

Promising Practices in Disaster Behavioral Health Planning: Plan Scalability

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Moderator: Let's begin with Promising Practices in Disaster Behavioral Health: Plan Scalability. The webinar will feature Ms. Terri Spear, Emergency Coordinator of the SAMHSA Office of Policy, Planning & Innovation. Ms. Lori McGee, Training and Curriculum Manager of SAMHSA DTAC and Dr. Anthony Speier, Interim Assistant Secretary for the Louisiana Office of Behavioral Health. We will start today 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 a 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 the series of which this webinar is one 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, present behavioral health problems, and promote better help. This initiative falls under trauma and justice. Research has shown that 8.9 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 many more that occur that are not declared. A critical component of planning of disaster response is planning and it is of utmost importance. This series is focused on disseminating the best of what is known to equip the best response possible with the resources at hand. I look forward to hearing from Dr. Speier as we continue this webinar.

Moderator: Thank you, Ms. Spear. I would now like to introduce Ms. Lori McGee. Ms. McGee serves as the Training and Curriculum Manager for SAMHSA DTAC. She has more than 11 years' experience working with program and curriculum developers to improve services using evaluation findings. At SAMHSA DTAC she supervises the development of training, both in person and web based. She is also the lead on the Crisis Counseling Assistance and Training Program activities. Ms. McGee has worked with at-risk and delinquent youth populations, populations receiving mental health services, women and families in crisis, and minority students. She has prior experience in providing counseling and legal services to survivors of domestic violence and in developing programs to reduce and prevent violence in schools. Ms. McGee holds a bachelor's in psychology from Barnard College and a master's in criminology and criminal justice from the University of Maryland, College Park. Please welcome Ms. Lori McGee.

Ms. McGee: Thank you and welcome to the last webinar in this series. We are grateful for all of you who have joined us and we look forward to hearing your feedback on the series. I want to take a couple of minutes for those that are joining us for the first time to tell you a little bit about SAMHSA DTAC. Our mission is to support States, Territories, and Tribes to prepare for and deliver an effective behavioral health response to disasters. When we say behavioral health we include both mental health and substance abuse in this response. We do that by providing several types of services. One of those is consultations and trainings. These are on disaster preparedness and response, acute interventions, promising practices; can be geared towards special populations. We do that in a variety of ways. We also provide dedicated training and technical assistance to disaster behavioral health response grants such as FEMA's Crisis Counseling Assistance and Training Program. I know many of you are familiar with that, CCP. We also do identification and promotion of promising practices in disaster preparedness and planning. Obviously this webinar falls into that category. Also, identification and promotion of promising practices and integration of DBH into emergency management and public health fields. We have those services and we also have resources. One of them is listed here. We provided Disaster Behavioral Health Information Series. We referred to that as our DBHIS series which contained themed resources, toolkits on these kind of topics that you see here. DBH preparedness and response, specific disasters such as a flood or tornado or, more timely, a hurricane; specific populations, there may be resources geared toward children and youth or public safety workers. All of that can be found on our website. You can go to our website and look up by topic area and get a multitude of resources, pamphlets, handouts, brochures, links, etcetera. In addition to those resources we have a few e-communications that help everyone stay abreast of what is going on in the field. We have the SAMHSA DTAC Bulletin, that is a monthly newsletter that contains resources and upcoming events and you can subscribe by emailing us at the address seen here, DTAC@samhsa.hhs.gov. We also produce The Dialogue that is a quarterly journal of articles that are written by professionals in the field. You can subscribe by going to the SAMHSA website and entering your email address and go through the process on selecting SAMHSA's Disaster Technical Assistance Newsletter as your preferred publication. Finally, we have the Discussion Board, SAMHSA DTAC Discussion Board where we post resources and upcoming events, we ask questions of the field, get discussion going on various topics or things that have come to light in the field and you can subscribe by registering at the web address listed here on your slide. Finally, here is our contact information. If you have any feedback regarding the webinar series itself or you find yourself in any need of training or technical assistance related to disaster behavioral health, we encourage you to call us. We have a toll-free number, email, and a website all listed here. Our Project Director, Dr. Amy Mack; she always looks forward to hearing from those of you that have questions or needs in the field. Her phone and email are listed here as well. Thanks for joining us.

