Disaster Preparedness & Response, cont.

Recent Activity of DMH Disaster Response Teams

<table>
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<tr>
<th>2016 Hurricane Matthew</th>
<th>2015 Mother Emmanuel Shooting</th>
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<td>2016 Townville Elementary School Shooting</td>
<td>2014 Midlands/Upstate Ice Storms</td>
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<td>2015 South Carolina Flood</td>
<td>2007 Sofa Superstore Fire</td>
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Townville Elementary Response

- Following the school shooting in Townville, DMH’s Anderson-Oconee-Pickens Community Mental Health Center (AOP), with additional personnel from other DMH Upstate community mental health centers, provided crisis counseling and support to the victims, families, and school personnel. Following the initial response, AOP continues to provide support for the affected community and the school’s children and personnel in dealing with the long-term impact of this tragic event.

Hurricane Matthew & Flooding Response

- DMH received almost $4.4 million dollars in FEMA grants to provide Crisis Counseling services to people impacted by the historic flooding of 2015; 87 Crisis Counselors worked in 24 counties for 14 months.
- As a result of Hurricane Matthew, DMH has received $2,769,657 thus far for crisis counseling services in impacted areas, with additional funding expected.
- DMH also provided clinical counselors to assist North Carolina’s mental health response in severely affected counties.
Local response includes…

Activating the Emergency Operations Center (EOC)

Coordinating the response with public and private organizations and agencies.

Notifying the SC Management Agency of the situation via Situation Reports (SITREP).

Activating necessary local governments and organizations.

Proclaiming a local state of emergency to authorize:
  Using local resources;
  Expending local funds; and
  Waiving the usual bidding process for goods and services.

Requesting the State Emergency Management Agency for State / Federal assistance.
At the State level...

When a local jurisdiction does not have the resources it needs to respond to a disaster, it turns to the State government for assistance. The State government may have many local jurisdictions requesting aid at the same time.

State governments serve as agents for the local jurisdictions if Federal disaster assistance is needed. Local governments cannot directly access Federal programs.
State response includes...

Monitoring the situation.

Reviewing and evaluating local:
  - SITREPs
  - Response efforts
  - Requests for assistance

Activating the State EOC to coordinate available State assistance.

Determining if the situation is beyond the capability of the State and if Federal assistance is needed.

Proclaiming a state of emergency by the Governor that:
  - Activates the State Disaster Preparedness Plan;
  - Provides for the use of State assistance or resources; and
  - Begins the process for requesting Federal assistance.

Requesting Federal assistance. Requests can include:
  - A request for “emergency” or “major disaster declaration” under the Robert T. Stafford Disaster Relief and Emergency Assistance Act,
Operating Conditions the OPCONs describe level of Activation

OPCON 5  Normal – we are OPCON 5 right now.

OPCON 4  Watching something – will have few members of Emergency Management involved. Ex – hurricane 5-6 days away.

OPCON 3  Increased activation. There is a threat and need for more people. Select agencies will be requested to be present. (MB)

OPCON 2  Imminent threat and full activation. Agencies with primary responsibilities at SEOC 24/7. (Prepare for Evacuation)

OPCON !  Full activation 24/7 for all primary agencies until threat has passed.
SEOC Activated at OPCON 2
SEOC is where Governors Receive advice and hold their Press Conferences.
At the Federal level…

When a disaster strikes and is so severe that the local governments and the State governments together cannot provide the needed resources, then the Federal government becomes the source for those resources.

The Federal Emergency Management Agency (FEMA) is the Federal agency that coordinates the activation and implementation of the Federal Response Plan (FRP).
Emergency Support Functions (ESFs) is the grouping of governmental and certain private sector capabilities into an organizational structure to provide support, resources, program implementation, and services that are most likely needed to save lives, protect property and the environment, restore essential services and critical infrastructure, and help victims and communities return to normal following domestic incidents.

• ESF1 Transportation
• ESF2 Communications
• ESF3 Public Works and Engineering
• ESF4 Firefighting
• ESF5 Emergency Management
• ESF6 Mass Care, Housing, and Human Services
• ESF7 Resources Support
• ESF8 Public Health and Medical Services
• ESF9 Urban Search and Rescue
• ESF10 Oil and Hazardous Materials Response
• ESF11 Agriculture and Natural Resources
• ESF12 Energy
Where Does SCDMH Work in ESF Structure?

**ESF 6**

Mass Care, Emergency Assistance, Temporary Housing, and Human Services coordinates and provides life-sustaining resources.

