Mental Health Disaster Preparedness and Response in Racial/Ethnic Minorities Populations and Communities
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Proposed National Recommendations

DRAFT RECOMMENDATIONS NOT FOR FURTHER DISTRIBUTION OR CITATION

There are a number of recommendations that will be contained in the final report that will be forwarded to Kellogg as well as various other relevant groups. The local recommendations are shared with the local on the ground community individuals and the national recommendations are being shared with you.

Some recommendations have a clear direction as to whom it should be directed and others do not. One goal of this meeting is not just to tinker with the recommendation but also to determine what agencies these recommendations should be targeted to in order to implement them. Our job as representatives of minority mental health organizations is to determine if recommendations adequately represent your specific racial/ethnic populations as it may require additional risk factors or strategies for those you represent. The most useful way to approach this would be if before and during the meeting that you insert track changes into your document with any changes that you wish to discuss at the meeting. During the meeting as the discussion take place modify the document in anyway that you wish so that you leave with a modified document and that I receive a modified document. This will help to move the document along and make sure that I capture all of your comments.

Our partners will be experts on discussing who they perceive should be at the table for each recommendation, the feasibility of the recommendation and if such things are already underway. Since there may be changes to the document by the time our federal partners arrive they may wish to offer us comments about those which are already being done if they are and then as we share the changes offer us guidance about how to craft them so that they can be implemented. While we all know that budget is a concern for both federal agencies and foundations we should not let that deter our recommendations but we should be mindful that budget considerations can be a reason for the recommendations not being to go forth. So we may want to be thoughtful about how many large scale retooling efforts we ask an agency to do but at the same time if it is necessary to allow it to go forth.

A. Infrastructure

A1. Rationale

One of the hardest hit groups post disaster in relationship to mental health are adolescents, particularly those who are school going. An emerging body of research indicates that racial/ethnic minority adolescents are not likely to seek mental health services through

traditional counseling avenues but rather are more likely to receive services through school mental counseling services.

A1. Recommendation

In areas where disasters are repetitive and have a high likelihood of occurring it is recommended that in predominantly racial/ethnic minority communities, particularly where the utilization of clinical mental health services are low and often a scarce resource that school based clinics with mental health counseling services be instituted. In the recovery process even if the school is not functional the mental health counseling service should be connected to the federal/state/local disaster response with a particular responsibility for racial/ethnic minority adolescents and their families. (Office Disaster Preparedness and Department of Education)

A2. Rationale

For a variety of reasons the educational resources in some racial/ethnic minority communities are below standard. Disruption to these available resources tends to decrease school readiness and school preparedness in communities already struggling to perform on standardized tests. In New Orleans there were kids who were out of school for an entire year with no educational activities during that year.

A2. Recommendation

In areas of great devastation and disruption when individuals are sheltered for long periods of time or put into large areas of temporary housing that those who set up those facilities should through the use of volunteers using structured and approved curriculum for children and adolescents maintain a predetermined number of hours per day an educational activities such as reading, math, social studies etc. Behavioral observations could be integrated into this activity in order to intervene early with children and adolescents who are noted to suffer uncharacteristic responses to the disaster. As an example if an area is developed to house families in trailers or temporary shelter one trailer or common area should be devoted to educational and supervised play activities. (Red Cross, Department of Education, FEMA, HUD, Office of Disaster Preparedness).

A3. Rationale

As the numbers of racial/ethnic minority mental health providers increase there is a growing ability for the disciplines of psychology, psychiatry and social work to develop and maintain thriving national organizations. The ability to grow these organizations varies with African American and Latinos being the strongest and Native American and ANHOPI being among the weakest in their growth and development.

A3. Recommendation

OMH, relevant federal agencies and private foundations should support for a 3-5 year period the development of the federation/council of Minority Mental Health Organizations whose sole goal is to build a council of racial/ethnic minority mental health groups in order to participate in and direct national policy on the mental health of racial/ethnic minority in the United States. It would be tasked as one of its first goals is to develop policies and procedures to ensure the participation of their members in disaster response and recovery and to advocate that its' chapter members throughout the United States participate in local disaster education and response. For the Native American and the ANHOPI groups their physician association should be the initial participants with additional funding to develop and to coalesce specific subpopulations, tribal and other specific clustering which can later join the federation. As an

example the National Council of Asian American Physicians would work to develop the Filipino Association of Psychiatrists, the Korean American Association of Psychiatrists. This federation should be funded to maintain an office in the District of Columbia area and represent the federation in working with the National Red Cross, FEMA, etc.,

B. Operations

B1. Rationale

Our work in NOLA began because the community requested racial/ethnic minority mental health providers.

B1. Recommendation

The Red Cross, FEMA, SAMSHA and other agencies that call out volunteers or send in evaluators or develop service contracts should correspond directly with racial/ethnic minority mental health organizations. These agencies may find it worthwhile to aggressively pursue training opportunities with the members of these organization to assure a trained culturally and linguistically similar volunteer and workforce. Training opportunities aligned with the national meetings and national conventions of racial/ethnic minority mental health associations should be considered.

