

Promising Practices in Disaster Behavioral Health (DBH) Planning: Implementing Your DBH Plan

July 28, 2011

Moderator: Let's begin with Promising Practices in Disaster Behavioral Health: Implementing Your Disaster Behavioral Health Plan. The webinar will feature Ms. Terri Spear, Emergency Coordinator of the SAMHSA Office of Policy, Planning & Innovation; Dr. Amy Mack, Project Director of SAMHSA DTAC; and Mr. Steven Moskowitz, Director of Disaster Preparedness and Response in the New York State Office of Mental Health. We will start today with Ms. Terri Spear. Ms. Spear serves as Emergency Coordinator in the Substance Abuse and Mental Health Services Administration's Division of Policy Coordination where she coordinates the SAMHSA response in emergency situations, including ensuring cross-SAMHSA coordination regarding terrorism and mass trauma events. She serves as the primary SAMHSA liaison with counterparts in other Federal, State, local, and voluntary agencies, organizations, and governments participating in crisis response operations. Ms. Spear earned master of education in counseling psychology from the State University of New York at Buffalo. Please welcome Ms. Terri Spear.

Ms. Spear: Hello, thank you very much. SAMHSA wishes to welcome all of those accessing this webinar. This is the fourth in a series of nine webinars that are being produced and presented this summer. The development of this series is directly linked to the efforts SAMHSA included in its March 2011 document entitled *Leading Change: A Plan for SAMHSA Roles and Actions, 2011–2014*. SAMHSA introduces eight new strategic initiatives that will guide SAMHSA's work to help build strong communities, prevent behavioral health problems, and promote better health. This particular initiative falls under trauma and justice. Research has shown that 8.9 percent of men and 15.2 percent of women in the United States report a lifetime experience of a natural disaster. Further, we know that over the past 10 years the average number of disasters occurring across the country ranges between 65 and 100 federally declared disasters and many more that occur that are not declared. Planning is of utmost importance and this series is focused on disseminating the best of what is known to equip the best response possible with the resources at hand. Today's program is targeted to States and territorial Behavioral Health Coordinators or any others that are involved in disaster planning, response, and recovery. Today's program is about 60 minutes in length.

Moderator: Thank you so much, Ms. Spear. I would now like to introduce Dr. Amy Mack. Dr. Mack is trained as a clinical psychologist and has been the SAMHSA DTAC Project Director since September of 2009. She has worked in the public and private sector, often addressing issues of violence and trauma. She has managed evaluation studies and program development projects to build capacity of professionals in the fields of mental health and public health and emergency management. Please welcome Dr. Amy Mack.

Dr. Mack: Thank you. Hello everyone. For those of you that are joining us again for this series I would like to welcome you back. For those of you who are joining us for the first time, welcome. I hope you all will continue to join us for the remaining webinars in this series. Remember they are being archived and we will be sure to get that information out to you as soon as we have it. I would like to take a few minutes to provide an overview for you about the SAMHSA 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 keep in mind that this refers both to mental health as well as substance abuse issues and needs that may arise. As you can see on your screen we have a brochure and you can download it for free from our website and I will provide that website address to you 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 populations, such as children and youth, older adults, Tribes, and people with disabilities or access and functional needs. We also have dedicated training and technical assistance for Presidential disaster declared grants. Such as the FEMA Crisis Counseling Assistance and Training Program, also known as CCP. Lastly, identification and promotion of promising practices. Things such as this webinar that we have produced. We also wanted to make sure that everyone is aware of the free resources we have on our website that are available to you. As you see on the slide, this webpage is of our 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/or response, information about specific kinds of disasters, such as floods, tornados, hurricanes, and also information on specific populations such as the ones that I mentioned earlier. On your screen now you will see the list of various e-communications that we have. For example, the *DTAC Bulletin*, which is our monthly newsletter. This one contains relevant resources related to events and happenings that might be occurring or soon to come, such as the hurricane season that is quickly approaching us. We look for materials and resources that we can put together that you can have at your fingertips. The next one is *The Dialogue*, which is our quarterly publication written by disaster behavioral health professionals in the field. Lastly, our discussion board which is a mechanism for disaster behavioral health professionals to ask questions, share comments, and discuss DBH related topics with each other. Ways to subscribe to each of these are on your screen. Lastly, as promised, here is our contact information and we will have this on your screen later at the end of the webinar. If you would like to request training or technical assistance for you or for your staff please either call the toll-free number or email us and be sure to visit our website. As always, if you would like to contact me directly, please feel free to do so. My contact information is on the screen.

