Disaster Planning for People Experiencing Homelessness

by Sabrina Edgington

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EXECUTIVE SUMMARY

Local and State emergency management plans often fail to meet the needs of people who are homeless. This publication provides an overview of important issues to consider when planning for the needs of homeless people during disasters. Practical guidance is offered to local officials, emergency planners, homeless service providers and others who are involved in their community's emergency planning process. The final part of this publication encourages Health Care for the Homeless providers and others involved in homeless service provision to participate in disaster planning efforts in their communities.

The following issues are addressed in this publication and described briefly below:
- defining special needs populations
- personal preparedness
- communication
- transportation and evacuation
- sheltering
- health status
- transition to housing

In emergency planning, the needs of homeless people are usually categorized within the needs of all "special populations." Such general categorization typically fails to consider the unique needs of people who are homeless. Failing to explicitly include homelessness in definitions has also resulted in unintended consequences in which people who are homeless have been denied services. Consistent definitions among State and local government emergency plans will aid in the coordination of services.

People who are homeless have limited resources to evacuate, stockpile food, store medications and shelter in place. For this reason, communities often struggle in their approach to prepare homeless people for disasters. Informational leaflets coupled with personal trainings have been effective in helping homeless people prepare for disasters. In addition to discussing directives such as locations of disaster shelters and evacuation pick up points, trainings might focus on what can be expected physically, mentally and emotionally during a disaster and how to work with first responders to get to safety. Trainings are also empowering when people from the homeless community are invited to develop the curriculum and participate in its implementation.

The Government Accountability Office found that most State and local governments have inadequate channels of communication to reach people who lack access to mainstream modes of emergency notification. People who are homeless have limited access to Internet and television and are often the last to know about emergencies. To communicate disasters

to people without homes, homeless service providers should be included in emergency notification systems. Service providers can quickly communicate the emergency situation to consumers concentrated near their facilities and deploy outreach teams to notify homeless people that are dispersed throughout the community.

Outreach teams deployed to make notifications can also transport people to shelters or designated pick up points for evacuation. Outreach teams employed by homeless service providers are familiar with the homeless community, have established trust and credibility and are better able to negotiate with people who might resist evacuation efforts. Outreach teams, drivers, and accessible vehicles should be coordinated and assigned to specific designations as soon as possible to prevent delays during a potentially small window of time.

The circumstances of homelessness and inadequate systems of care have contributed to high rates of mental illness, addiction, and poor physical health among people who are homeless. Individuals with serious mental illness may have a difficult time dealing with the abrupt disruption to their lives. The pandemonium of the emergency response may trigger symptoms of Post-traumatic Stress Disorder (PTSD), a disorder common to many homeless people. For people in recovery, disasters disrupt support systems and create a whirlwind of emotions that interfere with the recovery process. Others who are currently using substances may have difficulty dealing with the disaster or worse may experience symptoms of withdrawal. People who are homeless also experience higher rates of acute and chronic illnesses. Health Care for the Homeless providers are a valuable resource for caring for the behavioral and primary health care needs of people who are homeless. Disaster shelter workers should be trained to recognize symptoms and have access to trained professionals who can offer immediate assistance.

Communities are also encouraged to consider the housing needs of homeless people who are displaced after a disaster. Many areas inhabited by people without homes may not be suitable for living after a disaster. Disasters pose a unique opportunity for communities to acquire Federal funding to place homeless people into more stable housing.

Healthcare for the Homeless (HCH) projects and other homeless service providers are encouraged to get involved in community emergency planning to increase their community's capacity to respond to the needs of homeless people during a disaster. One way that providers can become more integrated in their community's emergency preparedness and planning process is by participating in an emergency planning advisory committee. Advisory committees provide guidance to emergency management officials in developing the community's emergency management plan. Committees generally include active participation from an emergency manager who will help facilitate mutual aid

agreements and coordinate the activities and resources among all the various stakeholders. Continuous trainings and exercises in emergency response activities will increase coordination and efficiency among the various stakeholders to best meet the disaster needs of people who are homeless.

It is the duty of the government to keep all Americans safe in times of emergency,
especially those in our society who are not always able to help themselves.
But in the days and weeks since Hurricane Katrina devastated the Gulf Coast,
it has become overwhelmingly clear that this was not the case.
The government did not adequately prepare to evacuate those who
could not afford a car, did not adequately prepare to evacuate the elderly, and
did not adequately prepare to evacuate those who were too sick to leave their beds.

We may not be able to control the wrath of Mother Nature, but
we can control how we prepare for natural disasters.

Barack Obama, September 12, 2005

INTRODUCTION

The aftermath of the September 11, 2001 terrorist attacks and Hurricane Katrina served as a wake up call for the entire nation prompting local, State, and national bodies to review and strengthen emergency planning efforts. Though emergency planning has improved over the last several years, many emergency plans fall short when it comes to the needs of homeless people. For example, in September 2008, days after Hurricane Ike hit Houston, homeless individuals receiving care at the Cathedral Clinic told staff members that they were starving and had not eaten in three days. Consumers also reported that they were turned away from the designated emergency shelter because they were homeless prior to the storm.

Recent research in the area of vulnerability science offers compelling evidence of the correlation between poverty and disaster vulnerability. Many people living in poverty have limited literacy, compromising their access to risk reduction information. People experiencing homelessness may be unable to engage in self-protective activities such as choosing a residence in a safe area, stockpiling food and supplies, and early evacuation once a threat to safety is evident. Homeless people who are undocumented or have a history of detention or incarceration may be hesitant to participate in disaster services for fear of deportation or arrest. Factors associated with mental illness and substance use disorders may interfere with the ability to cope with the trauma of disaster (Tierney, 2006).

Homeless service organizations in numerous communities have formed advisory committees to provide guidance to their local government in shaping community emergency management plans. Health Care for the Homeless (HCH) projects are particularly valuable in helping communities establish inclusive emergency management plans. HCH projects are not only equipped with the resources to respond to the unique medical needs of people who are homeless but have staff who are trained in effective outreach and engagement strategies. Because many low-income, homeless and ethnically diverse populations depend on health centers to manage their health needs, the health center becomes a natural and primary resource for these populations during a public health emergency or disaster (Wineman, 2007). In addition, many HCH projects have close relationships with local public health departments and other homeless service providers, which can benefit the planning process. According to the Health Resources and Services Administration (HRSA), "health centers are positioned to play an important role in delivering critical services and assisting local communities during an emergency" (HRSA, 2007).

Though HCH projects and other health centers are critical to the health of their communities during disasters, studies show that health centers are not very well integrated into community emergency preparedness and response processes. A 2005 study of HRSA funded health centers reported that only 39% of centers had staff that had viewed their local government's emergency management plan. Health centers also scored low on other indicators of involvement in disaster planning: "34% had completed a hazard vulnerability analysis in collaboration with the community emergency management agency, 30% had their role documented in the community plan, and 24% participated in community-wide exercises" (Wineman et al, 2007).

This publication is intended to help public officials, emergency planners, HCH providers and other homeless service providers understand both the structural and individual issues faced by homeless people during natural or manmade disasters. Practical guidance is offered in several issue areas. Guidance on facilitating collaborative relationships with emergency planning stakeholders is also offered and is aimed to encourage participation of Health Care for the Homeless (HCH) projects and other homeless services providers in shaping and implementing local emergency plans.

DEFINING SPECIAL NEEDS POPULATIONS

When homeless people are described in emergency plans, it is usually within a category of "special needs populations". FEMA describes the task of defining special needs populations as a critical first step in the planning process and recommends drafting a statewide definition prior to the development of local emergency plans. Using the definition consistently will improve communication and coordination of resources across state and local communities (FEMA, 2008). Although FEMA and other federal agencies refer to homeless people as a "special needs population" in some informational materials, the definition of "special needs population" used by the federal government as it appears in the National Response Framework (NRF) does not specifically mention homeless people:

> *Populations whose members may have additional needs before, during, and after an incident in functional areas, including but not limited to: maintaining independence, communication, transportation, supervision, and medical care. Individuals in need of additional response assistance may include those who have disabilities; who live in institutionalized settings; who are elderly; who are children; who are from diverse cultures; who have limited English proficiency; or who are non-English speaking; or who are transportation disadvantaged.*

Nevertheless, people experiencing homelessness are implicit in the NRF definition based on their need for transportation assistance. According to FEMA (2008), "Populations that will require transportation assistance during emergency response and recovery include... individuals who are transient, such as people who are homeless, and have no fixed address." States and local governments are free to make their own definition of "special needs populations" more explicitly inclusive of homeless people.

