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Providing Long-Term Services after Major Disasters

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Although disaster response is often seen as the first actions taken after a crisis, in reality it encompasses a continuum of services that may stretch over months and even years.

Nonprofit organizations are a crucial link in our nation's emergency preparedness and disaster response efforts, but their role is not always well-integrated into disaster planning. During Hurricane Katrina, faith-based and community organizations were among the first responders, helping to rescue, feed, and shelter victims of the storm. After 9/11, nonprofits provided both immediate and longer-term assistance to help people cope with devastating life changes and the emotional aftermath. Although disaster response is often perceived as the first actions taken after a crisis, in reality it encompasses a continuum of services that addresses various needs that may stretch over months and even years. The importance of longer-term services after major disasters is not well-understood or even acknowledged by victims and policymakers alike. Yet accounts of the long-term physical, mental, and emotional effects of disasters such as Katrina and 9/11 suggest the need for long-term services after an immediate crisis has passed.[1]

This brief highlights the lessons learned from an assessment of the American Red Cross September 11th Recovery Program (SRP), conducted by the Urban Institute. Although the Red Cross is best known for its rescue and relief efforts immediately after disasters, it departed from this model in large part because of the substantial charitable donations received in the wake of 9/11. A portion of the 9/11 funds was designated for a new program called the Recovery Grants Program (RGP) to help people directly affected by the events of 9/11 with their longer-term recovery needs. In particular, the funds gave grants to community-based organizations to provide case management, mental health services, and other services to facilitate recovery to eligible individuals (box 1).

To study the SRP and RGP, the Urban Institute conducted a telephone survey of 1,501 individuals who received SRP services from the Red Cross, telephone interviews with 66 community-based nonprofits that received RGP grants[2] and site visits to 12 of these organizations, and a web-based and telephone survey of 347 clients who received services from these community-based providers. The lessons learned from this program provide important guidance for strengthening the nation's emergency response system.

The Need for Services

As researchers and service providers are learning from more recent disasters, the need for assistance to help overcome the effects of traumatic events and their associated personal and property loss can be great and may continue for years after the actual event. In the Urban Institute survey of clients who received services through the Red Cross–supported recovery programs initiated in 2002, respondents indicated that they continued to have service needs and emotional issues long after the disaster, underscoring the need for longer-term recovery services. More than two in five (43 percent) service recipients who responded to the survey said they or their families *still needed* services approximately four years after 9/11 to help with their recovery. Mental health services were most frequently mentioned as a continued need (by 63 percent of service recipients). Nonetheless, a high proportion of respondents (79 percent) felt they were somewhat or much better off as a result of the assistance they had received.[3]

Box 1. Overview of American Red Cross 9/11 Recovery Services

The Red Cross used a portion of the charitable donations it received after 9/11 to establish the September 11 Recovery Program to provide longer-term recovery assistance to individuals and families with more lasting financial, health, and emotional needs related to the events of 9/11. Initially, SRP services, which included case management, financial assistance with unmet essential expenses, financial assistance with health and mental health treatment costs, and subsidies for health insurance, were primarily provided directly through the Red Cross (see Morley, De Vita, and Auer 2006). However, in 2004, the program transitioned to indirect support of services with the introduction of the Red Cross Recovery Grants Program to support community-based nonprofit organizations that provided services related to longer-term needs associated with the 9/11 attacks (see Morley et al. 2006). The grants enabled 9/11-affected clients to receive (or continue) longer-term services at a time when other sources were phasing out their financial support for these services.

RGP grants were structured as one-year grants, but grantees could apply for a second year of funding. The initial two rounds of grants, which began in January 2005, addressed Mental Health and Wellness (MHW) and Access to Recovery Services (Access).

- Forty-four MHW grants were awarded to nonprofits with programs focused on enhancing the emotional well-being and resilience of individuals affected by 9/11. Grantees provided various mental health treatment services, including individual and family/couples counseling, structured group activities, screening or evaluation to assess mental health needs, and psychoeducational outreach to promote mental health and wellness services.
- Twenty-one Access grants went to organizations to provide culturally competent services to underserved communities (generally minority populations, particularly immigrants) who may not have received services in the immediate and short-term aftermath of 9/11. Services included mental health and wellness programs, financial planning, employment assistance, or other services to enhance self-sufficiency and long-term recovery. Access grants also could be used for advocacy, information and referral services, and outreach to inform communities about these or other relevant 9/11 services.

The typical grantee was relatively modest in size: half had ten or fewer full-time employees and four or fewer part-time staff. Five grantees were family support associations that were newly established in the aftermath of 9/11. All but three grantees were located in the New York City metropolitan area.

