

Promising Practices in Disaster Behavioral Health Planning: Legal and Regulatory Authority

August 18, 2011

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. Let's begin with Promising Practices in Disaster Behavioral Health: Legal and Regulatory Authority. 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. Andrew Klatter, Assistant Deputy Director of the Office of Addiction Services and Disaster Management in the Indiana Family and Social Services Administration. We will start with Ms. Terri Spear. Ms. Spear serves as Emergency Coordinator in the Substance Abuse and Mental Health Services Administration, 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's of education in counseling psychology from the State University of New York at Buffalo. Please welcome Ms. Terri Spear.

Ms. Spear: Thank you. SAMHSA wishes to welcome all of those accessing this webinar. The development of this series is directly linked to the efforts SAMHSA included in its March 2011 document, *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 initiative falls under trauma and justice. Just today, which is August 2011, a report was released indicating with 4 months remaining in the year 2011, the United States has already tied its yearly record for the number of weather disasters with greater than \$1 billion or more of economic loss. This probably is not coming as a surprise to anyone in the disaster field. However, research has shown that 18.9 percent of men and 15.2 percent of women in the U.S. reported a lifetime experience of natural disasters. We also know that over the past 10 years the number of disasters occurring across the country ranges between 65 and 100 federally declared disasters and that many more occur that are not declared. The role of planning is clearer now than it has been in previous years. Planning is of utmost importance and this series is focused on disseminating the best of what is known, equip the best response possible with the resources at hand. Today's program is roughly 60 minutes in length and is the seventh in a series of nine webinars that are being produced.

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 2009. She has worked in the public and private sectors, often addressing issues of violence and trauma. She's 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 and hello everyone. For those of you who are joining us for this series, if you have joined us before, welcome back and for those of you who are with us for the first time, welcome. I would like to follow up as to what Terri just shared in terms of thinking about planning materials that do exist. Part of what I wanted to take a few minutes to do is to let you know about materials that we have at SAMHSA DTAC. Basically SAMHSA DTAC's mission primarily 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. For a point of clarification, when I use the term disaster behavioral health, or DBH, please note that this term is referring to both mental health and substance abuse issues. As you can see on the screen, we have a brochure and you can download it for free from our website. I will provide the link to that website shortly. On the next slide you will see an overview of these three different areas of free services that we offer. They include consultation and training and that relates to things focused on disaster preparedness and response, such as, compassion fatigue training and also 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 presidentially declared disaster grants, such as the FEMA Crisis Counseling Assistance and Training Program, also known as CCP. We also have identification and promotion of promising practices. A great example of this is this webinar series that we have been producing. 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 web page 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 DBH preparedness and/or response; information about specific kinds of disasters such as floods, tornadoes, hurricanes, and so forth; and also information on the specific populations, some of which I mentioned earlier. On the next screen is the list of our various e-communications. We have the Bulletin, which is our monthly newsletter and it contains relevant resources to particular topics that are current. For example, with the hurricane season coming soon you will see the Bulletin will focus on resources related to the hurricane season. We also have The Dialogue, which is our quarterly publication which is written by disaster behavioral health professionals in the field. Lastly, our Discussion Board—this is a great mechanism for DBH professionals to ask questions of each other, share comments and information, and really discuss DBH-related topics with each other. Ways to subscribe are on your screen. Last, as promised here is our contact information. 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. Of course, be sure to visit our website too and 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 Dr. Mack. I would now like to introduce Mr. Andrew Klatte. Mr. Klatte has worked in the field of mental health and developmental disabilities for 28 years, the past 21 years of which were with the State of Indiana. He is a nationally known speaker and has presented on the topics of psychological aspects of terrorism, disaster preparedness, and mental health planning and response. Mr. Klatte was the point person for the mental health teams that were deployed to Mississippi following Hurricane Katrina and to Haiti following the earthquake in 2010. He is also the Director of Project Aftermath, which is supported by the Crisis Counseling Assistance and Training Program and has responded to 11 major, federally declared disasters in Indiana since 1997. Please welcome Mr. Klatte.