Some communities have opted to create a separate emergency management plan specifically for homeless people rather than grouping their needs with all special needs populations. Many planners find the term "special needs" too broad. In an article published in the International Association of Emergency Managers (IAEM) Bulletin, the author writes, "Many of these groups have little in common beyond the fact that they are often left out of emergency planning" (Isaacson-Kailes, 2005). A separate plan can be incorporated into the broader emergency management plan as a functional annex.

PINELLAS COUNTY HOMELESS EVACUATION/ SHELTERING PLAN

In 2004, at the height of Hurricane Jeanne, Cliff Smith of the Pinellas County Department of Human Services received a call from two homeless men in need of help. By the time he received the call little could be done to help the stranded men. Fortunately, the men were able to find temporary refuge from the storm and survived unscathed. Outside of provisions for emergency shelters, the Pinellas County Emergency Operations Plan lacked any special provisions to prepare and assist homeless people during disasters. Smith called a meeting of the Pinellas County Coalition for the Homeless and invited law enforcement officers, emergency planners, and consumers (including the two men who were stranded) to create a disaster plan for homeless people. Today, Pinellas County has a separate plan to help homeless people in need of evacuation assistance and shelter during a hurricane. The plan includes procedures for education, notification, transportation assistance, homeless-support sheltering and recovery.

AN INFLUENZA PANDEMIC PLANNING GUIDE FOR HOMELESS AND HOUSING SERVICE PROVIDERS
Public Health Seattle-King County

The Public Health Department of Seattle-King County and the Vulnerable Populations Action Team worked together to develop a guide specifically for homeless service agencies that offers information and instructions for planning and responding to an influenza pandemic. The guide describes and offers guidance on issues such as the role of the public health department, expectations regarding shelter closures, supplies that agencies should consider stockpiling, outreach, infection control, dealing with deaths on site and more.

PERSONAL PREPAREDNESS

Personal preparedness is a critical component of emergency planning. Mainstream efforts to promote preparedness typically focus on people who are housed and have the resources to stockpile food and supplies and shelter in place. Few communities have adequately prepared people with limited resources for such emergencies.

Leaflets One way in which communities have attempted to prepare homeless people for disasters is by distributing leaflets or flyers, which generally include instructions for accessing current information about the emergency situation (211, radio station, etc), transportation, pick up points for evacuations, and locations of designated emergency shelters. It is also helpful to include information about accommodations for pets and items that should be taken to shelters (identification, medication, clothes, etc). Effective leaflets are written in languages representative of the community, have a simple message, use a large font, include one or two graphics, and focus on actions that should be taken rather than actions to avoid.

Trainings Many homeless people have difficulty reading and interpreting written instructions, in English or in any language. Therefore, communities are encouraged to supplement written material with personal preparedness trainings. In order to reach a large number of homeless people, trainings might be conducted at homeless service facilities, encampments and other locations where homeless individuals and families can be found. A curriculum developed in collaboration with those for whom it is intended and designed to educate both service providers and consumers will help to foster a sense of mutuality that can facilitate the emergency response process. By helping to develop and implement a curriculum, consumers are educated, empowered, and become valuable contributors to emergency planning. Nancy Carter's (1996) curriculum for preparing clients of community mental health centers offers suggestions for training topics to benefit any group with limited resources (see page 6). Other topics in a curriculum for homeless consumers might include:

- Pick-up points for evacuations
- How to access up-to-date information about the emergency situation
- Dangers of seeking inappropriate shelter such as under bridges and overpasses and in cars
- What to do if stranded
- What to expect physically, mentally, and emotionally during and after different types of disaster
- Guidance on dealing with first responders

Emergency kits If funds permit, providers should consider distributing emergency kits at trainings that contain water, a flashlight, first aid supplies, a whistle, a portable radio and batteries. Emergency kits add incentive for participation and are valuable, empowering resources that offer homeless individuals some sense of control and independence in a stressful situation.

Emergency health information cards Emergency health information cards provide first responders with potentially life saving personal and medical information. They are particularly important if the individual is unconscious or otherwise unable to communicate his or her needs. These cards can be distributed with leaflets or completed during trainings. Some individuals may be hesitant to complete a card in a public setting due to stigmatizing health conditions or inability to read. Trainers and providers might offer opportunities to complete cards privately. Announcements sent to first responders and hospitals will increase general awareness and utility of the cards.
An Emergency Health Information Card template recommended by the Independent Living Resource Center is available online at www.preparenow.org/tipcrd.html.

PLANNING FROM THE CONSUMER'S PERSPECTIVE

Preparedness phase: Planning for this phase might include teaching the differences between a forecast, a warning, and an alert, how these are issues, and what to do if any are issued. It would include talking about the kind of food and water to have on hand, how to rotate food and water so that it is fresh, and where and how to store it. Information about survival supplies would include use-and proper storage of candles, matches, flashlights, batteries, simple cook stoves and first aid kits. Planning might include locating area shelters for both consumers and staff, who might shelter at the same sites. Management of medications, including obtaining advance supplies and how to store medications if refrigeration is required, also would be appropriate. Information about what consumers could expect from staff and each other, and how to help one another prepare, could also be available.

Impact phase: Material on the impact phase would outline protective measures, which depend on the type of disaster. Instructions are different for earthquakes, tornadoes, floods, chemical spills, hurricanes, nuclear accidents, and fires. Which shelter to go to, depending on the type of disaster, may be an issue as well.

Response phase: The response phase would emphasize the chaos and lack of organization likely to be experienced during the first few days after the disaster. Possible reactions also might be discussed. Where consumers could go for food, water, shelter, and financial help would be reviewed, as well as how to locate program sites, fellow consumers, and staff. How consumers could help locate one another through outreach and help the community should be included, too.

Recovery phase: Material about the recovery phase would encompass the kind of assistance available through FEMA, Red Cross, Salvation Army, and other groups, and how to ask for or apply for this assistance. Knowing how to cope with the bureaucracy, the amount of time it might take for repairs, new housing, or financial assistance can help reduce later frustration by adjusting expectations.

Carter, 1996

COMMUNICATION

Communicating disasters to people who are homeless is perhaps the most challenging step in the emergency response process. According to a 2006 report by the Federal Highway Administration, most State, county and parish evacuation plans from each of the Gulf Coast States fell short in establishing proper channels of communication with special needs and hard-to-reach populations such as people experiencing homelessness (FHA, 2006). Some communities have even failed to communicate information directly to providers of homeless services during emergencies. For instance, during a 2003 severe acute respiratory syndrome (SARS) outbreak, homeless service providers in Toronto were not informed that the city had designated a specific shelter as a quarantine facility for homeless people (Leung et al, 2003).

Notify service providers Notifying service providers is a critical step in getting information to people experiencing homelessness. With a large number of homeless people concentrated at or near homeless services facilities, these providers can communicate information quickly and in person. In addition, many of these facilities are equipped with outreach workers who can make personal contact with individuals who are scattered throughout the community.

A number of strategies are used to communicate emergencies to local agencies. The Association of State and Territorial Health Officials (ASTHO), the National Association of Community Health Centers (NACHC), and the National Association of County and City Health Officials (NACCHO) (2008), in a joint publication, offer examples of different methods used by communities to coordinate communication. One recommended means of communicating emergencies is through a Health Alert Network operated by state public health agencies. In addition to sending alerts to health departments, hospitals and other partners, the Health Alert Network can be used for ongoing trainings and routine communication. At a minimum, emergency plans should include an updated phone tree that lists a designated person (and a back up) who is responsible for notifying homeless service providers. A plan should also be in place to communicate with agencies when mainstream modes of communication are not available.

> **VULNERABLE POPULATIONS ACTION TEAM (VPAT)**
> **Public Health-Seattle and King County**
>
> VPAT staff members created the Community Communications Network (CCN) to improve the Public Health Department's ability to reach vulnerable communities during an emergency. The VPAT asked each community-based organization (CBO) to provide staff members' after-hours contact information, which VPAT compiled into a master list. When an emergency occurs, VPAT staff can use the list to contact the appropriate CBO and provide it with critical information. CBOs pass this information to the vulnerable populations they serve and notify the VPAT if their clients need further assistance, resources, or information the CBO cannot provide.
>
> *FEMA, 2007 (LLIS.gov)*

Deploy Outreach Teams During disasters, communities will make best use of a potentially small window of time by deploying trained outreach workers to find homeless people who are dispersed throughout the community. Outreach workers from local homeless service programs are already familiar with members of the homeless community and can assure that more individuals are accounted for and taken to a safe place.