Moderator: Thank you so much Ms. McGee. I would now like to introduce Dr. Anthony Speier. Dr. Speier serves as the Interim Assistant Secretary for Development in the Louisiana Office of Behavioral Health. He has served as Deputy Assistant Secretary for the Office of Mental Health and chair of the adult services division of the National Association of State Mental Health Program Directors. He is also currently overseeing the Deepwater Horizon Oil Spill Recovery Operations. Please welcome Dr. Anthony Speier.

Dr. Speier: Good afternoon everyone. Thank you for joining us. As Terri said, this is the last in the series of webinars and our topic today is scalability. We have four very straightforward goals that build on a number of the other seminars as well. The first is increasing the awareness of the National Incident Management standards and its relationship to disaster behavioral health planning. This has been an ongoing theme and another example of how that integrating is essential. The second goal is to demonstrate

ways to integrate your disaster behavioral health plan with either your State, your Territory, or your tribal emergency response plan; always remembering that the DBH plan is in a disaster a subset of a larger response strategy in your State, Territory, or tribal area. The third is to share approaches about planning and lessons learned. Planning is a dynamic process. It is always changing and it is always getting better by its ability to be more responsive to the current structure in your State and community. Finally, provide an overview of services and resources that are available from various disaster behavioral health sources within SAMHSA and DTAC and elsewhere to assist in disaster behavioral health planning. The indicators of scalability are the following four items: written instructions, procedures for planning and future readiness as expressed in your operational plan. You will see throughout all of this an emphasis on memorializing or formalizing your planning and its scalability features because you can't count on the same people always being around. Second, is the standard operating procedures for implementing a disaster response and later on in this webinar you will see a very specific description of how to build a standard operating procedure. The NIMS guidelines associated with it and adaptability of plans to disaster type and scope. Additional indicators are having separate sections and annexes specific to high-probability events. Take for example the latest storms we had up the eastern seaboard. For some of those States a hurricane is not a high-probability response where in a Gulf State a hurricane would be a high-probability event. Chain of command is emphasized or specified; that is essential at each level of the response. Your communication plan has these three major components: it is inclusive of the situational assumptions, alternate communication methods, and equipment needed. When you are thinking of alternative communication methods you need to be thinking about texting and also about couriers. If no electronic method is available to you, what are some other physical means? Do you have vehicles and staff assigned to do just that, courier information? Then your scalability of your plan should show the cascade of authority among the different agencies and hierarchical as well as lateral manner. Your plan also should describe concept of operations. "Concept of operations" you will find is a term used in the NIMS model and it basically includes the following: your goals and objectives, the strategies and tactics, policies, and constraints. Being clear on these are really the boundary conditions that you have to be clear upon because the lines of authority and responsibility get blurred in the chaos of a disaster event. Going forward with these other areas of a concept of operations, you need to recognize who the organizations are, activities, and what the interactions are among participants and stakeholders. Oftentimes it is the interaction that creates the quality of the response. You also need to consider the statement of responsibilities and lines of authorities is delegated. This could be done through a cooperative endeavor agreement, clear ways of setting responsibility. Then the operational process for implementation; how do you move from the plan to implementation and the process for initiating, developing, maintaining, and retiring the plan and you will hear throughout the day an emphasis on the concept of retiring the plan. Again, look to your most recent disasters on the eastern coast to see how that was done in front of all of us. The term "scalability" is becoming used more widely and oftentimes when that happens people lose the true meaning of a word and what it was intended to reflect. In our context here it means that your plan should be very detailed with pre-identified actions, steps, and strategies so you know the most likely events that are going to have to happen or what generic processes happen that have to happen with greater intensity or less intensity and you can pre-identify those. Keeping in mind that your plan is just that, a basic framework for activation and response, it should be an all-hazards plan that speaks to all types and sizes of disasters, from man-made to radiological to human and of course natural-caused disaster or combinations of the three as we have experienced and elsewhere you often have a tornado and a hurricane combined event or in some cases you may have an oil spill or some chemical incident that is spawned by a series of natural disasters. Then again, the essential feature of any plan is your chain of command, your communication, and who the authorities are within the plan structure. In summary, your concept of operations really tells you how exactly things are supposed to work and they do it at these multiple levels. Facility, municipal, or sub-municipal level, your county, region, and State and Federal levels. It is important—a lot of plans overlook

