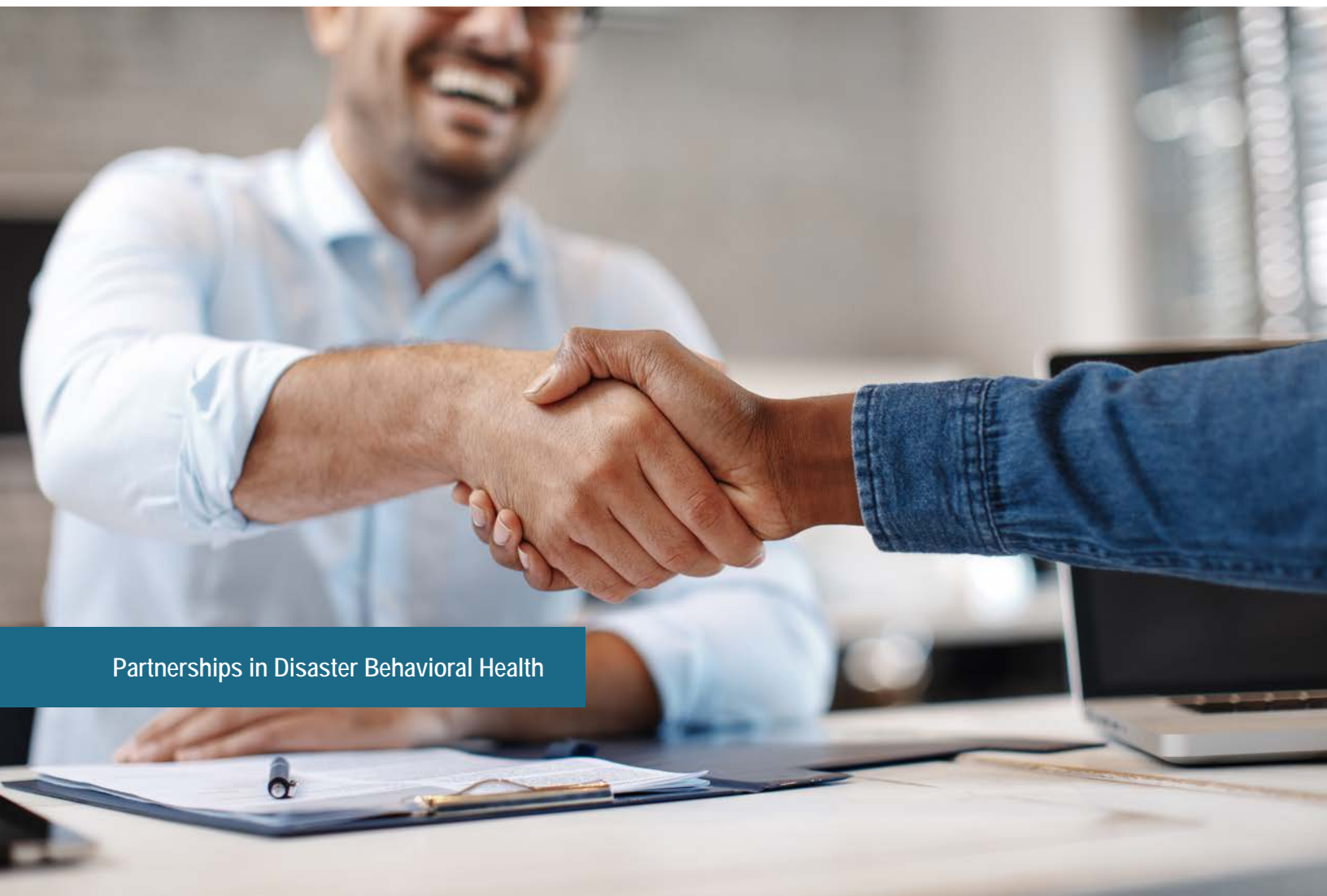


A Quarterly Technical Assistance Journal on Disaster Behavioral Health
Produced by the SAMHSA Disaster Technical Assistance Center

the Dialogue

2023 | VOLUME 18 | ISSUE 3



Partnerships in Disaster Behavioral Health

CONTENTS

- 3 In This Issue
- 4 Contributors
- 5 Technical Assistance Snapshot
- 6 State and Local Partnerships: Making Room at the Table
- 13 Private-Public Partnerships and Disaster Behavioral Health: New Resources From FEMA
- 16 Successful Partnerships in Behavioral Health Disaster Recovery: Lessons Learned Through Crisis Counseling Programs
- 27 Recent Technical Assistance Requests

COVER Photo by Adobe Stock

The Dialogue is a quarterly technical assistance journal on disaster behavioral health which is produced by the Substance Abuse and Mental Health Services Administration (SAMHSA) Disaster Technical Assistance Center (DTAC). Through the pages of *The Dialogue*, disaster behavioral health professionals share information and resources while examining the disaster behavioral health preparedness and response issues that are important to the field. *The Dialogue* also provides a comprehensive look at the disaster training and technical assistance services SAMHSA DTAC provides to prepare states, territories, tribes, and local entities so they can deliver an effective disaster behavioral health response.

SAMHSA DTAC provides disaster technical assistance, training, consultation, resources, information exchange, and knowledge brokering to help disaster behavioral health professionals plan for and respond effectively to mental health and substance misuse needs following a disaster.

To learn more or receive *The Dialogue*, please call 1-800-308-3515, email dtac@samhsa.hhs.gov, or visit the SAMHSA DTAC website at <https://www.samhsa.gov/dtac>.

The Dialogue is not responsible for the information provided by any web pages, materials, or organizations referenced in this publication. Although *The Dialogue* includes valuable articles and collections of information, SAMHSA does not necessarily endorse any specific products or services provided by public or private organizations unless expressly stated. In addition, SAMHSA does not necessarily endorse the views expressed by such sites or organizations, nor does SAMHSA warrant the validity of any information or its fitness for any particular purpose.

In This Issue

Partnerships are crucial in responding to behavioral health needs after disaster and mitigating disasters' behavioral health effects. The provision of disaster behavioral health services requires a multidisciplinary approach, involving mental health professionals, public health officials, emergency responders, and community leaders. These entities must work together before, during, and after an emergency to effectively serve the impacted populations. In recent years, governments around the world have recognized the importance of behavioral health partnerships in disaster response, particularly considering the increasing frequency and severity of natural disasters and other emergencies, and a clearer understanding of the devastating effects these events can have on the mental health of affected populations. Through partnerships, governments can leverage resources, expertise, and knowledge to build resilience, strengthen response capabilities, and enhance recovery efforts.

Collaboration between public health and emergency management agencies, as well as with nongovernmental and private sector organizations, is necessary to effectively respond to the behavioral health challenges posed by disasters. By working together, partners can share expertise and resources to better prepare for and respond to disasters, actions which are known to reduce the mental health and substance use impacts on individuals and communities. Effective government partnerships require pre-planning and development of coordination strategies that prioritize the safety and well-being of the public. These partnerships can ensure that emergency plans addressing behavioral health are in place, training and exercises are conducted regularly, and communication and coordination systems are established before a disaster strikes.

In this issue of *The Dialogue*, experts share their experiences with building and exercising partnerships. In the first article, two disaster behavioral health professionals discuss their experience with engaging



and maintaining partnerships at the state and local level. The second feature is a summary of recent Federal Emergency Management Agency (FEMA) resources focused on private-public partnerships. In the third article, an expert describes the lessons learned through several disaster behavioral health programs and shares several actionable items for those in the field.

