National Healthcare Preparedness Programs (NHPP)
Integrating Behavioral Health to Strengthen Healthcare Preparedness Capabilities and Coalitions Webinar and National Call

March 20, 2014
2:00 PM – 3:30 PM Eastern Time

I. Welcome, Introductions and Overview

– Dr. Cynthia Hansen, Senior Advisor, Division of National Healthcare Preparedness Programs (NHPP) (Cynthia.Hansen@hhs.gov)

On behalf of Dr. Nicole Lurie, the Assistant Secretary for Preparedness and Response (ASPR), Mr. Don Boyce, the Deputy Assistant Secretary and Director of the Office of Emergency Management and Ms. Jennifer Hannah, Acting Director for the National Healthcare Preparedness Programs, welcome to the sixth in the series of technical assistance webinars hosted by the National Healthcare Preparedness Programs. I am the Senior Advisor to the Division Director of NHPP, as well as a clinical psychologist with decades of experience in public and private sectors as well as disaster response.

Today's topic is integrating behavioral health to strengthen healthcare preparedness capabilities in coalitions. We would like to thank all our speakers for their great work and generosity in preparing for this webinar. The speakers will provide a wealth of information and a variety of strategies used to integrate behavioral health into all eight healthcare capabilities.

Each speaker will discuss the added value that representation from the mental health and substance abuse system at the state, local, tribal and territorial levels of government brings to healthcare coalitions. Speakers will also address:

- Strategies for continuity of operations and surge for behavioral health and substance abuse services
- How to incorporate behavioral health into gap and capacity analyses, particularly looking at behavioral health training programs that address both responder safety and health, and public health interventions
- Identifying behavioral health objectives for exercising

Measurement is critical. One of the Hospital Preparedness Program (HPP) budget period 2 program measures is related to the recovery plan and its inclusion of information on meeting the post-disaster behavioral and mental health care needs of communities. Measurement allows us to know what we are doing, what we can do better, and when we have achieved a successful outreach and response and recovery process.

Our first speaker will be Dr. Dan Dodgen who is the director of the Division for At-Risk Individuals, Behavioral Health, and Community Resilience in the ASPR Office of Policy and Planning.

II. Strengthening Hospital Preparedness Capabilities and Coalitions with Behavioral Health

– Daniel Dodgen, Ph.D., Director, Division for At-Risk Individuals, Behavioral Health, and Community Resilience (ABC), HHS/ASPR/Office of Policy and Planning (Daniel.Dodgen@hhs.gov)

– Rachel Kaul, LCSW, CTS, Behavioral Health Team Lead, ABC, HHS/ASPR/Office of Policy and Planning (rachel.kaul@hhs.gov)

Dr. Daniel Dodgen
Thank you, to everyone for being on this call and, in particular, to the NHPP team for ensuring these important issues around behavioral health, at-risk individuals and community resilience are integrated into the work of the HPP program. In addition to the support provided by HPP, ABC is also available to provide information and assistance on this topic.

We will discuss:

- How to integrate behavioral health into the work of NHPP, particularly around the healthcare coalitions
- Tools, resources, et cetera that exist at the federal level
- Identifying success

The ABC office provides the overarching policy guidance and coordination and subject matter expertise for at-risk individuals, behavioral health and community resilience and is here to help. In order to be successful at making our communities more resilient in the health sector, to have the kind of well-being that enables them to respond to and recover from emergencies more quickly, it is critical that planning includes not just behavioral health, but also attention to at-risk individuals. Resilient communities are communities that have robust connections within the health sector, broader social services, and even the social sector.

Today we will hear about some state-of-the-art projects and we welcome information from those on the call who are doing things in this mission space—innovative things around behavioral health or at-risk individuals or promotion of health resilience.

Our next speaker is Rachel Kaul who has been with ASPR for a number of years and before that was at the Substance Abuse and Mental Health Services Administration (SAMHSA). Prior to that, she was at the Pentagon helping with crisis response coordination and she also served as a state disaster behavioral health coordinator.

Ms. Rachel Kaul
I am going to discuss recent federal efforts underway aimed at promoting and facilitating behavioral health inclusion in preparedness activities.

In 2008, the Disaster Mental Health subcommittee of the National Bio Defense Science Board noted there was a need for improved coordination of disaster behavioral health activities at the federal level. As a result, ASPR convened an interagency working group comprised of representatives from federal agencies, regional staff and even nonprofit stakeholders. This group created the first national Behavioral Health Concept of Operations (CONOPS).

The first version was released in 2011 and it intentionally went beyond a traditional CONOPS in that it included conceptual language to frame disaster behavioral health and described not only federal roles and responsibilities, but also disaster behavioral health activities carried out at the state and local levels. The CONOPS has recently been revised to include lessons learned and practices developed during recent responses such as super-storm Sandy, the Sandy Hook shooting and the Boston Marathon bombing.

The CONOPS provides links to resources, such as a behavioral health capacity assessment tool, as well as links to other partners, such as the National Child Traumatic Stress Network, the Red Cross, and SAMHSA.

SAMHSA has created several resources including a disaster behavioral health response mobile application. The application has the ability to locate mental health and substance abuse providers in a disaster affected area and allows responders to quickly link to and obtain population- or event-specific resources on their phones or tablets.