Moderator: Thank you so much, Dr. Mack. I would now like to introduce Mr. Steven Moskowitz. Mr. Moskowitz is the Director of Disaster Preparedness and Response for the New York State Office of Mental Health, also known as OMH. He has extensive experience in providing clinical services for youth and family, not-for-profit agency administration, family mediation, and most recently, disaster mental health. In addition to his role with the New York OMH, Mr. Moskowitz has been active in the creation of a national peer group of disaster mental health responders and currently serves as the co-chair of the Multi-state Disaster Behavioral Health Consortium. Please welcome Mr. Moskowitz.

Mr. Moskowitz: Thank you very much welcome to all of you joining today's webinar and my thanks to the folks at SAMHSA and SAMHSA DTAC whose efforts have led to this series being presented. Today in the fourth webinar of the Promising Practices in Disaster Behavioral Health Planning series, we are going to look at the essential components and proven strategies in implementing a DBH plan in States, Territories, and tribal nations. Just a note here about my use of language throughout the presentation. For the sake of simplicity I will be using some verbal shorthand, for instance, DBH for disaster behavioral

health and I will also sometimes shorten the reference to plans for States, Territories, and Tribes to simply States. I hope the shorthand is not offensive to anyone who is participating today. Implementation of a DBH plan can be seen from two distinct perspectives. The macro view looks at the process of creating a plan and obtaining the buy-in necessary for the plan to be owned by those who will use it. These considerations were the focus of the previous webinar. They looked at building collaborations and partnerships necessary to construct an effective plan. In this webinar, we are going to look at the micro perspective. Our focus will be identifying and defining the key mechanisms and processes that put a plan into action in response to an event. Close attention to this micro perspective of plan implementation will have much to do with the ultimate success of the mechanisms that you define in your plan, if and when it is called upon to function. Some aspects, these two different elements stand alone while some you may find are intertwined. This would be the case throughout the nine-part webinar series, as none of the key elements of a plan are truly unrelated, but frequently overlap and are often interdependent. In the promising practices process that was recently conducted by SAMHSA DTAC, the theme that emerged with the loudest voice was the need to ensure that the mechanisms identified to implement a plan have to transcend the theoretical. That is, the plan has to be practical, it must be realistic, and it must have sufficient buy-in from the stakeholders if it is going to do its job. What you end up with is asking yourself the question, is your DBH plan going to be one more three-ring binder that is sitting on a shelf gathering dust possibly when it is needed the most. Work by SAMHSA has identified nine indicators whose inclusion would create a competent plan. Those indicators include the following: descriptions of implementation strategies to address a variety of potential incidences, identification of existing mechanisms to implement a CCP, processes in the DBH plan to provide training for disaster behavioral health first responders, processes to deploy disaster behavioral health responders, descriptions of qualifications of competencies for responders, integration with emergency and public health response. You have to make sure that it provides representation of behavioral health at the EOC, that it provides for coordination with local government and nongovernmental agencies. Lastly, that it has a plan of action for operating during the first 24 hours following a disaster. In today's webinar we are going to look briefly at what I describe as the essential components to a DBH plan. Following this initial overview we will then look at the details of each one of those seven components and break them down using both examples and insights provided by DBH Directors who participated in the recent review process conducted by SAMHSA DTAC. Above all, the number one component is acknowledging the all-hazards perspective. As described in the first item on the SAMHSA list, the plan must possess the ability to respond to a variety of potential incidences. You have to make sure that those roles and responsibilities are well defined. Resources need to be identified and those resources committed to the plan. Who does what? What exactly it is that they do? Under what set of circumstances is that work done? When do plans get implemented and what are the thresholds that activate your plan? Methods used to activate? Who makes the call and by what authority? Only one method or perhaps multiple launching points? The DBH plan has to integrate both horizontally and vertically into existing Federal, State, and local processes. The vertical would refer to the way that your plan fits into the Federal State, Territory, Tribal, local emergency management structures. The horizontal axis refers to just how DBH activity is organized among the various government and volunteer organizations that possess the actual disaster behavioral health resources. Creating and maintaining your resources, you have to address the role of training to support the plan. You have to include activities to ensure that identified resources are both capable and available to you. Your plan has to be specific and reality based. Generalities will doom your plan to the proverbial three-ring binders that sits on that shelf. The plan must detail the how's, the who's, and especially the when's in order to be effective. Having stated the importance of specificity I want to qualify that just a bit by admitting that later I am going to talk to you about plan flexibility. Are the two values mutually exclusive? I don't really think so. When we get into more detail on this a little later I think it will be clear how your plan can both emphasize specifics and maintain a necessary degree of flexibility. One other item is to remember that attention must be given to making sure that what is planned for to get done can be

