Presidentially-declared disaster area for which services will be provided and the number of people to be served in each area. List the geographic areas to be served in the left hand column. Areas to be served may be listed by service area, county, or other geographic or organizational designation identified by the State. All areas on the list must be with the disaster area declared by the President to be eligible for individual assistance. The service areas designated below will form the basis of the program plan and budget and therefore should be consistent throughout the application. In the right hand column, list the estimated number of people to be served in each area based on the CMHS Damage Assessment Formula, which is provided on the next page. For additional information on completing this section, see page 5 of the supplemental instructions.

[Insert text in table below. Insert additional rows or delete rows as necessary]

Designated Area	Estimated Number to be Served
TOTAL	

B. Needs Assessment Formula. Using the CMHS Needs Assessment Formula (located below) estimate the number of persons you will serve in each designated area (second column of the following table). Attach a CMHS Needs Assessment Formula sheet for each designated area. See the supplemental guidance (pages 7-9) for additional information on completing the CMHS Needs Assessment Formula.

CMHS Needs Assessment Formula for
Estimating Disaster Mental Health Needs Disaster: FEMA XXXX-DR-State

This is an estimate for the following disaster area___________________

Date of Report:_____________________ Completed by:___________________

Loss Categories	Number of Persons	ANH	Range Estimated	Total
Type of Loss	Number	Multiply by ANH[4]	At-Risk Multiplier	Number of persons targeted per loss category
Dead			100%	
Hospitalized			35%	
Non-hospitalized Injured			15%	
Homes destroyed			100%	
Homes "Major Damage"			35%	
Homes "Minor Damage"			15%	
Disaster Unemployed			15%	
(Others--Specify)				
Total estimated persons in need of crisis Counseling services (add total column)				

Revised June, 2000

[4]ANH means **A**verage **N**umber of persons per **H**ousehold. This figure can be obtained on a county/parish/area basis from the Census Bureau. If the State is unable to determine the ANH for an area, then use the average figure of 2.5.

A. Service Providers. In the table provided below, provide a list of the service providers included in this project. In the left hand column, provide the name of the service provider along with the address and contact information for the agency. In the center column, list the service area(s) to be covered by the service provider. Service areas should correspond to areas listed in Part I of this application. In the right hand column, provide the name of the crisis counseling project manager along with contact information. If the project manager has not been identified, provide the name of the agency director and indicate that the project manager has not yet been identified. For additional information on completing this section, see pages 13-14 of the supplemental instructions.

[Insert text in table below. Insert additional rows or delete rows as necessary]

Agency	Service Areas	Crisis Counseling Project Manager
Name Address Phone Fax Director's Name	Cite geographic or organizational designation	Name Address Phone Fax

B. Staffing Plan. In the table below, provide a list of staff positions for which the State is requesting funding through the Immediate Services grant. Staff whose services will be provided to the project as an in-kind contribution from the State or the service provider should also be included in this chart with the words "In-kind" in parenthesis next to the position. In-kind positions should be listed below those funded through the grant and should be clearly distinguished in the totals. This information must be provided for the State and for each service provider. In the left hand column list the name of the service provider. In the second column, list the number of supervisors or team leaders and the percentage of time dedicated to the project. In the third column, list the number of outreach workers and crisis counselors dedicated to the project. List separately if the provider has separate job titles for outreach workers and crisis counselors. In the fourth column, list any fiscal or administrative positions to be funded. In the fifth column, list the total number of full time equivalent (FTE) staff positions to be funded by the project. For additional information, see supplemental instructions on page 14.