Another SAMHSA resource is the Disaster Distress Helpline which is a toll-free, multilingual crisis support hotline available at all times nationwide. They can be contacted by:

- Phone: 1-800-985-5990
- Text: Text "Talk with us" to 66746
- Online: www.disasterdistress.SAMHSA.gov

In spite of the numerous efforts going on at federal, state and local levels, there is still more that needs to be done to better include behavioral health in public health and medical preparedness and response efforts. A report recently released by the Council of State and Territorial Epidemiologists (CSTE) highlights how far we have to go. The CSTE and the Centers for Disease Control (CDC) collaborated to conduct a needs assessment to better understand the relationship between public health and mental health in state health agencies. The assessment focused on surveillance activities related to mental health during emergency events and examined topics such as:

- Current use of state or federal mental health surveillance systems
- The extent to which mental health is included in disaster preparedness planning
- Types of mental health data and assessments needed following a disaster
- Barriers to mental health surveillance and the use of mental health surveillance data

Their analysis confirmed that effective and comprehensive integration of behavioral health into public health and medical emergency planning is sporadic at best across the nation. Some of the recommendations formulated by the CSTE include:

- Increase collaboration between mental health (MH) and public health (PH) prior to emergencies
- Identify surveillance goals to work toward common objectives
- Create opportunities to exercise and drill with partner organizations
- Include standardized, validated MH questions in national and state-based surveys
- Increase collaboration between MH programs, PH programs and emergency management personnel
- Meet jointly with partners (e.g., MRC, American Red Cross Chapters) to identify and recruit MH professionals.
- Develop guidance and training to address Federal Public Health Emergency Preparedness Capability 14 requirements
- Engage epidemiologists

Listeners are encouraged to read the full report for more findings and recommendations.

Deliberate and careful analysis of the capacity of the behavioral healthcare system in your state or locality can provide the information needed to leverage, promote and highlight the value of putting resources and efforts towards collaborating with and including behavioral health in emergency

preparedness and planning. This is a key aspect of community health resilience and we hope that today's webinar provides some strategies and insights into how to improve and expand on your current efforts and to engage with and incorporate behavioral health into your activities.

Please consider the ABC office a resource. Any member of our behavioral health team would be happy to help.

Dr. Cynthia Hansen
The CTSE report highlights how challenging it can be to connect public health and mental health. Within the 49 states that responded to the survey, only two states have the same department and division for public health and mental health or substance abuse agencies. That means it is necessary for most states to work outside of division/department lines.

The District of Columbia Department of Health will now speak about how they are bringing behavioral health to the table of their coalition with value-added for everyone's mission.

III. District of Columbia Department of Health

– Peggy Keller, PHEP/HPP Coordinator, (peggy.keller@dc.gov)
– Craig DeAtley, PA-C, Administrator/ Emergency Manager MWHC/MNRH, DC Emergency Health Care Coalition (DCEHC) (Craig.deatley@medstar.net)
– Kevin O'Brien, Ed.D., Director Disaster Behavioral Health Services (kevin.obrien@dc.gov)

Ms. Peggy Keller
One goal of the D.C. Department of Health is to integrate behavioral health planning into all planning and response activities. This concept was integrated into the health and medical planning for the inauguration. The Department of Behavioral Health team was at the table for all the planning and Department of Behavioral Health staff even paired with the Secret Service agents on the mall. Five-star training and disaster mental health components are also incorporated into preparedness, response, and resilience training.

Mr. Craig DeAtley
The D.C. Emergency Healthcare Coalition is a multi-organizational element of our healthcare system that includes all 12 D.C. hospitals, all 49 clinics, all 20 skilled nursing facilities, all 12 dialysis centers, all 9 blood banks, the poison control center and several other organizations including private sector membership. Equally important to the coalition function are our government partners including the Department of Health and the Department of Behavioral Health Services, among others. From its inception, our coalition intended to be both a planning organization as well as a response organization. To accomplish this, we realized we needed to be as inclusive as possible with a commitment to address the behavioral health aspects in addition to the physical aspects of an incident.

Two years ago the coalition formed a behavioral health task force composed of representatives from skilled nursing facilities, hospitals and the Department of Health, including the Behavioral Health Department. The intent was to better understand the issues, but also to establish a more standardized method of planning across the D.C. healthcare system and to develop a behavioral health planning template for all coalition facilities. Through this standardization and implementation across the spectrum of facilities, we hoped to better utilize private sector-based and public safety-based behavioral health resources. We are also committed to developing a better understanding of the unique aspects of

behavioral health as a component of response, regardless of incident type, through educational programs for the public and for individual clinical and nonclinical personnel at our healthcare facilities. To identify ways to be better able to take care of ourselves as well, we engaged Chip Schreiber to address psychological first aid for healthcare and behavioral health professionals.

The planning template identifies a variety of mass casualty or mass effect situations, as the behavioral health issues could vary depending upon the circumstances, but regardless of the event type, the response would require the community to seek assistance from healthcare facilities, the D.C. government, the Department of Health and the Department of Behavioral Health.

Mr. Kevin O'Brien
Disaster behavioral health in the District of Columbia involves mental health, substance abuse/misuse and basic stress management. It is an evolving field and we are working on two fronts: incident management and support of vulnerable populations. We have done training with the Department of Health for a variety of organizations and providers. The behavioral health factors directly and indirectly influence individual community risks, health resilience and the success of emergency response strategies.

Often people do not seek out behavioral health services following a disaster. Therefore, during the initial phases of behavioral health response, we use an outreach model that involves a myriad of interactions with a number of different jurisdictions.

In a disaster, individuals are going to be displaced and separated from their common supports and there will be some communication difficulties. Additionally, responders will be at risk. With that in mind, our trainings are designed to:

- Provide an overview of behavioral health needs assessment and triage
- Train all responders in the PsySTART model
- Identify targeted interventions for specific vulnerable populations

The Department of Behavioral Health is the agency responsible for the behavioral health response and it offers a certification program for disaster behavioral health responders. In this capacity, we are responsible for providing responders to hospitals and other facilities. We are working to triple the number of potential responders. All candidates go through a background check and an interview and are required to complete a two-day training program.

