

Promising Practices in Disaster Behavioral Health Planning: Assessing Services and Information

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Moderator: Hello and welcome, everyone. This is Marcela Aguilar from the Substance Abuse and Mental Health Services Administration's Disaster Technical Assistance Center (or SAMHSA DTAC). I will be your host for this webinar. This afternoon SAMHSA DTAC is pleased to present Promising Practices in Disaster Behavioral Health: Assessing Services and Information. The webinar will feature Dr. Anthony Speier, Interim Assistant Secretary for the Louisiana Office of Behavioral Health. This is the fifth webinar in the series of nine webinars presented by SAMHSA. The webinar is intended for State and Territory Disaster Behavioral Health Coordinators and others involved with disaster planning, response, and recovery. Before I turn the webinar over to Dr. Speier I would like to take a few minutes to provide an overview of SAMHSA's Disaster Technical Assistance Center. SAMHSA DTAC's mission is to provide training and technical assistance to States, Territories, and Tribes so that they are prepared for and able to respond to disaster behavioral health needs. When I use the term disaster behavioral health please note that this term refers to both mental health and substance abuse issues and needs. As you can see on the screen we have a brochure that you can download for free from our website. I will provide the website address shortly. SAMHSA DTAC provides an array of free services that include consultation and training about disaster preparedness and response, such as, compassion fatigue training and working with special population such as children and youth, older adults, Tribes, and people with disabilities and access and functional needs. Dedicated training and technical assistance for presidentially declared disaster grants, such as the FEMA Crisis Counseling Assistance and Training Program, also known as CCP and the identification and promotion of promising practices such as this webinar series. We also wanted to make sure everyone is aware of the free resources that are available to you on our website. This slide is of the Disaster Behavioral Health Information Series, also known as DBHIS. Here you can find tip sheets, fact sheets, booklets, and other materials about disaster behavioral health preparedness and response, information about specific kinds of disasters such as floods, tornadoes, hurricanes, and so forth. Also, information on specific populations such as the ones I mentioned earlier. These are our various e-communications. The *Bulletin* is our monthly newsletter that contains relevant resources. The *Dialogue* is our quarterly publication written by disaster behavioral health professionals in the field. Lastly, our discussion board, a mechanism for disaster behavioral health professionals to ask questions, share comments, and discuss disaster behavioral health-related topics with each other. Ways to subscribe are also on the screen. As promised here is our contact information. If you would like to request training or technical assistance for you and your staff please either call the toll-free number or email us. Be sure to visit our website, too. As always, if you would like to contact SAMHSA DTAC Project Director Dr. Amy Mack directly please feel free to do so. Her contact information is on the screen. I would now like to introduce Dr. Anthony Speier. Dr. Speier serves as the Interim Assistant Secretary for Development in the Louisiana Office of Behavioral Health. He has served as Deputy Assistant Secretary for the Office of Mental Health and Chair of the Adult Services Division of the National Association of State Mental

Health Program Directors. He is also currently overseeing the Deepwater Horizon Oil Spill Recovery Operations. Please welcome Dr. Anthony Speier.

