ON-LINE SUPPLEMENT

PLANNING FOR MENTAL HEALTH CARE IN DISASTER SHELTERS

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Background to this document. The Dallas, Texas area received many thousands of evacuees from Gulf of Mexico coastal communities hit or threatened by Hurricanes Katrina and Rita in 2005 and Hurricanes Gustav and Ike in 2008. The lessons learned in the Dallas area medical and mental health community in sheltering and providing care for these evacuees led to the creation and adoption by community stakeholders of a formalized set of policies and guidelines for future Dallas area evacuee shelter response efforts. This set of policies and guidelines has been refined into a generic version as a resource for other communities to use in planning their own mass shelter response.

Introduction

The need to provide mass sheltering for evacuee populations can result from a wide range of natural or man-made disasters. Large shelter operations are needed after local severe weather conditions such as flooding, tornados, extreme temperatures, and substantial housing fires or structural damage to facilities housing residential populations. Since 2005, large shelter operations have been needed in Texas for populations evacuating from coastal areas devastated by hurricanes striking the Gulf Coast. The responsibility for mass care, housing, and human services in a disaster is outlined as Emergency Support Function 6 (ESF-6 Mass Care) under Federal, State, and Local Emergency Response Plans. Health and medical support for shelter operations are outlined as ESF-8 (Health and Medical Services) under Federal, State, and Local Emergency Response Plans.

The determination for provision of medical support within the Incident Command Structure in accordance with the National Response Plan is made by leadership in the community. Preparation for conducting a shelter disaster response operation is established through a network of disaster health care response leadership in the community and development of: 1) the structure and function of shelter health care services within a larger Incident Command Structure and 2) specific guidelines for provision of medical and mental health care services. The guidelines begin with shelter health operations setup and next provide details of the shelter mental health care services structure and function, followed by demobilization of the operation. The final section covers disaster mental health preparedness and planning.

Shelter Health Care Services: Structure and Function

The public health system provides surveillance, prevention, and management of disease outbreaks in the shelter. The local Health Authority directs the medical response and coordination of medical operations with appropriate health entities within the local jurisdiction. Local disaster management entities provide coordination of supplies and personnel with local, regional, and state disaster response officials. The shelter Health Care Services function interfaces with the local public health system and local disaster management entities. Figures 1-3 shows the incident command structure for shelter Health Care Services and its Medical and MH Branches. The Medical Branch and Mental Health (MH) Branch constitute the two branches of the shelter Health Care Services structure.

Figure 1. Shelter Health Care Services Command Structure

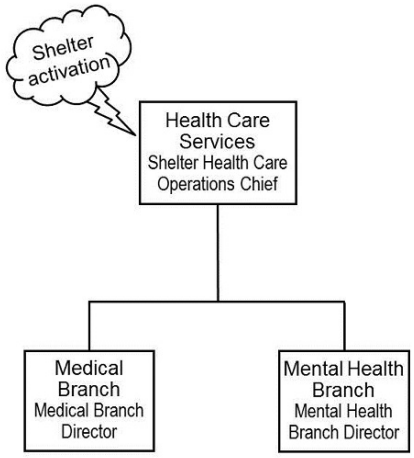


Figure 2. Medical Branch

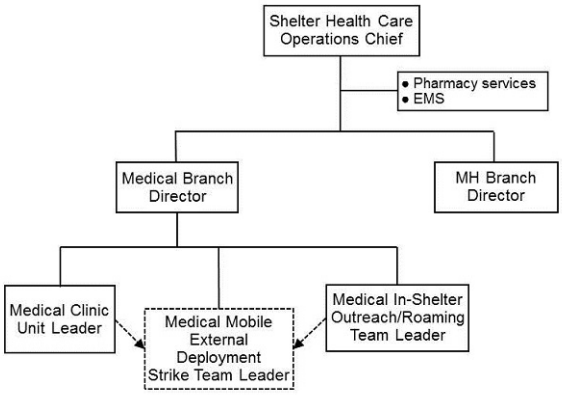
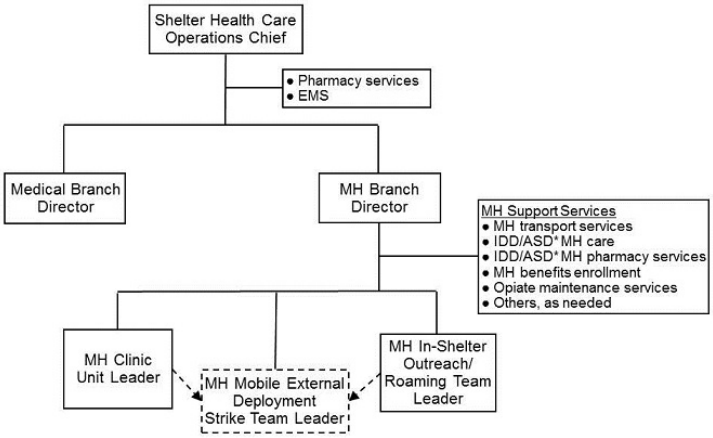