Primary Agency is Department of Social Services.

Chief support is American Red Cross

Also supported by Southern Baptist Convention, Salvation Army, other VOADs (Volunteer Organizations Active in Disasters), and SCDMH.

**ESF 8**

Public Health and Medical Services provides the mechanism to respond to a disaster, emergency, or incident that may lead to a public health, medical, behavioral health, or human service emergency.

SC Department of Health and Environmental Control is Primary Agency with SC Department of Mental Health designated to respond to all behavioral health needs.

Agencies assisting DMH include DAODAS, SCVR, DDSN, and VOADs.
Disasters are Local Events.
Healthcare Coalitions’ Roles,

Healthcare Coalitions bring providers together.

Are relatively new - ASPR funded.

Learn of, share, and acquire new resources.

Regional – Upstate, Midlands, Pee Dee, and Lowcountry

CMHCs are *increasingly* participating.
Why Increasingly?

Centers for Medicare and Medicaid issued a -

FINAL RULE

*Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers*

These regulations went into effect on November 15, 2016

Implementation date November 15, 2017

Compliance required for participation in Medicare / Medicaid!

Rule essentially required out-patient healthcare agencies meet similar requirements as hospitals and nursing facilities for disaster preparedness. (Generators and Shelter in place)
WHY?

- Millions of dollars have been given out in Hospital Coalition (and now HealthCare Coalition) grants or other federal funds.
- When disasters occur, many entities needing assistance do not know where to seek it – other than FEMA or other federal partners.
- ASPR and FEMA are requesting the CMS make better disaster preparation a requirement for Medicaid and Medicare participation.
The Four Provisions for Complying with the Emergency Preparedness Rule

- Risk Assessment and Planning
- Communication Plan
- Policies and Procedures
- Training and Testing
Does it Improve Local Response?

2016 – Hurricane Matthew
ARC Shelter requested clinicians due to tension.
Transgender individual threatened by others
Came to head when limited showers were available.

Shelter called ARC – who called SEOC – who notified ESF 8 – who notified DMH on duty – who contacted Center’s Disaster Person – who contacted on-call clinicians – who went to the shelter and eventually were able to resolve situation.

2018 – Hurricane Florence
As each shelter opened, local CMHC reps went to each and provided contact information.

No ARC Shelter issues went to SEOC but in after-action reviews, learned clinicians had assisted on several occasions.

May 2017
Response versus Recovery

SCDMH has various roles in:

Planning – extensively with others, among the organization, within centers, hospitals, nursing facilities.

Responding – at SEOC, local EOCs, to areas where needed until danger has passed (until people can begin to safely re-enter their communities).

Recovery – Where we work the hardest and for greatest benefit to our citizens – and in various means and methods and services,
One Such Service - Deaf Services

DMH’s Deaf Services provides a continuum of outpatient and inpatient behavioral health services to persons who are Deaf and Hard of Hearing. The program uses innovative technological and human service program initiatives to ensure that all services are delivered in a cost-effective and timely manner throughout the state.

Components include:

- Outpatient services for children, families, and adults, using itinerant counselors who are part of regional teams located across the state.
- School-based services in collaboration with the South Carolina School for the Deaf and the Blind.
- Residential services in supported apartments at locations across the state.
- Use of telemedicine and videotext to provide accessible services to rural areas.
- Inpatient services at Patrick B. Harris Hospital and William S. Hall Psychiatric Institute.
Definitions:

**deaf** – lacking hearing, either entirely or at a severe to profound level. This is a medical term.

**Deaf** - individuals who, in addition to not hearing, are members of the Deaf community, subscribing to the unique cultural norms, values, and traditions of that group. Members of this group typically use American Sign Language (ASL) as their 1st language.

**hard of hearing (HoH)** - an individual with a hearing loss (ranging from mild to severe)
**Definitions:**

- “hearing impaired” – Deaf community does not consider themselves impaired, and “hearing” is not the important word
- The Deaf community prefers the terms Deaf and Hard of Hearing.
- This term is also ambiguous as it does not define extent of hearing loss
Deaf Culture

- Primary language is ASL
  - Recognized language with its own rules of grammar and syntax

- English and ASL are NOT the same thing! Consider the possibility of ESL (English as a Second Language)
The “ASL” slides are either written using ASL gloss (a teaching tool used to transcribe ASL sign for sign for those learning the language) or were written by a Deaf woman for whom ASL was a first language. This is a representation of what a Deaf person might write in each situation.
WOMAN SILLY MOUTH WIDE MY FACE ME UNDERSTAND NO
THE WOMAN WAS SCREAMING. SHE WAS IN MY FACE. I COULDN’T UNDERSTAND HER
When interacting with a Deaf/deaf person...