Lessons Learned about Providing Recovery Services

Five prominent themes related to the provision of recovery services emerged from the assessment of the Red Cross September 11 Recovery Program.

Mental Health Stigma

Perhaps one of the most pervasive themes repeatedly cited by service providers is the stigma associated with receiving mental health services. Many individuals affected by 9/11 lacked personal experience with mental health services and were reluctant to seek such help. While the stigma seems to be nearly universal, different populations have different reasons and cultural barriers that deter them from using the services. For example, mental health problems and services are not widely recognized or accepted among some immigrant communities. Responders (such as police, fire, and EMS personnel) have their own "culture," which resists openly discussing feelings and admitting "weakness." Their jobs require them to be strong and help others, so seeking mental health services may threaten not only one's self-image but also one's career. Receiving mental health services may lead to being placed in a different type of job (for police officers, having one's weapon taken away and being placed on a desk job, for example) or having colleagues perceive them as being "in trouble."

A number of practices were used to reduce the barriers to accessing mental health services. Most of these approaches can be easily replicated.

- **Recast services in nonthreatening ways.** Several programs used alternative terminology to convey a less stigmatized and more comprehensive set of services. One program used the term "care management," rather than "case management." Others used terms such as workshops, educational seminars, stress management, or, for responders, "debriefings" to avoid

associations with therapy. Some providers attracted clients with services that are not traditionally considered "mental health" to bring clients together to interact and build support networks. For example, a program serving Chinatown residents offered "wellness" or "healing" groups, such as yoga, t'ai chi, or English classes, rather than "support" groups. Another program found its telephone support groups alleviated the stigma of in-person mental health services and made it easier for individuals to fit these appointments into hectic schedules.

- **Provide an introduction to mental health services.** Outreach was a key to introducing people unfamiliar with mental health services to these programs. Outreach presentations were conducted in familiar community settings, such as churches, libraries, and recreation centers. Some providers who focused their services on responders or recovery workers made presentations at workplaces or union halls.[4] Such practices enable potential clients to meet service providers informally and ask questions, as well as promoting a better understanding of the nature of services offered.
- **Attract clients by offering case management or other services in combination with mental health services.** Because the stigma of mental health services is strong, many providers found it beneficial to establish relationships and trust *before* offering mental health services. Programs that provided case management services addressing such needs as loss of housing, unemployment, health, or immigration issues later encouraged participants to access mental health services. Addressing nontherapeutic needs may be a higher priority than mental health services for some clients, particularly those in lower-income groups.
- **Create a welcoming, nonclinical appearance and atmosphere.** One provider affiliated with a large medical center deliberately located its recovery program in a storefront building that had a warm, informal atmosphere, furnished with comfortable sofas and children's artwork. Some programs were located in buildings not associated with health care (such as an office building) to make clients feel more comfortable coming to the service, since the reason for being in the building was not obvious to others. Several providers noted that food was always a good icebreaker and helped clients feel welcome and more relaxed; several served snacks at group sessions or planned activities around meals.

Cultural and Language Competency

Nonprofits providing post-9/11 recovery services generally emphasized the need to understand the culture of their target audience—whether a particular racial, ethnic or occupational group—and to adapt their services in ways that would be appealing and reassuring to that audience. Lessons to apply when working with a distinctive cultural group include the following:

- **Use staff and language from the particular culture.** Organizations focused on providing services to immigrant populations generally staffed their programs either wholly or in part with members of the ethnic group served, who were bilingual (and sometimes trilingual). Providing written materials in the client's native language was the norm for such organizations. Similarly, organizations that served responders came from, or immersed themselves in, the culture and language of responders. For example, one organization that focused on firefighters immersed its staff in the culture by going on ride-alongs and listening to dispatch, and taught its service providers common phrases and jargon used by firefighters to facilitate communication.
- **Adopt cultural practices and traditions of clients.** Some providers used such practices as serving traditional refreshments (such as tea for Asian clients) or celebrating traditional holidays to make clients feel more comfortable. This was especially common among providers that historically served a particular ethnic group. Others participated in culturally linked events, such as marching in a parade celebrating the heritage of a particular group. One made its "wellness room" look like a firehouse to make the firefighters feel more comfortable.

Attracting Clients and Conducting Outreach

While outreach is important for most service programs, for long-term recovery services it can be key for breaking down the stigma and barriers associated with mental health services. One grantee made outreach presentations an explicit job responsibility for its clinicians and social workers. Another had two part-time staff devoted to outreach functions.