Outreach workers have also established trust and credibility within the homeless community. Building trust is important when reaching out to people experiencing homelessness. The discrimination and exclusion that homeless people frequently experience, together with mental or physical illness, contribute to social isolation, distrust, and unwillingness to act. In a curriculum for training Health Care for the Homeless outreach workers, Ken Kraybill (2005) eloquently describes the value of outreach workers:

> *Unfortunately, in a culture in which the values of individualism and self-reliance hold sway, the natural inclinations and capacities to help seem to have diminished. This is particularly true as people experiencing homelessness have been increasingly pushed towards the extreme margins of community life. In a world that has become increasingly complex, disparate and unsafe, so has the ability to care for one another become more difficult. Thus, the need for specially designated workers to reach out and connect with those on the edges, in order to bring them closer to the center of care and life in the community.*

Some communities use outreach teams comprised of homeless service providers and law enforcement officers. Having a law enforcement officer on an outreach team can facilitate outreach efforts. Law enforcement officers are trained as first responders, have access to alternative modes of communication, and can offer a level of protection. A potential negative consequence of including an officer on the outreach team is that his or her presence may generate added anxiety for individuals who have experienced negative

encounters with law enforcement. However, planners should not immediately assume that the presence of an officer would undermine outreach efforts. A study in Colorado based on a focus group comprised of homeless individuals indicated a preference for disaster notification from police officers. The group believed that law enforcement officers would be able to provide them with essential information and transport them to a safe place (EPOC Vulnerable Populations Workgroup, 2008).

Some communities have also used specially trained Community Emergency Response Team (CERT) to notify and assist homeless people in the event of a disaster. A CERT can be particularly useful for communities that have a limited number of trained outreach workers. Communities that plan to use a CERT to assist homeless people should make sure that the CERT members are trained in understanding homelessness issues and effective outreach and engagement strategies.

Outreach teams deployed to areas where large numbers of homeless people congregate can deliver personal notification and transport people to emergency shelters or designated pick up areas. In areas where the concentration of homeless people is small or not easily accessible, some communities have opted to send outreach teams to announce emergencies over a loudspeaker or megaphone from their vehicles.

Proper planning is important for successful outreach during emergencies. Planning will increase efficiency and will make the best use of what could be a small window of opportunity. During the emergency planning process, homeless service providers and other emergency planners should determine where homeless people are concentrated in the community and assign different outreach teams to each location. This will allow outreach teams to know exactly where they are expected to go once their agency is employed during an emergency. See *Transportation and Evacuation* (pages 11–14) for more information about locating people who are homeless and coordinating transportation for them.

Delivering the Message For many people who are homeless, notification from an outreach team will be their first opportunity to hear about the emergency situation. Outreach teams are responsible for relaying messages quickly without generating panic.

If time permits prior to initiating personal notifications, the outreach teams should gather and evaluate data on the situation and synthesize it into concise information that is easy to understand and can be communicated to the target audience (Canavan Associates, 2008). Outreach workers should be prepared to "provide specific information about transportation, evacuation, and sheltering locations. When appropriate, message content should also include incident facts, health risk concerns, pre-incident and post-incident preparedness recommendations, and how to access assistance in a format or language

which a broad spectrum of the community can understand" (FEMA, 2008). In addition, the outreach team should anticipate questions regarding any shelter requirements for identification, accommodations for pets, ways the individual can help, and what belongings can be taken to the shelter.

When delivering a message and responding to questions, it is important to promote trust and confidence, avoiding harmful communication approaches such as fear-driven persuasion (SAMHSA, 2002). Also important in communicating disaster information is cultural sensitivity. According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2004), "survivors react to and recover from disaster within the context of their individual racial and ethnic backgrounds, cultural viewpoints, life experiences, and values." Outreach workers may encounter individuals who associate the tumult of the disaster response with past traumatic experiences or are unwilling to cooperate because of the presence of an authority figure. Culturally competent workers are able to negotiate situations arising from cultural differences efficiently.

SAMHSA's publication, *Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations*, a valuable resource to promote understanding of how culture can influence disaster response, is available online at www.mentalhealth.samhsa.gov/publications/allpubs/sma03-3828/sectionone.asp.

TRANSPORTATION AND EVACUATION

Since October 2006, State and local governments with mass evacuation plans have been required to coordinate transportation for special needs populations during emergencies. In its *Interim Emergency Management Planning Guide for Special Needs Populations*, FEMA (2008) stresses the importance of "procedures to ensure the availability of sufficient and timely accessible transportation to evacuate facilities or neighborhoods with a high concentration of residents who need additional assistance." The Federal Highway Administration advises planners to include: demographic data identifying the location of low-income, transient populations, provisions to work with community outreach agencies to coordinate transportation for special needs populations, and provisions for evacuating transient (including homeless) populations (FHA, 2007).

The Department of Homeland Security reported that only 10% of State and 12% of urban emergency plans adequately addressed the evacuation of transportation-disadvantaged populations in 2006[1] (GAO, 2006). One reason that many state and local governments lack adequate transportation and evacuation plans for special needs populations is poor coordination resulting from varying definitions of "special needs populations." Other barriers include: identifying and locating the special needs populations, determining transportation needs, acquiring transportation resources, and legal and social barriers (GAO, 2006).

Identifying and locating homeless people Evacuation plans generally do not include the locations of transportation-disadvantaged populations for the following reasons: these data have not been previously collected, the community lacks sufficient resources to collect the data, the data are not compiled, and/or data are not shared with emergency management officials (GAO, 2006).

Often communities depend on registries to identify the location of special needs populations. These registries primarily benefit people with stable housing who have mobility limitations, such as older adults and people with disabilities. Because of the transient nature of homelessness, the best way to collect data on the location of homeless people is to involve homeless service providers in emergency planning. Many homeless people congregate in and around homeless service facilities. Outreach workers from homeless service agencies are able to identify other areas such as parks, alleyways, under

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[1] The GAO uses the term "transportation-disadvantaged populations" to describe older adults and people with disabilities including mobility impairments; low-income, homeless or transient persons; children without an adult present during a disaster; tourists and commuters who are frequent users of public transportation; people with limited English proficiency; and others without a personal vehicle.

bridges and overpasses, and encampments where homeless people can be found. Once all known locations have been identified, geographic information systems (GIS) can be used to create a map that pinpoints the identified areas and outreach teams can be assigned to each location to make notifications and help transport people to safety.

Determining transportation needs To evacuate homeless people adequately, State and local officials need to know about their medical and transportation needs, according to the GAO (2006), including the following:
- Can individuals travel by themselves to pick-up points?
- Do individuals require transportation to pick-up points but do not require medical assistance or accessible transportation?
- Do individuals live in group homes for persons with mental disabilities and may require medical assistance but not accessible transportation?
- Are individuals medically frail but not hospitalized, and require acute medical assistance as well as accessible transportation?

Homeless service providers working with State and local officials should assess the aforementioned needs for each location where people who are homeless can be found. Because a disproportionately high number of homeless people are disabled and/or seriously and persistently mentally ill, it is very likely that emergency planners will need to send an accessible van as well as well trained drivers and outreach workers to these sites.

Identifying transportation resources Transportation resources should be identified pre-disaster. Many emergency planners underestimate the time needed to coordinate transportation resources. In addition to finding accessible, multi-passenger vehicles, planners must make sure that drivers are trained to operate the vehicles and know how to assist people with disabilities. Planners should consider contracting vehicles and drivers from the city/county government, schools, social service agencies, churches, taxi companies and other private charter companies. FEMA (2008) also advises emergency planners to be aware of programs that receive federal funding to support transportation services for special needs populations, such as mental health day habilitation programs and vocational rehabilitation programs.

Once transportation resources are identified, planners should prepare mutual aid agreements with the transportation providers and drivers. Mutual aid agreements with transportation providers create clear roles and responsibilities and contribute to effective coordination of services.

Legal and social barriers Some of the provisions of the mutual aid agreement may require local and State policy changes. Examples of provisions that may require policy change include those that address liability, transportation between counties, and reimbursement of drivers.

Concerns about breaching privacy laws that prevent the sharing of personally identifiable health information can present another barrier to evacuation. For example, outreach workers may be hesitant to share the location and medical and behavioral health needs of individuals requiring emergency assistance. FEMA (2008) recommends that planners consult with the Department of Health and Human Services Office for Civil Rights about how the HIPAA Privacy Rule permits covered entities to disclose identifiable health information for emergency planning purposes. A simple diagram specifying the entities that are covered (and not covered) by the HIPAA rule can be found online at www.cms.hhs.gov/HIPAAGenInfo/Downloads/CoveredEntitycharts.pdf.