B2. Rationale

Most Red Cross call outs for volunteers requires a two week commitment. In our work with racial/ethnic minority mental health providers we learned that many could not commit two weeks without devastating their own practices, or current employment. They wanted to help and tried to find volunteer activities through sources other than the Red Cross.

B2. Recommendation

In the case of domestic disasters reduce volunteer call out to 7 days. Racial/ethnic minority providers often have networks and contacts of their members to bring them up to speed. They can access communities via these networks and faith-based communities and can often be of great service in 7 days. The two week requirement is a particular hardship financially for many of the racial/ethnic minority providers but they are really needed.

B3. Rationale

Getting racial/ethnic minorities to leave their home can be difficult as well as fearful. Emerging research indicates that Latinos in particular are concerned about how they and their families will be treated (mistreated) and some who are not citizens fear deportation.

B3. Recommendation

In some racial/ethnic minority communities' churches/mosques/temples, particularly large ones should be considered as possible sites for shelters, for recovery service areas or for dispersal of food, clothing and other donated items.

C. Education and Training

C1. Rationale

Disasters are disruptive particularly to those who live fragile and marginal lives such the seriously mentally ill, substance abusers and the homeless. The loss of routine, physical space and disruption to treatment regimens can cause regression to active states of mental disorders and substance use/abuse. As a method to prevent harm to these individuals as well as others and decrease crime interventions by trained personnel are critically important.

C1. Recommendation

In order to qualify for ongoing federal disaster relief law enforcement and emergency response personnel agencies must have at least 20% of its personnel trained in a basic 40 hour Critical Incident Training (CIT) with refreshers every five years.

C1b. Recommendation

The Office of Disaster Preparedness should work with the CDC Funded Disaster Preparedness Centers to evaluate and develop mental health response training modules for the Community Emergency Response Trainings (CERTS) who in disasters will be called out to volunteer.

C1c. Recommendation

The Office of Disaster Preparedness should work with SAMSHA to develop guidelines for the use of mental health debriefings for volunteer CERTS and other volunteers who either work at a particularly devastating disaster (i.e. trained derailments, earthquake searches and rescue) or who work more than 7 days to decrease the likelihood of their development of PTSD or PTSD symptomatology.

C2. Rationale

Mental Health disaster education and response currently is taught outside of educational systems of universities and colleges or professional continuing education. It is learned through attendance at free courses taught through local Red Cross, fire departments and law enforcement agencies.

C2. Recommendation

HRSA, CDC, FEMA and others should consider the development of online as well as face to face mental health disaster education curriculums fused with cultural competency training in order to increase the number of trained racial/ethnic minority individuals or individuals in general with greater knowledge of the cultural demands of populations often at high risk. Increasing the workforce capacity of mental health professionals trained in disaster response could be facilitated through training grants through NIH's NIMH, training grants through the Association of Schools of Public Health, the CDC Disaster Centers could be required to engage their local groups in mental health trainings and HRSA offering training grants to mental health professionals who are training for mental health service delivery.

C3. Rationale

The definition of first responders is often used in a formal manner to include medical, emergency and law enforcement personnel. Yet there are within ethnic minority communities an additional set of individuals with authority and access to the community who should be viewed as first responders. Faith based leaders often function as first responders in disasters. They are called upon in leadership roles, their places of workshop become sites for gathering and they are called upon to minister to their congregants even when they are dislocated and are often a very good source of where individual are located.

C3. Recommendation

Develop curriculum and training for racial/ethnic minority faith based leaders in mental health disaster preparedness as well as disaster response. Faith based leaders must know their levels of expertise in order to respond as many are trained in pastoral care and counseling but not in mental health disorders. Curricular trainings in which faith based leaders could prepare their membership as well as the church itself for disaster response which would save lives.

C3b. Recommendation

Many faith based leaders will find themselves in leadership roles post a disaster.
While trained in pastoral care and counseling many are not trained in crisis intervention.
The federal government or private foundations should develop model curriculum for divinity schools and other school of religious training that can be integrated into their pre degree or training for their religious degree or used for continuing education credit. This course would be drawn from Critical Incident Training with a particular focus on how handle individuals and signs and symptoms of needed interventions for individuals who have been exposed to or involved in a disaster.

C4. Rationale

Language and culture are important components of health literacy and health education efforts. In recent years hospitals and medical care providers have collected data on race, ethnicity and primary language. Individuals are asked what language they prefer for the delivery of their health care services and health education.

C4a. Recommendation

The OMH has issued CLAS (National Standards on Culturally and Linguistically Appropriate Services. All federal agencies should be guided by these standards in the production of their written and online materials as well as in the conduct of trainings and other interactions particularly in regard to preferred language. Warnings, evacuation procedures and other critical information must be delivered in preferred mode and by credible messengers. This may involve the use of ethnic media, ethnic radio, ethnic cable stations and other ethnic preferred outlets that are both language proficient and credible in their commentary about the warnings.

C4b. Recommendation

All warnings and status reports about disasters should take into account research findings about the needs, worries and concerns of racial/ethnic minorities as well as be available in language preferred.