Have you been part of disaster behavioral health partnership planning and execution? Other planners and responders can learn from your efforts and experience. Please contact us to share your stories and lessons learned. ■

CAPT Erik Hierholzer, B.S.N., Program Management Officer, Emergency Mental Health and Traumatic Stress Services Branch
erik.hierholzer@samhsa.hhs.gov

Nikki Bellamy, Ph.D., Public Health Advisor, Emergency Mental Health and Traumatic Stress Services Branch
nikki.bellamy@samhsa.hhs.gov

Shannon Loomis, M.A., Director, Substance Abuse and Mental Health Services Administration (SAMHSA) Disaster Technical Assistance Center (DTAC)
dtac@samhsa.hhs.gov

Contributors



Kalie Burke, M.P.H., is the Disaster Mental Health Coordinator for Georgia at the Department of Behavioral Health and Developmental Disabilities. Burke attended Florida State University for both

her undergraduate degree and master of public health. Prior to joining the Georgia behavioral health team, Burke worked as a public health consultant in Florida and California during the height of the COVID-19 pandemic. Burke leads the Georgia Recovery Project, a team of Crisis Counseling Assistance and Training Program (CCP) providers located throughout the state providing information on stress management and mental health related to COVID-19. Additionally, she co-chairs the Georgia Emergency Preparedness Coalition for Individuals with Disabilities and Older Adults.



Sofia Cabrera, B.A., is a Technical Assistance Specialist for SAMHSA DTAC. Cabrera attended the University of Maryland and received a B.A. in English literature and language. She has worked in the public health field for 2

years. Cabrera provides guidance to states, territories, and tribal grantees developing disaster behavioral health support for affected communities. She also provides administrative support and promotes grantee development to address growing community needs after disaster events. Cabrera manages and writes content for several SAMHSA DTAC materials, including the *SAMHSA DTAC Bulletin* and *The Dialogue*. She specializes in highlighting culturally competent and accessible materials and systems for underserved populations experiencing inequities in access to behavioral health services.



Chance A. Freeman is the Director of Disaster Behavioral Health Coordination at the Texas Health and Human Services Commission. He has worked in the field of disaster behavioral health since

1998 and has responded to over 28 federally declared disasters and a variety of emergency events such as the Space Shuttle Columbia Recovery project; the West Fertilizer Plant explosion; church shootings in Sutherland Springs and White Settlement, Texas; school shootings in Santa Fe, Texas, and Uvalde, Texas; the El Paso Walmart shooting; the shooting spree in Midland/Odessa; and COVID-19. Based on his experience with the Federal Emergency Management Agency (FEMA) CCP, Freeman has been asked to provide technical assistance and training on CCP grant development and management, provided training at FEMA's Emergency Management Institute in Emmitsburg, Maryland, and he is a member of the SAMHSA DTAC Cadre of Consultants. He serves as the State Behavioral Health Initiative Advisor to the Terrorism and Disaster Network Committee and is a member of the Executive Advisory Board for the Texas Law Enforcement Peer Network where he advises organizational leadership for growth, training, and the betterment of the services provided to the law enforcement professionals of Texas.



Susan Robinson, M.Ed., is an Independent Health and Human Services Senior Consultant. She served in a variety of leadership, program management, and planner roles in her 36+ years with the North

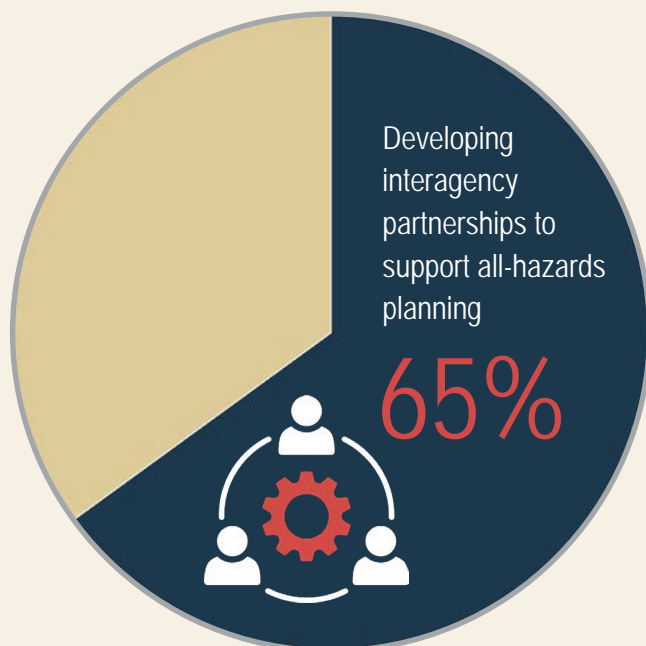
Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services within the state's Department of Health and Human Services.

She has served on the state emergency response team since 1990. She has expertise in areas including suicide prevention, 988, and crisis- and trauma-informed disaster behavioral health recovery supports and services. Her CCP experience spans a period of nearly 25 years, from responses to Hurricanes Fran (1996) and Floyd (1999) to Hurricane Florence (2018) and the COVID-19 pandemic (2020). She has offered training and consultation on topics related to the CCP as well as self-care and compassion fatigue, resilience tools and skills, shared risk and protective factors in disaster behavioral health recovery, framing a sustainable plan

for disaster behavioral health recovery, using data and benchmarking for success, working with special and marginalized populations, and building creative partnerships. She was the recipient of the 2015 System of Care Champion for North Carolina Children, Youth, and Families Award; the 2021 North Carolina Department of Health and Human Services Teamwork Leadership Award for Hope4NC Crisis Counseling Program (COVID); and the 2022 Cornerstone Award for Excellence in Promoting System of Care Values. She holds a master of education from the University of North Carolina at Chapel Hill.

TECHNICAL ASSISTANCE SNAPSHOT

Data From the 2017–2021 SAMHSA DTAC Customer Feedback Survey



The SAMHSA Disaster Technical Assistance Center (DTAC) uses the Customer Feedback Survey (CFS) to learn about current and prospective audiences and their needs. Through the CFS, we work to gather information to help us create and update products and provide services designed to best meet the needs of our audiences.

From 2017 to 2021, nearly two-thirds (65 percent) of CFS respondents reported high levels of need for training and technical assistance on “developing interagency partnerships to support all-hazards planning.”

INTERVIEW

State and Local Partnerships: Making Room at the Table

By **Chance Freeman**, Texas Health and Human Services Commission, **Kalie Burke, M.P.H.**, Georgia Department of Behavioral Health and Developmental Disabilities, and **Sofia Cabrera, B.A.**, SAMHSA DTAC



The Georgia Recovery Project partnered with local organizations to provide support across the state during the COVID-19 pandemic. Photo courtesy of Kalie Burke.

Partnerships are an essential piece to coordinating effective and inclusive disaster behavioral health response and recovery. *The Dialogue* recently spoke with Chance Freeman and Kalie Burke, leaders in states with exemplary and innovative partnership practices, to discuss their experience with engaging and maintaining partnerships. Freeman and Burke shared their state's partnership initiatives and goals to highlight the value of collaborative disaster behavioral health work and provide recommendations for those seeking to grow their partnerships.

What do you look for when you initiate the process of identifying and connecting with possible partners?

Chance Freeman: We familiarize ourselves with the skill sets available and the resources the community needs. This allows us to connect those specifically trained in disaster behavioral health response, first responder peer support, Psychological First Aid, and crisis counseling to serve the populations needing support. We determine how we can use those resources to

formulate an immediate response and ensure we have a strong system for referrals, confirming they can assist long-term with our disaster team and the community that needs them. We evaluate whether they can help us continue making connections and establishing relationships with other entities that have a vested interest in what we need to address.

Public health and emergency management are constantly evolving and changing, and recovery is an essential step that can't be ignored. When an incident occurs, our team is



immediately working on establishing those partnerships and pulling together those entities for long-term recovery. So, we have to ask our partners, “Are you in this for the long term? Do you have the resources and supplies needed?” We ask the hard questions to make sure we are on the same page. “What are you going to do in two years? Three years? Four?” And that includes all our partners: service providers, faith-based organizations, first responders, mental health professionals, and providers. That is how we identify who needs to be at the planning table.

Kalie Burke: In terms of disaster assistance, part of my job is to include individuals who may have been previously excluded from planning. Individuals with access

and functional needs, older adults, local organizations—we want to have them at the planning table to open those discussions and create a collaborative community effort instead of the state dictating what local individuals do. We love our local governments and providers. They do a great job and have a great network. Getting into those smaller communities is really important to us.