[Insert text in table below. Insert additional rows or delete rows as necessary]

Agency	Supervisors/ Team Leaders (Number of Staff)	Outreach Workers/Crisis Counselors	Fiscal/ Administrative Staff	Total FTE
Agency Name	FTE	FTE	FTE	FTE

Immediate Services Program
Summary of Costs for Entire Project

Disaster Declaration Number: FEMA-XXXX-DR-STATE

Budget Category	**State Budget: Total Estimate**	**Service Provider(s): Total Estimates*** *Note: attach Budget per service provider area	**Total Costs** of Immediate services. Add State and Service Provider total estimates.	**In-Kind Costs** Costs **contributed** to the project per agency.
Dates of Services				
Salaries and Wages Fringe Benefits (%) **Total Personnel Costs**				
Consultant Costs				
Office Supplies				
Travel				
Training				
Media/Public Information Costs				
Total Costs				

Immediate Services Program
Budget for State Mental Health Authority

Disaster Declaration Number: FEMA-XXXX-DR-STATE

Budget Category	**Interim Costs** Costs from the date of incident to the application deadline (14 days following the declaration)	**Projected Costs** Costs from the Immediate Services application deadline to 60 days or last day of program	**Total Costs** Add interim costs and projected costs	**In-Kind Costs** Costs **contributed** to the project per agency.
Dates of Services				
Salaries and Wages Fringe Benefits (%) **Total Personnel Costs**				
Consultant Costs				
Office Supplies				
Travel				
Training				
Media/Public Information Costs				
Total Costs				

*The State Mental Health Authority and each local provider should fill out this budget form.

Immediate Services Program
Individual Service Provider Budgets

Name of Service Provider:

Budget Category	**Interim Costs** Costs from the date of incident to the application deadline (14 days following the declaration)	**Projected Costs** Costs from the Immediate Services application deadline to 60 days or last day of program	**Total Costs** Add interim costs and projected costs	**In-Kind Costs** Costs **contributed** to the project per agency.
Dates of Services				
Salaries and Wages Fringe Benefits (%) **Total Personnel Costs**				
Consultant Costs				
Supplies				
Travel				
Training				
Media/Public Information Costs				
Total Costs				

*The State Mental Health Authority should work with each local service provider to develop budget and fill out this budget form.

Immediate Service Program
Budget Narrative

A budget narrative is required to document the types of expenditures included in the budget, justify the funding request, and demonstrate fiscal accountability. (See pages 21-22 of the supplemental instruction.) Please provide the following information:

1. How were salary levels and fringe benefits determined? Were they based on comparable positions in the local area? (If not, explain why.)

2. List all consultants, the services they will provide and their compensation.

Name of Consultant	Type of Service	Travel Costs	Compensation Costs

3. List the types of items listed under office supplies (i.e., cell phones, computers, and beepers, office supplies and maps). Detail on the number of items needed should correspond with the program plan.

4. List and describe the types of expenditures included in the travel category (i.e., mileage/rate, rental cars). Are the expenditures based on State rates for allowable travel costs? If not, explain and provide a justification.

5. List the trainers included in the training category.

Name of Trainer	Type of Training	Travel Costs	Compensation Costs

6. List and describe the types of expenditures included in the media/public information category.

Regular Services Program

A. List of Immediate Services Crisis Counseling Service Providers. In the table below, list the agencies providing crisis counseling services under the Immediate Services Program. In the left hand column, provide the name of the service provider along with the address and contact information for the agency. In the center column, list the service area(s) covered by the service provider In the right hand column, provide the name of the crisis counseling project manager along with contact information. (For additional information on completing this section, see page 11 of the supplemental instructions.)

Services under the Immediate Services Program have been provided by only one service provision agency.

Agency	Service Areas	Immediate Services Project Manager
Name *Address* *Phone* *Fax* *Director's Name*	*Cite geographic or organizational designation*	*Name* *Address* *Phone* *Fax*

B. Immediate Services Program Data. Using the table format below, provide service data from the Immediate Services Program. Reporting items in this format are based on data elements in the CCP "Data Management Tool Kit," which is recommended for use in the Immediate and Regular Services Programs. Separate reporting tables should be created for the each service provider in the Immediate Services grant and a combined table should be created for the overall project. (For additional information on completing this section, see supplemental instructions, pages 11-13.)

