Introduction to Promising Practices in Disaster Behavioral Health Planning

June 27, 2011

Moderator: Welcome to the Substance Abuse and Mental Health Services Administration's Disaster Technical Assistance Center's Introduction to Promising Practices in Disaster Behavioral Health Planning. I am going to turn over the presentation to our first speaker, Terri Spear from SAMHSA.

Terri Spear: Hello, it is with great anticipation that this webinar series begin. This initiative is directly linked to the other efforts that SAMHSA has published in its March 2011 document entitled, *Leading Change: A Plan for SAMHSA Roles and Actions, 2011–2014*. In that document SAMHSA introduces eight new strategic initiatives that will guide SAMHSA work for the next 3 years. In our efforts to help build strong communities, prevent behavioral health problems, and promote better help. This initiative falls under trauma and justice. It is number two of the initiative and justified by the fact that research has shown that 8.9 percent of men and 15.2 percent of women in the U.S. reported a lifetime experience of a natural disaster. We know that over the past 10 years the number of disaster occurring across this country ranges between 65 and 100 federally declared disasters and that many occur that are never declared. I can give examples in the last 2 years where the Haiti incident which had large national impact, the pan-flu episode is another. The third is the BP oil spill; are all disasters that required States to address behavioral health issues in the absence of a Federal declaration. We all know that planning is of upmost importance. This series is focused on disseminating the best of what is known to put the best response possible with the resources at hand. I think we have a speaker today that is very experienced and I look very much forward to hearing his discussion. Thank you all for your participation and I will be on these calls with you as they occur.

Moderator: I am now going to introduce Amy Mack, Project Director of SAMHSA DTAC.

Amy Mack: Thank you, hi everybody; glad you could join us today. We are very excited to kick off this series, the first of nine different webinars that we will be hosting between now and the end of August. I wanted to start by making sure, although I am sure many of you are familiar with him from DTAC, but I am sure there are those who are not. I wanted to take a moment to give a brief overview because obviously we are eager to hear what Steve Crimando has to share with us today. I want to go over our mission statement which is that the SAMHSA DTAC, SAMHSA Disaster Technical Assistance Center is here 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. I should mention when we use the term behavioral health, we are referring to both mental health and substance abuse needs and issues that may arise. The bottom corner shows a graphic of our brochure and it can be downloaded for free from our website, http://www.samhsa.gov/dtac. I am going to quickly go through some of the other pieces. To give an overview in terms of services we offer, we have consultations and training. Those are things that are focused on disaster preparedness and response pieces, looking at acute intervention, focusing and realizing

we can assist you in terms of working with special populations such as children and youth, older adults, and other categories. We also have dedicated training and technical assistance for disaster behavioral health grants. In particular what we support in terms of grants is through the Federal Emergency Management Agency, which most people know as FEMA, the Crisis Counseling and Assistance and Training Program, many people know that as the CCP. Once those grants are initiated we are there to provide the dedicated training and technical assistance. We also have identification and promotion of promising practices. A fabulous example of that is these webinars series that we are launching today in which we will be highlighting promising practices and helping all of those who are participating today be able to develop their disaster behavioral health plan. In terms of resources there is an image here of our website. This is our page that lists different resources and in particular I want to point out our Disaster Behavioral Health Information Series, also known as DBHIS. This contains different themes and different toolkits focused on preparedness and response. We have different specific disasters and specific populations. One could search on our website and for free download, click on the materials, print, and use. Lastly, we have various e-communications, ways in which we can get in touch with you and you can keep in touch with each other. We have the *DTAC Bulletin* which comes out monthly and you have here on your screen how to subscribe. *The Dialogue* which is our quarterly e-journal, an electronic journal, focused on information from the field that we highlight. Twice a year we are trying to focus on special topics and themes that are hopefully helpful to everyone in the field. We also have our DTAC Discussion Board. That is a place to post resources and ask questions and share information with one another. That is primarily it in terms of the brief highlight of SAMHSA DTAC. I would like to pass it on to Steve Crimando, our facilitator for the day and let him begin.