There can’t be too many people at the table, in my opinion. I think having a plethora of different perspectives from different fields is fantastic. Bring as many people as you can to the table and have those discussions. Local individuals experience things very differently—even between rural and urban communities, local providers are

experiencing different populations with different needs. Having those niche understandings and knowledge of these very small groups is helpful.

Once the partnership is established, how do you manage and maintain these working relationships?

Freeman: Disasters start and end locally. Disaster response coordination at the state level does not delegate or assign responsibilities to our partners. From our viewpoint, the way we take the lead is by finding community leaders. The gatekeepers, stakeholders, and local entities inform who should be at the table. When a disaster event occurs, there can be 15 or 20 entities at the table because they were invited by someone who knew somebody, that knew somebody. We proceed by narrowing down the size of the group by assessing their potential contribution. Who is in it for the long term? What services can the organization provide without funding? Who are they serving? Can their organization handle a larger caseload? Some organizations are not configured to meet the rapid changes that disasters bring. It is important to recognize that possibility and determine that some partnerships may not be the right fit for that point in time.

With the appropriate groups at the table, we start our weekly or monthly meetings. Our stakeholder groups meet once a week for nearly

3 months. A natural leader will emerge, and from a state level, we no longer need to facilitate these conversations or need to actively coordinate or direct the partnerships and connections being made across the table. Our state role transitions to staying in the periphery. These meetings are essential to establishing lasting collaborations and partnerships. We allow the entities to determine what their need is, what they hope to accomplish, and how long the partnership should last.

Burke: Processes to identify and coordinate partnerships naturally occur as we work on collaborations and agreements. We have contracts in place to have those working relationships, but a lot of it is

just built upon trust. Georgia has established a great trust system for emergency response. There are word-of-mouth and official agreements, but there is a shared understanding that these partners are proud of their work and are good at what they do, so they want to come together to provide for communities in the best way they can. You don't have to partner. You want to.

COVID-19 threw a wrench into the public health world and caused some stakeholders to be afraid to step in. The height of COVID-19 was a very scary time. So much happened, so many changes. Trying to get people to buy in was a very difficult thing. But we know that the locals have the most power and stakeholders rely

on the locals for what they do, so we don't have to convince stakeholders to buy in. We learn about groups providing for the community and let them know we are more than happy to support them.

What challenges have you encountered when managing partnerships, and how did you address these issues?

Freeman: The political climate can be a challenge at times. Priorities can change with turnover in key positions among partners. This can cause a learning curve. Some stakeholders may need to move their program in different directions. Some partners may have competing priorities. It can be difficult to maintain stakeholder interest in what one is doing.



You may have a group that wants to come in and participate in the group effort but is just not the right fit for what is needed at that time. You need to navigate that discussion, letting them know that you appreciate their help, but that their services are not needed at that time. On the other hand, you may have a group that you need to join the effort, but there may be some miscommunication that causes conflict.

One of the biggest challenges is that we all have limited resources. We are being pulled in so many different directions. Being stretched thin after a disaster is common for many, and it may be difficult to get stakeholders to sign up for more work.

You have to recognize where you fit in with the stakeholders and partners. I like to run meetings

and facilitate conversations. But I knew that, for our behavioral health workgroup, I wasn't the right person to lead the conversation. I stepped aside and let somebody else facilitate because they were known in the field. They were respected by the partners and spoke their language, adding to their credibility. Through that, the partners are able to build their own credibility. For example, within the field of disaster behavioral health, we have always struggled with the use of the terminology "crisis counseling" or "disaster behavioral health." How do we get people to come in and really understand what we do and what services we can provide? We want to have someone lead the group that speaks the community's language, so we get it right. We need to be culturally competent and aware with our stakeholder group to achieve our goals.

Burke: It is surprising how many people in the emergency management field do not understand mental health or the term "disaster behavioral health." But it is understandable. A lot of people come from different backgrounds, so they may not have that specific knowledge or training. And it can go the other way around. We at the state or federal level may not have the specific knowledge that group does. It happens all the time—the dichotomy of talking to someone who knows emergency management so well but does not know behavioral health, or someone who knows behavioral health so well but does not know emergency management. It is a difficult



“Partners can contribute to all aspects of the emergency management cycle by supporting risk assessments, communication, and other response and recovery activities”

(Rural Health Information Hub, Rural Emergency Preparedness and Response Toolkit, <http://bit.ly/3J4fYGc>).

navigation to be done, but that is why the partnerships are there in the first place. We are opening the dialogue, sharing a conversation to get on the same page.

It does get complicated when you begin to look at power and authority. We at the state level are sometimes met with distrust or a misunderstanding of what we do and what we can do to help. There is also a lot of stigma against mental health that is a huge concern for those wary of establishing these partnerships. We have met people who did not want to partner with us, and that is fine; we will continue reaching out. We will not get discouraged. The stigma is still very real, and there are people that do not share the same beliefs regarding our work. We want to ensure our services are out there and we are capturing all the people that need assistance in any way we can serve them. When we meet resistance, we want to understand why they say no and how we can still serve that population in whatever way they are comfortable receiving it.

What would you recommend to other states and organizations hoping to develop and maintain partnerships to improve their disaster behavioral health work?

Freeman: Learn to speak the language of emergency management, public health, and law enforcement. When I speak with my stakeholder groups, I can speak

their language. I don't need them to speak mine. Folks understand the importance of behavioral health. They just don't know what to do with it. If you can enter the conversation with clarity, you can lead a healthy conversation. Explain what you do, how you can make their lives easier, and how you can ensure the services they are providing in the field are complemented and supported.

Understand what your partners do and where they do it, and, most importantly, what you can do for them. Approach these folks and ask them how you can assist. A lot of leaders are problem solvers and have everybody coming to them for everything. You can be that one person asking them what they need. Your priorities may not always be the same or you may not see how they intersect, but give them the opportunity to ask you for something. You may not be able to complete their request, but you may know someone who can. Then you can make that partnership and connections for them.

Explore other disaster behavioral health programs involving partnership in the “Stronger Together” edition of the SAMHSA DTAC Supplemental Research Bulletin

https://www.samhsa.gov/sites/default/files/programs_campaigns/dtac/srb-community-approaches.pdf

We found that these entities may not be communicating with each other. They are each doing their own things—and doing them very well, but rarely does anyone pull them together. That is a direct quote from a member of our first responder behavioral health group—“that no one is bringing them together to discuss their work, their goals, and what a larger system may look like outside of the scope of their organization.” Our partners are glad to have an entity that pulled them together and started hosting these types of conversations. We support the development of emerging resources, the legislative process, and our state strategic plans.

I learned this acronym from a training I recently completed: WAIT, which stands for “Why am I talking?” I find myself asking that question a lot during our partner group meetings. What am I bringing to the table? What do my partners need? What can we do together to serve the community? Why am I talking? Sometimes taking a moment to sit in that uncomfortable silence, to not talk without a clear

“It’s somewhat of a mantra in the disaster response community . . . ‘Disasters are the worst time to hand out business cards.’”

— Curt Drennen, Psy.D., Promising Practices in Disaster Behavioral Health Planning:
Building Effective Partnerships webcast, <https://bit.ly/3ZhD2XC>



purpose, is a good way to leave space for everyone at the table.

All of us in disaster response want to make sure we are doing the best job possible for those impacted by disaster events. No organization is out there to put a feather in their cap. It’s not about our disaster team or our partners. It is about those we serve. Each state and community is different and will have its own challenges. Be flexible, be creative, and be honest with stakeholders. Understand their capabilities and your own.