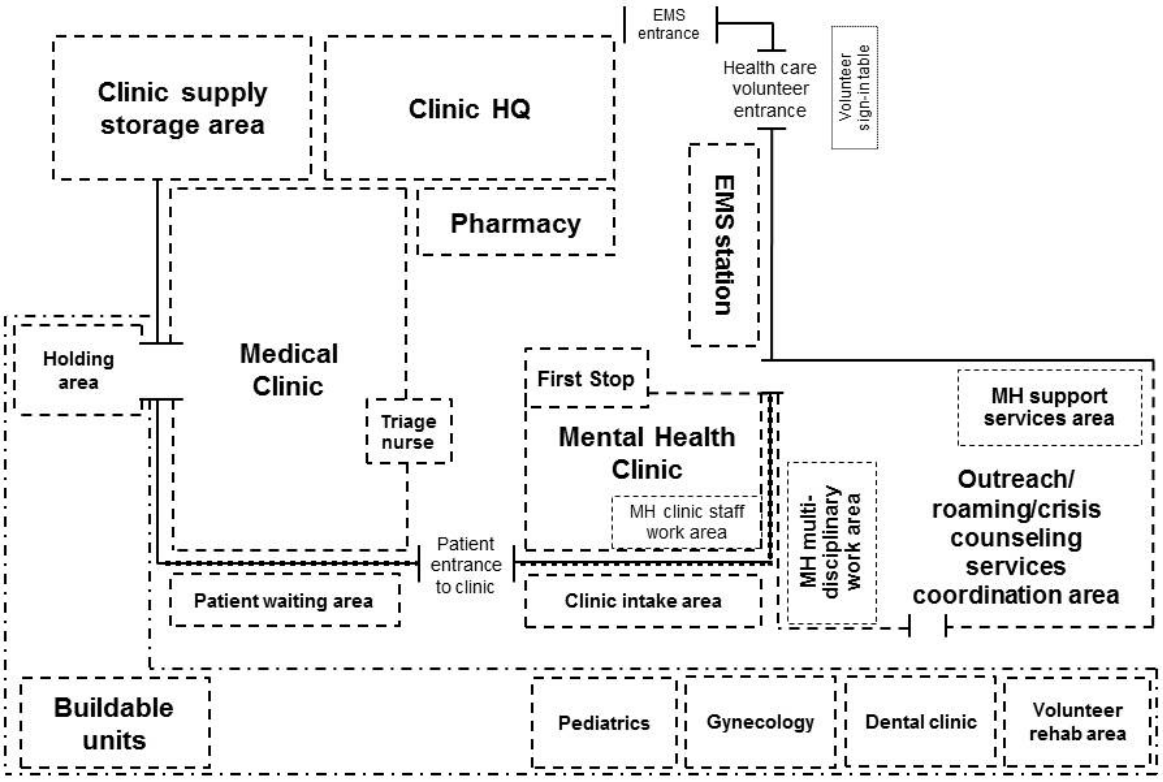
Figure 3. Mental Health (MH) Branch



*Intellectual Developmental Disorder/Autism Spectrum Disorder

Figure 4 shows a sample floor plan showing suggested placement of specific functions, based on the floor plan that was used in the hurricane evacuee shelter at the Dallas Convention Center.

Figure 4. Disaster Shelter Health Care Unit Floor Plan



Providing health care services in a large shelter for disaster evacuees depends on health care volunteers. The Medical Reserve Corps (MRC) is a national network of local groups of volunteers committed to improving the public health, emergency response, and resiliency of their communities. Currently MRC programs cover >90% of the US population with >207,000 volunteers in >990 geographically-based units nationwide. Most urban communities have MRC units associated with them; therefore, this document assumes a coordinated response with the local MRC. Communities without MRC affiliates will need to work with a partnering organization to provide the functions described in this document for MRC.

Medical Branch

Shelter medical care is provided by the Medical Branch of the shelter Health Care Services.

Medical Branch Structure and Components

The Medical Branch provides emergency care and general medical care. General medical care is delivered through the following components:

- Medical Clinic
- Medical In-Shelter Roaming Team
- Medical Mobile External Deployment Team

Two ancillary services that are shared with the MH Clinic are:

- Pharmacy Services
- Emergency Medical Services (EMS)

Medical Branch care providers are medically licensed physicians, nurses, and other healthcare providers (including trainees) in emergency, general, and specialty medical care. The Medical Branch Director is a medically licensed physician from the metropolitan area with experience in emergency and general medical services.

The Medical Branch performs several functions, including medical registration; medical triage; acute evaluation and disposition (including providing EMS activation and transport) for life-threatening emergencies; general medical evaluation, assessment, and treatment; referral to outside services; arrangement for nursing home placement and dialysis services; and health surveillance monitoring.

Mental Health Branch

Shelter mental health care is provided by the Mental Health (MH) Branch of the shelter Health Care Services.