this—the facility-level training and planning that needs to go into place. You could deal with something as simple as a— it sounds simple but something like an anthrax scare in receiving the powdered substance in the mail. Here is a very dramatic picture which emphasizes, following Hurricane Rita, what scalability is all about. You could have a small— on your left side of the screen you could have a power outage, a microburst of a little tornado that would wipe out two or three houses or you could have total and absolute devastation, like you see on the right. Your plan should be able to accommodate those because the resources are very different and the people you have to depend upon for resources become very different. The important thing with planning and knowing what needs to be scalable is knowing what your mandated responsibilities are. This requires pulling together your leadership and thinking through who is our population that we are serving. Is it seriously mentally ill? Do we have a child population? Are we responsible for an addictive disorder population, forensic population? All of the various facets of your populations that you all are serving, both institutional, as in 24-hour facilities, in secure facilities such as forensic facilities and a wide range of residential programs that your agency may be operating or responsible for through contract. In addition you have all of the persons and the infrastructure associated with community-run clinics. They could be addiction clinics, mental health clinics, or a combination or in our case here, behavioral health clinics and other community-based services. What about persons who are served by intensive case management or assertive community treatment teams and what is the responsibility for that staff and for the clients they serve? Then your general population requirements as a State behavioral health authority that you have in your State constitution or through your mental health or addiction enabling legislation a responsibility to the general population; understanding what that is and the expectations and where early interventions are necessary. Then the delegated duties within the emergency response framework as it relates to the Emergency Support Functions. In this case ESF-8 is the primary function. Then of course, any regulatory and legal mandates which prohibit or demand certain action from you in your agency. When you are looking at how you ensure scalability if you make sure your plan is interlaced and cascades from local, State, to Federal roles. Interlaced means that it is interlaced across agencies and that the assumption is always to provide services at the level closest to the incident. From local then to the State and then what Federal responsibilities are planned for so they can be activated when necessary. Interoperability and bidirectionality means that many times—and it has certainly been our experience that a plan must be able to move in two directions, getting feedback locally and then also knowing what kind of resources and actions are taking place from the helping agencies, either the State level or Federal level. Continuous and dynamic planning. Planning should accompany every part of your actions and if actually part of your intervention is planning, while you are implementing your plan you are also revising your plan. Then of course, knowing your collaborative partnerships. We have had other webinars speaking about partnerships. Your plan components also must address—after you have done all of the stuff that I have just spoken about you must think about it differently in terms of each phase of the disaster. Of course, those are your preparedness or phase where you are looking at your activation capabilities. Then your response and recovery phases and response phases can range from usually a shorter period of time than your recovery. They are very different phases but they do overlap. Then your phasedown of operations and maintaining continuity of operations for your activities that you have to provide services with throughout all of the incident phases. This is a staffing and resource issue one has to attend to and plan. Two tools that we use—I think they were provided to you as the response readiness checklist assessment tools provided as an attachment to your registration. This is a simple tool that we have developed that helps your agency at whatever you would want to use it. It identifies your actions for consideration in preparation for all hazards or a specific event and then there is the simple response readiness scale which ranges from no preparation to number five meaning that resources have been identified, simulation exercises conducted, and you are well on your way to addressing any particular issues. The hazards vulnerability analysis, many of you may be familiar with; it is something that is required in the JCAHO accreditation process and other accreditation processes. Having some sort of