C4c. Recommendation

Using findings from risk communication analyses studies of racial/ethnic minorities, warnings and requests for evacuation should be grounded in that research.

D. Services

D1. Rationale

Currently in our work in NOLA there are needed mental health counseling services for very specific groups, faith based leaders, adolescents who have returned and the homeless mentally ill. Mental health providers left in waves leaving the area without mental health providers yet for

some there were critical mental health needs that the longer they are unaddressed the worst the mental health.

D1a. Recommendation
The federal government should in the event of disasters that devastate the mental health workforce, particularly those with the expertise to serve racial/ethnic minority communities engage a loan repayment and housing allowance program to entice individuals to practice in the area for a 2-5 year period. This procedure should be engaged immediately in the event of a large devastation particularly after it has removed its commissioned core personnel.

D1b. Recommendation
The federal government should in the event of disasters that devastate the mental health workforce, particularly those with the expertise to serve racial/ethnic minority communities should engage a IPA sabbatical arrangement with academic institutions that would allow practicing academics to provide clinical services or collect data for surveillance, evaluation or research for a period of 1 quarter, 1 semester up to a two year period depending on the severity of the disaster. If the federal government is unable to pay the full salary they could consider some supplement and provide universities with some incentive (federal aid for students, educational grants and resources) to share/loan their faculty for a short term period.

E. Data Collection and Research Needs

E1. Rationale
The evidence based practices around disaster response are still in infancy. Research on disasters is often difficult to conduct because of their immediacy. The IOM offered a number of directions that future activities should proceed but there is an overwhelming lack of guidance around the services, treatment and assessment tools specific to the needs and experiences of racial/ethnic minorities. Recent studies indicate differential worry and concerns by racial/ethnic groups particularly Latinos. There are also differential levels of vulnerability based on resource availability, disability and language

E1. Recommendation
Concerns and worries about disasters and how they intertwine with individuals vulnerability such as disability, lack of economic resources, family responsibilities, language and citizenship status. It is recommended that CDC and NIH engage a research program that elucidates how diverse vulnerabilities intersect with behaviors of disaster response.

NIH and NSF should engage a research agenda that examines disaster related perceptions of risk, risk analysis and risk communications in order to develop better guidance for the disaster related decision-making in racial/ethnic minorities under particular sets of vulnerabilities that are factored into their disaster related response

E2. Rationale
Currently we do not have a standardized approach to PTSD assessments or to data collection on ASD.

E2. Recommendation

It is recommended that NIMH or IOM bring together a panel of experts in the area of PTSD, ASD, trauma, and mental health consequences of disasters to recommend assessment development work that is needed to capture the short and long term mental health experiences of racial/ethnic minorities. It is unclear whether our current instruments are sufficient in tapping the most important domains of fear, worry, concern and consequences. The field would enormously benefit from an examination of the current PTSD assessment tools and suggested changes that should be made in order to determine symptoms and mental health diagnosis particularly as it relates to racial/ethnic minorities and the ability to translate these concepts into appropriate languages.

E3. Rationale

Many of the racial/ethnic minorities impacted by disasters are sometimes in fragile living situations making the collection of data difficult.

E3. Recommendation

The National Committee on Vital and Health Statistics working with HIS should be tasked to explore how and what data should be collected for the purposes of surveillance of the mental health consequences of exposure to disasters. In particular a set of hearings should be held with geographically diverse populations such as Native Hawaiians, tribal communities continually at risk from wild fires, Pacific Islander groups, Gulf regions and other areas where there is continual disaster peril to determine how to collect data about their ongoing mental health states in order to ensure that adequate levels of services and education on how to reduce the distress, worries and concerns can be addressed.

E4. Rationale

We know little about the disaster experience of racial/ethnic minorities. We do not know the term prevalence of mental health consequences from disasters in this population as they are often hard to separate from consequences of other life experiences and exposures to other stressors.

E4. Recommendation

NIH/AHRQ/CDC should fund ethnic specific population based surveys that could examine exposure, response and belief, attitudes and worries about disasters for racial/ethnic populations particularly in those regions of the US and outlying territories that are in constant peril of disasters. This one time set of studies would help direct the research, mental health services and educational needs of private and federal agencies in mental health recovery efforts that are both long and short term.

E5. Rationale

One of the subgroups within the racial/ethnic minority community that has suffered severe consequences from some of the recent disasters have been children and in particular adolescents. Yet we have no evidence based practices that have been culturally tested with these populations and we have no true sense of the prevalence of their mental health disorders relative to long term consequences

E5 Recommendation

NIH should be engaged to develop a RFA or cooperative agreements through its Population Centers, particularly those focused on health disparities to examine the mental health experiences and needs of racial/ethnic minority children and adolescents, particularly those who experienced death, loss, family separation and displacement.

E5b. Recommendation

NIH should be engaged to develop a RFA to examine and test post disaster response approaches that include culturally preferred places of delivery, culturally consistent with rituals and world views and design RCT to determine if current psychological interventions work equally as well in racial/ethnic minority children and adolescents.