Steve Crimando: Hello everybody and welcome to our presentation today. I am Steve Crimando and I will be your facilitator. I have worked for the last 22 years in disaster behavioral health as trainer, consultant, and also working on numerous plans at the State level and with organizations across the country. I have also been a responder to disasters across the country, including a large number of natural disasters and technological disasters and acts of terrorism. I hope that during this program I can share and I can help you share experiences with our other participants to gain a better understanding of how best to develop effective State disaster behavioral health plans and integrate those plans into your jurisdiction's overall disaster and emergency planning process. Throughout the program today I am going to be using the term State, Territory, and Tribe somewhat interchangeably and a lot of times I will be using the term State primarily and that is mostly for simplicity but I do intend this to apply to all of those different government structures, all of those different jurisdictions. I understand and appreciate that we have an awful lot of experienced individuals on the call with us. My invitation to you today, I refer to the three As. Regardless of your level of experience and your expertise, adopt new ideas, some new learning, innovative ways of thinking, and planning for the needs of individuals, families, and communities in the wake of a disaster. To adapt or update your plans to incorporate some of the interesting approaches to developing the plans and integrating with your overall State, Territory, or Tribe emergency disaster plan. Lastly, where the rubber meets the road, applying these concepts in the larger context of your jurisdiction's unique risks and resources to ensure that these ideas actually fit the disaster behavioral health needs of your community. Given all of our experience, Nicole mentioned earlier, we will try to move through the presentation, share with you what we have today and then leave a good block of time towards the end for questions for discussion. Please do start thinking about questions, making a note or sharing them with the chat feature so we can get to those towards the end of the program. As an overview, our program has two major goals today. The first goal is to help individuals, help organizations develop a comprehensive disaster behavioral health plan and then take that plan and effectively integrate it into your jurisdiction's larger plans, response and recovery activities across all the types of government structures we mentioned, State, Territory, and tribal, so that there is a meaningful fit and so that it is not a standalone feature but we have

good integration and then of course good utilization of our disaster behavioral health services. Our approach in fostering these goals is to include a review of key findings of our recent survey of the disaster behavioral health coordinators about promising practices as well as introducing the eight standards for planning and integration that were developed from site visits and interviews with coordinators. The purpose of the promising practice project in disaster behavioral health is to document interesting, novel, and effective ways of creating and sustaining disaster behavioral health plans. In doing so, a number of States, Territories, and Tribes were identified as having been successful in integrating mental health and substance abuse to disaster behavioral health planning. The project was designed to help harness information from those jurisdictions in order to guide recommendations about future disaster behavioral health planning. There were a number of different data sources for the project. Among the sources of data were the [inaudible] or National Emergency Management System compliance standards developed by SAMHSA and SAMHSA DTAC, as well as a content review of 22 different State disaster behavior health plans; in-depth, semi-structured telephone interviews with individuals with long and diverse experiences in disaster behavioral health planning at the State and Federal levels; and site reviews to a few select States. All States, Territories, and the District of Columbia were invited to submit their disaster behavioral health plans and a total of 22 of those States did submit those and they became a large part of the different processes we are going to review today. Of the 22 plans, they were reviewed against the eight NIMS compliance standards and from that review nine States were selected to participate in telephone interviews to gather more in-depth information on the promising or emerging practices documented in their State disaster behavioral health plans. The results from the telephone interviews and other criteria were used to select three States to participate in site visits. From that selection process, the other criteria was looking at those State plans in terms of comprehensive plans that were submitted, States that had experience with major disasters in the last 5 years, and evidence of high implementation of some or all of the NIMS compliance standards that were described in the telephone interviews. The selected States were also validated by SAMHSA and SAMHSA DTAC staff members with knowledge about those States' disaster behavioral health response practices. Specifically to determine high implementation, aspects of collaboration with other organizations and agencies and other partnerships, implementation activities, such as tabletop exercise and drills and their own knowledge about that State's disaster behavioral health plan and their standards. A lot went into the selection process for review, for telephone interviews, and lastly for those site visits. As we look at the methodology further we know that the exploratory work generated mainly qualitative data and a content analysis was done to analyze this data with the study findings being released in a SAMHSA report on promising practices sometime in the future. We will actually have documentation of that as well. Many examples of the promising practices identified in this process will actually be shared in this and the remaining webinars throughout the nine-part series. You heard that today was our introduction and what we would do in the introduction is look from an overview standpoint at those eight different standards, touching on them. Please understand that every one of these subsequent webinars will go into much greater depth about these eight standards and the promising practices that support these. To help bring the lessons learned and promising practices identified in this survey to light, a literature review, feedback from coordinators, other sources of information have been used to launch this nine-part webinar series today with our introductory session. Today we will discuss ideas in promising practices in disaster behavioral health, specifically some of those findings from the survey, things that can be useful and actionable for you. We are also going to introduce the eight standards that guide planning, development, and sustainability. Each coordinator revealed a number of essential aspects and attributes of what they considered a comprehensive disaster behavioral health plan, also of an effective disaster behavioral health system. We will explore each of these in some depth today but understand the documents detailing the various elements of the standards have been provided and more certainly will be generated as we move forward, especially as those findings are shared. Each of the subsequent webinars will go into greater depth, give different case examples and more work from the field that demonstrate