Social barriers also prevent homeless individuals from complying with evacuation orders. According to the GAO (2006), individuals may be hesitant to evacuate for fear of being separated from family, friends or pets, due to the concern that riding in an evacuation vehicle may be painful due to a medical condition, anxiety provoked by lack of information about their destination, or reluctance to leave their belongings. General mistrust of authority figures and fear of arrest due for pending warrants or documentation status may also delay evacuation. To minimize potential delays, these social barriers should be addressed at emergency preparedness trainings offered to people who are homeless. Outreach workers trained in motivational interviewing are also helpful in resolving ambivalence.

Training transportation providers and drivers Once the emergency planner and the transportation providers have signed a mutual aid agreement, the planner should make sure that transportation providers and drivers stay up to date with the emergency plan, including designated routes, pick-up locations and shelter sites. In addition, it is important that transportation providers and drivers participate in community emergency preparedness trainings. The GAO (2006) also recommends incorporating members of the transportation-disadvantaged population into training exercises to emphasize the importance of serving the population and to increase emergency management and public safety officials' understanding of the population's needs.

CAN HEALTH CARE INFORMATION BE SHARED IN A SEVERE DISASTER?

Providers and health plans covered by the HIPAA Privacy Rule can share patient information in all of the following ways:

TREATMENT: Health care providers can share patient information as necessary to provide treatment. Treatment includes:

* sharing information with other providers (including hospitals and clinics),

* referring patients for treatment (including linking patients with available providers in areas where the patients have relocated), and

* coordinating patient care with others (such as emergency relief workers or others that can help in finding patients appropriate health services).

Providers can also share patient information to the extent necessary to seek payment for these health care services.

NOTIFICATION: Health care providers can share patient information as necessary to identify, locate, and notify family members, guardians, or anyone else responsible for the individual's care of the individual's location, general condition, or death.

The health care provider should get verbal permission from individuals, when possible; but if the individual is incapacitated or not available, providers may share information for these purposes if, in their professional judgement, doing so is in the patient's best interest.

* Thus, when necessary, the hospital may notify the police, the press, or the public at large to the extent necessary to help locate, identify, or otherwise notify family members and others as to the location and general condition of their loved ones.

* In addition, when a health care provider is sharing information with disaster relief organizations that, like the American Red Cross, are authorized by law or by their charters to assist in disaster relief efforts, it is unnecessary to obtain a patient's permission to share the information if doing so would interfere with the organization's ability to respond to the emergency.

IMMINENT DANGER: Providers can share patient information with anyone as necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public -- consistent with applicable law and the provider's standards of ethical conduct.

FACILITY DIRECTORY: Health care facilities maintaining a directory of patients can tell people who call or ask about individuals whether the individual is at the facility, their location in the facility, and general condition.

Of course, the HIPAA Privacy Rule does not apply to disclosures if they are not made by entities covered by the Privacy Rule. Thus, for instance, the HIPAA Privacy Rule does not restrict the American Red Cross from sharing patient information.

U.S. Department of Health and Human Services, 2006

Re-entry after evacuation Once government or emergency management officials declare the disaster area safe for re-entry, the local government will activate its re-entry plan. Most communities will set up roadblocks and permit entry using a tiered process. First responders and other emergency personnel are generally the first group permitted back to return, followed by large businesses (e.g., wholesale retail stores), then small businesses, and finally, the general population.

Despite the transient nature of homelessness, many homeless people want to return to their communities. A significant number of people experiencing homelessness have established supportive networks and have been connected with programs and other resources in their communities that aid in survival and well-being. Communities should make every effort to ensure that emergency management plans include accommodations for homeless people who wish to return to their communities after evacuation.

Homeless service providers should make themselves available at drop-off points to offer services and support to homeless people returning from an evacuation. Many areas where homeless people reside, such as abandoned buildings and outdoor settings, may not be safe for habitation following a natural or man-made disaster. In addition, many of the belongings that had to be left behind, such as extra clothes, may be gone. Moreover, depending on the disaster, the city may enact curfews and have police patrolling communities. Providers should be prepared to direct homeless individuals to shelters and other housing options. For more information see *Transition to Housing (page 25)*.

SHELTERING

The primary goal of emergency shelters is to ensure the health and safety of individuals requiring shelter in the communities in which they live[2]. FEMA stresses the importance of accomplishing this goal without violating civil rights (FEMA, 2008). Accounts of communities that turn individuals away from emergency shelters during man-made or natural disasters for lack of proper identification or because of housing status prior to the disaster are not uncommon. For example, a shelter in Spokane, Washington, refused to accept tribal-issued identification from homeless Native American grandparents who were seeking refuge in subzero temperatures. Consequently the couple slept in a car, putting their health and safety at risk (California Immigrant Policy Center, 2008).

In a document prepared for the U.S. Department of Homeland Security, the author unfortunately suggested that people experiencing homelessness might prey on other shelter residents and advised emergency planners to consider segregating them (Vogt Sorensen, 2006) further stigmatizing already marginalized people. Not only is segregation a civil rights issue, it fosters negative stereotypes that adversely affect vulnerable people. A more humane approach would be to provide safety and security for of all shelter residents (previously homeless or not) and to make referrals for residents determined to have greater needs. Referrals can be made to trained professionals who agree to discuss any issues and special needs with the resident.

The other extreme—strictly confining shelter residents to shelters against their will—should also be avoided. Tierney (2006) describes a situation in which many low-income individuals stranded in New Orleans after Hurricane Katrina were policed more than they were assisted:

> *Instead of having their needs addressed in a timely manner, those stranded in New Orleans after Katrina were not so much assisted as they were policed. Literally treated like criminals, they were confined to shelters under strict control. Later they were transported, again under the control of law enforcement agencies and the military, to over forty states around the country, without even having the opportunity to choose where they would be sent. Family units were broken up and sent in different directions.*

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[2] Trainings in shelter health are available through the National Health Care for the Homeless Council, www.nhchc.org. For a full discussion of health care considerations in shelters, see Kraybill, K. and Olivet, J. (2005). Shelter Health: Essentials of Care for People Living in Shelter. Available online at: http://www.nhchc.org/shelterhealth.html#toolkits.

THE KOCH EDICT

In 1985, Former New York Mayor, Ed Koch, campaigned for the mandatory removal of homeless people sleeping in public places on freezing nights. The edict gave law enforcement authority to take unwilling homeless individuals to a shelter or to a hospital for psychiatric evaluation. The New York Times quotes Mr. Koch as saying, "We believe that anyone who chooses to be out on the streets in the cold when we offer that person an opportunity to go to a shelter, that person is not competent." Advocates explained that many homeless individuals feared for their safety at crowded shelters and would rationally prefer to be somewhere else.

Barbanel, 1985

Homeless individuals may decline services for a number of reasons including feelings of estrangement from the community, fear of authority figures, and hesitancy of leaving belongings and/or a pet. Situations involving individuals who do not want to seek safety in a shelter are ethically challenging. It is a gray area that overlaps with concern for one's safety and respect for one's civil rights. In such situations, it is beneficial to involve a homeless service provider who is trained in outreach and engagement strategies to encourage the person to take proper safety measures. Individuals trained in motivational interviewing are also skilled at persuading individuals to make decisions that benefit their well-being[3].

Specialized Shelters Communities that wish to offer enhanced behavioral and medical services for individuals with special needs might consider a specialized shelter. Specialized shelters can be stand-alone entities or co-located within a general population shelter or as a unit within a medical shelter (FEMA, 2008). Shelters serving a large number of individuals with mental illness or substance dependence may want to consider designating detox areas or onsite psychiatric areas (DeWolfe, 1996).

Specialized shelters are a State, Territorial, Tribal, or local government responsibility. Mutual aid agreements between homeless service providers and local officials will create clear roles and promote effective coordination of shelter services. In a mutual aid agreement, homeless service providers can dedicate social workers, counselors, nurses, and others to work with vulnerable populations. It is important that emergency planners, homeless service providers and shelter staff understand that specialized shelters should be optional and that homeless people should not be turned away from general population shelters without due cause.

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[3] Trainings in motivational interviewing are available through the National Health Care for the Homeless Council, www.nhchc.org, and other fine training providers.

Both general and specialized shelters should incorporate a triage process to prioritize needs for assistance and/or "place individuals in shelters that meet their needs in the least restrictive manner possible." Triage staff should be trained to communicate with a wide range of populations, have access to interpreters to assist non-English speaking and hearing-impaired individuals, and have access to medical and behavioral health professionals who can provide appropriate care (FEMA, 2008).