Dr. Speier: Thank you and good afternoon everyone. I'm glad you are able to join us in this webinar. This webinar speaks to the assessing services and information and how to use that information in a constructive, proactive strategy in your planning and ultimately in your response and recovery operations. One of the things that this process will help you with is if you have been involved in a disaster you know that all of the sudden no one knew who you were and now they want you to be all things to all people. That is an impossible task and all you end up doing is being frustrated. Your staff is frustrated and everyone is disappointed because you didn't meet their expectations. A big part about first knowing what your capabilities are and having a way to continually evolve that information and knowledge keeps everybody's expectations within reasonable limits and allows you the opportunity to meet those expectations. The learning objectives for this particular webinar are to identify the methods of assessing capacity for providing services, data to determine when behavioral health needs are overwhelmed, and the mechanisms to ramp up services as needed. Secondly, to identify critical resources and services needed before, during, and after a disaster, describe the methods of conducting a needs assessment regarding your special populations groups which every disaster is filled with unique groups of people who are impacted. The last is to discuss methods and strategies to coordinate care for various behavioral health responders, teams, and personnel. There is a series of standards which you will be hearing more about that DTAC has been working on. This particular one is called standard five and the standard itself is, the plan demonstrates a range and clarity of services. That is needs assessment and ongoing identification of need and your capability will provide that clarity. Just a few of the indicators are on the next three slides and I will highlight a few of them. The implementation strategy needs to be clear. You should have a clear methodology and that is dependent on the capacity of your State to assess various aspects of the necessary information, both within and without your own organizations. Methods for effective communication, such as having a communication plan, description of the continuum of care that you will be able to offer as well that you are responsible for and a process for identifying the availability of resources. The needs assessment process should be specific to variables and items that are reflective of special population groups. You should be able to provide a full scope of services and spend some time on what the referral networks will be that are most active in a disaster. They are often different from those that are active in non-disaster times. Points of data for knowing where the behavioral health needs are overwhelmed. You can have threshold points that you don't want to exceed. Then, of course, a written plan for moving beyond the State's capacity when things do become overwhelming. Lastly on the last slide with respect to standards, you need the mechanics, the mechanisms for ramping up your services. You need a good descriptor of the acute elements of your response. What I mean by acute elements are the primary response sites and what it takes to operationalize them from a behavioral health perspective. Description of coordination between both mental health and substance abuse services. Simple things, making sure you have an active and updated list of where meetings are for people to go to for substance abuse support is very helpful for people who are displaced. A plan to address responder care; without the responders you have to remember we are not machines. Without the responders being able to stay on duty and active your whole response effort becomes greatly distressed. This item of stress management and healthy behaviors of your responders is a crucial feature to work out ahead of time. A description of deployment strategies. The more ambiguity you can take out of a situation for the staff to be involved the better off you will be and they will be. Some points to remember, when integrating a formal needs assessment methodology—everyone asks for a needs assessment, but nobody ever tells you exactly what they mean or how to do it. These are some points that we have acquired over the various disasters that Louisiana has been involved in. I am going to spend a moment reading these. Needs assessment involves the acquisition of multiple levels of information regarding demographics, socioeconomic, and

environmental factors. Here, what we are speaking of is that there are multiple levels within each of these content ranges, demographic, socioeconomic, and environmental. They interact and they interact specifically with the geographic location. Understanding your State and who acquires and keeps this kind of information ahead of time, having some baseline indicators will assist you greatly in seeing what kind of disruption to the individuals and communities is taking place. Second is needs assessment is ongoing prior to and through incident recovery. Continually redefining the stakeholder groups most relevant to the phase of disaster response. You will find and those of you that have done emergency recovery and response work, know that the volunteer groups, the different response agencies vary with the phase of the disaster. Therefore, your stakeholders vary and your data points and your needs assessment will also vary. What is important now might not be so important later. The pre-incident planning information informs the actual DBH incident program design. It is your actual program design which leads to both a short-term and long-term interventions. Over the next few webinars—I know the one that I will be doing in a few weeks will talk about scalability and that is part of what we are really emphasizing here, having a general program design and then one that works for you on the short term and the long term. Just as a rule of thumb, successful response strategies involve these three things, the analysis of present and future needs at the individual level and then relating those needs to what are the instrumental supports or tangible items needed and available to the recovery effort. Continuing re-assessment factors—you don't have to keep reinventing the wheel. You have to keep running the same wheel down the road over and over and that keeps you with some reliability in your data sets. The assessment of available community resources, which is a strength assessment model as opposed to assessment of loss. You should have those indicators pre-identified. Assessment of additional categories of impact, like in the case of a terrorist event, they are going to be a whole new set of variables and the concept of risk assessments will change. One should give some thinking to when you are doing all-hazards planning, what are the different classes of events and what are the variable sets that would be associated with that? Each disaster is unique. The assessment of special circumstances associated with the incident should also include questions specific to the degree, what is the human causation. In Katrina we thought it was a natural event and then there were human causation factors associated with the massive amount of flooding that we have. The indirect impact on communities and extent of ongoing threat and uncertainty all have to be evaluated in the process. Here is a rationale, this is a bureaucratic rationale for needs assessment. I will go over it. Folks at Federal Crisis Counseling Program are authorized under the Stafford Act and the whole point is to determine who is at risk, what is the identified strategy for assisting communities and individuals in moving through the process of response and recovery. There are always those “who” and “what” questions and then the “how” is really the strategy. As long as you stay on the who, what, and how you pretty well can design a needs assessment. It can be as elaborate or as simple as you need it. It just needs to be effective. When you are working with the needs assessment data and you are trying to determine the recovery trajectory of individuals and communities, your needs assessment starts to become not just a bunch of numbers but a way to design your programs. These are some of the points to keep in mind, knowing what your existing infrastructure is. What I mean by that is your resources, your buildings, your service delivery sites. The ability to sustain pre-incident service levels. As a behavioral health authority you had a whole cadre of people dependent upon your service, either run by the county or local nonprofit agencies that you need to sustain. Matching of recovery issues with the resource needs and of a strategy of continuity of operations and as you bring on new services because of the new issues associated with the disaster, how do you sustain those services? What is your funding and your human resource and skills that will be needed? The complexity, your assumptions of scope of the disaster behavioral health recovery needs really speaks to the complexity of it. Understanding the mental health needs of the stricken population will always vary by the scope, size, and the severity of the disaster. Individuals, disaster victims, or survivors are at greater or lesser risk due to their exposure. Some historical experiences they have had and the human makeup issues. We know that there are some stress experiences