novel approaches and just plain good ideas that can be useful in your disaster behavioral health planning efforts. As you can see by this slide, we start to introduce those eight standards that structure, that support, that help facilitate an effective State disaster behavioral health plan. The first of these is that plan has evidence, that it demonstrates scalability. We will discuss more about that in a moment. It exhibits clarity and collaboration, coordination, and partnerships, exhibits clarity of financial and administrative operations, demonstrates mechanisms for implementation, how you would actually launch and put into action your State disaster behavioral health plan. From that, demonstrates a range of clarity, of services. We can distinguish disaster mental health services from other sorts of mental health services and demonstrate clarity in logistical support as well. That is another important area we are going to spend a little time on this afternoon. Also, the seventh and eighth of these standards are exhibiting clarity of legal, regulatory, and policy authority and lastly, that there are processes in place for maintenance and updates of the plan. Sustainability is a very important feature of what we will be talking about both today and in the whole webinar series. Today these elements are taken together, these elements help structure a disaster behavioral health plan that anticipates a variety of different potential disaster types and sizes and ensures its efficient administrative controls are in place to effectively implement a disaster response and facilitate interoperability with key partners in government and the community around you in a sustainable manner. There is a lot of different levels of thinking going on simultaneously as we begin to look at the different standards. As I mentioned, the first of those standards was the standard of scalability. Let's spend a little time clarifying and then giving you examples from the field of how we understand scalability in terms of the development and implementation of the disaster behavioral health plan. With each of the eight standards there are several useful indicators that suggest that the disaster behavioral health plan adequately address critical areas of concern. For example, in standard one, scalability, it is important that the plan appropriately anticipate a range of different types of disasters as well as disasters of different magnitudes so that the plan can quickly be ramped up, scaled up to large and complex events and then as the event moves along a timeline where there are changes in the nature of the event it could be scaled down as needed. That is part of the key idea from our NIMS standards, the idea of scalability. Just on scalability there were nine useful indicators that identified promising practice standards. We are going to touch on a few but please review the materials as we share them today. There are lots of literature that goes into greater depth about any one of these standards. No one indicator is more important than the other; each is important to the development of the overall plan and to the concept of scalability. Several of these indicators are SOP, standard operating procedures for preparedness and response activities. What we see in the field is effective plans articulate action steps, both in preparing for and responding to disasters but there are written instructions that make its information clear and accessible to others who may not be as familiar with disaster behavioral health planning response but who may need to implement or at least integrate disaster behavioral health services into other operations in a time of crisis. SOPs become one of the indicators. Since disaster behavioral health plans and activities must be interoperable with other sorts of disaster and emergency management entities it is also essential that planning response recovery efforts be based on these NIMS principles and guidelines. The *SAMHSA Disaster Behavioral Health Toolkit* provides guidance in developing plans and implementing response activities in a NIM compliant manner. NIMS and the Instant Command Guide help focus all that we do in emergency management, both at the national and local level. It is important that plans be developed using a NIMS approach through the whole planning process to ensure the disaster behavioral health activities plug and play quickly and smoothly into overall disaster management efforts. Disaster behavioral health response is sensitive to specific types of disasters. This is another one of the ideas central to scalability. We talk often about how our interventions need to be phase specific. That is critical but here we also understand that intervention or modeling has to be hazard specific. The emotional behavioral impact of a natural disaster can be very different than that of a mass shooting or disease outbreak or a chemical or biological or radiological emergency. The disaster behavioral health plan should also include instructions or adaptations of