MH Branch Structure and Components

The MH Branch components are:

- MH Clinic
  - First Stop (intake/registration for MH Clinic)
  - Psychiatry Services
- MH In-Shelter Outreach/Roaming Team
- MH Mobile External Deployment Team

Various ancillary MH Support Services are provided to the MH Branch:

- Transportation
- Intellectual Developmental Disorder/Autism Spectrum Disorder (IDD/ASD) MH care
- Intellectual Developmental Disorder/Autism Spectrum Disorder (IDD/ASD) MH pharmacy services
- MH benefits enrollment
- Opiate maintenance treatment
- Others, as needed

Two additional ancillary services that are shared with the Medical Branch are:

- Pharmacy Services
- Emergency Medical Services (EMS)

The units/teams of the MH Branch are listed in Table 1 along with their purpose, and their key personnel roles/functions and qualifications.

Table 1. Units/teams of the MH Branch and key personnel

Unit/Team	Unit/Team Purpose	Personnel	Personnel Roles/Functions	Personnel Qualifications
MH Clinic	Provide psychiatric evaluation, treatment, and triage/referral services	Unit Leader	Determine psychiatric professional staffing and specific shifts in the MH Clinic and oversee care provided	Medically licensed local psychiatric physician with experience in emergency and general mental health services
		Psychiatric care providers*	Provide psychiatric evaluation and treatment; may provide on-call coverage during non-clinic hours and may function as part of MH Mobile External Deployment teams	Medically licensed psychiatric physicians or psychiatric nurse practitioners with an array of emergency, general, and specialty mental health care skills
		Psychiatric intake (First Stop) personnel	Mental health clinic registration, intake, staging, and triage. Also pharmaceutical sample supply maintenance, supervision, and documentation; secure storage of all MH Clinic records during the active shelter operation; and scheduling of First Stop personnel. On duty at all hours.	Local mental health professional with expertise in acute mental health care
MH In-Shelter Outreach/ Roaming Team	Provide crisis counseling services throughout the shelter (outside of the clinic areas)	Team Leader	Determine crisis counselor staffing needs and oversee care provided; coordinate with MH Clinic	Local mental health professional with expertise in crisis counseling
		Crisis counselors	Identify shelter guests needing mental health assessment and/or treatment, triage those in need to appropriate services, administer immediate disaster crisis counseling and psychological first aid to shelter guests and volunteer staff. Psychiatric care providers conducting in-shelter outreach/roaming may provide mild sedatives for sleep.	Psychologists, counselors/therapists, psychiatric social workers, and psychiatrists with skills in crisis counseling and disaster mental health (performing in the professional roles in which they are trained and routinely perform in non-disaster settings).
MH Mobile External Deployment Team	Travel to other shelters or facilities on request to provide mental health care services	Strike Team Leader	Determine the composition of personnel to be deployed, and request MH Clinic and MH In-Shelter Outreach/ Roaming Team Leader to select personnel from their teams to deploy	Member of MH Clinic or MH In-Shelter Outreach/ Roaming Team (i.e., psychiatric care provider or crisis counselor) as appropriate to team composition
		Strike Team member	Same roles and functions as in the primary shelter for psychiatric care providers and crisis counselors	Members of MH Clinic and/or MH In-Shelter Outreach/ Roaming Team (i.e., psychiatric care providers and crisis counselors) as needed

*The psychiatric care providers in the MH Clinic are organized into two tiers. The first tier consists of public/emergency psychiatric professionals with crisis psychiatry expertise and demonstrated ability to work in crisis and emergency psychiatry settings, as determined by the MH Clinic Unit Leader. The second tier includes other psychiatric professionals, such as those in private or public office-based practices. Second-tier psychiatric professionals are assigned if additional psychiatric professionals are needed (e.g., when the disaster is massive or longstanding and the first tier is overwhelmed, exhausted, or otherwise unavailable for assignment). Second-tier psychiatric professionals are paired with first-tier psychiatric professionals on MH Clinic shifts. Psychiatric providers who are not assigned to work in the MH Clinic might be assigned to work with the MH In-Shelter Outreach/Roaming Team. Additional expertise of child psychiatric professionals may be needed, which could potentially be met with on-call child psychiatric consultants.

The MH Clinic Unit Leader notifies the MH Branch Director of psychiatric personnel needs for shifts, to be fulfilled through volunteer enrollment, credentialing, scheduling, and badging processes. MH Branch care providers are medically licensed psychiatric physicians, psychiatric nurse practitoners, and other mental health care providers (including trainees) in emergency, general, and specialty (e.g., child/adolescent, geriatric, neurodevelopmental) mental health care. Most of these providers are supplied by the MRC's continuously updated roster of trained and deployment-ready mental health personnel. Partner agencies (e.g., ARC [American Red Cross], local police and firefighter chaplains and crisis counselors, the local medical and psychiatric societies, ARC-approved faith-based agencies) may also supply volunteers for the MH In-Shelter Outreach/Roaming Team. These agencies are pre-selected by the MH Branch leadership and vouch for their members' agency credentialing.

A psychiatric care provider is continuously available at all hours either in the shelter (in high-volume periods) or on call (outside of high-volume periods). When the MH Clinic is closed, First Stop maintains essential operations at all hours with on-call psychiatric coverage. According to the Functional Needs Support Services in general population shelters (per FEMA, 2010: www.fema.gov/pdf/about/odic/fnss_guidance.pdf), the optimal ratio of mental health staff to shelter occupants in a given shelter is 1:100 with a minimum of 2 present 24/7, and one psychiatrist is needed to be on call to the shelter 24/7.