and stressors, things that people experience that are more likely to cause long-term issues for them than others. You also need to keep in mind that it is not just the individual who has had the exposure that is affected; it is his or her whole household. This is true for response workers as well as people who are impacted in a negative way and categorized as survivors. When you calculate the impact and recovery needs you can't rely just on the quantitative numbers of direct victims that are impacted, number of dead, number who have lost their homes, the number who are injured. You need to go beyond those numbers. That last bullet about subpopulations and their risk and what signifies risk in those populations also needs to be factored into your plan to address the response needs of the community. Some structural elements that I consider essential components of a response strategy are these following items. You need to have your professional staff trained in community-based service delivery. You can't be in a situation where you are using people who are hospital-based service providers or pure clinic service providers that you are going to turn loose on your communities and expect them to be effective community outreach workers and in-home service providers. Pre-incident training and orientation allows these levels of professionals to transfer their knowledge base and skill set into those new environmental surroundings. Access, you should have this. We have always found this helpful. Local universities are often the best resource to get access to disaster mental health experts. It is really a content expertise you want here, how grief and loss issues, trauma disorders other items I have listed up here play themselves out within the context of a disaster event. Keeping in mind that the child and adult lifespan developmental issues and disorders that people are confronted with and many people no longer live in institutions, but in their homes. You will come in contact with individuals with these needs much more frequently than one would have ten years ago. Without saying, the assessment of cultural competency issues and ongoing weaving of that capacity to be culturally competent in your delivery of care is an ongoing process. Understanding in your response strategy a role for core social and community action groups; oftentimes these are leaders and nonprofits or civic groups that are active in the particular communities that are impacted and have the notoriety within those communities as leaders are most helpful to you. Volunteer agency support needs to be woven in. Your political structure and politically active groups that are indigenous also need to be woven in and you also need to target goals for project activity such as quantity and quality of staff that you will be providing. The next slide shows you how all of this rolls together and allows you to look at both long-term and short-term recovery project design or program design. I won't spend a lot of time on this. I will invite you at your leisure to look at it in a little more detail or just save it and look at when you have an event you need to plan for. It is basically trying to show you that in the red background that a disaster happens, an instant response is triggered, hopefully a planned one and the constituent groups are the OEP the emergency preparedness organization or office in your local area. It might be called homeland security or have different names in different States. That response infrastructure plus the other kinds of stakeholders identified and then once you involve all of the input from those people you want to go through the steps listed in the blue backgrounds of getting coordinated data acquisition, understanding the goals of your needs assessment, the assessment analysis of the information you are getting and stakeholder identifications that is further defined with short- and long-term program goals, and your design to actually implement those goals. This is an ongoing process and can be interpreted at the most simplistic level or within the most complex disasters. When you do your modeling given your own State needs you can play with this and have your team members play with this under a number of different scenarios and it is a very fruitful and active process for people to go through. I am going to spend a little bit of time speaking about some of the things that we have learned and this may fall into the category of the best way to learn and tailor your planning processes for your own State is to recall some event you have been through and how your response was structured within a context like we are presenting here if you don't have a current disaster event to use as your reference point. This is in response to Katrina. We have always considered ourselves pretty good at hurricane preparedness and response. In this particular slide you will see that the Department of Health and Hospitals has always had a disaster task force for the