objective way that your staff can routinely assess their capacity, capability, and readiness gives you a lot of indication on how scalable your plan actually is. Some of the Federal planning tools if you are interested in the things I have been speaking of can be found at these three particular Federal websites. These three are good places to get you started, the NIMS website, the CONOPS, or concept of operations, site, and then the National Response Framework. A lot of times you can use the positive macro-level thinking that has happened at the Federal level and adjust that thinking to our local and State-level planning. It is always good to steal from others when you can to not have to reinvent all of those good ideas that are already out there. Your traditional basis for response scalability is that one, it makes a lot of sense and then you think about it in terms of that all disasters are local, both in impact and in response and as the local spreads—and I guess I keep referring to the hurricanes Irene as it went up the coast, this is a one-State impact and as it rolled from one State to the next it was all about scalability, local impact then becoming regional and then becoming a national incident. This activated many mutual aid agreements and I bet all of those States and counties are revisiting their mutual aid agreements right now; seeing what worked and what was left out that may have caused them some kind of problems. Then, what triggers the activation of State capability and the Federal resources. If you will remember in the Irene example there was a Federal declaration before landfall for a lot of these States, which allowed the Federal resources to be utilized before landfall actually happened. That, again, is scalability and planning in a proactive method. Standards of operating procedures. These are some of the standard operating procedures or some of the basic tools within your planning process and I know that in our State we used to disregard the need for them because we had such a stable workforce that it didn't seem like anyone ever retired or left so everyone knew what to do. What we have experienced over the last few years is mainly people who were here have gone on to other jobs or have retired and all of the sudden you have a workforce where all of your institutional memory is gone. That to me is a really important reason to have your standard operating procedures in place. They ought to work a disaster response plan; its ultimate test is it can work independent of the personalities or the history of the people involved. If you can articulate clearly enough what your guidelines and instructions for response are and practice them well enough and do a cascading effect of responsibility and authority what happens is the plan supersedes any one individual and that is one of the goals you really want to emphasize for yourself. Some of the basics, when you are building a standard operating procedure think both about the operational functions and then the technical components. Not only what it is that you are trying to do but what do you need to do it and what is the best technology to use. Anywhere from personal protection devices, communication devices, redundancy planning, basic tools that you need in terms of personal survival. All of those features, if taken into account, reduce the stress on the individual responder and therefore enables them to be able to respond to the needs that are being expressed in that particular incident. The other thing that you do through your practicing, through simulations is that you hone your skills on coordination across agencies so that what you have is that while you have multiple jurisdictions that may be working together if they all are sharing a standard operating procedure they can work in a clear and effective fashion that allows for the deployment and development of your response to be smooth and not chaotic. When you actually write an SOP it is almost like writing any kind of formal procedural paper where you would want to first identify what capability does this apply to. Is it a capability to provide counseling? Is it a capability to move emergency resources, food supplies, or electrical supplies into place for people? When you are implementing it what need are you addressing? You are able to say to yourself and your planning team what is the recognized need. What triggers that need and then what capability it is necessary to address the need? You need to think through are there pre-established agreements already in place from the different agencies. Are they up to date or have they aged? If they are not in place what do they need to be replaced by. Then, is your standard operating procedure going to be used by a few people who know each other well? Is it going to be used by a bunch of strangers and volunteers who are solely reliant on the operating procedures? What is your rationale for bringing all of those people in and how are they going to

implement and address the recognized need? When you are writing the SOP it is good to be redundant. After you have described your capability and capabilities of the resources involved you need to speak to the authority, use, and responsibility. Lots of times at the height of an incident people start to question the authority as they become fatigued and they wonder, “Why should I be doing this and why do you have a right to tell me what to do?” If you have all of that clearly stated and it is articulated in the operating procedure what happens is you can diffuse many of those questions in a very businesslike manner. That way you put to rest a lot of issues that become side issues that are really stress related and have nothing to do with the actual SOP you are trying to put in place. The scope of the SOP, you need to practice this out clearly indicating the level of authority that is involved. Does it have to go all the way up through the command structure at the statewide level or is this an SOP that is implementable and governed by a local facility-level need. It can be that simple and isolated or it can be as global as a State level SOP. Your communication structure about when you have activated SOPs is very important. You do need to let the other levels of the hierarchy know that you have activated a particular strategic standard operating procedures because once you have activated them often it will trigger activation of other broad-spectrum SOPs associated with both State-level or inter-county relationships. Once you have everything activated you need at some point to discontinue it. You usually have to run it through multiple shifts. You have to take fatigue as an issue and you have to pull people offline, replace them with other people where the SOP would work for a new group of people or you have to have a phasedown feature. That should also be a separate module within your operating procedure. How you phase out and this would include debriefing of the staff involved, both your administrative and your frontline staff. You also need to think about your great planning and if it is no longer applicable and you don't have a standard operating procedure that works within the context of the particular incident you are involved in what are your alternative strategies? You can be thinking of the critical questions you should be asking yourself and your team that would provoke the kind of thinking that is necessary to build an ad hoc strategy that you can implement in an appropriate way given the context of that particular disaster. Having the skill, procedural knowledge to implement an SOP, does require either tabletop and then simulation exercises where you carry things out. We have done standard operating procedures on evacuations where we will actually load people up on the bus and load all of the equipment and time how long it takes us to do that so we know what we are looking at in terms of a real-time scenario. You can get very literal in your training on these items and testing it is what I am referring to. Then you have to think about who is a responsibility. Who is responsible for activating the standard operating procedure and carrying out the various components of that operating procedure and being able to have the authority to adjust it as needed as the situation demands it. In Louisiana—I have mentioned other States and how other States may take advantage of an SOP, one of the things we have done in our State is we have adjusted our Emergency Support Functions to include a 16th function which is our National Guard. Across the U.S. the National Guard was activated for all of the potential needs, which fortunately did not become a reality with Hurricane Irene. You need to always remember the primary response of the facilities that you are working with is the health and safety of the people that you are charged to protect. In the mass care function, the ESF-6 function, oftentimes the ESF-8 function is called in to provide additional assistance and crisis counseling. You have an interlacing here of the different support functions working together and that is not a constant, that will come and go so your scalability within in your standard operating procedures allows you to maximize the intensity of that interaction between the different support functions and agencies and then withdraw it as necessary. A local context, I have mentioned how we have used the evacuation of hospital. We also saw a lot of this across the whole southern coast, across the Gulf Coast of how the different operational units both in land and on the coast had to interact with a displacement and sheltering functions. Your sheltering functions on the east coast you saw lots of local sheltering goes into place and you have to activate different response groups to support those shelters. Not all of them will be Red Cross shelters. Thinking about special needs populations; one of the things that is really essential in your planning and scaling your response is