- **Make services accessible.** Services must be accessible during times and locations that are convenient to potential clients. Busy work schedules and family responsibilities can limit use of services. Lower-income people, in particular, may work two jobs or at odd hours, making it impossible to use services that are available on weekdays from 9:00 to 5:00. More than half the providers in the Red Cross study modified their business hours to make it easier for clients to access their services—adding evening hours (after 6:00 p.m.), weekend hours, or both. Some added a service location (and one relocated to another site) to facilitate access and attract clients.
- **Adjust outreach modes to the target population.** Programs targeting different populations found different modes of outreach successful.
  - Most programs serving immigrant and non-English-speaking

populations relied heavily on traditional outreach strategies, such as flyers, presentations at places or events that attract their target audience, word-of-mouth referrals, and outreach to organizations that deal with the same populations.
  - Technology-based outreach was useful, especially for reaching younger or middle-class households and geographically distant clients. One program used the Internet to provide information and guidance, and it conducted telephone support groups to reach individuals who were geographically dispersed.
  - Peer-to-peer outreach appeared successful for engaging uniformed responders. One program sent teams of two trained peers (police officers) and a clinician to police stations to make outreach presentations about the effects of traumatic events and the services available through the program.
  - Traditional media outreach, such as public service announcements, stories in local newspapers, and staff participation in radio or television interviews (including non-English-language media), was used by many of the nonprofits.
- **Involve stakeholders to facilitate access to individuals who are reluctant to seek services.** Establishing informal collaborations with other organizations was used to strengthen outreach programs. This approach requires groups to think broadly about the stakeholders who are affected by or might benefit from recovery services. One provider, for example, developed collaborations with public schools to access school-age children for its screening program. Several providers developed close ties to labor unions.[5] One provider included union representatives on the program's advisory board and committees, which facilitated information exchange and the placement of articles and announcements in union newsletters and web sites. Another program's clinicians and caseworkers conducted outreach at union meetings to help members apply for a financial benefit that was about to expire.
- **Use reminders to sustain client engagement.** Given the demands of daily life, making time for mental health services can be difficult. As a result, outreach is needed for existing clients as well as to attract new ones. Some programs sent written reminders (e-mails or postcards) about upcoming appointments. One sent clients two newsletters and two other forms of communication (such as flyers for educational workshops or a refrigerator magnet with contact information) annually as general reminders about the program.
- **Attract clients with nonthreatening services.** Some providers offered occasional services unrelated to mental health (such as workshops on budgeting, family finances, or immigration issues) to the broader community, to build familiarity and trust with potential clients before introducing mental health or other services.

Services for Children and Youth

Reaching children or teenagers provides unique challenges. Children do not express their feelings in the same ways as adults, and they face additional barriers to accessing services. Parents, for example, are gatekeepers to services for children, and some parents did not want their children to "revisit" 9/11 issues. Some may have interpreted suggestions that their child participate in such services as a criticism of their parenting skills. Three lessons emerged from this 9/11 experience for working with children and youth.

- **Parental resistance often must be addressed to provide services for children and youth.** Many parents are simply reluctant to acknowledge that their child has a problem, or a problem that the parents themselves cannot successfully resolve. In some immigrant communities, parents may not be accustomed to Western-style medicine, particularly mental health services, and they may not allow their children to participate in treatment programs. Given parental oversight and control, a first step is to educate parents about the services so they will allow their children to receive help. Engaging parents in helping their child, by providing activities that parents can do with their child at home, is also regarded as useful.
- **Work through schools and other institutions where children congregate.** Providing services in venues that are familiar and easily accessible to children is an important lesson, since children generally cannot come to a provider's facility unless brought by their parent or other adult. Schools can be an ideal place to reach children and youth, but they can require many levels of administrative cooperation. If a program operates in multiple schools, it needs to be consistent and fair in how it handles operational details. Relationships and agreements can disintegrate if one school believes it is being treated differently than another.
- **Use approaches and program materials targeted to the age group served.** Services need to be age-appropriate for different stages of child development. Several providers noted that teens, in particular, do not want to be singled out but want to be "normal kids." One program allowed teens to bring a friend (even one not directly affected by 9/11) to its group activities or sessions, to help them feel more comfortable. Another program began offering a conference call option to teens who wanted to talk about their 9/11 experiences, and it was exploring online options such as chat rooms.[6] Another program used teen educators to provide lectures, skits, and

discussion groups with teens, and it was developing a group to be run by teen educators.

Staff Support and Dealing with Staff Burnout

Well-run programs not only provide initial training for their staff but also try to minimize the impact of staff burnout. Dealing with victims of a disaster is a stressful job. After listening to stories of loss and trauma daily, it is often difficult to keep morale high and avoid feelings of depression. A key lesson for organizations that provide recovery services is to offer ongoing support for program staff.