Mr. Klatte: Thank you very much and thank you to SAMHSA DTAC for hosting this most important webinar. As we begin to put our disaster behavioral health plans together, one of the areas that is most

important is to make sure that we have the appropriate authority to act. This authority can take many shapes and sizes. The reason why we need this authority is because it really helps us to begin to understand the whole disaster response system. What DTAC did with their emerging practices the last few months is that they have looked at a number of State plans. They found some indicators of what a plan should have as far as types of legal authority. This would include citations of that legal authority, the process for developing, and how quickly you can obtain a memorandum of understanding or a mutual aid agreement. An issue that we all have to deal with, whether you are in fire or emergency medical services or in disaster behavioral health, is how is liability addressed in our plans and how does insurance work, how does workman's compensation work. Since we are not doing the traditional type of therapies, mental health therapies or substance abuse therapy, what about confidentiality and informed consent; how is this maintained and how is informed consent obtained following a disaster. Why is it important that we look at the issues of legal and regulatory authority? All responders who respond to a situation or an event are doing so under some type of legal authority. As I said before, these legal authorities may take on different shapes of the law or statute or code or policy or maybe an MOU between agencies or a mutual aid agreement. The city or county and local jurisdictions may take the form of an ordinance or on the State level, an executive order or directive of some type. By having this type of legal authority it really helps to minimize the confusion of who will respond, what jurisdiction is in command, and when and where is the help or assistance coming from. Those of us providing disaster behavioral health response, what we really need to do is mirror what is being done in all fields of disaster response. Let's begin by looking at what statutes are out there that address disaster response. The first slide that we are going to look at will address the Federal response. We have the legal authority through the comprehensive emergency management plan. We have the Stafford Act which also has listed under that the Crisis Counseling Program, disaster mental health. We have other access support, the Federal Government on what they can and will do following any type of disaster. We have the National Response Framework and that is similar to what each State and local jurisdiction has, part of the comprehensive emergency management plan. This plan, like their counterparts at the State and local level, include all 18 Emergency Support Functions. Please be reminded that behavioral health is under the Emergency Support Function 8. When we look at what is available at the State level all States have a statute, and I am sure this is true for your State, that addresses who and what type of responder will respond after any type of disaster event. Each State, all 50 States and Territories, are now members of the EMAC, which is the Emergency Management Assistance Compact. What this does is give States the ability to request from other States assistance following large-scale disasters and those States that are coming in to provide that assistance are given liability protection, given the fact that they can work under their scope of practice by coming to that State. EMAC is a very important way of having a response from another State and having that legal authority to do that. Often the statutes that we have at our State level, they also mirror the Federal legislation. This would be an example of the authority that the State would have in a disaster response. The Governor's executive orders which would be very similar to a Presidential directive, these orders are often given soon after disasters, most of the time in declaring a State a disaster the Governor will issue an executive order mandating that all State agencies under the executive level will be able and working in that disaster. States also have the comprehensive emergency management plan that mirrors the National Response Framework that they also include all 18 Emergency Support Functions and in those, how the State will provide that response. Again, disaster behavioral health is listed under the ESF-8 at the local level as well. We really need to remind ourselves that disaster events are local and they really do require a bottom-up response. That is the local response. The first response of these events would rely on local ordinances for that local responder to respond when the situation warrants it. Then there are mechanisms within local jurisdictions that when triggered, when the event is beyond that local government or tribal jurisdiction, that would then require the State to come in, just like there are triggers at the State response that when it is beyond the State control, to allow the Federal Government to come in and help. There are triggers in these authorities. This