last 10 years, has a bunch of very interested and people from different parts of a massive department of State government in Louisiana. We have organized all of the 12,000 employees into a callout registry. We have identified special roles for at that point in time with the Office of Mental Health and where were our primary sites and social needs shelters and medical shelters. We felt pretty good about that and we trained on that. We trained in 2004 a few months before Katrina hit in late August of 2005. We did routine training including the Federal Government participants on all-hazards response training, evacuation strategies, etcetera. One can look at that and say, "That is okay. That is not any problem." On a day-to-day basis it is not really a problem. Let me go into this a little bit more before I tell you what our problem was. Disaster response drills also included these various people and it may be of some interest to some of you, the term SARBO and team TMOSA, search and rescue base of operations and temporary medical operations staging area. You won't see those terms in any current literature. Those were terms that were developed here in Louisiana to deal with the evacuation of people out of New Orleans knowing that we would have to fly people out and putting them in different staging areas. That is what those terms referred to. The office of emergency preparedness which was not under an Incident Command structure in the way we talk about it today was our center of operations and they had to take on tasks like we evacuated our hospitals and we had a number of special missions with respect to sheltering of at-risk people in the locations identified here. To show you a little bit of the potential for complexity and miscommunications, you see all of these different boxes, you see all of these functions. This could work really well or not work really well depending on the personalities involved not on its structure because its structure is not sustainable as you see it there. We fast-forward this and the basic response went from August 29th, which was the day of the incident through late November and that was the first phase of it. I wanted to show you the number of items people were working on. If you consider each of those boxes a mission or a major activity you can see where you really are almost doing multiple disasters simultaneously in your response network. As we moved past that and really took into account lessons learned and our Federal friends and colleagues also learned a lot from this and new realities and how you address major incidents, in our case hurricanes. We had to make some assumptions and one of the first is that people won't plan for their own personal evacuation for the threat of the storm. I would ask each of you to look into yourselves. How many of you have an emergency preparedness plans that are personal plans for your family and people dependent on you that you can activate within the next half hour and other members of your family could also activate it without a lot of stress? The answer is probably no for almost all of us. If you did, it is decayed and you haven't reactivated it or re-practiced it on a routine basis. Emphasizing that on an ongoing basis is really important. People get worn out cognitively and emotionally and are not as able to manage stress and stay as effective in their decisionmaking. Structure and leadership are some mitigating factors which can assist with that process or help deal with the burnout. People need information in a way that is effective and meaningful to them. That is another way to speak to the cultural competency of your messaging and how you are providing assistance to people. Sheltering staff, when you go into a shelter and I would urge all of you, when you get a chance to go to a shelter for whatever reason you should and look at the number of roles that are under way in the shelter. It is always amazing the way it comes together. As you see from these items here, for people to be effective, the staff needs reassurance and relief on the deployment. They need to know they are doing a good job and they need some downtime and some personal time where they are not on call and at the beck and call of everyone in the shelter. Their job structure is important so they can judge their own performance by knowing the expectations; having those written is essential. You should establish a buddy system going into the program that you are assigned to participate in so somebody watches your back and makes sure they can tell you when you are not performing at the standards you would set for yourself. Continuing to respect each other and value each other even in small simple ways takes so much stress out of a situation for people. These little recognitions go a long way and that is part of the leadership role of whoever is in charge of the shelter. Shift change debriefings and onsite stress managers