procedures that will be necessary to address the consequences of a variety of different hazards and includes section or annexes that address those specific events, the ones that you determine to be of a high probability, high risk for your State, Territory, or Tribe. If you are unsure about which of those events or what type of events must be rated or must be considered the greatest risk for your jurisdiction, the State emergency management authority of your jurisdiction, those leaders of emergency management in your communities do perform hazard vulnerability assessments and can generate this sort of information that can be helpful when you are aligning your approach to what are considered the greatest risks for your area. In terms of scalability it is also important that your plan clearly describe the command and control structure that is in place for your emergency operation. Command and control specifically in disaster behavioral health planning in response and recovery activities as well. In doing so this is helpful in defining a chain of command including the names and titles of all of those involved and the description of how authority cascades throughout the organization during normal operations and during emergencies. Beyond identifying who is in command it is also important to describe how individuals and organization will communicate. The lines of communication, the primary and backup forms of communication, and even how tech support for communication will take place; all should be articulated in the plan. Lastly, a clearly defined concept of operations, sometimes abbreviated as con-ops helps you structure and guide the overall planning effort. It is particularly important in terms of scalability that you have a strong concept of operations. The con-ops section of a plan typically includes goals and objectives, strategies, tactics, and policies related to the plan, a description of various roles and activities of the defended participants and stakeholders involved with the plan. Beyond that, specifics about different operational processes that would be involved during the implementation or activation of a plan. In addition, con-ops typically also describe the life cycle of the plan, from how a plan is initiated and drafted and generated through how it is maintained. In fact, it typically even discusses how a plan may be retired or replaced at the end of that life cycle. When you understand scalability as it relates to an event, concepts of scalability relate directly to your plan itself, how it evolves, how it is maintained over time, and how it might be retired. Here are some examples; in one State the department of mental health expanded its contracts with community mental health centers requiring them not just to have readiness plans but to have readiness plans that specify procedures for scaling up and scaling down over the timeline of the disaster. Scalability started to reach right into the communities as well. In 2010 one State disaster behavioral health staff started to prepare for a response to blizzards but when it had massive power outages it did not take place because they had worked on a scalability concept; as much effort as they put in ramping up and preparing for the storm, when the storm did not have the impact they were very quickly and easily able to scale that plan down to the size of weather event that did hit them. Another State mentioned in their interviews that participation in drills and exercises was also important to understanding scalability and chain of command because it gave them an opportunity to see this in practice. It brought it to life for folks and during the course of the event or the exercise they were able to scale up to meet the demand and practice scaling down. As you can see, just on this one standard alone, we were not even exhausting all of the different indicators of scalability. You can see there is a good deal of thought involved in implementing any one of the standards. It is well worth the time and the effort working through the planning process so that you can identify challenges that may arise in an actual disaster and I always come back to this quote from President Kennedy, who said more than 50 years ago, “The time to repair the roof is when the sun is shining.” Taking the time, taking the effort to work through the standards and see where you come down with the different sorts of indicators can yield very substantial dividends when you are in a real-life, real-crisis situation. Standard two addresses collaboration, coordination, and partnership. I know I am moving through the material quickly. As I said, please jot down or using the chat window, notes across to our team about questions as they come up. Collaboration, coordination, and partnership as a second standard in disaster behavioral health planning process addresses proactive collaboration with other stakeholders as a necessary, important, critical step to creating and maintaining your disaster and behavioral health plan.