Burke: Oftentimes, the best way to make new partnerships is to lean on your current partners. We have an emergency preparedness coalition that I chair. For every meeting, we ask our participants to send the meeting invitation to two or three new people. They are able to join the meeting and introduce themselves, and suddenly our group grows tenfold. Finding that one person to get your foot in the door is fantastic. That one person may have worked for five different agencies in their career, and they know someone who has worked for five more. It is all about finding someone who knows

someone. We want everybody with an idea at our table. It is so vital to ensure health equity and safety. No group is too small.

I find that the best people to go to are the people who have lived it the longest: predecessors who have been with the organizations longer, those with intimate knowledge who have been here before me, even if it is just one person who knows about different nonprofit groups or smaller organizations in your state. You can also lean on your local healthcare coalitions, county health departments, and those types of groups that would be able to take information you have and directly relay it.

When it comes to emergency planning, local organizations give a lot of great feedback. They are able to speak on specific populations that are in need of help in certain parts of the state. Between the coast, South Georgia, Metro Atlanta, North Georgia—the state is so diverse, and the populations do not look the same. It is nice to have that buy-in at the local level so they can voice local concerns that our state-level employees may not be able to hear otherwise. ■

State and Local Partnerships Across the Nation



Partnerships in emergency management and disaster behavioral health are the rule rather than the exception. This graphic shows examples of partnership programs across the United States.

King County in Washington State has established its [Trusted Partner Network](#) to provide information to all residents in the event of a disaster or other emergency. The goal is for partners from every major language group in the county to serve as liaisons.

The [Nebraska Preparedness Partnership](#) brings together state agencies and businesses to build capacity for disaster preparedness, response, and recovery. Participants share information and resources and coordinate emergency management efforts.

The [Colorado Emergency Preparedness Partnership](#) encompasses about 3,200 member organizations across all sectors working together to improve planning, preparedness, and emergency management.

The Missouri [Governor's Faith-Based and Community Service Partnership for Disaster Recovery](#) works with the State Emergency Management Agency to coordinate emergency human services in disasters. Partners include state departments, nonprofits, faith-based organizations, and professional associations.

In Louisiana, [NOLA Ready](#) has [partnered with over 60 local and 20 national organizations](#) in disaster response. NOLA Ready is New Orleans' emergency preparedness campaign, which is managed by the city's Office of Homeland Security and Emergency Preparedness.

The Florida Commission on Community Service has an [emergency management partnership program](#) with disaster response and recovery volunteer organizations. Partners are notified of important events and grant opportunities through the Florida Disaster Fund.

The Virginia Department of Emergency Management [Partners in Preparedness](#) program enlists liaisons to help ensure disaster-related communications reach all Virginians, regardless of English proficiency, internet access, socioeconomic status, and other types of difference and diversity in the state.

New York City Emergency Management's [Partners in Preparedness program](#) includes over 670 partner organizations in fields ranging from arts and entertainment to finance and banking to government.

Wisconsin Emergency Management offers several [public-private partnership programs](#), all of which benefit all participants and help coordinate and improve emergency preparedness in the state.

Private-Public Partnerships and Disaster Behavioral Health: New Resources From FEMA

By the SAMHSA Disaster Technical Assistance Center

Private-public partnerships are an important component of disaster planning and recovery. A private-public partnership is a mutually beneficial formal or informal cooperative agreement between two or more private industry organizations and the public sector (Federal Emergency Management Agency [FEMA], 2021). This type of partnership is made to strengthen resilience, economic security, and safety in communities and can help survivors and communities recover from the behavioral health effects of disasters.

To assist with coordinating these essential partnerships across private and public sectors in response to disaster, FEMA has released several new resources. [*Restoration and Recovery: Guide for Private-Public Partnerships*](#) offers strategies and resources for jurisdictions to help them plan and coordinate restoration of community lifelines, plan recovery strategies, and start recovery operations by means of a private-public partnership which promotes

inclusive and equitable recovery from disaster.

This guide is for the private sector, community planners, local government,

nongovernmental organizations, and community stakeholders.

It describes how to build a collaborative planning team, create long-term recovery groups, and establish recovery task forces, as well as steps to take in the private-public partnership process.



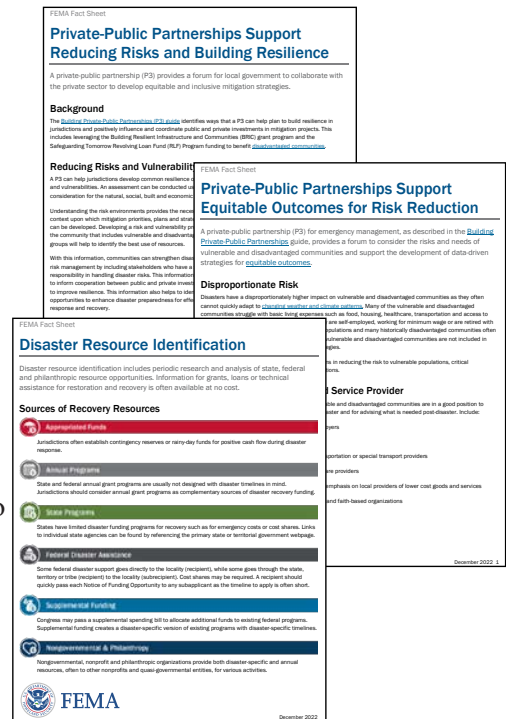
Also released by FEMA are several fact sheets that cover topics in the [*Building Private-Public Partnerships*](#) guide published in 2021. One of these fact sheets is [*Private-Public Partnerships Support Equitable Outcomes for Risk Reduction*](#). It provides strategies for the private-public partnership to consider the needs of disadvantaged and vulnerable communities and encourages the creation and use of data-driven guidance for equitable outcomes. The fact sheet is for disaster responders, local governments, and community leaders developing disaster risk reduction strategies. This resource discusses disproportionate risk faced by specific communities in disasters; local advocates and service providers to include in disaster preparation, response, and recovery; and the ways a private-public partnership can reduce disaster risk.

Another fact sheet that complements [*Building Private-Public Partnerships*](#) is [*Private-Public Partnerships Support Reducing Risks and Building Resilience*](#). This resource gives guidance to local governments on how to work with the private sector to assess risks and vulnerabilities and plan for risk mitigation and management. The fact sheet identifies key areas of potential risk and vulnerability and steps in each of these areas to build resilience.

FEMA has also released the [*Disaster Resource Identification*](#) fact sheet. This fact sheet provides information



on resource identification, how to search for resources, sources of recovery resources, and resource management. This guide is for disaster response leaders in local communities planning disaster recovery for their communities. ■



For further resources on disaster planning and recovery and disaster behavioral health for individual and communities, visit:

- FEMA's website at <https://www.fema.gov>



- The SAMHSA DTAC website at <https://www.samhsa.gov/dtac>



- The website of Ready, a national public service campaign of the U.S. Department of Homeland Security, at <https://www.ready.gov>





An Effective Partnership



Brings partners together



Identifies shared values, goals, and objectives



Identifies a role and function for each partner



Gets partners on the same page for a crisis response

Effective Partnerships



Have an effective leader



Give potential partners the opportunity to share concerns



Have entities with a shared set of goals and outcomes, where all partners see themselves as equal



Include the basic components of program evaluation

Partnership Types



Federal agency-federal agency (e.g., interagency agreement between SAMHSA and FEMA in support of the CCP)



State-state (emergency management, public health, public education departments/agencies/authorities, and nongovernmental organizations and community leaders with investment and focus in disaster behavioral health)



State, regional, and local levels (local community mental health and substance use provider organizations, American Red Cross, Salvation Army, victim advocates, and private practitioners)



Federal-state

Partnerships

From the SAMHSA DTAC Promising Practices in Disaster Behavioral Health Planning: Partnerships video, <http://bit.ly/3J3u7Cr>

Successful Partnerships in Behavioral Health Disaster Recovery: Lessons Learned Through Crisis Counseling Programs

By **Susan Robinson, M.Ed.**, Independent Health and Human Services Senior Consultant

All phases of disaster, from planning and preparedness to response to recovery, rely on partnerships. This is certainly what I found as part of North Carolina's state emergency response team from 1990 to 2022, and as a member and leader of Crisis Counseling Assistance and Training Program (CCP) grants and other disaster and crisis response programs in North Carolina. In this article I describe work I did as part of disaster response teams, important lessons learned in partnership development and maintenance, examples of unique ways that partnerships can help programs reach specific communities, and the role of partnerships throughout the emergency management life cycle.