are crucial. We do a 30-minute instant briefing between our shifts changes so people know what ongoing issues are and there will be a seamless set of services available to those who are depending on us. It is essential that staff knows who is in charge. A lot of people will sometimes act like they are in charge, but it is important to know the actual structure of what is the command structure within that particular location. Psychological First Aid is needed by everyone. Don't find yourself in a situation where you are making assumptions: "They don't need that." We all need it and can benefit from it. If you have not had the training or have not built that training in, it is available through the NCTSN website. Basic needs must be assessed and met. As your ongoing process, taking your same needs assessment model but doing it at the individual level in the shelter environment. You have to have a sufficient staffing or you aren't going to be able to address the behavioral health needs before they become so overwhelming that you end up having to implement a lot of crisis management protocols and even some hospitalization of people. Having these preplanned protocols to handle different settings in different situations is an essential part of your planning. Most of what we have learned from our experiences in 2005, we moved into using much more of an Incident Command structure process. This is one slice out of it, as you now see our communication pathways and our operations pathway is from the State-level Emergency Operations Center down into the desk for ESF-8 which is the health function. That is transferred to the whole similar set of operations that mirrors the State-level operation but specific to behavioral health. That is the message here, having a specific Incident Command structure for your behavioral health operations. For us that includes developmental disabilities. What you see here is the State level and you also see the regional—we have nine operational regions in our State. The functions are just the same but with this dotted line between Behavioral Health Regional Liaison and the Behavioral Health Section Chief; that linkage is essential to make all of the rest of this flow. This particular model has worked incredibly well with us and taken stress out of the process. This is the 2011 version of this and there have been a few refinements. You see we have had a consolidation of the Office of Addictive Disorders and the Office of Mental Health into the Office of Behavioral Health. That has simplified our processes and increased the effectiveness of our staff and their response. This next slide shows you a concept of how to facilitate integration of collaborative partnerships. Those overlapping boxes where the shapes of the various entities, community service providers, behavioral health service providers and school districts; in this context these entities come together in unique and special ways because of the incident. While you have the basic concept of how they are partners during non-disaster times, that changes a little bit. You need to be aware of how it changes and who are the particular stakeholders and bodies of influence within that process. There are some highlights on statewide services and the kinds of collaborative partnerships. These are post-Katrina and you will notice that there are family-related groups, public and private schools, a range of human service-oriented State-level and local county and municipal service agencies. The importance of including your methadone providers in your planning and response processes. Faith-based organizations are essential. They are the key to reaching so many levels of the community. Crisis hotline, the SAMHSA talk line, as well as any local lines need to be coordinated. You don't want parallel lines that are not communicating with each other in terms of the phone access. Building a stress management cadre which I will be glad to answer questions about that. You can't do without it, please don't try because you will regret it. First responder agencies, this includes their unions and advocacy groups and their retirees. Retirees from the first responder agencies are some of your best employees when you go into building your teams. Then again, who are your special population groups that exist and need to be recognized and cared for in particular ways. The planning process is ongoing. You will get tired of it, you will think, "I don't want to plan anymore," but you need to be judicious in how you involve people so they don't get burnt out from the planning itself. You need to keep it active throughout the course of the calendar year. Here are some points of pre-incident readiness that one should consider and be briefed on within your own State environment. It is important that you take behavioral health emergency preparedness and raise it to a core function within your local and State agencies. You don't

think about delivery of services without thinking about the aspect of emergency preparedness associated with it. If you do that it will change the level of attention and funding available. Work with your commissioners of behavioral health and local and State leaders. Behavioral health mitigation funds, there is no such thing formally out of FEMA or out of SAMHSA so this is something that you have to cobble together, but it can be done if it is one of your core functions, behavioral health emergency preparedness as a core function. Preparation of action request forms, you can pre-write these ARFs, as they are known, of resources you will need that will quickly be depleted if you understand your capabilities. If you understand your capabilities you can pretty well predict when you are going to run out and you are going to need something else. You can make those pre-requests available so you are not down without the necessary resources. Everybody should have the appropriate levels of the NIMS training that they require in their particular role and function. Just a few more of these readiness issues: call trees are very important. Pre-specification of just functions so people know where they are to go, what they are to do and how to do it, what the expectations are. Maintaining a volunteer cadre ahead of time, having pre-vetted that group of people, this is important practice, especially for the different venues you know you will be serving in. Preparing media shelf kits so you have your basic information available and it just needs to be structured for the various unique features of that particular disaster, keeping in mind the intensity of the incident, the duration, displacement of people, resource loss, and loss of human capital. If you keep those variables underway your outcomes for your needs assessment process you can build a really excellent program. The basic services are—I think you have heard a lot about some of these services, your components of your plan should address all of these. These would be in your program design itself. The basic component summary is looking at these items here, you need to have an education component, an ability to provide a technique, a structured technique of helping people, like Psychological First Aid, being able to do a just-in-time training specific to the disaster for your workers. Having an outreach capacity, ability to treat trauma, ability to deal with psychiatric crisis response not just disaster crisis response and your media and quality assurance plans and your financial, fiscal management business plan features. Your response and recovery goals, if you just operate under that guidance keep it simple and mission focused and you will stay right on track. Answering these questions, we did this over and over, any meeting you would ask these four questions, and we were able to be more successful that way. What is a disaster-related issue or challenge that is consuming you at the person or the community level? What can you, the person who is being consumed by it, do about it? What assistance do you need from us, the behavioral health authority? How do you know when the issue or challenge is resolved? People stay in a constant state of loss and don't know when they resolved their issue. That is not an uncommon thing to have happen. You have to remember that the Crisis Counseling Program is a supplemental program. It is not a new mental health system and therefore it must fit into existing systems. More flexibility in administration and local and State level is important. Try to build that much into it. Again, here is the logo that we have with Louisiana Spirit and it speaks to something that we can do a badging of the program, part of the communication. In our oil spill recovery, we just change it to coastal recovery from hurricane recovery but people have grown to recognize that as symbol of assistance to them in a disaster. This is some of the media print where a psychological disaster is the invisible damage as compared with a backdrop of the tangible loss of structure and damage to communities and the juxtaposition of the two is something that is helpful to keep in people's minds. With that, I have provided you with a reference section that you can read at your leisure and that concludes my presentation.

