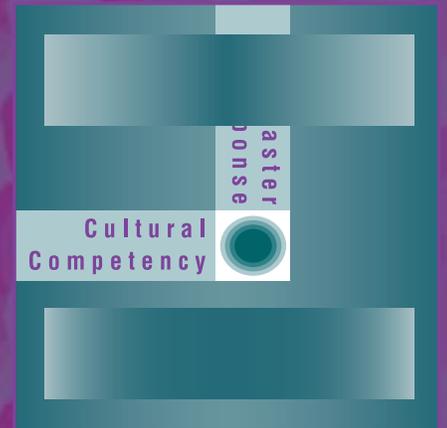


Developing Cultural Competence in Disaster Mental Health Programs



GUIDING
PRINCIPLES
AND
RECOMMENDATIONS



U S DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov





Developing Cultural Competence in Disaster Mental Health Programs:

Guiding Principles and Recommendations

2 0 0 3

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

Acknowledgments

The document was written by Jean Athey, Ph.D., and Jean Moody-Williams, Ph.D., under Contract No. 99M00619401D with the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS). Portland Ridley was a contributing author and also served as the Government Project Officer. Susan R. Farrer, M.A., was the content editor of the guide. The SAMHSA Disaster Technical Assistance Center operated by ESI, under contract with the Emergency Mental Health and Traumatic Stress Services Branch (EMHTSSB)/CMHS, edited the document and designed the cover and layout for the publication. *Numerous people contributed to the development of this document. (See the textbox at the end of this page.)*

Disclaimer

The views, opinions, and content of this publication are those of the authors and do not necessarily reflect the views, opinions, or policies of SAMHSA or DHHS. The authors and the staff of CMHS acknowledge, appreciate, and respect the diverse terminology associated with cultural competence and related issues, and regret any inadvertent omission of information or inclusion of statements that may be unfamiliar to our readers.

Public Domain Notice

All material appearing in this report is in the public domain and may be reproduced or copied without permission from SAMHSA or CMHS. Citation of the source is appreciated. However, this publication may not be reproduced or distributed for a fee without the specific, written authorization of the Office of Communications, SAMHSA, DHHS.

Electronic Access and Copies of Publication

This publication may be accessed electronically through the following Internet World Wide Web connection: www.samhsa.gov. For additional free copies of this document, please contact SAMHSA's National Mental Health Information Center at 1-800-789-2647 or 1-866-889-2647 (TDD).

Recommended Citation

U.S. Department of Health and Human Services. *Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations*. DHHS Pub. No. SMA 3828. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2003.

Originating Office

Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, Rockville, Maryland 20857
DHHS Publication No. SMA 3828
Printed 2003

Contributors and Reviewers: Lourdes Arellano-Carandang, Ph.D.; Robert Benedetto, D.P.A., L.C.S.W.; Marisa Brown, M.S.N., R.N.; Nan Carle, Ph.D.; Deborah DeWolfe, Ph.D., M.S.P.H.; Kana Enomoto, M.A.; Linda Fain; Renee Georg; Elzbieta Gozdzia, Ph.D.; Rachel Guerrero, L.C.S.W.; Robert Hammaker, Ed.D.; Angelia Hill; Joseph Hill; Carol Kardos, M.S.S.W.; E'layne Koenigsberg; Harriet McCombs, Ph.D.; Patricia Mendoza, Ph.D.; Mary Elizabeth Nelson, M.S.W.; Wanetta Noconie; Gladys Padro, M.S.W.; Constance Peters, M.S.P.A.; Steven Shon, M.D.; Anthony Simms, Ph.D.; Karen Stengle; Suganya Sockalingam, Ph.D.; Cecilia Rivera-Casale, Ph.D.; and Katherine White, M.Div., R.N., C.C.C.