Begin at the Beginning

Often in behavioral health disaster recovery we are faced with the question “*Where do we begin?*” Whether we are engaged at the state, regional, or community level, after a few deep breaths and longer exhales, we pause and find ourselves asking this question.

Within the context of the disaster event, more questions follow. What did our initial needs assessment



tell us? Who is most impacted and most at risk now? Where are these survivors located at the moment (shelter, sheltered in place at home, without housing, relocated to a new medical or skilled facility)? Where will survivors be located in the next month? In the next 2, 6, 9, or 12 months? What needs are anticipated based on disaster reporting by emergency responders, survivor self-reports, and the state/community emergency management network? Who are key partners “at the ready” to help support the behavioral health disaster response and recovery?

Begin with the end in mind.

With all good planning, needs assessments are ongoing and require gathering survivor and stakeholder perspectives in order to design and implement an effective, coordinated, trauma-informed behavioral health disaster recovery response that promotes survivor behavioral health recovery, sustained resilience, wellness, and preparedness for future events.

Consider current strengths and gaps, and anticipate gaps in the recovery process in the coming

weeks and months. Behavioral health disaster recovery planning considers how to be innovative in building on state and community strengths; identifying key partners; and prioritizing gaps that may impede survivor behavioral health recovery, resilience, wellness, and preparedness.

Identify strategic partnerships and collaborative opportunities through which behavioral health disaster recovery response can be strengthened or created. Strategic partnerships increase successful survivor outreach and engagement with needed behavioral health supports and services, including

referrals to more intensive services as needs are identified and linkages made.

Create and grow partnerships.

Initiate communications; be persistent, and make connections with existing community partners. Prepare a simple message and fact sheet to share on disaster behavioral health, emotional health and wellness through recovery, and how to seek CCP services. Be sure to include CCP team branding in the state/region and in specific communities impacted. In North Carolina, I served as the former State Suicide Prevention and Crisis Counseling Services Coordinator (retired) with the North Carolina Department of Health and Human Services, in coordination the Director of North Carolina Emergency Management. We administered the CCP Hope4NC in response to Hurricane Florence (DR-4393-NC) and later through the COVID-19 global pandemic (DR-4487-NC). In this capacity, I found that effective, consistent team branding across disaster responses provided “ready” recognition and connection with CCP staff statewide. Survivors especially connected with ease to help provided by our Hope4NC blue shirt counselors, as did community partners.

Determine common goals and populations most impacted and potential “early wins” of collaborative survivor outreach and engagement. Public health and rural health departments along with



“The delivery of disaster behavioral health is too large of an activity to be handled effectively by any one organization or agency. Without effective partnerships in place prior to the disaster, we risk significant and negative impacts on individuals, families, and communities.”

— Curt Drennen, Psy.D., Promising Practices in Disaster Behavioral Health Planning: Building Effective Partnerships webcast, <https://bit.ly/3ZhD2XC>

public social services/child and adult welfare departments are often existing relationships to build upon when providing behavioral health disaster services and supports.

- Recovery through hurricanes, flooding, and tornadic events brings opportunities to collaborate with different offices within public and environmental health regarding basic self-care in the areas of physical and emotional health, including accessing safe drinking water and temporary facilities to shower and wash, cleaning supply distribution sites, and mosquito and other pest abatement services.
- Behavioral health disaster recovery during the COVID global

pandemic required combined and coordinated public and rural health outreach with community health workers and pop-up clinics in hard-to-reach, often culturally and/or linguistically marginalized neighborhoods, including communities of migrant farmworkers and people experiencing homelessness.

- Also during the COVID pandemic, it was essential to provide cross-training and coordination among community health workers and crisis counselors as well as offering coaching support in self-care to mitigate the impact of trauma and compassion fatigue staff experienced. These supports helped to sustain effective recovery efforts over time.

Growing and Sustaining Partnerships

“What is your story? What happened to you?” Begin talking with folks by listening to them and their stories. Whether creating new alliances and partnerships or working with existing partners, meet people where they are in their own disaster recovery experience as survivors. Consider the diversity of experiences related to culture, race and ethnicity, language, gender, ability, age, and family among communities of survivors and that of the CCP staff when creating and building partnerships in providing behavioral health disaster recovery services, supports, and referrals.

Be a constant, reassuring presence. Practice safe, trauma-informed messaging. Behavioral health terms and concepts are often misunderstood along with language we use related to mental health and mental wellness. It is important for outreach messaging to be safe, trauma-informed, clear, and simple. This attuned messaging combined with consistent CCP branding, such as the presence of “*Hope4NC blue shirts*,” brings hope and reassurance. People with lived experience with behavioral health challenges who are also disaster survivors are unique partners in effective behavioral health disaster recovery and safe messaging to find a way through the loss and pain.



Peer survivors help reduce barriers and are strategic partners

in leveraging and deploying existing resources to diverse populations, including those with sensory impairments (vision and hearing). Peer survivors are key partners who can effectively conduct outreach and engage with diverse populations across disaster declared and designated service areas. It is essential for CCP program managers to stay attuned to the impact of emotional distress of survivors and peers on an ongoing basis through reflective supervision and supportive coaching. One program manager's daily staff check-ins included text messages such as "take a deep breath," "sip some water," "3-minute stretches," etc., to help staff practice self-care coping skills as they worked throughout the community.

Challenges in Starting and Maintaining Partnerships

Timeframes are challenging when implementing the CCP, especially in the timing of the Immediate Services Program (ISP) transition to the Regular Services Program (RSP) while the application is pending review by federal partners. This tenuousness is unsettling for both the CCP staff and the communities reliant on the CCP continuing to be a constant active presence, a "ready partner" in collaboration with others in disaster recovery.

Staff recruitment and retention.

In addition to uncertainty of CCP funding and timeframes, it is

// Whether creating new alliances and partnerships or working with existing partners, meet people where they are. Consider the diversity of experiences related to culture, race and ethnicity, language, gender, ability, age, and family among communities of survivors and that of the CCP staff when creating and building partnerships. //

important to recognize that the CCP team outreach model faces new health and community safety risks because of COVID-19 and increasing community violence and emotional unrest. To help recruit and retain staff members, it is essential to have attuned, intentional leadership; emotional support for staff; somatic resilience skill practice; and evidence- and trauma-informed behavioral health disaster skills-based training recommended by SAMHSA DTAC. *Sustaining resilience among CCP staff is vital to effective CCP outcomes.* Begin and sustain connections among all levels of CCP staff across sites/communities with one another and across states on a regular basis, even if for 30 minutes weekly (e.g., skill-building, successes/ challenges/

opportunities, business functions). Connections among peers made through a supportive learning community are key to emotional support, sustaining creativity, and promoting continuity and effectiveness among all levels of CCP staff.

Supportive relationships are fostered through effective partnerships with a common understanding and outcomes that help sustain collaborative efforts over time. Stay in touch, communicate with partners, stay focused on the CCP priorities, and continue services. Collaborative partnerships with law enforcement and other first responders offer support as crisis counselors engage in outreach activities in communities.