We also work with our provider agencies on their continuity of operations planning to minimize the need to surge seriously mentally ill or vulnerable populations to hospitals. We provide the agencies with continuity of operations plan templates and provide training to implement the plan. As a result of this planning, some of our residential group homes that house seriously mentally ill people obtained a grant to purchase a standby generator so that residents will not have to be moved in the event of a power outage.

In most instances, the psychological footprint for an event is larger than the medical footprint. In the 1995 Sarin attacks in Tokyo there were 978 people hospitalized, 63 injured and 12 people died, but over 4,000 people showed up in emergency rooms directly following the attack. During the 2001 anthrax attacks in the Washington, DC area, 17 people were affected and five people died, however, there were thousands of people seeking treatment in hospitals and emergency rooms throughout the area.

For every mortality it is generally assumed that eight to ten people are directly affected and they may not be in the same area. The psychological and behavioral treatment goes for days, months and years after the incident. Research has shown the link between exposure to trauma and other health-related concerns that increase costs and the need for care. Events can impact responders, individuals, families, healthcare facilities and the community as a whole and incident management may continue for years beyond the event.

IV. Los Angeles County Department of Health Services, Emergency Medical Services Agency

– Sandra Stark Shields, LMFT, CTS, Sr. Disaster Services Analyst (sanshields@dhs.lacounty.gov)

This presentation will highlight the mental and behavioral health initiatives that Los Angeles County has been able to implement as a direct recipient of HPP funding. Los Angeles County has focused on mental and behavioral health since the beginning of our grant program. For example, the county hired me, the first mental health professional ever to be hired by the EMS agency.

We have worked with RAND and key stakeholders, including our Department of Mental Health and Department of Public Health. We developed a training program called "Preparing hospitals and clinics for the psychological consequences of a terrorist incident or other public health emergency." The training takes about two hours and focuses on how to integrate mental health within hospital and clinic disaster planning. Included in this training is a disaster planning template called a "Repeat Tool" that addresses staff and patient considerations. The training program is available at http://ems.dhs.lacounty.gov/Disaster/DisasterTrainingIndex.htm.

Some key recommendations for integrating behavioral health are to:

- Include mental health professionals, chaplains, etc. on disaster planning teams. Mental health or behavioral health staff should work with the hospital incident command structure (HICS) to plan for the mental health of staff and patients.
- Recruit a disaster mental health response team in advance
- Include planning for a surge of psychological casualties in disaster exercises

Los Angeles County has a disaster health advisory committee that includes representatives from 88 hospitals, 33 clinics, the county Departments of Mental Health and Public Health, dialysis, long-term care facilities, hospice facilities, ambulatory surgery centers and others. The committee meets quarterly. There are also stakeholder groups, including the Disaster Resource Center (DRC) group, that meet more frequently and send information up to the advisory committee.

We then began to work with Dr. Chip Schreiber from the University of California, Irvine, to integrate the PsySTART disaster mental health triage within our hospital and clinic settings. We began with a small pilot group of hospitals and clinics and then expanded from there.

Our stakeholder groups asked for a tool for the care of staff following a disaster, so we developed a staff resiliency system called "Anticipate, Plan, Deter." The tool includes a Concept of Operations (CONOPS), an exercise plan, and a sustainability plan. Initially not everyone saw the need for the tool, but once H1N1 hit, the reality of a surge of psychological casualties became apparent.

Some of the tools/information that can be found on the Los Angeles County website include:

- Concept of Operations

- Exercise guidebook
- Anticipate, Plan, Deter: Healthcare worker resiliency training
- PsySTART: Application for phones, computers, and tablets to enter triage data

The PsySTART application can also provide an overview of where the psychological casualties are by hospital and clinic and what elements of the surge are being experienced, i.e. what exposure people have had. This is an excellent planning tool that can be used to make strategic decisions during a disaster and following for future mental health response.

The Anticipate, Plan, Deter training is provided to healthcare workers prior to a disaster and its principles can be applied during a disaster as well. It grew out of our stakeholder group's desire to take better care of staff members. We need to own the fact that our staff is going to be impacted by disasters and we need to act in advance to develop resiliency. We provide training to hospital staff and also provide train-the-trainer sessions so hospitals can do additional training themselves. The training is designed to have staff develop a coping plan for a disaster with mass casualties so they have that in mind prior to the disaster. There are also some monitoring tools that allow supervisors to monitor staff exposures to help determine what support is needed.

Other resources available include:

- ***Mass Fatality Management Guide for Healthcare Entities*** (http://ems.dhs.lacounty.gov/Disaster/MassFatality.htm) – This was developed by a wide stakeholder group. It is available as a PDF or in Word format so that it is easy to use and adapt. It was developed in close consultation with our Coroner Department, Departments of Mental Health and Public Health, hospitals, clinics, and other healthcare partners.
- ***LA County Family Information Center Planning Guide for Healthcare Entities*** (http://www.calhospitalprepare.org/FIC) – This is a planning guide to help hospitals and clinics bring up a family assistance center or family information center within the hospital setting. It encourages planning for providing comfortable family waiting areas, caring for unaccompanied minors, etc. The plan includes the use of Ready Net, the messaging system that connects the hospitals, clinics, and healthcare partners so individuals can locate family members in another facility without having to go from hospital to hospital looking for family members. We think that is very important.
- ***California Hospital Association (CHA) Mental/Behavioral Health Resources*** (http://www.calhospitalprepare.org/mental-behavioral-health) – The California Hospital Association has been very proactive with mental health and behavioral health. They have a number of mental health resources on their website as well.
- ***State of California Mental/Behavioral Health Disaster Framework*** (http://www.cmhda.org/go/portals/0/cmhda%20files/breaking%20news/1212_dec/ca_mental-behavioral_health_disaster_framework_(12-20-12).pdf) – California conducted a state-led initiative with many stakeholders to develop a framework for mental health/behavioral health planning. The guide is organized according to the disaster planning cycle of mitigation> preparedness > response > recovery. Each section has recommended actions to consider with your stakeholder group in terms of how to move mental health/behavioral health planning forward in your jurisdiction.