INDIVIDUAL CRISIS COUNSELING CONTACTS
Project Name

-Demographic Information-
Date Completed:

Age	**Contacts**	**Ethnicity**	**Contacts**
Preschool (0-5)		White	
Childhood (6-11)		Hispanic Origin	
Preadolescent/ Adolescent (12-17)		African American/Black	
Adult (18-59)		American Indian/Alaska Native	
Older Adult (60 +)		Other	
		Don't Know	
Language	**Contacts**	**Gender**	**Contacts**
English		Male	
Spanish		Female	
American Sign Language			
Others [specify in text]			

INDIVIDUAL CRISIS COUNSELING CONTACTS **Project Name** **Observed or Reported Reactions**			
Behavioral	**Contacts**	**Emotional**	**Contacts**
Aggression		Sadness	
Excessive Activity Level		Irritability/Anger	
Apathy/Decreased Energy Level		Despair, Hopelessness	
Isolation/Withdrawal		Guilt/Self-Doubt	
Hypervigilance		Mood Swings	
Reluctance to Leave Home		Preoccupation with Disaster, Safety	
Other [describe in text]		Other [describe in text]	
Physical	**Contacts**	**Cognitive**	**Contacts**
Headaches		Confusion	
Gastrointestinal Problems		Recurring Dreams/Nightmares	
Sleep Disturbances		Lack Concentration	
Memory Problems		Difficulty Making Decisions	
Appetite Changes		Questioning Spiritual Beliefs	
Worsening of Chronic Conditions		Other	
Fatigue/Exhaustion			
Other [Describe in Text]			

INDIVIDUAL REFERRALS **Project Name**	
Source	**Number of Referrals**
Within Project	
Other Disaster Agencies	
Longer Term Mental Health Services	
Community Services	
Other [Describe in Text]	

GROUP CONTACTS **Project Name**	
Group Crisis Counseling (List Groups)	**Number of Participants**
Group Educational Services (List)	**Number of Participants**

Material Distribution **Project Name**	
Type of Material Distribution	**Number of Materials Distributed**
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	

A. Geographic Areas and Estimated Need. In the table provided below, list the areas within the Presidentially-declared disaster area for which services will be provided and the estimated number of people to be served in each area. List the geographic areas to be served in the left hand column. Areas to be served may be listed by service area, county, or other geographic or organizational designation identified by the State. All areas on the list must be within the disaster area declared by the President to be eligible for individual assistance. The service areas designated below will form the basis of the program plan and budget and therefore should be consistent throughout the application. In the right hand column, list the estimated number of people to be served in each area based on the CMHS Damage Assessment Formula, which is provided on the next page. For additional information on completing this section, see pages 15-16 of the supplemental instructions.

Designated Area	Estimated Number to be Served

B. Needs Assessment Formula. Using the CMHS Needs Assessment Formula (located below) estimate the number of persons you will serve in each designated area (fourth column of the following table). Attach a CMHS Needs Assessment Formula sheet for each designated area. See the supplemental guidance (pages 16-19) for additional information on completing the CMHS Needs Assessment Formula.

CMHS Needs Assessment Formula for
Estimating Disaster Mental Health Needs Disaster: FEMA

This is a partial estimate for the following disaster area: ________________

Date of Report:_ _______ Completed by:____________________

Loss Categories	**Number of Persons**	**ANH**	**Range Estimated**	**Total**
Type of Loss	Number	Multiply By ANH[5]	At-Risk Multiplier	Number of persons targeted per loss category
Dead			100%	
Hospitalized			35%	
Non-hospitalized Injured			15%	
Homes destroyed			100%	
Homes "Major Damage"			35%	
Homes " Minor Damage"			15%	
Disaster Unemployed			15%	
(Other Loss—Specify)			10%	
Partial estimate of persons in need of Crisis Counseling services				

<u>Note</u>: Please see Needs Assessment Matrix (next page) for complete estimate

[5] ANH means **A**verage **N**umber of persons per **H**ousehold. This figure can be obtained on a county/parish/area basis from the Census Bureau. If the State is unable to determine the ANH for an area, then use the average figure of 2.5.