Collaborative Partnerships Create Possibilities

“Who are the people in your neighborhood?” In population-based behavioral health disaster recovery, there are often challenges in crisis counseling outreach or developing responsive services to meet survivor needs. This is especially true among special populations and survivor communities who are close-knit and less likely to welcome support from outside their known community. This may include those who are more isolated or less socially connected due to location, transportation, age, abilities, ethnicity, cultural and/or linguistic differences, or those for whom the existing health and human services system of care is less than equitable and accessible due to historic and current marginalization. With a **solution focus** in mind, questions arise: *“Where do we begin?” “How can we reach and support recovery in disaster survivors who are the most impacted and often more marginalized?” “What changes can we make to attain desired CCP outcomes for survivors?”* **Solution-focused examples of partnerships, meeting survivor population needs, and attainable outcomes** include:

- **Survivor outreach to older adults and those living with disabilities residing in low-income urban housing and rural communities.** Partnering with the state and regional area agencies on aging and agencies

for people with disabilities and their loved ones in the disaster-impacted regions expands outreach to survivors. Collaborating with the adult, aging, and disability provider networks who are engaged in meal delivery, home visiting, transport, and health and personal care resulted in increasing combined health and mental health messaging, normalizing signs and symptoms of disaster-related stress and seeking and accessing support, screening, and referrals to more intensive behavioral health services. This often helped to re-engage in needed services, and provided crisis counseling support to the providers who tirelessly were engaging with this population and experiencing personal/family disaster recovery. In my experience with administering CCPs since

Hurricanes Fran (DR-1134-NC) and Floyd and Irene (DR-1292-NC) through Matthew (DR-4285-NC) and especially during Florence (DR-4393-NC), as well as COVID-19 (DR-4487-NC), cross-training and coordinated community outreach to address survivor emotional distress and isolation were essential strategies. Improved outcomes resulted from strengthening self-care skills, social connection, and wellness through leveraging the development of skill-based tools such as wellness calendars, tip sheets, and accessible voice messages, and 2- to 3-minute video skill-building tools. CCP survivors reported an improved sense of connectedness and used coping skills; caregivers and home visitors reported improved skills to offer support and resources; and



all reported an improved sense of wellness and feeling less alone.

- **Sustaining trauma-informed survivor recovery learning communities and grief and loss support groups.** We made connections with new partners, e.g., faith communities, and nontraditional partners, i.e., small business owners, farmers, and migrant health providers, to continue learning communities and support groups formed in response to and beyond the disaster event. Many of these and surrounding communities acknowledge that holidays are often challenging for some, especially disaster survivors. “Blue Holiday” or “Pause for Gratitude” events are now part of many communities’ traditional activities planned. “Paws for Hope” offered support to companion animal shelter/rescue and veterinarian services with pet deaths, surrenders, and other disaster-related, high-stress losses. One community leveraged resources to help pet owners shelter their pet or companion animal at home when surrender seemed the only option. These events promote mental wellness and resilience, honoring survivor loss and expressing gratitude to first responders and healthcare professionals, among other survivor supports.
- **Tribal and faith community leadership in behavioral health disaster recovery.** Crisis counselors with community health



A North Carolina CCP team meeting with survivors. Photo courtesy of Susan Robinson.

workers among others continued to show up and make connections with Indigenous leaders in communities, such as with the trusted leaders and members of tribal and faith communities in rural North Carolina. After several months of experiencing devastating disaster-related health and behavioral health impacts of the COVID-19 pandemic in their families and communities, through outreach alliances, tribal leaders participated in filming videos and messages highlighting the need to seek health and behavioral health care to be resilient and recover well. A youth musician developed a video reinforcing a message of hope to her peers promoting the CCP. These tools continue to be used in community education and outreach and spurred additional

like messaging for recovery and preparedness prevention.

- **“One size does not fit all” among diverse survivor communities.** Behavioral health disaster recovery has common components; however, the delivery of the message and messengers may vary. Building survivor trust of a CCP and counselors is essential to effective outreach and engagement. Recruiting and matching crisis counselors with specific population outreach efforts and pairing outreach with other key partners, including Indigenous partners and those who are community member allies, are often the pathways needed for effective outreach. In most counties in North Carolina, as in other states, several communities

may exist who have common languages of origin, with bilingual or ethnic and/or cultural traditions. Although language is common, dialects, traditions, and guiding leaders are different; how community members relate to one another or how local and state services or assistance is welcomed may vary. Forming strategic partnerships with local public health and community health workers is invaluable in the CCP and public, rural, and migrant health programs effectively engaging with diverse survivor communities. We have also found it helpful to form strategic alliances with Latino coalitions, immigrant and refugee sponsoring organizations and assistance programs, migrant health centers, and employee assistance programs. The lesson learned over

time is that what works for one community may not work for all.

- **Be the news employers can use.** Small businesses, vehicle repair garages, diners, factories, meat packing plants, grocery stores and pharmacies, vision and dental practices, and personal care salons (barbers, stylists, nails, etc.) all need resource supports during disaster recovery to help their employees and families get help needed to stay mentally and physically well through recovery. Offer to provide educational outreach during breaks or mealtimes for owners and employees—both for their own self-care and referring their clientele to seek crisis counseling. Make survivors aware of common reactions to stress, normalize stress responses, and teach self-care

skills to cope throughout the day.

- **Be a strategic communicator.** Use state and local public agency communications systems to promote awareness and trauma-informed, safe, normalizing messaging on signs and symptoms and on seeking help through crisis counseling. Such communications systems use multi-channel communication strategies which leverage local media who readily disseminate public messaging. Systems such as public schools are key partners in getting the word out in the disaster-impacted communities and statewide as needed. Public schools, often used for shelters, are more readily able to share social media posts, emails, robocalls, and street sign postings to promote access to crisis counseling through disaster recovery. Strategic relationships can effectively extend and increase accessible messaging among those most impacted during recovery. Strategic communication strengthens consistency in branding and normalizes help-seeking during recovery.
- **Engage peer-to-peer supportive outreach, training, and ongoing support.** Often the eastern coast of North Carolina is most impacted by disasters. Over time, managed care organizations and provider networks in non-disaster-affected areas have become trained and attuned to the needs of their peer organizations/providers. Peer-to-

Potential Partners for Disaster Behavioral Health Programs

- Adult, aging, and disability provider networks
- Faith communities
- Tribal leaders, governments, communities, and organizations
- Local community health workers
- Immigrant and refugee sponsoring organizations and assistance programs
- Public schools
- Regional and state military, veteran, and National Guard liaisons and veteran services coordinators

peer disaster behavioral health outreach and support to staff and teams has been invaluable in recovery of help givers who are also in the midst of recovery themselves. The key lesson learned is to engage others as peer partners to partner with managed care organizations and provider networks who are not only in the midst of crisis response in the immediate disaster, but also survivors impacted and in recovery themselves. This initial and ongoing or periodic trauma-informed behavioral health disaster recovery support is critical for these entities to recover well and be resilient and prepared in helping their community and those with whom they work to recover.

- **“Ask the question”—strategic alliances with veterans, military, and National Guard members and their families** extend the opportunity to effectively provide crisis counseling services, prevent deaths by suicide and suicide attempts, and increase referrals to treatment providers who can help in recovery. Reach out to the regional and state military, veteran, and National Guard liaisons and the regional and county veteran services coordinators. Develop relationships with state-level veteran collaboratives or workgroups and public school military family liaisons. Engage them in promoting disaster behavioral health recovery services and supports through their



broad stakeholder communications portals in the disaster-impacted region and statewide. It is important for crisis counselors and disaster case managers to “ask the question” of survivors—“Have you or someone you love served in the armed services?”—in order to be aware of additional stress and needs and to link survivors with the vast array of services and supports specifically designed to help.

Mechanisms That Support Partnerships

Formal agreements such as memoranda of understanding (MOUs), while important, are often time-intensive and can often take longer to draft and get formal signature approval of than the timeframes for the CCP allow. Identify existing MOUs that support the needed functions and common

outcomes of behavioral health disaster recovery. These may include existing regional, county, or town/city MOUs for resource or job fairs, health fairs, or educational events in which crisis counselors will be included as participants providing educational outreach for behavioral health recovery, resiliency skills, and preparedness.