Like the term, "special populations," the term "specialized shelter" lends itself to broad interpretation. Issacson Kailes (2005) asserts that specificity is more useful for planning purposes (i.e. medical needs shelter). By being more specific, planners avoid situations in which individuals are placed in shelters that do not meet their needs. For example, many people who have disabilities and special activity limitations do not have special medical needs. To avoid confusion, emergency plans should describe the services to be offered at the various specialized shelters.

HEALTH STATUS

Mental Illness

In his preface to the publication, *Responding to the Needs of People with Serious and Persistent Mental Illness in Times of Major Disaster*, Dr. Brian Flynn (1996) states:

> *The needs and desires of people with serious mental illness are closer to the needs and desires of the general population following a disaster than previously thought. People with mental illness have the same need for housing, stability, and support as their neighbors in the days following a disaster. They are as capable as anybody else in behaving heroically during and after the disaster event. They have the same difficulties maneuvering through the complexities of the recovery process. And they share the desire to see their lives and communities restored.*

> *The presence of mental illness does not preclude an individual from having the resources and strength to physically and psychologically survive major disaster, and from assisting in the rebuilding of their lives and community following disaster. Indeed, people with mental illness do share the same pain and fear as everybody else.*

According to conservative estimates, about one in 3 adults who are homeless have a serious mental disorder (such as major depression, bipolar disorder, and schizophrenia), compared to approximately one in 17 adults in the general US population (NAMI, 2007). More than one-half of those with mental illness have co-occurring substance use disorders (HCH Clinicians Network, 2000). The prevalence of these disorders is considerably higher among people who have been homeless on a long-term basis. Sixty-five percent of the 23 cities participating in the U.S. Conference of Mayors' 2007 survey of hunger and homelessness reported mental illness and lack of needed services as the most common cause of homelessness for single adults, closely followed by substance abuse (61%).

Serious mental illness has a disproportionately negative effect on people experiencing homelessness, due to their limited access to mental health services and social supports, as well as their exposure to the highly stressful experience of living without stable housing. Though it is not uncommon for mental illness to precede (and precipitate) homelessness, many people develop mental illness as a result of homelessness. People who lose their homes encounter social exclusion and often suffer from sleep deprivation and poor nutrition, increasing their vulnerability to situational depression and anxiety.

People who are homeless—particularly individuals with mental illness and co-occurring substance use disorders—have difficulty navigating service systems. Inadequate access to

care coupled with the extreme stress of surviving on the streets exacerbate symptoms of mental illness. With limited places to find respite during the day, homeless people with uncontrolled serious mental illness are often seen on the streets experiencing episodes of their illness. As a consequence, stigmas and stereotypes are created further isolating these vulnerable individuals. During disasters, emergency planners and shelter workers have an opportunity to address the mental health needs of people who are homeless and must do so without adding to the existing stigma that surrounds their lives.

Individuals with serious mental illness may have difficulty adjusting to further disruption of their daily lives caused by the disaster response process. Reactions may vary, including heightened reactions (e.g. easily startled, outbursts of anger), and false perceptions of their environment. This may cause a reluctance to seek help and misperception of services being offered. Successful intervention is dependent on outreach programs that are effective in engagement strategies. In the engagement process, the worker must have a competent understanding and awareness of how the individual perceives the services being offered and how aspects of one's mental illness may make the individual reluctant to seek help (Speier, 1996). Once engaged, the individual should be referred to a trained professional to receive any support services, medications, or hospitalization necessary to regain stability.

A common mistake that shelter staff make is to misinterpret disaster-related stress as a symptom of underlying illness. Common reactions to disasters such as grief, anxiety, regressive behaviors (e.g., thumbsucking), isolation, the need to express feelings, and the desire to help others should not be misinterpreted as symptoms of mental illness (Speier, 1996). People react to disasters in many of the same ways, regardless of their mental health status. Individuals demonstrating symptoms of underlying mental illness can benefit from the same mental health services available to all disaster survivors. Trained mental health professionals should evaluate individuals who do not show gradual improvement in signs of stress (SAMHSA COCE, 2007).

Many individuals with mental illness function fairly well following a disaster, if essential services (including mental health services) have not been interrupted (DeWolfe, 1996). Individuals who have participated in comprehensive preparedness trainings will have some knowledge about how to store medications and seek help for primary and behavioral health care needs. Training participants may also have an emergency health information card describing their health care needs. Shelter workers encountering a homeless person seeking assistance should listen carefully and make any necessary arrangements to ensure that the individual is able to receive care to address their mental and physical health needs.

Trauma The majority of people experiencing homelessness have lived through one or more traumatic events. Ninety percent of homeless women have experienced severe physical,

sexual, and/or emotional abuse and 43% were molested as children (HCH Clinicians' Network, 2003). Homeless children, often victims of abuse, repeatedly witness violence and assault on the streets and many are abruptly taken from their caregiver (National Child Traumatic Stress Network, 2005). Homelessness itself is characterized by extreme stress and anxiety as well as increased vulnerability to assault, violence and injury. Such traumatic experiences often result in post-traumatic stress disorder (PTSD). PTSD is the name given to the broad spectrum of psychological and somatic disorders characteristic of trauma survivors. Symptoms of PTSD include hyperarousal (startles easily, easily irritated, sleeps poorly), intrusion (reliving the event after it is over, flashbacks) and constriction (state of surrender and helplessness) (Herman, 1997).

Almost all disaster survivors have experienced trauma and manifest some trauma symptoms. For most people, symptoms will lessen over the course of a week with traditional disaster counseling. People with preexisting PTSD may experience prolonged and exacerbated symptoms. Individuals demonstrating prolonged PTSD symptoms should be referred to a trained professional.

Crisis Counseling Assistance and Training Program The U.S. Department of Health and Human Services, the Substance Abuse and Mental Health Services Administration and the Centers for Mental Health Services recommend that mental health and human service workers supplement their training with information from the Crisis Counseling Assistance and Training Program administered by the Centers for Mental Health Service and FEMA. The Crisis Counseling Assistance and Training Program model contends, "disaster mental health is a specialized service which requires distinct training. The skills, knowledge, and attitudes required for disaster mental health and crisis counseling are quite different from those needed in therapeutic, clinical mental health services" (DeWolfe, 2000). Workers that have received Crisis Counseling training are discouraged from trying to treat people with a mental illness but are encouraged to "identify them, assess their needs, and help them receive professional or community support though more regular channels" (DeWolfe, 2000). This is not to say that people with a mental illness should not receive general disaster counseling, but that this service should be offered simultaneously with other behavioral health services (Thomas, 1996).

TIPS FOR MENTAL HEALTH PROVIDERS STAFFING A SHELTER

- Wear clear identification
- Begin and maintain contact with individuals with mental illness in the shelter, and help them connect or reconnect with known mental health services, providers, and resources
- Identify any individuals with mental illness who cannot manage the chaos of the shelter or who are disruptive to other residents, and find other places for them to stay
- Set up a charting and reporting system for people receiving psychiatric evaluations, medications, or intensive interventions
- Provide training and consultation to shelter staff about working with people with mental illness who live in the shelter.

DeWolfe, 1996

Substance Use Disorders

Substance use disorders are overrepresented among people without stable housing, who are estimated to be 2–5 times more likely to have these disorders than the general population (Post et al., 2007). According to the most comprehensive study of homeless people conducted nationwide (Burt, 1999), approximately two out of three homeless people in the United States (66 percent) have an alcohol or drug problem. A 2007 survey of 23 cities conducted by the U.S. Conference of Mayors found that close to 47% of homeless people (combined single individuals and individuals in households) have substance abuse problems. In 2004, SAMHSA reported that people experiencing homelessness comprised 13% of people admitted to substance abuse treatment facilities. The primary substance of abuse in homeless admissions in 2004 was alcohol (52% of admissions), followed by opiates (21%), cocaine (17%), marijuana (4%), stimulants (4%), and other (2%) (SAMHSA, 2006).

Disasters pose a significant challenge for people affected by substance use disorders in that it interferes with treatment programs and displaces support networks. Disasters also increase stress for individuals who are attempting to remain sober or for those walking the fine line between moderate use and addiction (Curley, 2005). Furthermore, recent studies have shown increases in substance use among disaster survivors, particularly those with PTSD (NASADAD, 2005). Fornili (2006) states that "people who are subjected to chronic stress or who show symptoms of PTSD often have poorly regulated hormonal responses that do not return to normal when the stress is relieved, perhaps making them more prone to stress-related disorders and relapse to drug or alcohol use."