Typical partnerships include but are not limited to, developing the kind of and nurturing the kind of relationships with agencies and with the leaders in those agencies across many types of disciplines that you will need during real-time activation. Those range from mental health and substance abuse provider agencies in your communities and contracted agencies: other emergency management entities at the State and local level; law and public safety organizations; public health agencies; all of the VOAD's, volunteer organizations active in disaster. Also academic institutions—and we will give you an example of that in a moment—and media outlets can all add a very significant voice during a disaster. We certainly understand the importance of forming those relationships in a pre-disaster environment so they are in place when you need them. An example of collaboration with academic partnerships can be seen in the different disaster mental health institutes at college or universities such as the well-established longstanding University of South Dakota Disaster Mental Health Institute and the State University of New York New Paltz. Those are examples of academic institutions to promote research into and the development of disaster behavioral health field. They really help us grow the field from that research and academic standpoint. They are important partners to their State and help feed our whole field with information both nationally and internationally. I understand that not every State or region has such an institute but very often there are other colleges or university programs that are focused on trauma, violence prevention, and other related topics that also can be meaningful academic partners in developing disaster behavioral health plans and systems in your States, Territories, and Tribes. Feedback from the coordinators repeatedly pointed out the importance of building these strong relationships with key partners, the sort of relationships that are based on trust and confidence developed in the pre-disaster planning phase that would hold up in times of high stress, during the actual disaster. The idea of having a written, memorandum of agreement, memorandum of understanding, an MOU, with partner agencies also surfaced as being important. Several States did identify that having partnerships was important, getting those partnerships documented in writing really reinforced the agreement and functioned best when you had a combination of strong relationships and those written documents clarifying each partner's role. Partnerships and collations of partners form the foundation for the kind of collaboration and coordination needed for disaster behavioral health services. Let's move ahead to our next slide. Building on our idea of a collaboration and coordination there were several other indicators that a disaster behavioral health plan demonstrated clarity in this area, clarity and collaboration and coordination with other agencies and organizations. While this is not a full list, when we do have the webinar focused on this standard, a lot more detail will be there but for today, some that surfaced to the top are documentation of understandings with the State emergency management authority. Whether the State, Territory, or tribal level, having that relationship in place, understanding roles and responsibilities clearly with the emergency management authority in that jurisdiction and clarifying specific responsibilities of State, county, and local agencies and their officers, specific individuals—what are their roles and what are their responsibilities becomes important in every phase, including deployment. For cities some other ideas came to the surface and that included ideas about partnering with public health departments, the American Red Cross, the VOADs, volunteer organizations. Other social service organizations that may be involved in mass care and disability services, mental health and substance abuse partners, agriculture, Department of Education. Where it applied, large employers who are critical stakeholders in the community and may actually have something to contribute and certainly would rely on effective disaster mental health or disaster behavioral health response in the wake of an event. There was a number of different ideas in terms of who partners would be. Everyone really came down in the survey to understand the importance of pre-incident planning, forming proactive partnerships and as you see, taking them to where they are going to be most critical during a disaster. Representatives in several examples, representatives of disaster behavioral health entities played a role and had a place in the State's EOC, emergency operations center. This becomes an important indicator for us. Representation at the EOC allows for and if we organize that pre-event, addresses issues of clear authority in terms of who will have a seat, who will have a voice in the emergency operations center when your State plan is activated. Here a