Action in lieu of a formal agreement. In several North Carolina rural towns and counties, the town managers and town councils took action, welcoming CCP staff presentations during their meetings, and identified ways in which the town leaders and businesses would learn about and support behavioral health disaster recovery in their communities. One town council hosted “meet and greet” breakfast and lunch events to help inform and engage community members in normalizing behavioral

health responses in recovery and increase access to needed CCP services. Strategic partnerships grew as a result to further expand outreach and access to CCP services such as expanded media coverage aimed at educational outreach in understanding signs and symptoms, joining “listening circles,” and seeking crisis counseling support.

Letters of intention and letters of collaboration between entities are often a timelier and more accessible way to initiate or solidify a partnership during disaster recovery. Examples include establishing:

- *Transportation agreements* for a negotiated period of time with reduced fees or free passage on ferries or toll roads for crisis counselors who must use these means to access survivors on disaster-impacted coastal islands.
- *Intra-departmental budget transfer agreements* among two state offices in order to facilitate expedited CCP implementation.

These agreements may be between the state office of emergency management and the state mental health agency (SMHA) for the CCP ISP implementation, or the SMHA and the divisions of vocational rehabilitation, services for the blind, and services for the deaf and hard of hearing in order to complete mailings, including in large print, auditory messaging, braille, Spanish, and other languages, as well as videos in American Sign Language.

- *Administrative policies and agreements in advance of and preparation for disaster events.* The SMHA’s budget and contract offices need to have nimble procedures and processes in place or that can be readily activated to support expedited mechanisms for establishing budgets, accessing and distributing funds, and invoice processing for timely reimbursement within a compact CCP timeline for the ISP and smooth transition to RSP. Delays

in funding create serious delays in needed CCP behavioral health disaster recovery response.

- *Agreements and joint communications* with local public libraries, schools, childcare programs, and faith communities that welcome regularly scheduled crisis counseling outreach, group counseling, and “listening circles” for staff, families, students, and community members at large.

Be “a constant reassuring presence.” As a CCP, one’s goal is to always engage with existing partners and create new partnerships such that the CCP will be readily recognized as “a constant reassuring presence” in their communities. Being well-branded and well-known in the eastern coastal and central regions of North Carolina promotes easily renewed recognition when future events occur. With disaster recovery through COVID-19, this recognition is now true across North Carolina’s 100 counties.

During COVID-19, for many, the CCP was a new resource that grew statewide in recognition as an integral behavioral health resource promoting wellness, building resilience, and supporting recovery as well as working with public health partners in promoting prevention and preparedness in the unprecedented times of the COVID-19 global pandemic.

Often many of the community stakeholders within existing





partnerships are impacted and are survivors of the federally declared disaster event. With this in mind, CCP crisis counselors provide comfort, reminding survivors that they are not alone and someone cares. Stakeholders report still using skills and strategies they learned from CCP outreach and group counseling and sharing these coping skills and tools with those with whom they work, family, friends, coworkers, and faith communities.

Be stronger together. “. . . *Look for the helpers, they are always there . . .*” Key partners exist within the state and county emergency management operations network as well. In significant Individual Assistance disaster recovery needs assessment plans, Disaster Case Management (DCM) program assistance is often approved to allow states to offer additional support to survivors with physical property damage. Crisis counselors building alliances with the disaster case managers provide survivors with both emotional support and coping skills to help them be able to take the next steps in their physical recovery process with

the disaster case managers. Crisis counselors are often supported by the voluntary organizations active in disaster (VOAD) partners who connect with the long-term recovery groups and community volunteer assistance supports through disaster recovery. Often, VOAD members and crisis counselors collaborate to create needed survivor resources where gaps arise. Crisis counselors provide training in trauma-informed resiliency skills and self-care strategies for DCM and VOAD collaborative partners.

Celebrate partnerships and transitions. *What are the connections that sustain hope?* Contributions of partners, big or small, for a week or months, in the disaster recovery arena are valuable. Lessons are learned; next steps and new strategies and new partnerships are forged. Transition planning is essential when implementing ISP to RSP, acknowledging anniversaries, and phasing down the RSP. It is crucial to leave the disaster-impacted community well and survivors and partners connected with resources and services in communities or

nearby. During disaster recovery, resource directories are created or updated with current services and supports. These resource directories will continue to be used by survivors and updated by existing community collaboratives and regional agencies on adult and aging services, veteran services coordinators, public libraries, long-term recovery groups, and VOADs.

Celebrate lessons learned. Crisis counseling services implementation requires ongoing needs assessment and data collection, planning and implementation, evaluation, data and adjustments, and beginning again. Gather perspectives from survivors, partners, staff, and all stakeholders. Use a simple survey tool or inquiry process. Consider recommendations and priorities in preparing for future behavioral health disaster recovery responses.

Disaster behavioral health recovery begins with the end in mind, leaving communities recovering well and resilient, and survivors and partners connected with nearby resources and services. With each behavioral health disaster recovery event new lessons are learned to apply in preparation for when future events occur.

Celebrate transitions acknowledging individual and community strengths and resilience, expressing gratitude for partnerships, connections that sustain hope, contributions, survivors reached and success stories, lives saved, and lessons learned. ■

RECOMMENDED RESOURCES

Promising Practices in Disaster Behavioral Health Planning

This short video from SAMHSA DTAC defines the core components of effective disaster behavioral health partnerships and how to build them. Throughout the video, examples are provided of successful partnerships.

You can watch the video at <https://bit.ly/3J3u7Cr>.

Partners and Collaborators for Emergency Preparedness and Response

Part of the [Rural Emergency Preparedness and Response Toolkit](#), this web page explains the importance of partnerships as part of emergency preparedness and response and describes how they might be established. The page also identifies potential local, state, and national partners and provides links to more information for and about American Indian and Alaska Native communities in emergency preparedness and response. The toolkit appears at the website of the Rural Health Information Hub, which is funded by the Health Resources and Services Administration's Federal Office of Rural Health Policy.

Access the page at <https://bit.ly/3J4fYGc>.

Partnerships for Recovery Across The Sectors (PRACTIS) Toolkit

This toolkit translates a study on the New York Department of Health and Mental Hygiene Office of Emergency Management and Response and their existing partnerships into actionable guidance for local health departments. Designed for emergency managers, community resilience coordinators, and community outreach staff, this resource instructs users on how to engage and leverage relationships with community-

based organizations. The toolkit will help the user assess current partnerships and strengthen recovery efforts.

This resource is available for download at <http://bit.ly/3n2r8m2>.

Communication Partnerships for Public Health Emergencies

In this webinar from the Centers for Disease Control and Prevention's Emergency Partners Information Connection (EPIC), a senior health communications specialist presents on how to plan and pursue partnerships, how to make partnerships beneficial, and how to work with partners to reach those who need information the most. The presentation covers best practices for health communication in a crisis supplemented with examples from EPIC's own partnerships.

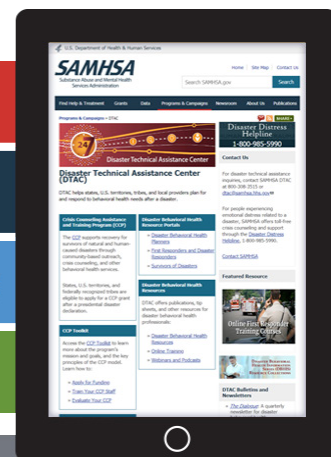
The webinar can be viewed at <http://bit.ly/3LxTDCu>.

E-Learning

Webinars

Conferences

Trainings



<https://www.samhsa.gov/dtac>

Recent Technical Assistance Requests

In this section, read about responses SAMHSA DTAC staff have provided to recent technical assistance (TA) requests. Send your questions and comments to dtac@samhsa.hhs.gov.

Request: A representative from Disaster Behavioral Health Services within the Texas Health and Human Services Commission requested trainings and resources on mass violence for disaster behavioral health professionals.

Response: SAMHSA DTAC provided a list of trainings and resources on mass violence. The resources below are a sample of those sent. For additional information, please contact SAMHSA DTAC at 1-800-308-3515.