would be the example on the slide of local jurisdictions. Again, it would mirror the State. Often in State statutes these are the local ordinances or statutes or extensions of the State statute, oftentimes creating local emergency management agencies and that sort of thing. All local jurisdictions just like the Federal and just like the State are required to have a comprehensive emergency management plan that addresses all of those support functions. All 15 Support Functions are listed and they also need to address the ESF-8, health and medical, which is where we will find the behavioral health response under the ESF-8 Support Function. When we begin to develop our disaster behavioral health plan, the legal authority, one of the things I think is very important, it should be clearly defined. We need to ask ourselves the following questions: Under what authority are you developing your disaster behavioral health plan? Is it under a statute? Is it in code? Is it under an executive order? Is it a policy within your agency? Memorandum of understanding, a mutual aid agreement? As we work within the comprehensive emergency plan it is very important for us to find out who the lead agency is under Emergency Support Function 8, health and medical. It may be your health department. It may be your emergency medical services. Are you currently working with or have you identified who that ESF-8 agency is that you are going to be working with? Is your plan being written as a policy for your agency or is your plan a standalone plan or is your plan—it could be all three. It could be a policy, a standalone plan. It could also be an annex to the State CEMP or the State ESF-8 plan as well. In Indiana in our disaster behavioral health plan it is clearly stated in two places where we are codified in State statutes. The disaster behavioral health is mentioned in Indiana code as a responder so we are within the State statute. We are a part of the overall State emergency management plan disaster response. Disaster behavioral health is mentioned and we have also developed within our own department and through our own Policy Development Committee and has reviewed our State plan and all of our revisions with our director signing off. In our plan, because it is all one plan, it clearly defines who can respond. It clearly defines that we will use and define the Incident Command System. It also includes procedures imbedded into our plan that clearly state how and when our disaster behavioral health teams will respond. Our plan is an annex to our overall State emergency management plan. We also have an annex to the ESF-8 plan. Both of these agencies, our State Department of Homeland Security as well as the lead agency for ESF-8, has reviewed our plan, their staff has reviewed it and their leadership has signed off on our disaster behavioral health plan. That kind of gives us that level of authority in order for us to make an appropriate response. The next few slides are clearly listed. This is taken out of the Indiana plan, what these legal citations would look like in a disaster behavioral health plan. The executive order that is listed on there, 05-34 and 05-09, those are executive orders that were established declaring a State disaster and that all State agencies would respond appropriately. For the next couple of slides it lists what a legal citation would look like if it was a part of your disaster behavioral health plan. Part of the reason why we are looking at the authority and regulatory issue when it becomes part of a disaster response is one of the issues that is constantly brought up at responder training and in policy meetings, the issue of liability. People want to know if they respond, if their agency responds, if the State asks for folks to go out and respond following a disaster, what is the liability in the event that one of our responders is hurt during that response. What is the risk? What is the liability that people would have? That is a really good question and that is a question that we all need to take very seriously. It has to be spelled out very clearly to everyone, whether it is our leadership or responders or other responders, everyone needs to understand that risk is involved in any type of response and has to be clearly stated that if a person is going to respond following a disaster that there inherently is some risk and it doesn't matter if it is fire, EMS, hazmat, disaster behavioral health; there are some risks involved. While we can't do away with risk there are certain things that we can do in our plans to help minimize some of this risk. Some of this can be written into our plans that liabilities may be mitigated by clearly defining the role of our responders, what is it that we are asking them to do. We need to have clear information on understanding the workman's compensation laws for your State. We would have to get—in our State it would be the Department of Labor involved. The staff at your emergency management agency probably