- Be extra aware of your body language and facial expressions
- Be on the lookout for the “smile and nod” that signals lack of comprehension
Communicating with the Deaf:

It is important to remember that not all Deaf people’s communication needs are alike, and you should ask the person directly what their needs are. They may communicate through:

- **Sign language (ASL, SEE, PSE, etc)**
- **Speech/lipreading**
- **Writing**
Communicating with the Deaf

There is only one dumb question you can ask a deaf person (verbally):

**CAN YOU LIPREAD?**

Do you read lips?

Why is this a dumb question?
Lipreading: The Imprecise Art

Depending on lipreading as a communication method means you are gambling on the following:

- The deaf person has a high level of English proficiency
- The deaf person has a thorough understanding of the subject you are speaking of
- The deaf person is an expert lipreader
- Your body language and facial expressions are conveying the correct message
- The lighting and placement of both speaker and lipreader are correct
- 50-75% of the information is sufficient
Always ask how the deaf person wishes to communicate. Give options. Example: “Communicate best, how? Interpreter (I will pay), writing, lipreading?”
Communicating with the Deaf

- Hands down, the best way to sit is... hands down!
- Remember not to look at paper while talking
- Be conscious of lighting... don’t sit with back to light
- Speak at a reasonable pace, but not S...L...O...W...L...Y
- If the person doesn’t understand what you say at first... don’t repeat. RESTATE.
Relay:

- Allows phone communication between Deaf and hearing people when the hearing individual does not have a TTY
- May use either text-based relay or video relay (VRS)
- Many prefer VRS due to its linguistic accessibility but the technology is not always available
Mental Health and Deafness

Individuals who are Deaf have the same mental health problems as hearing people

Accessible social services are often not there
It may not “look” the same as with hearing people and the family may not know that they have a mental illness

DMH has specialized services for Deaf and Hard of Hearing people
Laws and Regulations Related to Deaf and Hard of Hearing Individuals

Americans with Disabilities Act

Requires that public agencies provide equal access to people with disabilities

Section 504 of the Rehabilitation Act of 1973

Requires interpreters if you receive Federal funds

Title VI of the Civil Rights Act

Mandates language access
Lack of accessible/culturally competent services

- Hotlines not accessible – often hang up
- Advocates not trained
- Lack of interpreters on hand
- Lack of knowledge as to how to find an interpreter
- Lack of understanding about Deaf culture
- Lack of appropriate treatment - No signing therapists, doctors, etc
Challenges in Emergencies

- Chaos everywhere
- Live TV not always captioned or have interpreter
- Delayed time in getting urgent information
- Rural areas less likely to have high speed internet and technology
- Power outage and cell service outage
- Populations: Urban and rural
- Poverty level vs. access
Responses in recent events

- Hurricanes
  - Live interpreter
  - Closed captioning
  - Videophones in shelters
  - Social media
  - Deaf community alerts
  - Call in phone conferences with other Disability partners
  - Interpreters

- Mother Emmanuel AME Church shooting
  - Provide interpreters
  - Social media
  - Victims advocate
Collaboration: Response to the Mother Emanuel AME Shooting

On the evening of Wednesday, June 17, 2015, nine people were shot and killed in an attack during a prayer service at Emanuel AME Church in Charleston.

Due in part to excellent working relationships with local law enforcement and community groups, staff from Charleston-Dorchester MHC were able to respond immediately in the wake of the tragedy.

The Center reached out to victims, their families, the Emanuel Community, the Office of the Mayor, first responders (EMS, law enforcement, the Coroner’s office), the Media, victims’ advocates, and the community at large.
Collaboration: Response to the Mother Emanuel AME Shooting

CDMHC quickly collaborated with multiple community partners, including:

- Berkeley MHC
- Orangeburg MHC
- Waccamaw CMHS
- DMH Central Administration
- The National Crime Victims’ Center (MUSC)
- 211 hotline
- Lowcountry Pastoral Counseling
- SAVE, Inc. (County and City employee assistance program)
Collaboration: Response to the Mother Emanuel AME Shooting

Together, these partners were able to provide immediate access to care, via:

- A Family Assistance Center
- A Church Assistance Center
- Regular and timely debriefings
- Funeral planning meetings
- Phone banks and interviews
- Community assistance at the Mental Health Centers
- Support presence at prayer vigils
- Support presence at every victim’s wake and funeral
- Highway to Hope RV presence at the memorial service at Emanuel AME
Collaboration: Response to the Mother Emanuel AME Shooting

The group who responded to this tragedy was careful to ensure that they “Cared for the Caregivers”; many staff at the nearby MHCs knew victims or their families. The entire community was affected.