- **Develop mechanisms to help staff cope with stress and minimize the effects of burnout.** One common practice was conducting periodic "debriefing" sessions or case conferences to allow staff to share their own feelings and experiences, review problems, and receive help in handling troublesome cases.[7] In one program, quarterly self-care groups were led by a program clinician, and teams also could organize peer support groups as needed. Other organizations had occasional off-site "retreats" or organized occasional "self-care" days (which might include professional massage or acupuncture therapy). In response to staff requests, one program expanded its staff training to address worker stress and compassion fatigue.

Lessons Learned about Creating Long-Term Recovery Programs

As communities plan and prepare for future emergencies and disasters, the experiences of the Red Cross September 11 Recovery Program can offer important lessons. In particular, the relationships and expectations of donors and local nonprofits are critical for creating successful programs. The following lessons can help guide that effort.

- **Lead time.** Service providers and funders should seek to establish realistic timeframes for service start-up within the context of quick response. Organizations may need time to recruit appropriate staff; develop outreach, education, and assessment materials; or inform clients that the services are available. Such start-up activities may take more time than anticipated.
- **Flexibility.** Long-term recovery programs often uncover unanticipated situations that may require modifications to the original plan—for example, clients' needs change, clients seek help later than expected (sometimes months or years after the actual disaster event), recruitment is more complex than expected, and so on. Funders should be open to discussing midcourse corrections that are appropriate and essential to achieving good outcomes.
- **Administrative costs.** Nonprofits frequently underinvest in their administrative systems in an effort to direct as many dollars as possible to their program activities. As a consequence, administrative structures are often underfunded and inadequate to carry out program activities and meet funders' reporting requirements. Building administrative costs into a program budget is essential for the health of the organization and the quality of the service program.
- **Outreach.** Attracting clients to recovery programs requires outreach efforts; these costs should be considered part of the direct-service budget of service providers, not an ancillary or overhead cost. Establishing and advertising a central helpline or web site to refer individuals to appropriate service providers can reduce duplication of outreach efforts on the part of individual providers. This form of outreach might be centralized in one place, such as in an existing information and referral service, to facilitate and coordinate use of the system.[8]
- **Communication and referrals.** Community-based nonprofits are generally eager to share ideas and learn from one another, particularly when engaged in an evolving area such as long-term recovery services. But too often there are limited opportunities to do so. Awareness of other providers' services facilitates the referral process and enables clients to get the services they need more quickly and effortlessly. Bringing providers together for periodic meetings where they can learn from each other, and extend their referral networks, benefits not only the service providers but also the clients. Another approach that can facilitate communication and referrals is preparing a directory (web-based or printed) of recovery service providers, with brief program descriptions, client eligibility criteria, and contact information.
- **Performance measurement and reporting.** Like other human service delivery programs, it is important to document and measure the activities and outcomes of long-term recovery services. This information can contribute both to quality assurance monitoring, by identifying when midcourse corrections are needed, and to better program performance. To be most effective, reporting systems should be developed and implemented at the start of a recovery program to capture all aspects of the program, not as an afterthought (box 2).

Incorporating Longer-Term Services in Disaster Planning

Service provision after a major disaster is best viewed as a continuum. It begins by addressing the immediate needs of those directly affected and extends to longer-term services for this same group and for the broader community. The latter portion of the continuum has not been commonly available, although the assessment of the September 11 Recovery Program indicates that it is a highly valued

and much-needed part of the disaster relief and recovery system.

To integrate longer-term recovery services into disaster plans, the following recommendations are offered:

- **Include faith-based and community nonprofit organizations as part of the disaster preparedness planning process and the coordination team.** These groups have always been central to disaster relief and recovery operations, and their knowledge of local people and resources makes them critical players for developing and implementing emergency plans. Their involvement is also likely to facilitate use of services, particularly those of a sensitive nature, after the disaster because these groups are often more trusted by local residents than are government entities.
- **Plan to set aside some portion of disaster funds for longer-term services.** For private donations, establishing a grant program to distribute the funds appears to be a useful model.
- **Designate an entity (such as a private foundation or large nonprofit organization) to be responsible for managing the grants.** This designation would preferably be named in the disaster plan to avoid delays that might ensue in the wake of a disaster.
- **Identify the types of longer-term services likely to be needed after a disaster and potential eligibility criteria for such services.** While these decisions may need to be modified in the aftermath of an actual disaster, such advance planning is likely to reduce the time needed to get services up and running.
- **Compile a directory of potential recovery service providers, including organizations that usually provide such services.** This potential pool of service providers will help jump-start service provision efforts.
- **Address longer-term recovery services in written plans and agreements developed to address disaster response.** For example, memoranda of understanding can be used to "prequalify" local nonprofits to work with national disaster teams. Plans can also develop a standard intake form for disaster victims, which would facilitate sharing information among providers and reduce the paperwork burden on victims and organizations (De Vita 2007).
- **Disseminate lessons learned and promising practices from other communities that have experienced a disaster and provided long-term disaster services in the aftermath.** This information can be instructive to many groups around the country that are trying to formulate preparedness plans and help service providers and policymakers lay the foundation for their own services.
- **Encourage communication and collaboration among service providers before and after disaster strikes.** Opportunities for networking and learning can not only enhance referrals and services in the short term, but also build sector capacity by creating stronger links within the sector. Such collaboration promotes familiarity with other services in the area and develops personal relationships among providers that can facilitate communication and cooperation during and in the aftermath of emergencies.