Moderator: Thank you so much Dr. Speier. We are now going to open up the floor for questions. We have received five so far. I will read each one and let you answer. The first question is, I am responsible for disaster behavioral health in my State. It is a State with a small population and we have not had a history of many disasters. Do we still need to do all you are suggesting in terms of needs assessment and

exercise drills or do you only suggest this for States that are more like Louisiana in that they are more likely to be hit by major hurricanes and other disasters?

Dr. Speier: Thank you. That is a good question and people want the answer to be that I don't have to worry about it, it is only those States that are subject to all of the big disasters. If you take time to go through the slides and look at them from the point of the principles that are being addressed and the various levels of variables that are mentioned, those are applicable to all States. A good beginning point for you is everybody has had a major fire somewhere in their State, either a flood, they have had different kinds of things that are incidents not disasters where you will see these same principles at work.

Moderator: In building your State's behavioral health response capacity, how do you address continuity of operations post-event?

Dr. Speier: Continuity of operations is a term that refers to keeping your business model and your service delivery models intact when an exceptional event has occurred. When you start doing your planning for the emergency response aspect of your duties you also simultaneously plan for the staffing of your ongoing business. You basically split your staff into your responder's staff and your continuity of operations staff. Oftentimes people you will find a lot of your staff has child care or older adult caring responsibilities that they can't play primary roles in a response, but they can play the appropriate roles in the continuity of care. Planning that ahead of time as part of your emergency preparedness process is essential. The other pieces, if you have a lot of people you are following on medication, you can prescribe 30 days and fill prescriptions early for people than the 10-day window so that the demand for refills on medication and medication checks will be reduced for the days immediately following the event.

Moderator: Are there any realistic examples of how States can effectively deal with staff burnout?

Dr. Speier: There are; one of the things to look at is—I don't know if the Project Liberty website is still up, but there was a lot of work after 9/11 with uniformed staff who work in the public sector, from subway drivers to fire and police and the long-term exposure not to all of the physical features, but to the stress and how those different organizations and faith-based communities worked together to assist people with that. The examples that have been most helpful to us is working with the fire and police agencies from New York City who came down and assisted us in our first responder burnout—anti-burnout campaign. One of the biggest features we have found that is common to this and other disasters in the country is use of a buddy system and the training of leadership to know not to always rely on the person who is always volunteering to do the hard jobs. We all have a certain degree of frailty we have to come to terms with and you don't want that to happen in the middle of a mission.

Moderator: Did you negotiate MAAs with each partnership and how did you determine the cost?

Dr. Speier: Usually with partnerships we don't negotiate funds for our planning processes or even in the initial response phases. What we assume is that we have a common purpose and a common mission. We collaborate within our own existing funding streams. If we are going to use a particular partner or collaborator in the delivery of new services and there is a grant that we are going after together then we would determine costs and we determine costs on a market price for a particular service or we use a cost

reimbursement methodology and stick to the normal and specific contracting and administrative requirements of your particular State or local.

Moderator: You mentioned some wonderful tools for evaluations, such as a needs assessment. We don't have funding for an evaluator on our staff. Are there needs assessments already developed that we can adapt for our State?