To ensure that those providing services to others were well, partners:

- Held internal “town hall meetings”
- Conducted debriefings
- Provided ongoing training and consultation
- Ensured constant communication
- Received ongoing DMH Central Administration support

The CDMHC and its partners have made sure the local community knows they are “in it for the long haul,” and will continue to provide support as long as it is needed.
Florence Shooting - State Support

October 3, – 7 police officers shot. One dies

DMH State Office
Charleston Mental Health
A-O-P Mental Health and
Pee Dee Staff met to coordinate services to best support Florence and neighboring communities.

And to support staff.
State Support (cont)

MH staff embedded in law enforcement attended.

MUSC Crime Victims’ Center plans to provide specialized training for trauma survivors.

Charleston’s First Responders Unit

Highway to Hope moved to Florence
Federal Assistance – Individual Assistance Declarations

Housing
Case Management
Legal Services
Emergency Medical
Unemployment assistance
Funeral assistance
And for SCDMH -
Crisis Counseling Programs

Following 2015 Floods, FEMA funded 81 employees for 12 months to serve in affected counties.

Following Matthew in 2016, funded over 100 employees.

Those two grants resulted in $13 million dollars of services with no state match.

Grant has been approved to begin serving people suffering from Florence.
Key Concepts of Crisis Counseling Programs

• Everyone who experiences a disaster is affected by it in some way.
• People pull together during and after a disaster.
• Stress and grief are common reactions to uncommon situations.
• People’s natural resilience will support individual and collective recovery.
Key Concepts (cont.)

• Typical outcomes of disaster:
  – Some will have severe reactions;
  – Few will develop diagnosable conditions;
  – Most do not seek treatment; and
  – Survivors often reject help (stigma)
Individual Reactions

Types of individual reactions:

• Physical.
• Emotional.
• Cognitive.
• Behavioral.
Collective Reactions

Typical phases of disaster:

Adapted from CMHS, 2000.
Resilience

What is resilience?

• An ability to recover from or adjust easily to misfortune or change.

Merriam-Webster Online Dictionary
Range of Crisis Counseling Services

- Individual crisis counseling.
- Brief educational or supportive contact.
- Group crisis counseling:
  - Support groups;
  - Self-help groups; and
  - Psycho-educational groups.
- Public education.
- Assessment, referral, and resource linkage.
- Community support and networking.
- Development and distribution of educational materials.
- Media messaging and risk communications.
**Key Concepts (cont.)**

**Traditional treatment vs. crisis counseling:**

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<th>Crisis Counseling</th>
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<tr>
<td>• Office based.</td>
<td>• Home and community based.</td>
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<td>• Diagnoses and treats mental illnesses.</td>
<td>• Assesses strengths and coping skills.</td>
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<td>• Focuses on personality and functioning.</td>
<td>• Counsels on disaster-related issues.</td>
</tr>
<tr>
<td>• Examines content.</td>
<td>• Accepts content at face value.</td>
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<td>• Explores past experiences and influence on current problems.</td>
<td>• Validates common reactions and experiences.</td>
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<td>• Psycho-therapeutic focus.</td>
<td>• Psycho-educational focus.</td>
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<td>• Keeps records, charts, case files, etc.</td>
<td>• Does not collect identifying information.</td>
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At-Risk Populations

- Children and Youth
- Parents or Caregivers with Children
- Older Adults
- People with Prior Trauma History
- People with Serious Mental Illnesses
- People with Disabilities
- People with a History of Substance Abuse
- Low-Income Groups
- Public Safety Workers (PSWs)
Range of Crisis Counseling Services

Typical partners:

- Schools
- Substance Abuse
- Mental Health
- VOADs – Unmet Needs Committee
- Consumer Advocacy Groups
- First Responders
- Faith Based
- Elected Officials
- Healthcare Providers
- Other Partners
Who was a major CCP Fan?
Any Questions?

Thanks!!