done. Time will erode any plan; changes occur over time. Have you anticipated the potential challenges that your plan may encounter and identify a strategy for responding to those changes? Now we are going to take a look at the details behind each of these essential components. In doing so I will be illustrating many points, utilizing examples and advice quotes that were gathered as part of the recent promising practices interviews that were conducted this spring by SAMHSA DTAC that generated input from DBH Directors across the country. Much of that information and advice was spot on and reflects actual process practice being conducted in the field. Just as the nature of States, Territories, and tribal nations varies geographically, politically, and socially, their practices in DBH differ as well. Hopefully by using illustrations from these different sources I will be able to provide varied enough samples for you that each one of you can find something that you can relate to and find helpful. We are going to look first at acknowledging that all-hazards perspective. Keep in mind that your plan should anticipate more than a single type of response. Here is how one of the DBH respondents described how their plan meets this need. The plan lists each type of potential hazard the State may face and identifies factors that could affect the psychological response and planning considerations and includes examples of typical response steps. Responses have also been adapted for different geographic areas. Additionally, your plan needs to ensure that it outlines responses that will be sufficiently adequate to meet any of the anticipated needs. A plan should be sufficiently flexible to accommodate events that differ in scale or type. Several of the considerations to be taken into account are found in the next couple of responses. Having a brief table that outlines the all-hazards risk, the factors influencing the psychological response, and planning considerations assist in the implementation of the response and identifying specific outreach strategies. One DBH Office Coordinator reported that the State has plans for natural and human-made disasters and commented that when it comes to implementation, practice very frequently differs from the plan. A lot of work has been done to upgrade what responders do, but the update has not been written into the plan. In New York State our DBH plan provides illustrations of different sets of circumstances in which OMH might be called upon to provide DBH resources. One, which describes our activation via the State Office of Emergency Management and the other, how we might respond to a request from a sister State agency. Ensuring that roles and responsibilities are well defined was summed up well in this response. Have a clear expectation of what you want your disaster responders to do. We even have a code of conduct for our responders. The expectations of what they are getting into are clear. That clear definition of roles benefits both the response leads and the responder. You know what to expect from them and they know what to expect when they're deployed. Make sure that your plan clearly defines what services are included. Fully describe the scope of services. If there is a flood will you be responding at multiple sites across the area or just a single major center? Identify what you will provide and under what circumstances. Can your responders be used at any type of assistance center, a regional assistance center, or even at a morgue? Anticipating and then defining the potential roles in your plan's writing stage means not having to do so after the flood has engulfed nine counties or the plane has already hit the ground. Another aspect that will pay dividends if addressed in this planning stage is providing some description of the length of time services will be available. This does not have to be a specific number. It might simply be a statement that identifies when in the process of recovery States supported services will generally be expected to close. I am going to take a moment to talk about the models in DBH response. There are a multitude of models. They tend to reflect the organizational structure found in that State, Territory, or Tribe. Your plan should reflect the organizational makeup that meets your particular needs as well as the types of quantity of resources you have available to utilize. In New York State we have a large number of psychiatric facilities and many counties with highly organized Red Cross chapters. As such, our model for DBH response relies on an escalating process beginning with local Red Cross response backed up by DMH staff from our State facilities. Another qualification on my use of terminology, New York State has not adopted the more general reference to disaster behavioral health and we still refer to the New York State responders as disaster mental health responders. I am going to offer another example. During my own efforts to create a DBH plan I learned about the plan in Pennsylvania where disaster behavioral health