One of the challenges we face is that disaster mental health planning is still kind of the caboose on the train when it comes to disaster planning. Some hospitals and clinics have been very enthusiastic and

others have not started. Our strategy is to continue to encourage and provide training, but it can be a bit of an uneven process. To combat this we recommend:

- Providing initial training – An approach that has really worked for us is to start with some basic training. It is very helpful in terms of beginning the conversation about integrating mental health into a hospital and clinic setting and what to have in your facility disaster plan to make sure that mental health is covered for patients and staff.
- Identifying staff benefits – Our Anticipate, Plan, Deter training piqued stakeholder interest because it demonstrated how to take care of staff. That can be the hook that motivates participation.
- Ongoing training and involvement – Another hook has been the trainings that we have developed, some related to PsySTART. This has provided a way for mental health and spiritual care staff to be involved in disaster planning. PsySTART has allowed them to have a bigger, more visible role in disaster planning and response.
- Identifying champions – It is important to identify and develop disaster mental health champions within each facility. Having "true believers" that understand the surge of psychological casualties will help move that planning forward.
- Identifying opportunities – Facilities, hospitals and clinics that have experienced a surge of psychological casualties (shooting, etc.) tend to be more willing to participate because they can clearly see the value.

Moving forward, it would be helpful to have a nationwide way to estimate psychological casualty surge as a routine part of disaster exercises. Just as every disaster exercise scenario indicates expected physical injuries, there should also be a forecast of the surge of psychological casualties to encourage consideration of the surge of psychological casualties as part of disaster exercises on a routine basis. We will know that we have success in terms of mental health and behavioral health when we start to see scenarios that routinely mention the surge of psychological casualties and there is a model or some agreed-upon method to forecast what those psychological casualties might be.

We also need to use whole community planning tools that allow us to have a common operating picture of what is happening with mental health following a disaster. I believe in the efficacy of disaster mental health triage and PsySTART has been helpful in that area. Not only does it help with site management in determining who to see first and who was most exposed to the disaster, but there is also a tool that provides an overall picture by facility to show where those psychological casualties are, what they are experiencing and how those factors are changing over time.

Those items will help get mental health into disaster planning and incident command in a much stronger way using emergency management language and measurable surveillance data. I would urge development of a common way of looking at surveillance and psychological impact following a disaster.

Dr. Cynthia Hansen
Thank you, Sandra. I asked Sandra how she measures success when we were preparing for this call and she said we need to put a mark on the wall in terms of identifying surveillance data that looks at how we anticipate psychological surge and how we move the literature into a real world planning scenario for an exercise with behavioral health objectives. These measures are critical for us to get our heads and our hearts around these needs.

V. Kentucky Community Crisis Response Board

– Deborah M. Arnold, Executive Director (Deborah.m.arnold2.nfg@mail.mil)

I am going to speak to a unique perspective that Kentucky has and how we have integrated even further down into other entities and fully into the emergency management and community level.

The Kentucky Community Crisis Response Board (KCCRB) is a state-funded office that was created following several catastrophic events. The first was a horrible bus crash where a drunk driver hit a bus resulting in 24 pediatric and 3 adult fatalities. The second involved a gentleman who returned to his place of employment where he killed 8 coworkers and wounded 12 others. Those events and additional natural disaster highlighted the need for increased behavioral health planning for disasters.

With the support of the mental health community, a law was passed in 1996 creating the KCCRB. We are a state agency that has the responsibility to recruit, train, credential and direct the state crisis response team to provide free disaster behavioral health services statewide to any community involved in a critical incident or natural disaster. We have been able to integrate behavioral health response services into healthcare coalitions, local emergency management, and responder agencies, by:

- Cultivating relationships – Cultivating a strong relationship with our Department for Public Health was one of our primary activities. We help them meet the CDC's fifteen public health preparedness capabilities through many initiatives and training, community education and planning efforts and they provide us with HPP grant funding to help sustain our staff.
- Creating awareness of behavioral health needs – By performing activities, such as providing free community training programs for providing disaster behavioral health response services at the community level, we have increased awareness of the behavioral health needs. For example, we support the Medical Reserve Corps (MRC) program by providing training to the MRC volunteers. We also support public health events including a mass H1N1 flu vaccination clinic held in Louisville by providing 27 team members to provide stress management for all those who waited 45-60 minutes in a carload of screaming children to get their vaccine.
- Integrating behavioral health into the disaster system – We have partnered with Dick Bartlett at the Kentucky Hospital Association. Through this relationship we have been invited to participate in HPP regional leadership meetings, putting us in contact with the phenomenal HPP leaders who know how to get things done in their coalitions and communities. Through those relationships, we are able to exercise with hospitals and private and public agencies on a routine basis, integrating behavioral health services down to the local level.

  We also work side-by-side with our sister agency, the Department for Emergency Management to increase mutual understanding of priorities and activities and how to work together on any incident or disaster that occurs in Kentucky. There are 120 counties in the state of Kentucky and every county has an emergency manager. Any time a new emergency manager is appointed, they go through a state-level training that includes a module on disaster behavioral health services. The module provides information on what services are available and why it is important to include behavioral health in their community planning and response. It also familiarizes them with KCCRB staff and other resources.