understanding who the special populations are and whose responsibility they are, what are their particular needs. When people are taken away from their normal support areas, how will those needs be addressed? You need to be aware of needs before, during, and after an incident and very basic functional areas. The important thing is to keep people as independent as they possibly can be; therefore maintaining the kinds of support necessary to assure independence is something that needs to be thought through, both in general shelters and in special needs shelters. These are areas—thinking about communication with loved ones and with medical professionals. What are the special transportation needs and what medical supplies would be necessary. In your planning you probably wouldn't identify everything you would need in a shelter but what you do need to identify is the communication and logistic method of securing the medical equipment and supplies that you would need in various locations. One of the biggest challenges is people who live in institutions and you would have to evacuate an institution. You saw in New York where they were evacuating institutions that had never been evacuated. It would be interesting to know if they had practiced any kind of institutional evacuation and did they have a plan, a standard operating procedure, they could use for the sheltering at other hospitals or non-hospital locations of those individuals. When you are in multicultural areas you need to take particular time to understand the various languages people speak. What are their dominant languages and have your materials and translation teams available to assist persons so that people aren't struggling with communication on something as basic as their primary language. I think I may have mentioned this to you before, in an evacuation such as we have done, bus triage evacuations here, which is how we get people out of New Orleans and into safety in other parts of the State, you need to understand and have in place the command structure and the operations group structure so when there are issues there is a clear chain of command. This is an example on a very micro level of having a group supervisor, transportation group, evacuee group, volunteer group. You are talking about maybe 15 people involved in each of these groups and maybe three to four people per team, then you can ramp that up as necessary based on the intensity and number of people you are evacuating or having to triage. What we have shown you today is basics of scalability, its importance and relevance to your overall disaster plan, and once you start using that concept you find that you really can't do it in isolation. You have to do it within the context of the larger statewide emergency response plan and preparedness activity and that you have to do it in relationship to each level of the plan, the county level, multi-county response or regional response, local municipal response, and facility-level response. When you can test the components of your plan through a local incident at a single facility and also statewide and assure yourself the same principles are at work and the only dynamic is the scalability of it, then you have a pretty good planning process that will move with the flexibility and grace and speed that you need in a particular event. That concludes the basic presentation. We are now open to any questions people may have.

Moderator: Thank you so much for your presentation Dr. Speier. We have four questions for you. When developing the disaster behavioral health plan, can you offer specific examples of planning for general population prevention and early intervention?