■ **Crisis Services: Meeting Needs, Saving Lives**—The book is composed of SAMHSA’s “National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit” and related papers on crisis services. The toolkit reflects relevant clinical and health services research and offers a review of top national program practices, as well as replicable approaches that support best practice implementation.

<https://store.samhsa.gov/product/crisis-services-meeting-needs-saving-lives/PEP20-08-01-001>

Request: A territory reached out to SAMHSA DTAC to enlist the team’s assistance in updating a chapter of a disaster response plan specific to disaster behavioral health.

Response: SAMHSA DTAC conducted a thorough review of the chapter and provided recommendations. The items below are a sample of those sent. For a review of your state’s, territory’s, or tribe’s disaster response plan, please contact SAMHSA DTAC at 1-800-308-3515.

SAMHSA DTAC recommended the following:

■ Plans for forming an emergency planning committee

should include details regarding how committee members will be recruited, what qualifications will be required for members, how long members will serve on the committee, and whether committee members will be financially compensated for their work.

- Disaster response plans should identify applicable grants or funding opportunities and requirements for grant applications. SAMHSA DTAC identified possible grants or resources of interest from the Federal Emergency Management Agency Disaster Case Management program or the American Red Cross, as well as the Crisis Counseling Assistance and Training Program.
- The territory should establish policies and standards regarding information management and sharing between federal and local community partners and the public.
- States, territories, and tribes should identify partner agencies to develop cooperative agreements. SAMHSA DTAC recommends establishing responsibilities, limitations, and possible jurisdictions with partnering agencies.
- Disaster response plans should identify training opportunities provided to response staff, volunteers, and first responders. Plans should include information about the administration and requirements of trainings.
- Disaster response plans should identify steps to support demobilization of partner agencies, staff, and volunteers transitioning from disaster response programs.
- Disaster response plans should include information regarding deploying, monitoring, and demobilizing staff and volunteers. This information may include plans to coordinate arrangements for staff and

volunteers such as sheltering, transportation, and psychosocial support to address stress, burnout, and other possible challenges.

Request: A state behavioral health coordinator requested assistance revising the state's behavioral health emergency response plan.

Response: SAMHSA DTAC coordinated a meeting with the state to discuss their behavioral health service structure and foundational documents for revising behavioral health emergency response plans. SAMHSA DTAC connected the state with a consultant who was able to support the state's revision of their behavioral health emergency plans. The team highlighted resources included in the Disaster Behavioral Health Planners Resource Portal on the SAMHSA DTAC website as well as other relevant resources. A sample of these resources is included below.

■ **Disaster Behavioral Health Planners Resource Portal**—This SAMHSA DTAC web page provides resources to assist states, territories, and tribes with aspects of disaster behavioral health planning. It features pre-recorded webcasts and tools that explore strategies for developing comprehensive plans and identifies tips for ensuring timely and effective crisis communication.

<https://www.samhsa.gov/dtac/disaster-planners>

■ **Psychological First Aid (PFA) Online**—The National Child Traumatic Stress Network offers this online course to train new disaster responders in PFA, as well as to provide a refresher training for responders who want to review this approach to disaster response. The course describes the core actions of PFA and how they can be applied after a disaster and discusses provider well-being.

<https://learn.nctsn.org/course/view.php?id=596>

■ **Skills for Psychological Recovery (SPR) Online**—

An evidence-informed intervention for disaster response workers, SPR (<https://www.nctsn.org/treatments-and-practices/psychological-first-aid-and-skills-for-psychological-recovery/about-spr>) is based on six skills disaster survivors can use to cope with challenges encountered during disaster recovery.

People providing SPR to disaster survivors can do so in a single session for each skill, with reinforcement with handouts and practice done after the session. To complete SPR Online training, you must create an account at <https://learn.nctsn.org/login/signup.php>.

<https://www.nctsn.org/resources/skills-psychological-recovery-spr-online>

■ **TAP 34: Disaster Planning Handbook for Behavioral Health Service Programs**—This Technical Assistance Publication (TAP) from SAMHSA provides guidance for management and staff creating a disaster plan. It explores planning, response, and recovery strategies to promote behavioral health, recovery efforts, and partnerships.

<https://store.samhsa.gov/product/tap-34-disaster-planning-handbook-for-behavioral-health-service-programs/pep21-02-01-001>

Request: Lions Club International Foundation, a national partner with the U.S. Drug Enforcement Administration Operation Engage, was planning a webinar to raise awareness around disaster preparedness and response. A representative from the organization requested assistance finding an expert to participate in a panel focused on disaster relief and reduction of mass casualty events.

Response: SAMHSA DTAC shared several experts in the field who might be able to participate in the panel. SAMHSA DTAC provided the contact information for these experts as well as biographical sketches for each.

REFERENCES

Rural Health Information Hub.
(n.d.). Partners and collaborators
for emergency preparedness
and response. *Rural emergency
preparedness and response toolkit*.
[https://www.ruralhealthinfo.org/
toolkits/emergency-preparedness/1/
partners-collaborators](https://www.ruralhealthinfo.org/toolkits/emergency-preparedness/1/partners-collaborators)

Spear, T., McGee, L., & Drennen,
C. (2011, July 27). *Promising
practices in disaster behavioral*

*health planning: Building effective
partnerships* [Webcast]. [https://www.
youtube.com/watch?v=e95C4yMybP4](https://www.youtube.com/watch?v=e95C4yMybP4)

Substance Abuse and Mental Health
Services Administration Disaster
Technical Assistance Center. (2019,
December 17). *Promising practices
in disaster behavioral health*

planning: Partnerships [Video].
YouTube. [https://www.youtube.com/
watch?v=jmffK-aPuyY](https://www.youtube.com/watch?v=jmffK-aPuyY)

*The views, opinions, and content
expressed in this publication do not
necessarily reflect the views, opinions,
or policies of the Center for Mental
Health Services (CMHS), the Substance
Abuse and Mental Health Services
Administration (SAMHSA), or the U.S.
Department of Health and Human
Services (HHS).*

Help Improve SAMHSA's Disaster Services and Products



As a subscriber to this newsletter, you are invited to participate in a short, web-based survey to provide the SAMHSA Disaster Technical Assistance Center (DTAC) with feedback about your experiences with our products and services. The survey should take no more than 15 minutes. Complete the survey by going to the [survey web page](https://iqsolutions.qualtrics.com/jfe/form/SV_bjYCSJDUQAGi1h3), or copy and paste the URL https://iqsolutions.qualtrics.com/jfe/form/SV_bjYCSJDUQAGi1h3 into your web browser.

Are you looking for disaster behavioral health resources?

Check out the new and updated
SAMHSA DTAC Disaster Behavioral Health Information Series (DBHIS) installments.



<https://www.samhsa.gov/resource-search/dbhis>

Prepare • Respond • Recover Inform • Assist

SUBSCRIBE

The Dialogue is a publication for professionals in the disaster behavioral health field to share information, resources, trends, solutions to problems, and accomplishments. Contact SAMHSA DTAC to be added to *The Dialogue* subscription list.

SHARE INFORMATION

Readers are invited to contribute to *The Dialogue*. To author an article for an upcoming issue, please contact SAMHSA DTAC at dtac@samhsa.hhs.gov.

ACCESS ADDITIONAL SAMHSA DTAC RESOURCES

The *SAMHSA DTAC Bulletin* is a monthly e-communication used to share updates in the field, post upcoming activities, and highlight new resources. Contact SAMHSA DTAC to be added to the *SAMHSA DTAC Bulletin* subscription list.

The SAMHSA Disaster Behavioral Health Information Series contains resource collections and toolkits pertinent to disaster behavioral health. Installments focus on specific populations, specific types of disasters, and other topics related to all-hazards disaster behavioral health preparedness and response. Visit the SAMHSA DTAC website at <https://www.samhsa.gov/resource-search/dbhis> to access these materials.

CONTACT US

SAMHSA Disaster Technical
Assistance Center

Toll-free: 1-800-308-3515

dtac@samhsa.hhs.gov

<https://www.samhsa.gov/dtac>