response rests with a coordinated consortium of State, local government, and nongovernmental organizations utilizing an all-volunteer DBH response. One of the technical tools that you can—I apologize for the slide that you are seeing, I moved ahead a little too quickly. One of the technical tools that can ensure that what is included in your plan actually happens are memorandums of understanding or statements of understanding. These agreements can be utilized to effectively define roles and responsibilities with any organization that you name as a key player in your process. The inherent challenge in making such agreements is to be mindful of what is actually being accomplished. New York State has an SOU between our State, the Red Cross, and the State organization of county mental health directors. The SOU reflects general principles and is not a functional blueprint for how response will be made. The significance of this distinction was illustrated in 2009 during the American Civic Center shootings in Binghamton, New York where DBH services got off to a difficult start and never recovered fully when a previously undefined player in DBH response, in this case, the Crime Victims' Assistance Bureau, suddenly became the DBH lead agency. Ultimately, the confused process led to significant shortcomings in the broader DMH response. We learned from this that while the SOU was a significant accomplishment in defining intent, it fell well short of assisting in actual response. Now on to activation and triggers. While it makes sense that your plan will include procedures for putting it into action, it is necessary to make sure that there is both clarity in the process and that it is capable of working in various sets of circumstances that could trigger responses. In keeping with the all-hazards perspective this will necessitate defining your activation process in such a way that implementation reflects the specific need. In my work on the New York plan I learned that in North Carolina, their plan includes a general sequence of actions section that details the methods for initiating response based on the scope of the incident, including specific descriptions for State plan response as well as a community-level response, including also descriptions for both large-scale and small-scale events. That North Carolina plan also describes the methods to be utilized by local emergency management entities on how to access their DBH services. Notifications, what methods are utilized to communicate the activation of your plan can be crucial. Here is a description of what one of those DBH Directors ran into. We had difficulty in communicating when a response was needed. The Coordinator was sent an email message over the weekend that wasn't seen. This pointed out a need for redundancy in communication. A phone call would have facilitated a slightly quicker response to the need. We all know that smartphones have made the issue of prompt and effective notification of DBH Coordinators much more effective, but you should question the types of methods that you need to include to ensure that you can reach out to your responders. Frequently utilized techniques include phone trees, email blasts, and many State emergency management and health agencies have technologically sophisticated systems for communicating with large groups of responders or providers. Explore those resources that are available to you. Another lesson from the field: Maintain accurate contact information for volunteers who want to respond. Reach out to your membership in an ongoing basis. You don't want to be doing that during a disaster. It may also be beneficial to include multiple means of putting the plan into action. An example from the field, make sure it has multiple launching points. There should be several positions which can activate the plans. We have it set up to where the disaster behavioral health authority can launch the plan, but so can public health and so can emergency management. Others can launch the plan and get the ball rolling without having to wait on any specific entity or person to begin the process. Another consideration is that it may be helpful if the processes described are functionalized rather than individual specific. In New York when I came on board as the DMH Coordinator I inherited a plan that listed my predecessor's name, complete contact information so that he could be reached 24/7. Unfortunately, the plan became obsolete when he retired from State service. Our emergency contact numbers have since been changed to identify offices rather than individuals. The DBH plan must integrate both horizontally and vertically. The vertical integration ensures that your plan fits structurally into existing government processes. The component reflects basic ICS expectations designed to ensure effective planning and response efforts. Such attention not only ensures that your plan will run smoothly within the context of ICS, it often provides secondary benefits as well. The comments of two DBH

Directors who offered insight on this found that such integration enhanced their ability to better define roles and responsibilities. Just to give you a break from my voice for a moment, rather than reading these next two responses out loud I am going to invite you to read through the comments on your own. [Pause.]