  Additional funding from the emergency preparedness grant funds also enables behavioral health staff to visit the counties to provide technical assistance and facilitate the integration of a disaster behavioral health response piece into the county's emergency response plan. This will fully integrate disaster behavioral health services at the local level into response planning, preparing,

resiliency and mitigation. Having the support of our state emergency management department has really facilitated the growth and acceptance of disaster behavioral health.

Our crisis response team is not exclusively made up of mental health professionals. We strongly embrace including peer professionals, such as law enforcement officers, EMTs, paramedics, dispatchers, coroners, firefighters and emergency managers on the team. By having team members from all the first responding agencies, we have an opportunity to educate those entities about the importance of including behavioral health services to support our first responders, as well as the communities that are impacted.

As a state crisis response team, we respond to critical instances that occur across Kentucky. Recently Officer Ellis was shot and killed on his return home from work and there was a house fire where eight children and their mother perished in one of our smaller communities. We provided crisis response services to the first responders, as well as the coroners, the families and the community following these events.

We also developed free pre-incident training for first responders that we deliver to help prepare first responders for the emotional impact of doing their jobs. This is in line with the HPP/PHEP Responder Safety and Health capability which we take very seriously. Responders must be kept strong and emotionally able to sustain their efforts in any response.

Exercising is a huge way to educate everyone involved in community emergency response about the importance of behavioral health. One of the largest activities we conducted was a national level exercise in 2011 where the scenario was an earthquake on the New Madrid fault line. In preparation for this exercise we contacted every mental health association in the state and invited all mental health professionals to come to strategically placed regional centers where our team provided just-in-time training for disaster behavioral health professionals who would be responding during a surge. This allowed us to make more mental health professionals aware of the need for responders and it also educated those who participated on disaster behavioral health services. If there was a large event like an earthquake, we would not be able to meet the surge capacity with KCCRB staff alone, so recruiting other mental health professionals to fill that just-in-time role is critical.

Another capability is focused on recovery and community resiliency. Because the KCCRB is designated as the mental health authority for the state when declared disasters happen, we are able to apply for the FEMA Crisis Counseling Program (CCP) grant. Funding is short everywhere and states generally do not have extra money to provide much needed disaster behavioral health services following a major event. CCP grant funding allows you to provide an immediate service program for 60 days following a disaster. If there is still a need beyond 60 days, you can apply for a regular service program grant for up to an additional nine months. Kentucky applied for this funding following the 2012 tornadoes and it probably brought in in excess of $700,000 to the state for the crisis counseling program in the most impacted communities.

We are implementing some unique approaches to meet the disaster behavioral health needs of the at-risk population. We provide free training to the AmeriCorps volunteers who have established relationships through the services they provide to individuals such as the homeless, youth in lower socio-economic situations, and the elderly. We also partner with the Counsel for Developmental Disabilities, the Commission of the Deaf and Hard of Hearing, etc.

Kentucky has many best practices to share regarding the provision of disaster behavioral services. I will be happy to share any information I have on how we do that.

Dr. Cynthia Hansen
Thank you so much, Deborah. Your presentation reminds us that being poised administratively to be able to apply for and receive those crisis counseling programs funds is another piece of the pie of preparedness. Administrative preparedness is as important as content preparedness.

VI. Maine DHHS Center for Disease Control and Prevention

– Kathleen Wescott, M.A., Director, Disaster Behavioral Health, Office of Public Health Emergency Preparedness (Kathleen.Wescott@maine.gov)

I appreciate the opportunity to discuss some of the efforts underway in Maine. In 2012, most of our efforts were focused on providing training opportunities and volunteer management to build up a team of responders that would be available throughout the entire state. Our state is organized in three regional healthcare coalitions: north, south and central. The coalitions are maintained through hospital triage trauma hospitals in each region and our program works very closely with the coalitions and all levels of healthcare providers.

We also work with the county-level emergency managers. For each county, we identify the primary crisis agency and pair them with our county emergency managers, putting in place memoranda of agreement designating them as the resource person in the event of an impacted critical need for their particular county or local town. Codifying this relationship gives them access to the county emergency operations center so they can act as a resource to those towns.

To provide psychological first aid skills for psychological recovery, we have developed a two-day training for our disaster behavioral health critical response.

In 2013, a survey was distributed to behavioral health providers in Maine aimed at:

- Identifying the preparedness of Maine's behavioral health infrastructure to respond to a disaster
- Determining the needs to strengthen preparedness and recovery within the state while gathering information on the kind of assistance needed to supplement current capabilities
- Bringing behavioral health partners to the table to share the data collected and begin building more extensive, collaborative preparedness relationships

The survey summary is available at http://www.mainedisasterbehavioralhealth.com/resources/. Survey data is currently being leveraged to increase opportunities for agencies to work together through community coalition building and to develop comprehensive and sustainable disaster response plans.

Over 82 providers completed the survey. Many identified themselves as mental health or substance abuse agencies, primarily community-based providing outpatient services. What we found is that nearly half of them had some type of disaster response plan, but that the plans were not comprehensive, were not necessarily ever exercised, were not implemented in conjunction with their county emergency management agencies, and were not inclusive of healthcare coalition partnerships that could benefit them.

Our strategy is to identify those who did not have a written plan for ongoing treatment with their agency, clients and participants and to provide them with planning resources. For instance, we ordered and distributed hundreds of the new SAMHSA Technical Assistance Publication (TAP) 34: Disaster Planning Handbook for Behavioral Health Treatment Programs (http://store.samhsa.gov/product/TAP-34-Disaster-Planning-Handbook-for-Behavioral-Health-Treatment-Programs/SMA13-4779). TAP 34 has a nice matrix in the back of the plan for people to follow. It is very specific to behavioral health and the need for client communication, staff communication, provision of services, etc.