Dr. Speier: When you talk about general population planning and early intervention what you want to do is have a planning goal of increasing the very specific information people need in the here and now to protect themselves and the safety of their loved ones and property if possible and giving them very direct guidance and advice. You don't want to give partial messaging which then can create an opportunity for miscommunication and for people to panic in their response strategies. Thinking through who your population is, is it a multicultural population where you need to send out your public service announcements in multiple language and starting your messaging through your communication plan a good bit earlier than an actual incident. When you are in a season where you may be more vulnerable to

tornadoes or hurricanes or ice storms, part of your routine messaging to the population should be strategies that sensitize them that these events can occur and the importance of having their own emergency response plan for themselves and their family members. You can often do this by emphasizing the importance to children and people who are dependent upon you. A lot of times people say they are strong and tough and they don't need any help but they will do anything to help their loved ones.

Moderator: How effective are these principles for some of the most vulnerable communities in a tornadic type event with little or no warning?

Dr. Speier: That is a very good question. A tornado could come up in a moment and people have very little time to prepare and can't spend days thinking about it, it is on top of them and they have a very rapid response they have to put together to bring themselves to safety. If you know you live in an area like that and even if you don't know you live in area like that, as a family member, practicing with your family your emergency strategy that you would have if a tornado or if a fire happened would work very well. Think about it at the family level and then you think about it as family members who are related to each other; you are talking about scalability where there are multiple levels of response in a family system. In your planning if you get all of the way down to the individual response and then work your way back up through agency- and community-level responses it becomes more realistic for people. This will allow people to have very rapid response strategies that they don't have to think about because they have practiced them both at an agency level and an individual level and that will assure a greater likelihood that the planning process is successful.

Moderator: Dr. Speier, during a man-made event how is the disaster behavioral health plan integrated into the overall response to the event utilizing the NIMS structure?

Dr. Speier: In a man-made event you will have an event that has many of the characteristics of a natural disaster, meaning that it has disrupted a community. It has created a threat to community members or community infrastructure. In the case of say you had a large oil spill or fire due to a refinery explosion or you had—which would create a smoke cloud that would be of danger or hazard to the breathing or individuals or you had a massive oil spill like we had across the three States in the Gulf where you have an impact on the community but also on the environment. You have to add into your regular planning on mobilization and response the fact that there is an anger component and your communication and your use of Psychological First Aid techniques of doing counseling have to take into account respecting the shock and awe the people may feel and also the anger that comes after that. In your training what you would want to do is make sure that you were training people to respect the fact that people are angry. Do not minimize anger but allow people the opportunity to work through that because it will become a major feature and the desire to demonize whoever is the responsible party for causing the man-made event.

Moderator: How do you plan for access to behavioral health supports to the general population not already served if the event is not eligible for CCP funding?

Dr. Speier: CCP funding and the Crisis Counseling Program funding from SAMHSA and FEMA is often what people rely on. If you have done your planning well where if you refer back to earlier slides in this training we talk about other stakeholder groups, other community partners; you will find that your agencies that are voluntary agencies that are active in disasters. A number of your local ministries and foundations will have procedures already in place to where they can activate dedicated funds to assist

communities in disasters. That is one important thing to have in your plan, how to access nontraditional funding in local communities. That wouldn't flow through the State but would be available and administered through some ad hoc structure established that one may have standardized operating procedure to put in place at the time. The other is in your agency planning budgets many agencies will plan a contingency fund to help with ongoing operations and the financing of your concept of operations. It is something that one should consider in a non-federally support disaster response.

Moderator: Thank you for your presentation Dr. Speier. Ms. Terri Spear has some closing remarks for us.

Ms. Spear: Thank you very much Dr. Speier for your very thoughtful presentation. It was very helpful, I hope, to those who participated. This activity concludes the Plan Scalability webinar as well as the Promising Practices in Disaster Behavioral Health Planning series. SAMHSA DTAC hopes you have found this series to both informative and useful to your disaster behavioral health planning needs. We do hope that very soon each webinar in this series will be archived on SAMHSA DTAC website and the address is given there. Thank you very much for your participation.

Moderator: Thank you so much Ms. Spear. Before we conclude today's webinar we wanted to give you the contact information for SAMHSA DTAC again. Please feel free to contact the SAMHSA DTAC team at any time. Thank you all for participating in the Promising Practices in Disaster Behavioral Health: Plan Scalability webinar.

[End of session.]