specific section of the plan can define not only who will staff the EOC but talk about what kind of equipment may be necessary, whether it is telephones, computers, software applications, what kind of clearance may be necessary to move in and out of the EOC, transportation issues and so forth. This idea of having a designated rep at the EOC becomes very important as an indicator. This is an interesting twist, one State reported that their disaster behavioral health representative to the EOC functioned as the emotional safety officer, or the safety officer in general at the EOC to help ensure psychological and emotional safety in the EOC environment. They had two hats there in the EOC at the same time. Another indicator was a clear description of roles and responsibilities of the regional offices of the State mental health authority. If the State or Territory or Tribe has offices across a large geographic area, the individuals in those various regional offices also had clarity and it was described well in the plan how that relationship and responsibilities were spread across regions where that applied. The last but certainly one of the most important indicators of collaboration is evidence contained in the disaster behavioral health plan of active participation of other stakeholders throughout the planning process. The folks are not brought in as an afterthought but that there is a voice given to those folks and there is a partnership for them throughout the whole life cycle of developing the plan. Working to get this buy-in helps ensure that those partners will fulfill their roles and responsibilities if and when your plan is activated. All that work up front in establishing and creating those relationships has very meaningful payoffs when we need them. A quick example—let me go back one slide. A quick example of standard one was team structure. One of the ways we did see and we did hear about team structure was using a NIMS-compliant idea. It is one you may be familiar with and the term is, span of control. You can recall in command training, span of control is simply the ratio of supervisors to workers, to counselors, or other disaster, mental health disaster behavioral health responders. Articulated in the plan, this same structure, the ratio, the degree or the way we supervise our disaster behavioral health responders during activation is in this NIMS-compliant way was another example with some other form of evidence of how we actually met that first standard of being NIMS compliant. I think I may have gotten one or two ahead of myself. Let me back up. I apologize for that. We should be here, talking about standard three. Standard three is about financial and administrative operations. Standard three talks about specifically those feature, financial and administrative aspects of the plan, the disaster behavioral health plan. Indicators for those standards were focused on important tasks, which is identifying sources of financial support and funding throughout the whole plan, throughout disaster behavioral health services including policies and procedures for preparing grant applications such as that for CCP or Counseling Crisis Program. Balancing the demands for actual disaster response during a crisis with the demands of the grant process development. Obviously, leaders can be pulled in several directions simultaneously when they are in a real disaster environment. Other indicators address staffing of a disaster behavioral health response, including team recruitment, hiring, organization, and communication with team members. Are they a pending disaster, putting people on a standby or standing them up or having mechanisms in place for the financial aspects pre-events? For example, one State had a feature where every behavioral health contracts with a provider—that was about 30 mental health centers, 50 managed care facilities, and more than 100 other entities—actually included a zero dollar addendum that can be modified when a response calls for a particular provider to involved or activated. Other States use budget letters for short-term needs or retainers and one State set up the zero dollar funding code specifically for disaster response to help facilitate swift action on budget approval in times of disaster. Once budget approval is secured that State can shift funds wherever it needs to under that zero dollar code, using that code. In the past funds could not be used until the right code was obtained. Doing this up front, getting that coding taken care of from an administrative and fiscal standpoint allowed for really nimble financial response to a disaster. I am going to motor through some of these slides a little quicker. I know that we have lots that we want to share with you today. Let me finish the last thought I have on the financial administrative operations. That comes from one State that shared or suggested that disaster behavioral health leaders, without strong backgrounds in financial management should make an effort to