It is important at the state level to know how facilities will continue to provide services. We want to be prepared and know each county's capability. Over 26 percent had only a partial plan or no plan at all so we targeted these facilities to address this high risk for the vulnerable populations in those communities. We provide tools and offer to assist in other ways including reviewing plans, planning and conducting exercises, and facilitating coalition relationships.

The survey has provided a lot of information that allows us to make real, specific interventions and planning decisions on where to focus our efforts. As with Los Angeles County, we are working to beef up surveillance and assessment tools. One of my colleagues is working on a plan for communication with vulnerable populations which will go to behavioral health treatment programs and providers including Catholic Charities and many larger national organizations. The goal is to get the message across in a clear, concise and non-scientific way so people will take it and use it to protect themselves.

My colleague is developing a MOA for those providers that will establish a means to send out messages for at-risk individuals. For instance, the message would go to a Meals on Wheels program that would deliver flyers with the meal. We also provide translation services as needed.

Another component of the survey was the ability of the facilities to take care of their own employees. This includes determining staff ability to get to work and assessing whether they are resilient, ready and able to work. Only 40 percent of respondents said they had some kind of plan that considered their staff and how to help them.

The survey results really provided us a good snapshot of what we need to do for preparedness and planning. Although Maine has not had a large federally declared event, it is something we plan for. There are a lot of exercises conducted in Maine and organizers have been much more willing to include behavioral health.

VII. Questions

Dr. Cynthia Hansen
Thank you, Kathleen. And thank you to all our speakers for your engaging and stimulating presentations that gave us a nice perspective on some of the really great work that is going on across the United States. I really appreciate the emphasis on practical tools and strategies and shareable resources so that everybody can learn from each other and especially your ideas about measuring progress and success. As you know, that is something that NHPP is focusing on very strongly. This webinar is really an opportunity to hear good ideas and to spark conversations in your coalitions, state, territory, tribe or other jurisdictions about how to better integrate behavioral health in the healthcare system preparedness capabilities and coalitions.

There are so many more ideas and resources than we could squeeze into our allotted time today. Many other programs across the country are doing great work, and I just want to acknowledge that we painted some broad strokes here to give you an idea of the variety of great programs underway at this time.

One of the capabilities that has not been addressed in this presentation so far is mass fatality. We know that behavioral health is a key partner in standing up family assistance centers. If there are people on the line who want to ask questions about that particular function, the speakers are available to answer questions about that and we open up that topic for additional conversations.

- **Question:** Which of these materials and resources are available through social media platforms?

    - **Answer:** *(Mr. Darrin Donato, ABC, HHS/ASPR)* While this does not entirely answer the extent of that question, the National Library of Medicine at the National Institutes of Health has a Disaster Information Management Research Center (DIMRC) website http://disasterinfo.nlm.nih.gov) has a subsection that lists a whole range of disaster apps that are available for use on mobile devices. A number of them have to do specifically with behavioral health and stress management concerns. The page specifically for disaster apps and mobile optimized web pages is http://disasterinfo.nlm.nih.gov/dimrc/disasterapps.html.

      (Dr. Cynthia Hansen): Another place that information can be found is in Appendix D of the Behavioral Health Concept of Operations (http://www.phe.gov/Preparedness/planning/abc/Documents/dbh-conops-2014.pdf).

- **Question:** What process do you suggest when a healthcare provider is severely injured by a patient from a vulnerable population such as those mentally ill that are receiving treatment?

    - **Answer:** *(Dr. Daniel Dodgen)* It really is a workplace issue. If you are injured in the work place, then the first line of recourse is your policy and all of the things that go along with that. That would also be true of federally deployed behavioral health workers like PHS officers or NDMS workers. They would be covered by their agency insurance.

      From a management perspective, there are different strategies. But in terms of actual workplace injury, it has to be treated like any other workplace injury.

      (Mr. Kevin O'Brien) This can be seen as a commercial for the reason why you want to integrate behavioral health training into the workforce. If there is a situation where a number of vulnerable people or seriously mentally ill persons are converging in an area and the staff had no training or no awareness of how to work with them, that is a risk. And similar to what Dr. Dodgen said, in day-to-day practice, it seems to fall under risk management, but when planning for a surge, advanced training on dealing with the public and large crowds is needed.

      (Dr. Daniel Dodgen) There is good information available on how to manage crowds and other things that could reduce the risk of public health strain.

- **Question:** Can you address the behavioral health needs of members of the emergency responders workforce?

    - **Answer:** *(Ms. Rachel Kaul)* Sandra and Deborah and some of the other speakers brought this up in their presentations. As evident in the Disaster Behavioral Health Concept of Operations, we really never talk about delivering disaster behavioral health services without mentioning responders. Their exposure to extreme levels of stress and large numbers of distressing situations in previous responses make them vulnerable in spite of their training, and in some ways, almost because of the nature of their work.

      That is not to say that they do not function even under those stressful conditions, but it is important to protect the longevity and the health and well-being of first responders by integrating behavioral health into their pre-response training, making sure that there is appropriate follow-up and services available to them after responses and ensuring that seeking behavioral health support is integrated into the culture so that there is no stigma associated with seeking assistance. Peer support programs are a good way to do that, as long as they are supported by professional mental health guidance and staff.

- **Question:** During a recent emergency exercise, we found that our methadone treatment facility in one part of the state was not able to get methadone to 12 of our patients. Do any of the states have a great resolution to opioid treatment options?

    - **Answer:** *(Dr. Cynthia Hansen)* I know this was an issue for both Louisiana and Texas during Katrina. The SAMHSA Technical Assistance Publication (TAP) 34: Disaster Planning Handbook for Behavioral Health Treatment Programs (http://store.samhsa.gov/product/TAP-34-Disaster-Planning-Handbook-for-Behavioral-Health-Treatment-Programs/SMA13-4779) publication focuses very specifically on those facilities.