Dr. Speier: I think there are. If you were in that situation and you had a particular disaster, what you can't predict with that would be reaching out to the network either through DTAC or through the various collaborations of State disaster emergency response personnel, you will find people have developed a lot of needs assessment tools. You will also find that your universities, your schools of sociology, social work, psychology, and a lot of other different departments, especially a lot of the GIS mapping departments will have done a lot of work which will provide you with threshold data and would be more than happy and might even have grants in place that are ready to respond to a disaster event in your State.

Moderator: Can you briefly talk about the financial impact of using private consultants or contractors in DBH response and if this is a viable option, especially given limited State resources?

Dr. Speier: You think about this in two contexts. The cost of your experts can usually be rolled into whatever your long-term plan is. If it is a large event which is the only time I would recommend that you have experts, you will have either through the Stafford Act, access to the CCP program or there will be some foundation funding or unique funding like in the case of the oil spill along the Gulf Coast, our funding comes from BP. When you do that you really already have a funding source. The value, even if you don't is by using experts who are knowledgeable about the field, protects you from your own conventional wisdom. Oftentimes the expert opinion is based on experience in addressing the needs of a particular population. You will find the intervention you create is cheaper and less intrusive than you would have otherwise done without that information. We also deploy as well as employ a range of professionals to guide our ongoing service development. You can get a lot of that pretty cheap from statewide organizations, such as your various colleges.

Moderator: We have two more questions for you. First, how do we effectively include volunteers, especially those who are not part of a specific group or organization, such as community members who want to help in the range of services available during a disaster.

Dr. Speier: Volunteers are essential to successful response. Ongoing year-in year-out activity is assisting in the communication of volunteer opportunities in your States, such as through the American Red Cross, through the different faith-based emergency response voluntary actions in your State so you have a pre-vetted, pre-established group of volunteers of people who just want to help in that respect in a way that they can have successful experiences in providing assistance. People who want to provide assistance specific to behavioral health, you need to have a process of verifying credentials and a term we use, vetting their eligibility to participate. That kind of activity, you need to set your structure, the rules of the game, your certifications process, and who on your staff will be doing it. Do you have a contract to do that vetting ahead of time or one that is activated just during the disaster? You need to have thought through those processes and if you do so, you can channel the volunteer resource in terms of their skill set to the appropriate venues to provide services.

Moderator: Our final question. What are behavioral health mitigation funds and how can States access them?

Dr. Speier: Mitigation funds are funds to help lessens the impact of an incident. They are most often understood if you have a levee and it has been topping over, do you improve the drainage assistance associated with it or do you raise the levee two feet. Those would mitigate the impact of a swollen river at X number feet of flood stage. In behavioral health, there are no such funds such identified. You can design through your normal budgeting process in the State, procedures of where you would request of your legislator mitigation funds. I can tell you even in Louisiana we have not been successful with that. What we are successful with is if you have this communication going on at the three levels of government, local, county, and State. At the end of the year people usually have some unspent funds. If you have an agreement that people will take a percentage of that and buy materials and resources, anywhere from MREs to appropriate protective equipment you need, as well as hosting an education and training seminar at various locations or doing e-learning trainings. You do a lot of one-time activities that result in a pretty sophisticated mitigation response at very little fiscal impact because you are using money that was obligated, but unspent.

Moderator: Thank you for your presentation, Dr. Speier. This concludes the Assessing Services and Information webinar, a part of the Promising Practices in Disaster Behavioral Health Planning series. Subsequent sessions will explore each of the standards in greater depth, providing examples, lessons learned, and good stories about how to enhance your disaster behavioral health plan. Our next webinar will focus on logistical support and will be held on August 10th at 2 p.m. eastern time. The webinar will feature Mr. Steve Crimando as the speaker. Other upcoming webinars include, Legal and Regulatory Authority on August 18th with Mr. Andrew Klatt. Integrating your Disaster Behavioral Health Plan on August 25th with Mr. Steven Moskowitz. Plan Scalability on August 30th with Dr. Anthony Speier who will be joining us for the final webinar of this series. Thank you to Dr. Speier for his presentation and to all of you for participating in the Promising Practices in Disaster Behavioral Health: Assessing Services and Information webinar.

[End of session.]