At times, other shelters or other disaster service sites may request MH assistance from this shelter's mental health teams. The MH Mobile External Deployment Team mobilizes psychiatric and/or other MH workers to provide MH services to other evacuee service sites in the vicinity at their request. At the direction of the MH Branch Director or designee the MH Clinic Unit Leader mobilizes psychiatric personnel are mobilized from on-duty psychiatric care providers, and the Mental Health In-Shelter Outreach/Roaming Team Leader mobilizes other mental health personnel from Mental Health In-Shelter Outreach/Roaming Team, as appropriate to meet the specific needs of the external deployment situation. As the MH Mobile External Deployment Team membership is created from staff of two other teams, coordination between the leaders of teams providing these staff and with the MH Branch Director is essential to effective deployment.

The MH Branch also has available to it various ancillary MH Support Services provided by core participating agencies: transportation services (e.g., patient transportation to outside services; pharmacy runners), intellectual developmental disorder/autism spectrum disorder (IDD/ASD) MH and pharmacy services, MH benefits enrollment, and opiate maintenance services. Any other services deemed to be needed can be added to the MH Support Services on an ad hoc basis. Some of these agencies will be located near the MH Clinic in the shelter. Other agencies will receive patients triaged/referred to disaster mental health services, who may be transported from the shelter to their agencies. These agencies need to have pre-existing agreements about their roles and functions in the MH Branch and vouch for their members' agency credentials.

Provision of Shelter Mental Health Services

Depending on a given disaster situation in a particular community, the purpose of the shelter mental health services to be provided may vary. Certain goals and objectives, however, are likely to be consistent across most disasters. Two general goals for implementing a mental health response are to:

1) provide mental health care for disaster evacuees with immediate needs during the shelter operation;
2) protect local emergency care systems from being overburdened by large numbers of evacuees with emergent psychiatric crises presenting for care in a short time.

More specific objectives for provision of mental health care are to:

1) stabilize pre-existing or new postdisaster psychiatric conditions;
2) manage acute mental health problems in the short term, either until they resolve or until ongoing formal mental health care can be arranged;
3) start new psychotropic medications or continuing or restart established psychotropic medications for pre-existing or new postdisaster psychiatric conditions;
4) provide symptom relief and emotional comfort for distress related to disaster experience and displacement;
5) triage patients with specific psychiatric needs to outside sources of care (e.g., transport patients with critical psychiatric needs to hospital emergency care or patients needing specific psychiatric services to specialized care such as methadone maintenance programs);
6) conduct surveillance of the shelter population, identify mental health needs, and connect individuals with appropriate sources of care.

In a disaster shelter, professional psychiatric care is needed for evaluation and management of psychiatric illness, whereas other types of mental health interventions such as psychological first aid, crisis counseling, and social services are appropriate for addressing psychological distress and psychosocial needs. The work of crisis counselors and other mental health professionals is to provide symptom relief and emotional comfort for distress related to disaster experience and displacement, and to identify individuals with needs for psychiatric evaluation and care, and connect them with appropriate care. Psychiatric care providers in a MH Clinic address emergent psychiatric problems through focused psychiatric assessment, stabilization of psychopathology, and referral to outside sources for more extensive care.

Shelter guests may come into initial contact with mental health services in various ways. They may have a clinical encounter with a crisis counselor in areas of the shelter outside the MH Clinic. They may present to the clinic's waiting/intake area requesting services of the MH Clinic. They may be referred to the MH Clinic from the Medical Clinic or by a crisis counselor in the shelter.

Shelter guests presenting to the MH Clinic register at the intake/registration area (First Stop), provide a brief history of the presenting problem, and complete the informed consent and information privacy processes for psychiatric treatment, as appropriate.

Registered patients may be triaged to a psychiatric care provider in the MH Clinic or to another service (e.g., mental health support service or crisis counselor).

The psychiatric provider's mental health examination consists of an abbreviated standard psychiatric examination, including presenting problem/chief concern, current psychiatric problems, disaster-related exposures/stressors, past psychiatric (including relevant substance use) history, medical history, a mental status examination, psychiatric assessment and plan (including medications prescribed/dispensed), and disposition with a plan for discharge or referral to hospital or other facilities. This process may include provision of over-the counter medications, physician or pharmacy dispensing of on-site medication samples, and/or a prescription for appropriate medications usually for just a few days (not more than 30 days) or until the patient can establish a source of formal mental health care. Additionally, psychiatric providers providing in-shelter outreach/roaming functions at night may dispense individual doses of sedatives (usually for sleep) in the shelter sleeping areas.