has already addressed some of these issues as they are learning and working with their responders as well. Descriptions before the disaster, the responsibilities of the responder, that we really don't want our responders getting outside of their lane, that they are there to provide a disaster behavioral health response. They are not there to help cut down a tree that they have to maintain work within the scope of their practice. I am telling you, training, training, training, is a really very important part of talking about liability and talking about risk. Having open discussions during your training about a risk as a response. Let me go back for a second and talk about the Good Samaritan law. One of the things that I would do is look and contact your staff attorney or your emergency management attorney or attorney general to see if your State does have a Good Samaritan law and would that apply within your agency. One of the things that is very important to help mitigate some of the liability is that requiring all responders, all disaster behavioral health responders to complete the NIMS training. It is free online for FEMA. It really does help people understand the whole issue of incident command and what that looks like and how we fit under an Incident Command System. It should be mandated before anyone responds. Another way that liability can be mitigated is by working with your emergency management agency and having the disaster behavioral health response work under the State liability, as an asset of the State response. As we are looking at our disaster behavioral health plan, does your plan include the following features: clear and concise supervision and team management plan, including an organization chart. One of the things that responders want to know is who is in command, who is their team lead and be able to work under that Incident Command System. It is very important that in our plans we have very clear and concise supervision and team management plan. It is also important in our plans that we have some really concise language on policies and procedures for our responders, including a very vigorous application process. Folks who want to do a behavioral health response go through; that includes training, the completion of the required NIMS, a medical screening, interviewed by the team leaders and other folks. An orientation to a code of conduct or a code of ethics are also important. If you don't have a code of conduct or a code of ethics I would certainly recommend that you develop them. Under no circumstances would our disaster behavioral health team self-deploy. If you are working under an Incident Command structure you would have mission assignments, requests from Homeland Security or from your emergency management agency requesting disaster behavioral health teams be deployed. That also offers a sense of authority and regulation that we are working under the Incident Command System. Most of our State department also have the use of policy development committees. Most State statutes that talk about creation of State departments it gives us the authority to develop polices to carry out our official duties. One of the ways that we can have some of this authority is to have our disaster behavioral health plans reviewed by, looked at, vetted by our policy development committees. Some of the examples of a disaster behavioral health policy would be a development of a disaster behavioral health committee that helps oversee training and exercises, that sort of thing. The actual establishment of our disaster behavioral health teams could be a policy by our department. Certainly the code of conduct and our ethics for those who are responding have those codified through the policy mechanism. In those policies it should be clearly spelled out, the roles and responsibilities of the responders. Those polices should also clearly state who and what and under what authority the responders will be deployed to a disaster. Also I think it would be very important in our disaster behavioral health plans to begin to identify and look at what other agencies are looking at. Who are those other agencies we are working with? What are their roles? How will we coordinate with those other agencies? Whether it be Red Cross, NOVA, chaplains, how are we going to coordinate with them? Who is going to do what? Have these agreements and information spelled out before the disaster. You certainly don't want to try to work out agreements and that sort of thing during the disaster. It is quite difficult. Have these agreements worked out prior to the disaster. Another way to address the issue of authority may be that our plans would have some type of agreements with these agencies that we are working with. As we begin to identify who else we will be working with and identify how we work together it might be a good idea that perhaps we want to go and formalize these types of relationships

before that disaster occurred. It would cut down on confusion. It would cut down on who is responding it cuts down on whose turf issues and that sort of thing. If you had this in some type of agreement, are these folks that you are working with also working under the Incident Command structure. I want to go over briefly two ways that we can do this. We can do it either through a memorandum of understanding, which is a document describing bilateral or multilateral agreement between parties. This really is a way that folks who have some common interest spell out who is doing what and integrating some of those services. An example of an MOU might be that your disaster behavioral health team and the Red Cross mental health folks may have some mutual interests. A lot of the Red Cross folks may be working in shelters. Our folks may be working in the community and can we provide some cross training and work together in order to have more comprehensive response. MOUs are a way to do that. A lot of folks in the disaster response field understand and know about mutual aid agreements. These have been quite common for many years, especially in fire departments where you would have a mutual aid agreement between counties where if one county is being overwhelmed in an emergency response such as a big fire, another county would provide assistance to that county and these understandings usually take a form of personnel, equipment, materials. They usually can be done pretty rapidly. Sometimes they are done during that disaster but a lot of times mutual aid agreements are done beforehand and these are quite common in disaster response, especially with fire and that sort of thing. An example of a mutual aid agreement might be there may be a district mental health team that would go over and provide assistance to another district. They would have the mutual aid agreements done beforehand where either side could activate it and request assistance from the other. We are going to go through very quickly the elements of the memorandum of understanding. You have these on your slides so I won't go over it too much. We have an introductory section. We have the purpose section. The introductory section is probably the one that we really want to make sure that you have some really clear concise language on why the MOU is necessary, what are the agreements that are going to be set forth in this MOU. Then we have the scope section, what are the capabilities that this MOU is going to apply to, what it is that you are wanting done in this MOU. What it is that you are going to provide each other is spelled out in the scope section as well as the definitions. We all have different terminology for everything that we use. Crisis counseling may be one entity and it may mean something different to someone else. Debriefing may mean one thing to one group. It may mean something to another group. In the MOU we want to make sure we have common language and a good way to do that in our MOU is to have a definition section. Then we have the policy section that spells out when and where and who is going to authorize the use of this MOU, who can activate it. Who is going to be the one to actually implement this MOU? Then we have the user procedure section which talks about what trainings are available and are trainings going to be cross training. Will I accept the training of your group if you accept the training of our group? All of that can be spelled out in the MOU. Then we have the oversight section where we are looking at who is going to provide that oversight, the updates. One of the things that I really like is that standard operating procedure, the compliance section that if you sign this MOU you will agree to use your procedures. I have the copy of your procedures. You will have the copy of mine that those SOPs are going to be followed as well as the updates later on if we need to update our MOU. The other thing I want to talk about briefly are these mutual aid agreements. These are done to establish terms and conditions by which either party may request aid and assistance from the other. These are a little bit less formal than an MOU. They can be done quickly. They can be done specific for that particular response agency. The mutual aid agreements that I am familiar with are usually long-lasting mutual aid agreements where primarily disaster response folks will provide mutual aid to each other following any type of big disaster where my agency is being overwhelmed and I need additional assistance from your agency. What I like about these two is that the agreement date usually is a day of the actual signatures. Once that party has signed it and signed off on it then that is the date of the execution of the mutual aid agreement. A lot of times these mutual aid agreements, what a lot of agencies like about them, there is usually no reimbursement because you are assuming that if you come and provide aid to me, I will be able