Mr. Moskowitz: Another key element of vertical integration is that it is necessary to include a provision that describes how your State would initiate and then implement a Crisis Counseling Program. That would include preparing and submitting a grant application to FEMA, SAMHSA and if well-designed it is going to identify resources that would be needed to implement the program as well. Horizontal integration would be described as how your plan fits across the behavioral health continuum. Responding to the structural realities related to mental health, people with developmental disabilities, and the substance abuse community. This will usually include both governmental and the not-for-profit organizations that tend to represent behavioral health concerns and frequently provide the human resources in DBH response. Another additional thing to keep in mind: integration must also be accounted for programmatically. Described in this example, the Plan Coordinator reported that most of the planning and response takes place at the local level and includes the State professional volunteer corps and local mental health authorities. About DBH models of practice, there are a lot of them out there. Some are organizationally sophisticated where the DBH office oversees training and sometimes even formal credentialing programs. Others use less centralized models that rely on local behavioral health organizations to provide response with modest direction from the State. What is important is that the sophistication of the model is not a key indicator of the quality of DBH response. What you may wish to keep in mind is that DBH offices utilize varied methods and models, each one of those designed to reflect the particular needs and realities of the populations that they serve. If you are in need of guidance on what model might work best in your plan, there is a wealth of resource information that you can take advantage of. You are part of a very large peer group of DBH professionals, not to mention there are also the services of SAMHSA and SAMHSA DTAC. As you work on defining your model for the first time or even if it is a revision, the third time, fifth time, or tenth time, keep in mind you are a part of a community willing to offer assistance, guidance, and support in your efforts. It is up to you to reach out to get the information that you need to best meet your needs. While it is displayed here very simply, I can't understate the value of training and drills to support your plan. Training offers all participants who are a part of your plan with the actual hands-on experience it takes to bring your plan to life. Drills and exercises give all participants an opportunity to see how words on a page translate into tangible activity. This leads not only to better preparedness as repetition of behavior hones skills, but playing out your plan under simulated conditions will provide important feedback pointing out strengths and weaknesses and allowing you to continually refine and refresh your plan. Not exclusive to the subject of plan implementation, the value of creating plans that are explicit and based on real life is an essential characteristic of every good plan. In this context the importance cannot be overstated. If your plan calls for utilizing DBH responders from the Red Cross make sure that you define the parameters of the utilization. How the request for assistance to go to the Red Cross and under what circumstances that request can be made. A plan can be dynamic, it can avoid becoming stale and outdated if it builds in a process for a regular review of how it functions and how to make adjustments in responding to changing circumstances. Another lesson from the field highlighted just one of those potential challenges. The lack of funding during the previous two years inhibited training and support efforts to provider organizations. The plan is clear about who will respond when and how training qualifications and competencies for responders were less clearly delineated. That wraps up my essential components and my suggestions on implementing your State DBH plan. My thanks to all of you who took time from your busy schedules to attend today's webinar. My thanks to SAMHSA and SAMHSA DTAC for supporting this effort to provide guidance on promising practices. Now we move on to questions.

Moderator: Thank you so much Mr. Moskowitz. We do have a number of questions. I am going to read them and let you answer. Our first question is, you talked about being specific, naming planned partners, defining their roles. Doesn't such specificity create a weakness in the plan every time there are changes among any of the organizational partners?

Mr. Moskowitz: It is a good question and it raises a challenge in maintaining a plan. It can't be seen as a weakness because having those partners in your plan is essential. You won't have a plan without them. What you are identifying is the challenge of how do you invest the time and energy and have you identified a mechanism. For example, regularly scheduled meetings with defined participation at specific points in time, quarterly, or semiannually to bring the partners back together. Drills and exercise are another excellent way to maintain the commitment by those partners to your plan. My suggestion is that you look—rather than as a weakness, you would look upon it as a challenge that you have work to accomplish.

Moderator: Mr. Moskowitz, you mentioned that the need to identify thresholds that trigger an activation of a plan. Can you explain what you mean by that?