Appendices. Documentation and forms to support the shelter mental health services are provided in several appendices:

- Staff Job Descriptions (Appendix A)
- Shelter MH Clinic Supplies (Appendix B)
- Shelter MH Care Documentation Records (Appendix C)

MH Clinic staff maintain mental health care records on file for each patient presenting to the MH Clinic for treatment (Appendix C). At a minimum, the file contains:

- Consent for Treatment and Information Privacy Form
- Rapid MH/Psychiatric Assessment Form (first page completed by First Stop staff, second page completed by MH Clinic Psychiatric Services Providers)

(Additionally, there may be forms that must be completed for state or other jurisdictional documentation and reimbursement purposes that can be included in this file.)

Memorandums of Understanding (MOUs) can be implemented with local pharmacies for the provision of services with the shelter Health Care Services. Red Cross evacuation shelters have alliances and partnerships with local retailers and other disaster service organizations that have the ability to supply medications and pharmacy services. In a state-declared disaster a state-contracted pharmacy may be reimbursed their costs, and in a federally-declared disaster, FEMA may reimburse cost to pharmacies. Psychiatric providers may use prescription pads supplied by First Stop for 2-3 days of medications to be filled by Pharmacy Services or for larger supplies of up to 30 days to be filled by an outside pharmacy. Psychotropic medication samples, if available, are housed in a locked cabinet in the MH Clinic for direct psychiatric provider dispensing to patients using handwritten labels applied to zip-lock baggies. The specific psychotropic medications to be dispensed as samples are quetiapine 100 mg, risperidone 1 mg, trazodone 50 mg, lorazepam 1 mg, and clonazepam 1 mg. A log is maintained of drugs stored in and dispensed from the sample cabinet, with both log and cabinet maintained by First Stop.

Caution is needed for prescription of abusable medications, especially alprazolam. Patients may present for refills of large standing dosage regimens of alprazolam that have been prescribed to them by their local physicians, resulting in urgent need for refills to avoid medically serious withdrawal. It is generally desirable to continue the prescribed medications the patient requests to be refilled (as long as the patient is not deemed to be diverting medications), even if the clinic's psychiatric care provider does not consider these medications to represent an optimal long-term care plan for the patient. Regardless, in a large disaster evacuee shelter setting, alprazolam and other abusable medications are easily diverted and word of their availability can spread quickly, resulting in surges of patients presenting to the clinic requesting abusable medications. Some of these patients may require referral to a community source of detoxification services. Because of safety and logistical issues related to managing opioid maintenance medications in the disaster shelter, it is advisable to provide this service for patients by transporting them to facilities that specialize in this service.

Certain psychotropic medications (especially newer agents or formulations) can be prohibitively expensive in this setting. For patients without insurance (typically, patients from outside the geographical area), a payor will be needed for provision of long-term regimens of prohibitively expensive medications. If no payor is available, as an alternative, equivalent conversions can be made to other medications for the same psychiatric indication.

Appropriate medical records of all patient contacts are kept by each mental health unit. During the active shelter health care operations, all mental health clinical records are securely stored in a central shelter storage site under the direction of the MH Clinic's First Stop. First Stop staff complete a consent for treatment form and a one-page Rapid Mental Health Assessment form. For patients then seen by a Psychiatric Care Provider in the MH Clinic, the provider completes the back page of the Rapid Mental Health Assessment form to document the psychiatric assessment. MH In-Shelter Outreach/Roaming Team members carry a Shelter MH Contacts Log sheet to record basic contact information for each clinical encounter, delivering it back to the team leader for tabulation of contacts and storage on site by the First Stop team during the shelter Health Care Services operation. Records of services provided by MH Mobile External Deployment Team are kept by personnel deployed using the standardized forms of their teams, and are returned to the First Stop area and stored with the other mental health clinical records. During the shelter operation, the MH Branch Director tabulates ongoing volumes of the MH Clinic's First Stop and psychiatric care contacts and MH In-Shelter Outreach/Roaming Team and MH Mobile External Deployment Team contacts from the completed forms to regularly update the numbers served by each mental health component and total numbers served to date. At final closure of shelter operation, all clinical records are transported under the direction of the MH Branch Director for permanent storage with the local health authority, where they can be accessed for subsequent analysis to inform planning and future response efforts.

Referrals to outside services can occur at any point in the MH service provision, such as emergency referrals to local acute psychiatric/medical facilities. Referrals to local outpatient substance detoxification services are made to pre-selected outside agencies. Referrals to local inpatient substance detoxification services are also made to pre-

selected outside agencies. Patients are transported to receive these services as appropriate to these agencies by ambulance or by transportation service.

Shelter Health Care Services Activation and Setup

The shelter health care operation begins with activation of the shelter medical support process through the Incident Command System (ICS). Volunteer responders are also activated, processed, and deployed. The mental health care operation ordinarily functions in coordination with the medical care operations.

Upon notification of the event and designation of the facility as a large evacuee shelter with health care services, the Medical Branch Director and the MH Branch Director are activated. The MH Branch sets up a MH Clinic alongside the Medical Clinic of the Medical Branch. The MH In-Shelter Outreach/Roaming Team is also activated. The MH Branch Director, MH Clinic Unit Leader, and MH In-Shelter Outreach/Roaming Team Leader also arrive and set up the mental health functions as described in the *Shelter Health Care Services: Structure and Function* section of this document. On-site core participating agencies (e.g., transportation and social service agencies providing support services to the health care operation) also arrive and set up. Lists of equipment and supply inventories, actions to be taken, and parties responsible may facilitate the setup process. The MH Branch Director distributes copies of the various clinical encounter forms to the appropriate MH Branch Unit and Team Leaders and ensures that all needed equipment and other resources are available.