Individuals with an addiction who have been cut off from their treatment programs or their supply of street drugs may need medical supervision. Every effort should be made to connect these individuals to community programs before making a referral to a nearby city or, in extreme circumstances, having to manage the addiction on site.

Workers who are trained to recognize symptoms of withdrawal will be more efficient in connecting individuals to appropriate services. A list of commonly used substances and associated withdrawal symptoms are available at www.addictionwithdrawal.com.

Additional resources for the provision of mental health and addiction services during a disaster can be found at SAMHSA's Disaster Technical Assistance Center: http://mentalhealth.samhsa.gov/dtac.

THE ADDICTIONS COMMUNITY RESPONDS

After Hurricane Katrina devastated Louisiana, the recovery community was in a state of crisis. Of the addiction population in treatment, 88% were unaccounted for; all seven opioid treatment programs in the New Orleans area were closed or destroyed; nineteen outpatient treatment programs and 25 prevention programs were destroyed; and overall, one third of treatment capacity was destroyed (SAMHSA DTAC, 2006). Some SAMHSA funds were allocated to Texas ($150,000) for methadone services for storm evacuees. Additional funds supported hotlines for people with addictions, promising referrals to 12-step programs, treatment services, crisis-intervention teams, methadone maintenance, and other resources. The resources were not sufficient to care for the thousands of individuals in need of immediate addiction treatment. The addictions community across the country stepped up. A North Carolina physician persuaded drug companies to donate medication needed for detox services and drove down to Baton Rouge in a motor home to help people in withdrawal. The Betty Ford Center offered to provide treatment for a half-dozen patients, and the National Council on Alcoholism and Drug Dependence began mobilizing its affiliates nationally to help storm victims. In addition, the National Association of Addiction Treatment Providers (NAATP), which happened to be holding its annual meeting in Florida, pulled together its membership to pledge a total of $5 million worth of primary inpatient and other treatment services for Katrina victims.

Curley, 2005

Co-occurring Behavioral Health Disorders

The co-occurrence of mental illness with substance use disorders is not unusual, regardless of housing status, but individuals with co-occurring disorders who are homeless are particularly vulnerable. Estimates of the number of homeless people with co-occurring behavioral health disorders vary, depending on the population studied and the definition of co-occurring disorders employed. In a national sample, 75% of homeless clients with a past-year drug disorder had a comorbid nonsubstance related mental illness (Kertesz, 2006). National Alliance on Mental Illness (NAMI) (2003) cites an estimated 50% of homeless people have co-occurring disorders. SAMHSA's Co-Occurring Center for Excellence (COCE) (2007) cites 32% of homeless men and 37% of homeless women have comorbid mental illness and substance abuse disorders.

According to NAMI (2003), individuals with co-occurring disorders have greater propensity for violence, medication noncompliance, and failure to respond to treatment than do individuals with a substance abuse disorder *or* a mental illness. Co-occurring disorders also lead to poorer functioning and a greater chance of relapse (NAMI, 2003). Optimally, treatment for both disorders should be integrated and simultaneous. Unfortunately, a large number of people with co-occurring disorders go without treatment. Workers at emergency shelters should link these individuals to integrated care systems.

To accomplish this, shelter staff need to be trained to recognize signs of co-occurring disorders and make appropriate referrals. Recognizing the signs of co-occurring disorders can be complicated for the following reasons: "[S]ubstance use can cause psychiatric symptoms and mimic psychiatric disorders, substance use can initiate or exacerbate a psychiatric disorder, substance use can mask psychiatric symptoms and syndromes, withdrawal from substances can cause psychiatric symptoms and mimic psychiatric syndromes, psychiatric and substance use disorders can coexist independently, behaviors related to psychiatric symptoms can mimic substance use problems" (Winarski, 1998).

Winarski (1998) stresses, "The treatment needs of people with co-occurring mental health and substance use disorders differ significantly from the treatment needs of individuals who have a mental health or substance use disorder by itself. The term implies the need for an integrated response to two or more disorders. It does not assume the primacy of one disorder over the other." Integrated care models in which mental health and addiction services are available at one location from a team of clinicians with mental health, addiction, and case management expertise should be arranged at specialized shelters for optimal treatment (HCH Clinicians' Network, 2009).

SAMHSA's COCE (date unknown) offers some guidance for non-professionals, healthcare providers and human service providers who encounter individuals with co-occurring

disorder in a disaster situation. The COCE advises nonprofessionals to seek assistance from a trained professional if symptoms of stress do not ease over the days immediately following the disaster event. If symptoms of co-occurring disorders are evident, human service providers are advised to engage the individual in a process that leads to referral for further screening (if needed), assessment, and coordinated or integrated treatment. Health care professionals are advised to anticipate the possibility of co-occurring disorders and to treat both mental illness and substance abuse as primary disorders. An integrated approach should be adopted at the initial contact with the individual and used in screening, assessment, and treatment planning. If no specialized services for co-occurring disorders are available, care should be provided by a substance abuse and/or mental health provider(s) who are willing and able to engage in coordination and mutual consultation as treatment progresses.

Other Health Conditions

Homeless people have the same health problems that stably housed people do, but at rates three to six times greater. Exposure to the elements, living in tight quarters, poor hygiene, high-risk behaviors, inadequate nutrition, and lack of health insurance contribute to this health disparity.

About two-thirds of the health problems experienced by homeless people served by Health Care for the Homeless (HCH) providers are acute in nature. Common acute illnesses among homeless people include:
- Respiratory infections (cold, influenza, pneumonia and pleurisy)
- Trauma (lacerations, wounds, sprains, contusions, fractures, burns, etc.)
- Minor skin ailments (sunburn, contact dermatitis, psoriasis, corns, and calluses)
- Infestations (lice, scabies)
- Nutritional deficiencies
- Acute gastrointestinal disorders

Chronic conditions make up one-third of the medical problems seen by HCH providers. The most common chronic conditions in order of frequency are:
- Hypertension
- Gastrointestinal problems (including ulcers and hernias)
- Neurological disorders (mostly seizures)
- Arthritis and other musculoskeletal disorders
- Chronic obstructive pulmonary disease

Peripheral vascular disease—venous or arterial deficiencies in the extremities—is another chronic condition commonly seen among people who are homeless. "This is primarily due

to people being on their feet all day, the lack of opportunities to elevate the feet and legs, and even having to sleep in a sitting-up position" (McMurray-Avila, 2001).

"Communicable diseases are of particular concern because of the potential for rapid spread among people living in crowded shelters or unsanitary conditions. About one in five HCH clients have an infectious or communicable disease. Most are minor, such as lice or scabies infestations, other skin diseases, etc. However, serious respiratory infections are found in 4%, STD in about 3%, and active TB infection in about 1%" (McMurray-Avila, 2001).

In addition to being sicker than people who are housed, 70% of the people who receive care at HCH sites have co-occurring physical and behavioral health needs (Clinicians' Network, 2006).

Given the extensive health care needs of homeless people, HCH providers are a critical resource during disasters. In addition to providing integrated multidisciplinary care, HCH centers perform a number of other important functions during disasters, including (Wineman, 2007):
- disease surveillance
- reporting and assisting with medical and mental health surge capacity both at the health center and at the site of an emergency
- serving as points of distribution for pharmaceuticals and supplies
- acting as mass vaccination clinics and alternate care sites
- providing translation services and risk communication

TROPICAL STORM ALLISON
HEALTH CARE FOR THE HOMELESS CLINICIANS RESPOND

After the devastation of Tropical Storm Allison, the Houston Healthcare for the Homeless responded using the street outreach model to help homeless individuals access care. The HCH parked its mobile medical van outside a relief site and clinical staff treated conditions caused by wading in high water. Clinical staff were also able to provide care for people experiencing psychological trauma, a condition common in people who are homeless.

HCH Clinicians' Network, 2004

TRANSITION TO HOUSING

People experiencing homelessness often remain at disaster shelters until alternate housing is made available or until they are forced to leave (DeWolfe, 1996). Encampments and other areas where people without homes took refuge prior to a disaster may no longer be fit for habitation. In addition, the process of recovery from a disaster may be difficult when individuals are forced back onto the streets or into overcrowded shelters.

In the past, housing assistance has been difficult for homeless people to attain for reasons having to do with their housing status prior to the disaster and lack of documentation. Criticism from advocates around the country as well as from the U.S. General Accounting Office (GAO) stimulated policy changes intended to prevent such discriminatory practices. Recent amendments made to the Robert T. Stafford Disaster Relief and Emergency Assistance Act assure that all individuals in need of disaster assistance are eligible for housing and other supportive assistance.