Mr. Moskowitz: Very often, regardless of how much effort we put into defining or creating definitions in our plans, the events as they happen on the ground sometimes fall into gray areas. My suggestion is that you take the time to anticipate and think about what some of those are. If there is a Cat 3 hurricane coming up the coast you can be pretty sure that you are going to be implementing your plan and you are going to be anticipating a call from your State emergency management office. However, I will use an example from here in New York State from just a week ago. There was a very tragic accident in the Finger Lakes region of New York in which six people were killed in a motor vehicle accident. Usually that would not trigger our emergency response plan. However there were particulars in this that—where the first responder community turned out to be adversely affected in responding to this particular incident. In our plan we also allow for an informal process between State emergency management to reach out through our Office of Mental Health field offices, regional field offices to at least begin inquires to see what kind of assistance can be made. What I would encourage is that you think about the different types of situations that you can incur and within the context of your plan you try to identify different types of thresholds that you may encounter.

Moderator: Thank you so much Mr. Moskowitz. You also mentioned a code of conduct for responders. Is it possible for participants to get a copy of that code?

Mr. Moskowitz: I would say that if anyone wanted to contact—I will put SAMHSA DTAC on the spot here. I would think that if you contacted SAMHSA DTAC, I would be more than glad to work with them to pass along the request to the State that has that code of conduct.

Moderator: Thank you so much. Our final question. Do you have any suggestions about the physical DBH plan? You mentioned three-ring binders that sit on shelves. Is there a way to avoid that?

Mr. Moskowitz: That is a pretty challenging one. I think that today technology does offer us some alternatives. I think that it is always important to have that printed manual that is available should people use it. I am going to suggest that people also think in terms of things like USB memory sticks that plans can be put on those memory sticks. They can be distributed to the participants so that it is a resource that is easy for people to have with them at all times and be able to take right out into the field with them.

Moderator: Thank you again, Mr. Moskowitz, for your presentation. We also have two questions for Ms. Terri Spear. Ms. Spear, is there a requirement for each State to have a DBH plan?

Ms. Spear: At this time there is no Federal requirement for a State disaster behavioral health plan. That is an unfortunate circumstance, but facilitates in meeting their needs through their planning efforts. However, if a State were to choose not to have a plan because there were no financial or direct responsibilities or requirements, they then stand the risk of being—I don't want to say flying by the seat of their pants, but the planning at the time of disaster is often a disaster in itself and they would not be able to sit at tables and other kinds of discussions that are critical. There is currently no Federal requirement.

Moderator: Our second question is, is there an example or a template of a DBH plan that is available for use by participants?

Ms. Spear: Because each State has a slightly different structure that is in each of its proximities, no one single plan has been developed. We do know that several States have gathered together and are working towards a single template and we have looked at that for the various regions that they have representatives from. As that information becomes available and able to be disseminated we will share that information with DTAC and they will be able to include it in the DBHIS.

Moderator: Thank you so much Ms. Spear. I believe you have some closing remarks for us.

Ms. Spear: I do. Thank you very much for your participation today on this webinar. I want to thank everyone for their participation and their very thoughtful questions. This concludes the Implementing Your Disaster Behavioral Health Plan webinar as a part of the Promising Practices in DBH Planning series. Subsequent sessions will explore each of the standards in greater depth and good stories about how to enhance your disaster behavioral health plan.

Moderator: Thank you again. Dr. Mack will now tell us about the upcoming webinars.

Dr. Mack: Thank you. Just so everyone is aware, the next webinar is going to be about assessing services and information. That is being held this coming August 4th at 2 p.m. eastern time. That will be featuring Dr. Tony Speier. We wanted to make sure that we got the information about the other upcoming webinars in the series. This will be closing out the total of nine that have been produced for this segment. That is as you see on your screen, Logistical Support on August 10th with Steve Crimando. We have Legal and Regulatory Authority on August 18th with Mr. Andrew Klatte. Integrating Your DBH Plan with Mr. Moskowitz on August 25th and Plan Scalability, the scalability topic will be covered August 30th with Dr. Tony Speier. Lastly, we also wanted to make sure because we had the slide up earlier but we wanted everyone to have it again. Feel free to contact us toll-free or by email. If you would like to contact me directly my information is there. If you have questions or want information about materials or information that is out there on disaster planning we are happy to help you with that as well.

Moderator: Thank you so much Dr. Mack, Ms. Spear, and Mr. Moskowitz, and thank you all for participating in the Promising Practices in Disaster Behavioral Health: Implementing Your DBH Plan webinar.

[End of session.]