Volunteer Coordination

The elements of volunteer coordination are activation of volunteers through notification and enlistment; processing of volunteers through certification, badging, and scheduling; and deployment of volunteers to their shifts in the shelter. These functions are performed through a volunteer coordination headquarters that is established for the disaster operation. Depending on the local community's cultural and organizational architecture, this could be coordinated, for example, under the aegis of the County Health Department, the Medical Reserve Corps, or the local medical society, or through a coordinated effort of several organizations.

Activation: notification and enlistment of volunteers

The Medical Branch Director provides initial notification to the local medical center's department of emergency medicine and the local medical society. The MH Branch Director provides initial notification to the local medical center department of psychiatry, and the local psychiatric society.

The MH Branch Director notifies the MH Clinic Unit Leader and the MH In-Shelter Outreach/Roaming Team Leader of the activation of the MH Branch. The MH Clinic Unit Leader notifies any additional emergency psychiatric personnel deemed to be needed.

Notification memo templates calling for mental health volunteers, sign-up sheets, and complete enlistment instructions are available in Appendix D. These templates can be modified as needed for notification of local professional organizations. The first memo

is an “Emergency Notification” of an impending disaster shelter health care activation and the potential need for volunteers. Professionals may enlist using an available form also provided in Appendix D. Organizations may distribute the memo and enlistment form to their members. The second memo is a “Disaster Update” memo for notification of enlisted volunteers being called up and instructions for deployment. The MRC Coordinator obtains volunteer information from the organizations.

The MRC maintains an active roster of disaster-ready mental health responders enlisted from community partners and the community at large. The MRC conducts annual formal shelter training for medical and mental health volunteers to provide supporting roles at emergency shelters (see *Preparedness/Planning* section of this document). The core participating mental health agencies maintain their own volunteer rosters as do many of the partner agencies.

Volunteer processing

Credentialing and Badging. In a screening interview through the volunteer coordination headquarters, inquiry is made about the prospective volunteer’s mental health specialty, employer, and professional license. Volunteers are credentialed for work in the shelter according to the following criteria:

- Verification of identity through State driver’s license or other picture ID
- Professional status verification through 1) or 2) below:
  1) Verification of current professional licensure through state records of professional licensing boards
  2) Deployment from a core participating agency or a partner agency vouching for the volunteer’s agency credentialing.
- Mid-level licensed practitioners (e.g., Physician Assistant, Nurse Practitioner) must have current state prescriptive authority with a delegating physician to be a Clinic Provider for the Medical Clinic or MH Clinic. Without current documentation of prescriptive authority or delegating physician, such volunteers must be utilized in a medical capacity other than a provider (e.g., Registered Nurse, Medical Assistant) not requiring provision of prescriptions.

All core participating and partner agencies that send volunteers provide a list of credentialed members to the volunteer coordination headquarters. Assurances by these agencies of current credentialing of their volunteers are to be generally accepted without further investigation.

Licensed professional disciplines may include psychologists, psychiatrists (MD, DO), general or specialty physicians (MD, DO), physician assistants (PA), nurse practitioners (NP), nurse midwives (CNM), nurse clinical specialists (CNS), nurses (RN, LVN), professional counselors (LPC), masters and bachelors level social workers (LMSW, LBSW), family therapists (LMFT), and chemical dependency counselors (LCDC).

Some clinicians (e.g., QMHP, bachelors-level technicians, unlicensed professionals, therapists for WIC children’s play/activity area) from some partner agencies do not have licensing authorities.

For unaffiliated spontaneous volunteers who do not have professional licensure and who were not sent by one of the core participating or other selected partner agencies, their name and contact information is recorded on a list of potential volunteers who can be called up if the need arises. These individuals are invited to be entered into the MRC database and to become MRC members. A background check (e.g., via calling their employer; criminal background checks) can be conducted rapidly on a case-by-case basis to determine credentialing. These newly credentialed volunteers receive rapid training prior to their deployment, by trainers prepared in advance to conduct this rapid training.

The volunteer coordination headquarters issues to certified volunteers an official disaster volunteer photo ID badge (signifying credentialed disaster volunteer status for a specified period of time such as a year) and a temporary access tag (certifying deployment to the current operation, the specific shelter site, and the estimated date span of operation). *The volunteer badge and access tag are required for entry into the shelter*.

Scheduling. Shelter census counts are monitored closely, and staffing for clinical operations is adjusted accordingly. MH volunteers for the MH Clinic and the MH In-Shelter Outreach/Roaming Team are scheduled as needed for specific shifts appropriate to their specialty and professional background. A list of names of volunteers who are enrolled and scheduled is maintained and regularly updated.