Emergency planners and homeless service providers should establish a plan to respond to housing needs immediately following a disaster. Housing assistance is available through the Disaster Housing Assistance Program (DHAP) administered by the U.S. Department of Housing and Urban Development's network of public housing authorities (PHAs). Individuals or head of households receiving temporary housing assistance under the DHAP program are required to work with case managers in order to facilitate the transition to permanent housing. The PHA is ultimately responsible for the provision of case management and may choose to contract this service out to another agency. Homeless service providers might consider contracting with their local PHA to assist homeless individuals negotiate the DHAP application process and find appropriate permanent housing.

People who are chronically homeless (29% of homeless individuals, 18% of the homeless population) have difficulties staying in permanent housing due to complex medical problems, serious mental illness and/or alcohol or drug addiction (NAEH, 2007 & 2009). The best model for housing chronically homeless individuals is a permanent supportive housing model using a housing first approach (NAEH, 2007). "Permanent supportive housing is an approach to subsidized housing designed for people with very low incomes and chronic, disabling health conditions which provides voluntary access to a flexible and comprehensive array of support services and places no limits on length of tenancy as long as terms and conditions of the lease or agreement are met" (Post, 2008). The housing first approach assumes that people who are living in adequate housing are better able to manage their physical and behavioral health needs. This approach places individuals into housing with the expectation that the individual will participate in treatment plans once housed.

Funding for permanent supportive housing and housing first is available through the U.S. Department of Housing and Urban Development. More information about permanent supportive housing and housing first including additional funding sources can be found online at http://www.nhchc.org/supportivehousing.html.

A COLLABORATIVE APPROACH TO DISASTER PLANNING

During times of disaster, the efficiency of service delivery is dependent on a well-coordinated and integrated response by all stakeholders. Confusion about the roles of various agencies could result in a delay in providing crucial services to survivors, as was the case in New Orleans with Hurricane Katrina. To ensure efficiency and maximize the quality of services available to homeless people during a disaster, it is critical that HCH projects and other homeless service providers build relationships with the relevant stakeholders involved in the emergency response process. To facilitate the relationship building process, providers should get to know their local emergency manager, get involved in an advisory committee, and establish mutual aid agreements.

Know your local Emergency Manager A multitude of agencies are involved in the emergency response process. Building linkages among the various stakeholders can be daunting. Fortunately, each local Office of Emergency Management employs an Emergency Manager whose job is to coordinate linkages among agencies and ensure an efficient, integrated response in emergency situations. According to the Principles of Emergency Management, the Emergency Manager "ensures unity of effort among all levels of government and all elements of a community; creates and sustains broad and sincere relationships among individuals and organizations to encourage trust, advocate a team atmosphere, build consensus, and facilitate communication; and synchronizes the activities of all relevant stakeholders to achieve a common purpose" (FEMA Emergency Management Institute Working Group, 2007).

Participate in an Advisory Committee Advisory committees can provide guidance to the local emergency management agency in determining and meeting the needs of homeless people during disasters. Committees are made up of consumers, members of the local emergency management agency, provider organizations, advocacy groups, and local government agencies. According to FEMA (2008), advisory committees can be a stand-alone group, a subcommittee of the local disaster planning group, or sponsored by the local Citizen Corps Council.[4] Some communities have formed advisory committees to focus on all special needs populations including people who are homeless, while others have focused their attention exclusively on people experiencing homelessness. Advisory Committees that focus specifically on homeless populations seem to be more effective in establishing emergency management plans that more comprehensively meet the needs of homeless people.

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[4] The mission of Citizen Corps is to harness the power of every individual through education, training, and volunteer service to make communities safer, stronger, and better prepared to respond to the threats of terrorism, crime, public health issues, and disasters of all kinds. A state listing of Citizens Corps Councils can be found online at: www.citizencorps.gov/cc/listCouncil.do?submitByState

The Emergency Manager is a critical member of the advisory committee, whose role is to ensure that all of the necessary stakeholders are at the table, coordinate and implement suggestions, and provide guidance on delivering services in a coordinated and integrated manner. If the Emergency Manager cannot attend meetings, a representative should attend in his or her place.

In some cases, local governments designate another agency such as a social service agency to coordinate special needs planning. Other communities may employ a special needs advisor to "provide focused special needs expertise for the emergency planning process" (FEMA, 2008). Providers can call their local Office of Emergency Management to determine whether or not an advisory committee already exists and find out who is responsible for coordinating emergency management efforts for special needs populations (*i.e. Emergency Manager, Special Needs Advisor, or official at a lead agency designated to coordinate special needs planning*). If an advisory committee does not currently exist, homeless service providers are encouraged to speak to their Emergency Manager to seek guidance for setting up a committee.

Some smaller communities may have just a few people involved in emergency management and the provision of homeless services. In such cases, a practical alternative to an advisory committee is to set up a meeting with the emergency manager to walk through and revise the community Emergency Operation Plan.

Mutual aid agreements Once the advisory committee has identified linkages among service providers, the Emergency Manger might coordinate mutual aid agreements to clarify the roles and responsibilities of the various agencies involved in an integrated emergency response. Providers should avoid developing mutual aid agreements until a proper assessment shows compelling evidence that they are able to meet a specific need using their own resources. In a NIMS Intrastate Mutual Aid course, FEMA (2007) stresses, "when developing a mutual aid agreement, you must understand the risks, requirements, capabilities, and shortfalls that exist. By following the steps [listed below], you can either evaluate existing agreements for effectiveness or seek out new ways to meet preparedness goals, such as developing new mutual aid agreements."

STEPS IN DEVELOPING MUTUAL AID AGREEMENTS

Step 1: Review existing agreements and authorities

Step 2: Review hazard identification and vulnerability assessments

Step 3: Conduct capability assessments

Step 4: Update emergency operations plans and resource inventories

Step 5: Identify resource needs and gaps

Step 6: Develop new agreements or update existing agreements

FEMA, 2007

Once a mutual aid agreement is established, FEMA encourages stakeholders to implement a mutual aid operational plan or mutual aid action plan. The mutual aid action plan offers detailed information about how the mutual aid agreement will be implemented. Components of the mutual aid action plan include:

- Activation
- Requests for Assistance
- Mobilization
- Resource Accountability
- Demobilization
- Documentation

- Training
- Exercises
- After-Action Review
- Plan Maintenance

(FEMA, 2007).

The Centers for Disease Control and Prevention's mutual aid website offers an inventory of mutual aid agreements and related resources: www2a.cdc.gov/phlp/mutualaid/index.asp.

Other important collaborative activities Once an inclusive emergency management plan is in place and appropriate mutual aid agreements are established, homeless service providers must make sure that their own organizational emergency plans are consistent with their local government's emergency management plan. Inconsistent plans could result in conflicting procedures and confusion among staff members around roles and responsibilities and subsequently a failure to meet the needs of people who need immediate assistance.

Homeless service organizations should also understand and utilize the National Incident Management System (NIMS). NIMS provides a template that can be used to facilitate a seamless response from all governmental and nongovernmental (private/nonprofit) organizations working together to respond to a disaster. The U.S. Department of

Homeland Security (DHS) makes clear that "NIMS is not an operational incident management or resource allocation plan. NIMS represents a core set of doctrines, concepts, principles, terminology, and organizational processes that enables effective, efficient, and collaborative incident management. NIMS is based on the premise that utilization of a common incident management framework will give emergency management/response personnel a flexible but standardized system for emergency management and incident response activities" (U.S. Department of Homeland Security, 2008). Integrated within NIMS is the Incident Command System (ICS). The ICS is an incident management approach that facilitates the coordination of disaster response activities and management of resources among the various government and non-government sectors. To best meet the needs of people who are homeless, all homeless service and community organizations involved in the disaster response process should participate in community NIMS/ICS trainings and exercises.

CONCLUSION

The plight of the poorest members of our communities is explicit, yet we as a nation do little to respond. We must exert our best efforts to assure that those who lack the means to participate in our free market society are not left to die on the streets or live in conditions not meant for human habitation. One way that we can do this is to assure that emergency planning efforts take into account the special needs of poor and homeless people.

The Government Accountability Office reports that evacuations of over 1,000 people occur more than three times a month. Public officials, emergency planners and homeless service providers are encouraged to consider whether or not they are prepared to meet the needs of the poorest members of their communities if a natural or manmade disaster were to occur tomorrow. Federal evaluations of State, Territorial, Tribal, and local emergency management plans conclude that we are not prepared. Despite efforts to make emergency plans more inclusive of vulnerable populations, the media continue to report on groups whose needs go unmet during disasters.