Disaster preparedness planners should ask themselves, "What do we want the service system to look like?" and then build a system that reflects that vision. The Red Cross Recovery Grants Program demonstrated the

Box 2. Establishing Reporting and Measurement Systems

Growing numbers of nonprofits and funders are recognizing the value of reporting and measurement systems to monitor program performance and increase accountability. Indeed, funders can be a catalyst and supportive force for encouraging nonprofits to engage more systematically in outcome monitoring and quality assurance activities. Their proposal requests can encourage or require use of outcome measurement, and they can provide training or materials to assist their grantees in setting up reporting systems.

A few simple rules can guide this process:

- Keep the reporting system simple, particularly if many different types of grantees will be required to use it.
- Get grantee input in designing the concepts, measures, definitions, and reporting forms or tools.
- Be flexible in implementing and administering the system.
- Provide training and technical assistance in how to use the system—even if it appears straightforward.
- Include a narrative section in the report form to enable organizations to explain quantified information and elaborate on program activities.

For guides on developing outcome and performance measurement tools, see the Urban Institute Outcome Management for Nonprofit Organizations series, edited by Harry Hatry and Linda Lampkin (http://www.urban.org/center/cnp/Projects/outcomeindicators.cfm).

feasibility and desirability of providing longer-term services and better access to services for hard-to-reach populations, such as immigrants and rescue and recovery workers. The lessons learned from these programs should be widely shared so service providers and policymakers can lay the foundation for building and sustaining future partnerships that will address common needs. Although every disaster situation will differ, the promising practices identified through the Red Cross Recovery Grants Program can be instructive to other groups around the country. These ideas can help shape response and strengthen the capacity of both the public and private sectors for dealing with the longer-term effects of disasters.

Notes

1. See Julia Cass, "For Many of Katrina's Young Victims, the Scars Are More than Skin Deep," *Washington Post*, 13 June 2006, http://www.washingtonpost.com/wp-dyn/content/article/2006/06/12/AR2006061201746.html?sub=AR; Ellen Barry, "Lost in the Dust of 9/11" *Los Angeles Times*, 14 October 2006, http://www.latimes.com/news/nationworld/nation/la-na-cleaners14oct14,0,3275974.story?coll=la-home-headlines; Greg Sargent, "Zero for Heroes," *New York Magazine*, 27 October 2003, http://nymag.com/nymetro/news/politics/columns/citypolitic/n_9384/; and Centers for Disease Control and Prevention (CDC), "Impact of September 11 Attacks on Workers in the Vicinity of the World Trade Center—New York," *Morbidity and Mortality Weekly Report (MMWR)*, 9 September 2002, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm51SPa3.htm.
2. These organizations received funds under the initial two rounds of RGP grants, which were awarded in December 2004.
3. For additional detail on the SRP program, see Morley, De Vita, and Auer (2006).
4. Recovery workers include members of various construction trades involved in demolition, repair and clean-up efforts after 9/11.
5. Many construction workers engaged in the recovery effort were union members, as were many responders.
6. This program's clients were geographically dispersed over a large metropolitan area, making it difficult to find a central location where everyone could meet. Using communication tools that are popular with teens may help overcome geographic barriers.
7. Such sessions might be held frequently, such as weekly, in the early stages of a program, then move to a biweekly or monthly schedule over time, as done by one RGP grantee.
8. The American Red Cross provided financial support to a 24-hour multilingual hotline service for its 9/11 Mental Health and Substance Abuse Program (which predated the Recovery Grants Program). The hotline, operated by a separate mental health entity, provided initial eligibility assessments, referrals, and, when needed, crisis counseling or intervention. The service continued to be available after the Recovery Grants Program was initiated.

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