      (Mr. Craig DeAtley) Last year in one of our exercises across the system, we had a conflagration that resulted in one of our methadone centers having to be closed. Among the steps that were rehearsed was the transfer of patient information from that methadone center to one of the others, along with making arrangements to transfer their pharmaceutical cache. This was done as a collaborative effort between Kevin's department and D.C. Fire, and I believe even the Metropolitan Police Department had a notional hand during the transfer.

      (Mr. Kevin O'Brien) That's exactly what occurred. The Department of Behavioral Health is a recent merger between the Department of Mental Health and the Department of Substance Use Services so the substance use and the methadone clinics are now under our jurisdiction. There is an issue with a recently instituted a policy that requires all of the methadone providers to have an accurate and updated COOP plan so that we can address it. But I believe the methadone clinics in our area do advanced dosing and, if that's not feasible, we work out the procedure that Craig detailed earlier.

- **Question:** Are there best practices for providing emotional and spiritual support for associates in the midst of a disaster which is being triaged at a major medical center?

- **Answer:** *(Ms. Sandra Shields)* Part of the work with PsySTART is to be able to learn how to use mental health triage, but also we want our facilities to think ahead of time and strategize ahead of time in their concept of operations, how they're going to address each level. For people who are most impacted by a disaster, what is their strategy based on the resources they have not only for mental health or behavioral health, but what are their strategies going to be within that system, and how are they going to address people who are less impacted? Are they going to use things like psychological first aid?

  We have worked with Dr. Schreiber and our Department of Public Health on a psychological first aid model called "Listen, Protect and Connect." Psychological first aid may be appropriate for people who are less impacted by a disaster, but it is not the entire answer in terms of the strategies that need to occur for those people who are most impacted by a disaster. We want our facilities to think those through ahead of time in terms of what they would do, ranging from assessment crisis intervention to some other referrals for longer-term treatment.

  In order to get to that strategy, you really need to be able to think strategically about who needs the most care first to be able to get the right care to the people who are most impacted and to think about mental health casualties and response more on a strategic site basis, but also a community-based or operational area, county-based strategy in order to move forward. Triage is the lead-in to how you develop those strategies and best practices.

- **Question:** How are children made resilient in our communities?

  - **Answer:** *(Dr. Daniel Dodgen)* That's a great question for which I think you could get a lot of answers. Obviously, the best way to make children more resilient is to make sure that attention to children is integrated into everything we do for emergency preparedness, response, and recovery. If we are serious about helping our children to be more resilient, that means we have to think about them as not just victims or not just auxiliary members of a community, but as really fully integrated into the whole community.

    The things that we do to promote preparedness and recovery should include attention to schools and other places where children congregate, etc. I am sure everyone on the phone has already thought about a lot of these things. Here are a couple of referrals:
    - The replay and resources associated with the June 2013 webinar on Pediatric Preparedness for Healthcare Coalitions (http://www.phe.gov/Preparedness/planning/abc/Pages/webinar-resources-130620.aspx) includes a number of resources for integrating children into preparedness activities.
    - The Public Health Emergency website (http://www.PHE.gov/abc)
    - The National Child Traumatic Stress Network website (http://nctsnet.org/)
    - HRSA's Emergency Medical Services for Children website (http://emscnrc.org/)

    These sites will provide ideas about how to integrate children into your preparedness efforts and promote the kind of resilience that we desire.

Dr. Cynthia Hansen

We are out of time, but will develop responses to the unanswered questions that have come in through the web chat and will include those responses in the meeting summary. Please contact me or any of the other speakers if you have specific questions following this call. Please also let us know if there are activities or programs out there that you think we should know about.

This is one of many in a series of webinars hosted by the National Healthcare Preparedness Programs. The next webinar will be on May 15 and it will be a follow-up call to our pediatric webinar that occurred last June. On September 18, the focus will be coalitions in response. On November 20, there will be a follow-up call on rural healthcare coalition development. On January 15, 2015 there will be a call on linking the National Disaster Medical System (NDMS) with HPP.

If you have any follow up questions, your HPP field project officers are available or you can contact me. We are interested in questions but also suggestions, promising practices, challenges and opportunities. The webinar and PowerPoint will be posted on the NHPP and ABC websites at http://www.phe.gov/Preparedness/planning/hpp/meetings/Pages/default.aspx or http://www.PHE.gov/abc.

Thank you very much to our speakers and participants for being here today to exchange promising practices for integrating behavioral health into healthcare preparedness. I hope everyone has taken away some great ideas, new contacts, new resources, and we here at NHPP and ABC look forward to continuing this conversation.

The following questions were not answered on the call, but were submitted via the webinar chat or through email following the teleconference.

- **Question:** Are there best practices for providing emotional and spiritual support for associates in the midst of a disaster which is being triaged at a major medical center?

  - and -

  For a medical clinic with a small behavioral health department, what training would be best to start with to introduce behavioral health disaster training/concepts to staff with mostly a medical background?