The MH Clinic Unit Leader works in tandem with the volunteer coordination headquarters to select psychiatric professionals (psychiatric physicians and psychiatric nurse practitioners) for specific MH Clinic shifts. The MH Clinic Unit Leader develops a two-tiered system used for scheduling of psychiatric professionals (see footnote to Table 1).

The core group of participating MH Support Services agencies credential and schedule their own staff and provide a list of their volunteers to the volunteer coordination headquarters. The staff of these agencies must report to the volunteer coordination headquarters to receive their disaster volunteer badge and an access tag for entry into the shelter during the current operation, before going to the shelter.

Deployment to the shelter. Volunteers who have received their badge and access tag and a shift assignment may proceed to the shelter at the time of their scheduled volunteer activities. *A disaster volunteer photo ID badge and shelter access tag are required for entry into the shelter*. At the shelter volunteer entrance, all volunteers arriving for shifts or other designated service sign in at a volunteer registration desk, and they sign out upon leaving the shelter at the end of their service period.

Fastidious hand-washing procedures are followed by all health care volunteers in the shelter.

HIPAA privacy guidelines are maintained by all shelter health care staff.

Demobilization of Medical Shelter Operations

Emergency shelters are temporary by nature, and at some point a decision will be made to close the shelter and its health care operation components. In anticipation of this

inevitability, transitioning guests to better living arrangements or back to their homes begins as soon as the shelter opens. Registration logs and medical records are retained and transported to the health department or other designated repository for long term storage. All emergency shelter healthcare volunteers are invited to participate in an after-action debriefing. Lessons learned are incorporated into a formal After Action Report to update plans, procedures, and trainings. The After Action Report is distributed to relevant stakeholders. This report will be useful for updating the local planning and operational guidelines in preparedness for future incidents.

Reimbursement for Services Provided

For federally declared disasters, a limited time window specified by FEMA is available for submission of materials to request funding reimbursement for services provided. The link to the web site below provides all the information on reimbursement and has information on state and FEMA reimbursement forms:

http://www.fema.gov/public-assistance-local-state-tribal-and-non-profit

A plan to address the requirements for reimbursement needs to be in place at the start of the disaster shelter operation, to determine the types of data that must be collected during the operation to support the request for reimbursement afterward. The types of information that are typically required include, for example, the number of disaster victims provided assistance by each clinic shelter service seeking reimbursement, a detailed report of services provided, counts of personnel providing the services, time sheets with a daily 24-hour sign-in sheet providing a record of the presence of service personnel at specific hours, and estimated costs incurred for each service substantiated by records of receipts for purchases. Forms to support reimbursement documentation (specific to state and local jurisdictions) will need to be assembled and can be placed in Appendix E.

Preparedness/Planning

Networking with core participating agencies and other partner agencies

Core participating agencies provide essential support functions of crisis assessment/management, transportation, child mental health care, public insurance enrollment, opioid maintenance treatment and substance abuse services, and other services as appropriate. Each agency sends its members to provide the essential services that the agency contributes to the functions of the MH Branch. These agencies have pre-existing agreements about their roles and functions in the MH Branch and vouch for their members' credentialing by their agencies.

Partner agencies (e.g., ARC, local police and firefighter chaplains and crisis counselors, the local medical and psychiatric societies, ARC-approved faith-based agencies) send members to serve as volunteers within the MH In-Shelter Outreach/Roaming Team. These agencies are pre-selected by the MH Branch leadership and vouch for their members' credentialing by their agencies.

Development and maintenance of volunteer rosters

Local mental health agencies maintain their own volunteer rosters. The MRC maintains an active roster of potentially deployable mental health responders enlisted from community mental health agency rosters and the mental health community at large.

Shelter volunteer training

Annual formal training for emergency shelter volunteers

A general 2.5-hour disaster training program may be offered by the MRC or the local health department for medical and non-medical volunteers seeking to provide supplemental support to emergency shelter MH services. This training program consists of two parts: 1) general orientation to disaster shelter structure (single session of all attendees) and operations and 2) role-specific disaster shelter training (concurrent breakout sessions).

Part 1. Introduction to the emergency shelter healthcare operation (60 minutes)

This one-hour presentation provides an overview of disaster shelter emergency operations and is targeted for all volunteers. It covers first-time deployment and assignment protocols, an overview of the ICS, the overall structure and operations of the emergency preparedness unit, and the role of the MRC in shelter health care. In addition, practical functions of the shelter health care operations, descriptions of different volunteer roles, general procedures (e.g., shelter parking, entrances, registration), credentialing and badging, checking in and out of shifts, job action sheets, and volunteer pouches (for badges, job action sheets, laminated Just-In-Time [J-I-T] training review cards, and various informational sheets). (Presented by MRC coordinator, Medical Branch Director, and other designated presenters.)

Part 2. Role-specific break-out sessions (concurrent, 90 minutes)
This role-specific training is presented in four separate modules for: 1) medical volunteers, 2) MH In-Shelter Outreach/Roaming volunteers (crisis counselors), 3) MH Clinic Psychiatric Care Providers, and 4) non-medical, non-MH volunteers.