get to know the people and processes in their financial and fiscal departments way ahead of a disaster but also become known to them so that those leaders in the financial departments have a better idea of the unique sorts of things that disaster behavioral health is called upon to do and how funding may need to be looked at and structured in somewhat of a different way, proactively to help facilitate rapid response. I am going to move ahead. I did just a moment ago talk about our team structures being NIMS compliant so I am going to jump ahead to standard four. Standard four is about activation and implementation. Some of the standards here do have that overlapping indicators. The EOC does come to the surface both in standard two and standard four. Here this is both a systems and personnel issue. It is important to have the right people representing the disaster behavioral health system in the EOC. Other indicators related to staffing include descriptions of how team members are selected, qualified, and trained to be disaster behavioral health responders as well as how they integrate with operations from public health and other entities during actual deployments. You may know that several States have begun to develop disaster behavioral health credentials and processes to incorporate these key elements. They make sure that folks have the appropriate NIMS and ICS training. Many of these also put people through a screening and selection process, some including a criminal background checks to ensure that we have the right personnel in place when we do activate. An important standard or indicator is some description of an action plan specifically to guide the first 24 hours of operation following a disaster. It is critical in that first 24 hours to launch any sort of activation or implementation properly in the wake of a violent or traumatic event. Articulating those action steps in the plan, the 24-hour section becomes very critical to you. One State had 10 disaster teams from around the State participate in a statewide webinar that featured an earthquake scenario. With the plan as their guide the team answered questions and completed exercises that helped them understand the first 24 hours and beyond. It helped them understand scalability in that event, the chain of command and in particular that sort of drill and drills across the board help participants understand that they should not deploy until they are asked and get clear instructions about where they are going in terms of staging. There are a number of good ways and a number of good ideas in our implementation standard that foster what I refer to here as response-ability. The ability to implement and activate your plan when called upon but that requires testing, participation of the stakeholders and even a NIMS-compliant idea of scalability that we began with several moments ago. Moving ahead, when we talk about standard five it is about clarity. That the plan does a good job of helping the reader understand the difference between what are traditional disaster mental health services and what are disaster-specific disaster behavioral health services. There is a useful graphic on this slide if you can look at the red cone on your screen. We move from the lower, the tight and narrow part of that cone, we call low-volume, high-intensity services, one-on-one crisis counseling, up to high-volume, low-intensity services such as public service announcements. The plan, as we craft our disaster behavioral health plan actually reflects an entire continuum envisioning how we may use all of the different tools available to us in a disaster environment across this continuum. Beyond that, if we move ahead to the next slide, a graph that many of you may be familiar with, does a great job—this is one that I would encourage people to share with partners who may not be as clear about disaster behavioral health services and how they differ. It helps make a striking distinction between what are traditional forms of mental health and substance abuse treatment and what is the crisis counseling that we do out in the wake of a disaster environment. An important standard is clarifying this in the various ways that you should set in the plan so that readers understand and can act upon those differences, knowing how and where they would fit in with the overall continuum of behavioral health services that exist in your State, Territory, or Tribe. Standard five talks about a range of services, clarifying those. One of the first bullets you will see as we move forward, the importance of active stress management for your responder teams. This typically comes up and many coordinators do appreciate and some incorporate descriptions in the plan. It is important to document it in the plan but not just as a post-deployment sort of activity. In fact, what we see is when the plan actually described a cycle of stress prevention or stress management activities for disaster behavioral health responders that begin from the onset of the disaster

through deployment and post-deployment as well. That may also be described across different shifts in terms of rotations and breaks, not just in terms of mobilizations and demobilization. Addressing specific stress management activities, describing who will provide those and how they will provide a timeline, all become important to the reader and the user of the plan to understand the importance of the responders stress and how it is incorporated into the larger planning effort. Standard six—I did mention several times, there will be a webinar specific to each one of these standards. I am only touching on a few of the indicators today. Standard six addresses logistical support. Very clearly, one of our coordinators in interviews said that this aspect of the plan should not be taken lightly. A lack of logistical planning can undermine what could otherwise be a very solid plan. This is not necessarily someone else's job. When we talk about logistics in this context, we have to understand our partner's goals and how they will provide logistical support. We also have to think about in the context of the DBH plan and DBH teams. It is important for State coordinators to understand not just logistics for their in State, Territory, or tribal use but also the larger concept of EMAC and ESAR-VHP and things like the Medical Reserve Corps, how all of those fit together in addressing response and how logistics may be driven by some of those relationships as well. Some things that may be shared and some services that may stand alone. Here are some examples of how we describe logistical support in a disaster behavioral health plan. Listing titles for and visually identifying the disaster behavioral health responders. If they are going to wear specifically identifying clothing such as a lanyard, a jacket, a hat, a T-shirt, spell it out in the plan so that other teams looking at that, other partners as we go through out planning cycle will understand what our teams look like and how they operate. Those visual identifying items are useful for teammates finding each other, for supervisors being able to spot them, and also for incident managers looking at the big situation to be able to pick us out. Beyond that, describing a process for using and coordinating and supervising volunteers who may come into the mix, discussing how disaster behavior health personnel may cross-train with other disciplines, such as public health. Those are all part of logistics. As with some of the other standards that we have touched on, exercising is a great way to surface logistical needs, rather than in a static planning mode, envisioning, trying to imagine. Once you put boots on the ground in an exercise environment a lot of the logistical concerns do start to surface quickly and those are great lessons learned. If you needed it during the exercise there is a very good chance, whatever that logistical element was, and you will probably need it during a real deployment as well. Going quickly to the last of our two standards is standard seven, clarity of legal, regulatory, and policy authority. As with everything else that we do, just like I mentioned earlier, you don't want to be meeting your fiscal people or explaining what disaster behavioral health is all about during a crisis. The same goes to those who are in charge of our legal or regulatory departments. They need to know specifically the sorts of things that we need to know, the things we do. We need to make sure that we articulate that in the plan and likewise that they can support us well during an actual deployment. Some of the things that continually come up in disaster behavioral health services and really benefit by being articulated in a plan are things like background checks for our responders, and how screening occurs. HIPAA and other confidentiality regulations, workers compensation, mandatory reporting, and things like volunteer protection statues; where they exist should be incorporated in that plan in a way that the user of the plan, the readers of the plan have a good sense of how that all comes together. On that note, as you include that in the plan, certainly a strong recommendation, is that you tie back and include citations to the different legal authorities and references that you mention in the document so when push comes to shove and the challenge is "where did that come from" it is right there, it is all self-contained in the plan. Memorandums and agreements, citations, liabilities and insurance sorts of issues all together in that legal/regulatory sort of way. I am going to jump ahead one slide. We are getting close and I want to make sure we leave some time for questions. We close out with plan maintenance and updates. This is the end of the planning cycle. In that section of a disaster behavioral health plan, identification who is responsible for maintaining and updating the plan, a timeline for when it gets updated for scheduling, schedules for training and exercising. All of the various forms and