Revised June, 2000

Needs Assessment Matrix (Optional Format) FEMA

INDICATORS		**INFORMATION SOURCES**			
Total number		Amer. Red Cross	Disaster Field Office/ State Emergency Management Agency	Media	Key Informants (list sources)
Homes Destroyed					
Homes - "major damage"					
Homes - "minor damage"					
Deaths					
Injuries (not hospitalized)					
Hospitalized					
*Displaced					
Unemployed					
# Shelters					
* # Persons Sheltered					
*Number of applications for assistance					
Closed Businesses					
Closed Schools					
*Number of impacted students					
Number of Impacted rural families					
% of Impact Rural					
% of Impact Small Town					
Population of Declared County					
Impacted population of declared areas					
*Amer Red Cross DMH contacts					
*Project recovery Rusk Co. indiv. crisis couns. Contacts					
*Elderly within affected area					
Estimated Number Needing Crisis Counseling Services					**Calculated**

*Categories of people not included in standard Needs Assessment Form (Displaced, persons sheltered, applications for assistance, impacted students, American Red Cross DMH Contacts, Project Recovery Individual Crisis Counseling Contacts, and Elderly), and therefore used in calculating additional needs.

Additional needs: [4,720 x 2.5 x 10% (multiplier for "other") = 1,180] + 355 = 1,535

Regular Services Program

Summary of Costs for Entire Project

Disaster Declaration Number:

Budget Category	**State Budget Request: Total Estimate**	**Service Provider(s): Total Requests** **Note: attach budget for each service provider area**	**Total Regular Services Grant Request. Add State and Service Provider total estimates.**	**In-Kind Costs Costs contributed to the project per agency.**
Dates of Services	**(9 months)**	**(9 months)**	**(9 months)**	**(9 months)**
Salaries and Wages (Describe specific positions and rates in budget narrative) Fringe Benefits (34.63%) **Total Personnel Costs**				
Consultant Costs				
Office Supplies				
Travel				
Training				
Media/Public Information Costs				
Evaluation				
Total Costs				

Regular Services Program
Budget for State Mental Health Authority

Disaster Declaration Number:

Budget Category	**Grant Request**	**In-Kind Costs Costs contributed to the project per agency.**
Dates of Services		
Salaries and Wages (Describe specific positions and rates in budget narrative) Fringe Benefits (34.63%) **Total Personnel Costs**		
Consultant Costs		
Office Supplies		
Travel		
Training		
Media/Public Information Costs		
Evaluation		
Total Costs		

*The State Mental Health Authority and each local provider should fill out this budget form.

Regular Services Program
Individual Service Provider Budget

Disaster Declaration Number:

Name of Service Provider:

Budget Category	**Grant Request**	**In-Kind Costs** **Costs contributed to the project per agency.**
Dates of Services	**(9 months)**	**(9 months)**
Salaries and Wages (Describe specific positions and rates in budget narrative) Fringe Benefits (34.63%) **Total Personnel Costs**		
Consultant Costs		
Office Supplies		
Travel		
Training		
Media/Public Information Costs		
Evaluation		
Total Costs		

*The State Mental Health Authority should work with each local service provider to develop budget and fill out this budget form.

Regular Services Program
Rusk County Department of Health and Human Services Budget

Disaster Declaration Number:

Budget Category	**Grant Request**	**In-Kind Costs Costs contributed to the project per agency.**
Dates of Services	**(9 months)**	**(9 months)**
Salaries and Wages (Describe specific positions and rates in budget narrative) Fringe Benefits (34.63%) **Total Personnel Costs**		
Consultant Costs		
Office Supplies		
Travel		
Training		
Media/Public Information Costs		
Evaluation		
Total Costs		

FTE Position	Hourly Rate	9-Month Salary (1440 hours)	Benefits (34.63%)
	Total:		

7. List all consultants, the services they will provide, and their compensation.

Name of Consultant	Type of Service	Travel Costs (in	Compensation Costs

8. List the trainers included in the training category.

Name of Trainer	Type of Training	Travel Costs	Compensation Costs