  - **Answer:** There are a number of educational resources that have been developed on how to provide disaster behavioral health services, attend to the behavioral health needs of workers and responders, and address continuity of operations for service providers. For example, here are some suggested websites and resources:
    - SAMHSA Disaster Technical Assistance Center (DTAC) Disaster Behavioral Health Information Series (DBHIS): The SAMHSA DBHIS contains themed installments of resources and toolkits in disaster behavioral health. Each installment focuses on a specific population, disaster type, or other topic pertinent to disaster behavioral health preparedness, response, and recovery. (http://beta.samhsa.gov/dtac/dbhis-collections)
    - SAMHSA Behavioral Health Disaster App: The SAMHSA Disaster App makes it easy to provide quality support to survivors. Users can navigate pre-deployment preparation, on-the-ground assistance, post-deployment resources, and more—at the touch of a button from the home screen. Users also can share resources, like tips for helping survivors cope, and find local behavioral health services. And,

self-care support for responders is available at all stages of deployment. (http://store.samhsa.gov/apps/disaster/?from=carousel&position=4&date=05052014)

- SAMHSA TAP34: Disaster Planning Handbook for Behavioral Health Treatment Programs. This Handbook offers guidance in creating a disaster preparedness and recovery plan for programs that provide treatment for mental illness and substance use disorders. It covers the planning process, preparing for disaster, roles and responsibilities, training, and testing. (http://store.samhsa.gov/product/TAP-34-Disaster-Planning-Handbook-for-Behavioral-Health-Treatment-Programs/SMA13-4779)
- National Center for PTSD Resource: Spirituality and Trauma: Professionals Working Together (http://www.ptsd.va.gov/professional/provider-type/community/fs-spirituality.asp)
- Psychological First Aid (PFA): Psychological First Aid is an evidence-informed approach for assisting children, adolescents, adults, and families in the aftermath of disaster and terrorism. (http://www.nctsn.org/content/psychological-first-aid)
- Center for the Study of Traumatic Stress:
  - Curriculum Recommendations for Disaster Health Professionals: Disaster Behavioral Health. This product is a result of a unique collaborative effort between NCDMPH and the Center for the Study of Traumatic Stress and provides resources on planning education and training activities on behavioral health factors in disasters to those working with health professionals. (http://www.cstsonline.org/curriculum-recommendations-for-disaster-health-professionals-disaster-behavioral-health/)
  - Sustaining Caregiving and Psychological Well-being While Caring for Disaster Victims. (http://www.cstsonline.org/wp-content/resources/CSTS_FS_Sustained_Care_Giving.pdf)

- **Question:** Any consideration to mirror Google's Fluview to "hot map" psych stress by disaster?

  - **Answer:** Information of this type is collected by SAMHSA (www.samhsa.gov), CDC (www.cdc.gov), and State epidemiologists . However, we are not currently aware of a dedicated web interface for psychological stress indicators. The following resource may be of interest:

    The Disaster Mental Health Surveillance at State Health Agencies: Results from a 2013 CSTE Assessment is available at: http://c.ymcdn.com/sites/www.cste.org/resource/resmgr/EnvironmentalHealth/DMHSFinalReport.pdf

- **Question:** Is there a link to the survey the last speaker administered to the local providers, or could that be sent out/posted with the presentation?

  - **Answer:** Yes.
    - The Maine Disaster Behavioral Health Provider Preparedness Survey Summary Results are available at: http://www.mainedisasterbehavioralhealth.com/wp-content/uploads/2014/03/2013BehavioralHealthProviderDisasterPreparednessSurveySUMMARY.pdf

        - The ASPR Disaster Behavioral Health Capacity Assessment Tool is available on the www.phe.gov/abc Web site. The direct link is http://www.phe.gov/Preparedness/planning/abc/Documents/dbh-capacity-tool.pdf. You may also contact Rachel Kaul at ASPR-ABC at Rachel.Kaul@hhs.gov if you have any questions about the tool.

- **Question:** Question for Sandra from LA. Are the county employees that are MH professionals used as MH responders during a disaster or are they considered just regular disaster workers that could be working at any task?

    - **Answer:** Disaster behavioral health responders can play a number of different roles in response ranging from providing basic psychological support to providing traditional behavioral health services in accordance with their profession education and license to practice. Basic supportive interventions such as Psychological First Aid (PFA) (http://www.nctsn.org/content/psychological-first-aid) and Crisis Counseling (http://beta.samhsa.gov/dtac/ccp) can be provided by trained individuals who are not necessarily behavioral health professionals. Sometimes the responders providing basic psychological support may be supervised by behavioral health professionals. There is also a role for supporting responders through behavioral health force protection as well as a role for traditional mental health services that require a professional mental health clinician.

      The FEMA Resource Typing Library Tool (RTLT) is an online catalogue of National Incident Management System (NIMS) resource typing definitions and job titles/position qualifications. National NIMS resource types support a common language for the mobilization of resources (equipment, teams, units, and personnel) prior to, during, and after major incidents. Resource users at all levels use these definitions on a consistent basis when identifying and inventorying their resources for capability estimation, planning, and for mobilization during mutual aid efforts. Two behavioral health position descriptions follow:
        - Behavioral Health Specialist, Licensed: https://rtlt.ptaccenter.org/Public/Position/View/12-509-1041?p=2
        - Behavioral Health Specialist, Unlicensed: https://rtlt.ptaccenter.org/Public/Position/View/12-509-1042?p=2

- **Question:** Do these plans describe how to engage other social services in the communities to help victims?

    - **Answer:** The HHS Disaster Behavioral Health CONOPS (http://www.phe.gov/Preparedness/planning/abc/Documents/dbh-conops-2014.pdf) references the connection between human services and behavioral health. The HHS Human Services CONOPS (http://www.phe.gov/Preparedness/planning/abc/Documents/disasterhumanservices-conops-2014.pdf) discusses coordination of human services in detail.

- **Question:** Are there any examples on how state health departments have provided power generators to mental health facilities? Was this provided through a regional health coalition

and/or HPP funding?

- **Answer:** DC provided grants for 8 community mental health residential facilities (group homes) through HPP funding from DC DOH. In addition, we work with HSEMA and DC General services and at times our emergency health care coalition for some facilities to receive temporary trailers with generators for emergency use in disasters or city wide declarations.