to come in and provide aid to you and there won't be any reimbursement costs, or very little reimbursement costs. As we are looking at the legal, regulatory, or policy authorities it should be very clearly stated that the disaster behavioral health plans need to address some of these issues: liability, confidentiality, how we are going to implement the memorandum of understanding, how we are going to implement the mutual aid agreements, confirmation that your plan is looking at HIPAA. You need to work with your HIPAA compliance officer. Discuss with him or her the role of disaster behavioral health following a disaster. Who are the people who are going to respond? What are their licensing, their credentialing, and who are you working with, survivors, responders. All of that needs to be spelled out very clearly in your disaster behavioral health plan. How will you document your interactions with those folks that you work with? That is very important as well. Other issues that we need to look at is this whole issue of confidentiality. A lot of States—what a lot of people have done is have responders sign confidentiality statements that the work that they do, the people that they see will have that measure of confidentiality. The plan should also address clear and concise management plan. Who is going to be in charge of your team? Who is going to be able to activate your team, deploy your team, and under what authority? Plans should also address the mandatory reporting requirements, adult protective services, child services. How are you going to deal with a survivor that is dealing with suicide? These are issues that need to be addressed in your plan as well. Your plan should also include the process for credentialing. I know there has been lots of talk on credentialing, registering responders. How will we do that? Our plans probably should also deal with reimbursement issues. Are we going to have some reimbursement issues from our response and how are you going to be able to reimburse responders, agencies, and that sort of thing? As we are looking at different States' plans and some of the cool things that a lot of States were doing, listed here are just some of the best practices that DTAC and others have found in our disaster behavioral health plans. State liability coverage is in State statutes and district team structures in State statutes. The disaster behavioral health people have a seat at the State emergency operations center, which also includes the legal desk. Disaster behavioral health is listed as a State asset under the State homeland security department and this provides a level of authority when deployed by the State. That the State mental health authority provides a legal requirement for background checks on all responders. These are some of the best practices that came out of plans that were reviewed. We will quickly talk about confidentiality and informed consent. We know that most of the time we are not required to open up medical records on the people that we serve so we have to make sure that we do document, that we do somehow figure out how we are going to record information, not necessarily names. I would have all of those in place before the disaster because our policy directors and emergency management folks will want to know how many survivors you met with, what their issues were, and that sort of thing. Be prepared to document. Informed consent is very important; I think it is important that we train our staff on how they approach survivors. That they need to be very clear of who they are and why they are there and who sent them. This is very important to be clear because most people, after disasters, have trouble concentrating so they may need to be reminded who you are. It is very good to have training as part of training curriculum on how to approach survivors. Disaster mental health programs do not require that medical records be opened or maintained but a lot of States and some States have a code of conduct that addresses confidentiality and making sure that the confidentiality is part of that persons license or profession certainly carries on over to the disaster behavioral health. The next step for when we start developing our own plans, I would contact our homeland security folks, your emergency management folks, and get copies of all of the relevant laws. I would contact your legal staff and legal staff at emergency management to see how you could get disaster behavioral health implemented into State statute or work through existing policy development. You need to find out who your Emergency Support Function 8 lead and I would survey community agencies that you are currently working with to see if there is a need to formalize that relationship. With that, I am finished and I will be happy to take any questions.