1) Medical volunteers. This module is designed for physicians, physician assistants, registered nurses, and medical social workers who provide medical services in a disaster shelter. This module covers the levels of medical care to be provided, medical roles, the medical clinic layout, management structure, pharmaceutical resources, medical records, protection from legal liabilities arising from volunteer service, and incident-specific protocols. (This module does not include mental health training.) (Presented by Medical Branch Director.)

2) MH Clinic volunteers. This module is for psychiatric care providers who will be working shifts in the MH Clinic to deliver acute psychiatric care. This module covers basic procedures for volunteering in the MH Clinic, how the clinic functions, and protection from legal liabilities arising from volunteer service. It provides an overview of the mental health effects of disasters, differentiates nonspecific distress from posttraumatic psychopathology after disaster exposure, covers the types of acute psychiatric problems typically encountered in disaster shelter populations, and reviews basic acute psychiatric care in disaster shelters. It also presents procedures for dispensing and prescribing medications, emergency care triage, referral to

psychosocial resources in the community, and care of special psychiatric problems such as methadone/suboxone treatment for opiate dependence. This module also includes a brief review of Psychological First Aid and short-term management of acute psychiatric symptoms. Instruction is provided on documentation of patient contacts using designated Rapid MH/Psychiatric Assessment medical record forms for the MH Clinic. (Presented by MH Branch Director and/or MH Clinic Unit Leader.)

3) Shelter mental health outreach/crisis counselor volunteers. This module is for licensed MH professionals, including psychiatric social workers, MH counselors, psychotherapists, psychiatric nurses, and selected faith-based counselors who provide outreach and roaming MH services throughout the shelter (outside of the MH Clinic). In addition, psychiatric care providers who will be working as part of shelter MH outreach rather than in the MH Clinic may attend the mental health outreach/crisis counselor training. This module is designed to prepare crisis counselor volunteers to engage in psychosocial outreach in the shelter, identify shelter guests with difficult emotional reactions to disaster and general psychological distress, address shelter staff with difficult emotional reactions, provide appropriate reassurance, normalize the distress of disaster exposure, assist with problem-solving and coping, and direct individuals with psychiatric problems or needs to appropriate levels of psychiatric services. A key component of this training is a review of basic principles of Psychological First Aid. Instruction is provided on documentation of shelter guest and staff contacts on designated shelter MH contact log sheets. (Presented by MH In-Shelter Outreach/Roaming Team Leader.)

4) Non-clinical support volunteers. This module is designed for other volunteers serving in various non-clinical health care support roles (such as language interpreters, medical record data entry volunteers, clinic receptionists, assignment coordinators, volunteer scheduling assistants, clinic inventory managers, and inventory clerks). It provides an overview of the specific roles non-medical volunteers may be asked to fill after arriving at the shelter. Highlights of the following roles are covered in order to cross-train all course attendees: data entry of clinic medical records, duties of the clinic staff receptionist and assignment coordinator, training as a volunteer scheduling assistant, and the roles of clinic inventory manager and inventory clerk. (One hour of this module covers role-specific activities and 30 minutes covers mental health training, especially Psychological First Aid. Participants are also encouraged to attend a 4-hour Psychological First Aid training course.) (Presented by MRC staff and MRC volunteer crisis counselor specialist.)

As part of the disaster shelter mental health volunteer training (modules 2 and 3), links for resources on the National Center for PTSD website are provided to volunteers for their review and reference. The materials available on these websites provide a brief review of the fundamentals of psychological first aid for disaster responders and a phone app for quick access in the field.

http://www.ptsd.va.gov/professional/manuals/manual-pdf/pfa/PFA_2ndEditionwithappendices.pdf

http://www.ptsd.va.gov/professional/materials/apps/pfa_mobile_app.asp

Just-In-Time training

Mental health volunteers presenting for their first shift but have not completed the MRC disaster mental health training receive a brief presentation by a volunteer from their mental health group who orients new volunteers on the fundamentals of disaster mental health intervention, based on material from the website links listed above, and on procedures to be followed at the shelter.

Supplies/equipment/resource readiness

Lists of equipment, supplies, and documents needed in support of mental health care services in the shelter, templates for volunteer notification/activation, forms for documentation of mental health disaster shelter services, job action sheets for volunteer roles, and J-I-T review cards are maintained by the MRC. Ideally, these lists are reviewed and updated annually, e.g., just before the start of hurricane season.

Operational resources for mental health services may overlap with some of those of the medical/emergency services. Resource requests are obtained as they are anticipated by communication to local and/or regional disaster medical operations centers and appropriate agencies, e.g., to the local Office of Emergency Management (OEM). These resources are then placed into operation as the service is assembled. Advance planning with local OEM to identify and address needed resources should ensure the availability of the items in the supplies and resources list in Appendix B.

Table of Contents for Appendices

Appendix A: MH Volunteer Job Action Sheets

Appendix B: Shelter MH Clinic Supplies and Resources List

Appendix C: Shelter MH Care Documentation Forms

Appendix D: Volunteer Documents (Notification Templates, Volunteer Instructions, Volunteer Liability)

Appendix E: Reimbursement Documentation Forms (must be assembled locally according to requirements of state and local jurisdictions)