formats the plan will be kept in, whether it is paper or electronic, all need to be articulated in how plans are maintained. The last thing on that note as we move ahead is the idea that what if we have to do something, ad hoc to amend the plan, is there language in there that talks about how we would actually do that on the fly if you are challenged with something very unique, very novel as a crisis or disaster event. I am going to stop there. I probably went a little further than we would have liked. Questions, comments that we have been gathering, now is a great time for us to put them in the table and see if we can address a few of them.

Moderator: Thank you so much Steve. This is when we open it up to questions. This is a reminder to submit your questions through the chat feature now if you have not already.

Steve Crimando: Becky has a question for Nicole and Amy. Do we have a date for the next webinar yet?

Amy Mack: We have the Financial and Administration Operations and that is July 21st at 2 p.m. eastern time with Anthony Speier, Tony Speier which many people are fairly familiar with Tony.

Moderator: We do have one question for Steve. Do you have any evidence or records relating to tribal-based disaster behavioral health?

Steve Crimando: I threw the question back to the group, as well as to Amy and Terri. I don't have any great examples specific to tribal disaster behavioral health plans. Unfortunately my strength is probably in the States and I have lots of good examples there and I am short on tribal evidence.

Moderator: Terri would you like to add anything to what Steve just said?

Terri Spear: I do. SAMHSA has been working with tribal entities to encourage the development of disaster behavioral health plans that would meet their community's needs and be culturally sensitive. We do have a technical assistance center outside of DTAC that has begun working with the tribal units on identifying what disasters they would want to plan for and efforts are underway. We currently do not have any of the disaster plans for the tribal units. We do work very closely with the Indian Health Service in meeting the behavioral health needs when a disaster does occur. The answer is kind of yes, kind of no.

Moderator: This is another chance for everyone to submit questions. Does anyone have any other questions? Unfortunately we will not be able to pose questions to the group because we did have one person with music that was distracting. If you have any other questions this is your last chance, please enter them into the chat feature. We are going to close out. Thank you everyone for participating. Amy or Terri are going to address future, upcoming webinars. Terri, if you could take it away and close us out for the day.

Terri Spear: Thank you. This activity closes out the first of our disaster behavioral health planning webinars. The next step that we are looking for, as stated earlier, the next will address financial and administrative operations; it will be held on July 21st at 2 p.m., featuring Mr. Anthony Speier. We will look at what the financial supports and funding streams for disaster behavioral health care and describe what goes into developing those types of relationships and we hope that it will be useful. Other upcoming webinars—here is a listing of the other upcoming webinars. We hope you see as many of you participate.

If you know of others that would benefit from detailed explanations on each one of these criteria and issues, please forward the registration information to them and have them register for the seminar. We would hope to have all of you back again. That concludes this seminar.

[End of session.]