Although this publication emphasizes the important role of Health Care for the Homeless (HCH) projects, it is intended for a broader audience, including providers and advocates who are dedicated to removing barriers that further isolate homeless people. This publication does not attempt to elaborate on the myriad of roles that an HCH project or any other provider might assume during an emergency, nor does it attempt to describe the relationships between stakeholders; rather, it is a tool to identify issue areas that should be addressed in local emergency management plans and help providers begin the planning process.

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Other Resources

Even the most carefully devised emergency plan can fail to meet community needs if the roles and responsibilities of all stakeholders are not well understood and well coordinated. The following resources describe the relationships between Health Centers and other stakeholders.

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Glossary

Case management: A method of providing services whereby a provider assesses the needs of the client and the client's family, when appropriate, and arranges, coordinates, monitors, evaluates, and advocates for a package of multiple services to meet the specific client's complex needs.

Chronic homelessness: A state in which an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four episodes of homelessness in the past three years.

Community Emergency Response Team (CERT): Community members trained to assist others in their neighborhood or workplace following an event when professional responders are not immediately available to help. CERT members also are encouraged to support emergency response agencies by taking a more active role in emergency preparedness projects in their community.

Co-Occurring Disorders: The presence of a substance abuse or chemical dependency diagnosis with a coexisting psychiatric disorder.

Cultural competence: Cultural competence is a set of academic and interpersonal skills that allow an individual to increase their understanding and appreciation of cultural differences and similarities within, among and between groups. This requires a willingness and ability to draw on community-based values, traditions, and customs and to work with knowledgeable persons of both and from the community in developing targeted interventions, communications, and other supports.

Disabling condition: A diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions.

Emergency Operations Plan/Emergency Management Plan: The ongoing plan maintained by various jurisdictional levels for responding to a wide variety of potential hazards.

Functional annex: A plan organized around the performance of a broad task. Each annex focuses on one of the critical emergency functions that the jurisdiction will perform in response to an emergency. The number and type of functional annexes included in the EOP may vary from one jurisdiction to another, depending on needs, capabilities, and organization. Since functional annexes are oriented toward operations, their primary audience consists of those who perform the tasks. They do not repeat general information contained in the Basic Plan.

Geographic Information System (GIS): A system of hardware and software used for storage, retrieval, mapping, and analysis of geographic data

Health Alert Network: A nationwide program to establish the communications, information, distance-learning, and organizational infrastructure for a new level of defense against health threats, including the possibility of bioterrorism.

Heath Care for the Homeless project: A health center that receives federal funding through section 330(h) of the Public Health Act to provide health care and other related services to people who are homeless.

Health Insurance Portability and Accountability Act (HIPAA): A US law designed to provide privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers.

Homeless person: An individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facility, abandoned building or vehicle; or in any other unstable or non-permanent situation. An individual may be considered to be homeless if that person is 'doubled up,' a term that refers to a situation where individuals are unable to maintain their housing situation and are forced to stay with a series of friends and/or extended family members.

Housing First: An approach to ending homelessness that centers on providing homeless people with housing quickly and then providing services as needed.

Motivational Interviewing: A non-confrontational approach to eliciting recovery-seeking behaviors. The approach emphasizes relationship-building (expressions of empathy), heightening discrepancy between an individual's personal goals and present circumstances, rolling with resistance (emphasizing respect for the individual experiencing the problem and their necessity and ability to solve the problem), and supporting self-efficacy (expressing confidence in the person's ability to recover and expressing confidence in recovery).

Mutual aid agreement: A written or oral agreement between and among agencies/organizations and/or jurisdictions that provides a mechanism to quickly obtain emergency assistance in the form or personnel, equipment, materials, and other associated services. The primary objective is to facilitate rapid, short-term deployment of emergency support prior to, during, and/or after an incident.

National Incident Management System (NIMS): System that provides a proactive approach guiding government agencies at all levels, the private sector, and nongovernmental organizations to work seamlessly to prepare for, prevent, respond to, recover from, and mitigate the effects of incidents, regardless of cause, size, location, or complexity, in order to reduce the loss of life or property and harm to the environment, supporting technologies, and the maintenance for these systems over time.

National Response Framework: Guides how the Nation conducts all-hazards response. The Framework documents the key response principles, roles, and structures that organize national response. It describes how communities, States, the Federal Government, and private-sector and nongovernmental partners apply these principles for a coordinated, effective national response. And it describes special circumstances where the Federal Government exercises a larger role, including incidents where Federal interests are involved and catastrophic incidents where a State would require significant support. It allows first responders, decision makers, and supporting entities to provide a unified national response.

Outreach: Contact with any individual who would otherwise be ignored (or unserved) in nontraditional settings for the purpose of improving their mental health, health, or social functioning or increasing their human service and resource utilization.

Permanent Supportive Housing: an approach to subsidized housing designed for people with very low incomes and chronic, disabling health conditions which provides voluntary access to a flexible and comprehensive array of support services and places no limits on length of tenancy as long as terms and conditions of the lease or agreement are met.

Post-traumatic stress disorder: A debilitating condition that is related to a past terrifying physical or emotional experience causing the person who survived the event to have persistent, frightening thoughts and memories or flashbacks, of the ordeal. People with PTSD often feel chronically emotionally numb.

Recovery: A lifelong process of change to abstain from alcohol/drug usage. A whole range of changes in behavior and outlook made by the individual to abstain permanently from drinking and drug use, to improve emotional well-being, to relate to others in a more positive way, to find new ways of spending leisure time, and to develop alternative ways of coping with stress. A person who is an alcoholic or addict has to "work on recovery" in order to achieve it. Recovery is much more than simply abstaining from alcohol and other drugs – it involves active, continually evolving behavior changes.

Robert T. Stafford Disaster Relief and Emergency Assistance Act: A US law that constitutes the statutory authority for most Federal disaster response activities especially as they pertain to FEMA and FEMA programs.

Serious mental illness: A diagnosable mental disorder found in persons aged 18 years and older that is so long lasting and severe that it seriously interferes with a person's ability to take part in major life activities.

Special needs population: Populations whose members may have additional needs before, during, and after an incident in functional areas, including but not limited to: maintaining independence, communication, transportation, supervision, and medical care. Individuals in need of additional response assistance may include those who have disabilities; who live in institutionalized settings; who are elderly; who are children; who are from diverse cultures; who have limited English proficiency; or who are non-English speaking; or who are transportation disadvantaged.

Specialized shelter: A shelter that is co-located within a general population shelter or a stand alone facility to offers assistance to individuals who require intensive medical care or assistance with daily life activities.

Vulnerability science: A multidisciplinary approach to hazards and disasters that systematically explores disaster vulnerability as a function of both physical place and social conditions that expose some social groups to the potential for greater harm and that limit their ability to cope when disasters strike.

Withdrawal: The symptoms experienced by substance abusers when they stop using the drug upon which they have become dependent. These symptoms are usually unpleasant and uncomfortable; they may include nausea, insomnia, anxiety, weakness, trembling, sweating, dizziness, convulsions, and dementia.

About the National Health Care for the Homeless Council

Founded in 1985, the National Health Care for the Homeless Council is a membership organization comprised of health care professionals and agencies that serve homeless people in communities across America. The National Council works to improve the delivery of care to homeless people, and to reduce the necessity for dedicated health care for the homeless programs by addressing the root causes of homelessness. www.nhchc.org

Statement of Principles

We recognize and believe that:
- homelessness is unacceptable
- every person has the right to adequate food, housing, clothing and health care
- all people have the right to participate in the decisions affecting their lives
- contemporary homelessness is the product of conscious social and economic policy decisions that have retreated from a commitment to insuring basic life necessities for all people
- the struggle to end homelessness and alleviate its consequences takes many forms including efforts to insure adequate housing, health care, and access to meaningful work.

Mission Statement

The mission of the National Council is to help bring about reform of the health care system to best serve the needs of people who are homeless, to work in alliance with others whose broader purpose is to eliminate homelessness, and to provide support to Council members.

Consistent with our Mission Statement, we:
- Advocate for universal health care and for the improvement of current systems intended to serve people who are poor and homeless
- Research critical issues
- Train and organize health care providers, service agencies, and homeless people themselves to improve care
- Publish newsletters, monographs, action alerts, policy statements, training videos and books
- Collaborate with a broad range of public and private entities interested in the
- problems of health care and homelessness.