Moderator: Thank you so much for your presentation, Mr. Klatte. We have three questions for you. I will read you each one and give you some time to answer. Can you further explain how you think the Incident Command System liability can be mitigated?

Mr. Klatte: All responders are required to work under the Incident Command structure. What that does is it really prohibits a lot of responders from going out and actually self-deploying. That you wait until there is a request for your services. As disaster behavioral health people we need to wait until some jurisdiction, local, State would want a disaster behavioral health response. What that will also do is by running this through the Incident Command System there is documentation that certainly is part of that that we all have to keep track of, mission assignments, who is assigned that mission and what was the followup that was done. I think it really does help with cutting down on responders self-deploying.

Moderator: You mentioned the use of having a code of conduct for responders. What are some examples of this?

Mr. Klatte: From what I could put together some of the code of conduct that responders have put together in our State and other States is such as that responders will follow the National Incident Management System. That you will maintain confidentiality, that you will respect, honor everybody that you are working with. That there is—most responders wear uniforms so that part of that conduct is that you are part of a team so you are there as part of a team. You are not there self-promoting or anything like that. That would be part of a code of conduct. A code of ethics would be following the code of ethics for your own particular discipline or license and that you perform as part of a team that provides services in accordance to the approved models that has been outlined by the State or by the overall authority for disaster behavioral health.

Moderator: Do our responders need to have a consent form signed by a survivor before they can talk with them?

Mr. Klatte: Again, I would check with your local legal folks. I would think not as long as you identify who it is that you are, why you are there, and under what authority that you are there. Giving that person the option if they don't want to talk, they certainly don't have to engage you at all. They can say, "I don't want to talk." I don't think you need to have an informed consent as long as you are telling that person exactly who you are and they certainly have every right to not want to talk to you if that is their choice.

Moderator: Thank you Mr. Klatte. We have had one question come in via chat. We wanted to check in and see if you knew by any chance how many counties or States incorporate and cover healthcare coverage for all responders when deployed?

Mr. Klatte: Healthcare coverage? From what I understand for responders, fire, police, and that sort of thing, they would have their health coverage part of their occupation. As far as disaster behavioral health, I don't know if any of that would cover health care while on deployment. They would probably have to use their own insurance.

Moderator: Thanks so much Mr. Klatte. Ms. Terri Spear has some closing remarks for us.

Ms. Spear: Thank you very much Mr. Klatte for your informative presentation. This section concludes the Legal and Regulatory webinar as 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.

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

Dr. Mack: Thank you. As you see on your screen the next webinars are Integrating Your Disaster Behavioral Health Plan and that takes place August 25th at 2 p.m. eastern time. That is featuring Mr. Steve Moskowitz. The last one, Plan Scalability, that is August 30th at 2 p.m. eastern time, featuring Dr. Anthony Speier. As promised to give you contact information so that you have it if you want to follow up with us you can feel free to contact me directly or any of our technical assistance staff at the toll-free number on the line or by emailing us. Lastly, I want to thank you Mr. Klatte for your time today. We do recognize it has been a very difficult time for you and for the staff who has needed to respond to the recent tragedy in which there was a concert stage that collapsed. Five people were killed and 48 were injured. We know that it has been a difficult time. We appreciate you taking the time to share your expertise with us today and we greatly appreciate that.

Moderator: Thank you Dr. Mack and thank you all for participating in the Promising Practices in Disaster Behavioral Health: Legal and Regulatory Authority webinar.

[End of session.]