Table of Contents

FOREWORD	1
INTRODUCTION.....	4
Background and Overview	4
ORGANIZATION OF THIS GUIDE	7
SECTION ONE: CULTURE AND DISASTER.....	8
Understanding Culture.....	8
Diversity Among and Within Racial and Ethnic Minority Groups.....	10
Cultural Competence: Scope and Terminology.....	11
The Cultural Competence Continuum	12
Cultural Competence and Disaster Mental Health Services	14
Disaster Phases and Responses	17
Cultural Competence and Disaster Mental Health Planning.....	19
SECTION TWO: GUIDING PRINCIPLES AND RECOMMENDATIONS.....	22
Guiding Principles for Cultural Competence in Disaster Mental Health Programs	22
Principle 1: Recognize the Importance of Culture and Respect Diversity	23
Principle 2: Maintain a Current Profile of the Cultural Composition of the Community	24
Principle 3: Recruit Disaster Workers Who Are Representative of the Community or Service Area.....	26
Principle 4: Provide Ongoing Cultural Competence Training to Disaster Mental Health Staff	27
Principle 5: Ensure That Services Are Accessible, Appropriate, and Equitable	28
Principle 6: Recognize the Role of Help-Seeking Behaviors, Customs and Traditions, and Natural Support Networks.....	29
Principle 7: Involve as “Cultural Brokers” Community Leaders and Organizations Representing Diverse Cultural Groups	33
Principle 8: Ensure That Services and Information Are Culturally and Linguistically Competent.....	34
Principle 9: Assess and Evaluate the Program’s Level of Cultural Competence	37

Table of Contents CONTINUED

REFERENCES.....	40
APPENDICES	45
Appendix A: Cultural Competence Resources and Tools.....	46
Appendix B: Disaster Mental Health Resources from the Center for Mental Health Services	48
Appendix C: Sources of Demographic and Statistical Information.....	49
Appendix D: Sources of Assistance and Information	50
Appendix E: Glossary	54
Appendix F: Cultural Competence Checklist for Disaster Crisis Counseling Programs.....	57
FIGURE	
Figure 1-1: Cultural Competence Continuum.....	13
TABLES	
Table 1-1: Percentage Distribution of the Population by Race and Hispanic Origin.....	9
Table 1-2: Federal Government Categories for Race and Ethnicity.....	11
Table 1-3: Characteristics of Disasters	18
Table 1-4: Questions to Address in a Disaster Mental Health Plan.....	21
Table 2-1: Key Concepts of Disaster Mental Health	23
Table 2-2: Important Considerations When Interacting with People of Other Cultures.....	25
Table 2-3: Staff Attributes, Knowledge, and Skills Essential to Development of Cultural Competence.....	27
Table 2-4: Special Considerations When Working with Refugees	30
Table 2-5: Guidelines for Using Interpreters.....	37
Table 2-6: A Cultural Competence Self-Assessment for Disaster Crisis Counseling Programs.....	38

Foreword

Disasters—earthquakes, hurricanes, chemical explosions, wars, school shootings, mass casualty accidents, and acts of terrorism—can strike anyone, regardless of culture, ethnicity, or race. No one who experiences or witnesses a disaster is untouched by it.

Peoples' reactions to disaster and their coping skills, as well as their receptivity to crisis counseling, differ significantly because of their individual beliefs, cultural traditions, and economic and social status in the community. For this reason, workers in our Nation's public health and human services systems increasingly recognize the importance of cultural competence in the development, planning, and delivery of effective disaster mental health services.

The increased focus on cultural competence also stems from the desire to better serve a U.S. population that is rapidly becoming more ethnically and culturally diverse. To respond effectively to the mental health needs of all disaster survivors, crisis counseling programs must be sensitive to the unique experiences, beliefs, norms, values, traditions, customs, and language of each individual, regardless of his or her racial, ethnic, or cultural background. Disaster mental health services must be provided in a manner that recognizes, respects, and builds on the strengths and resources of survivors and their communities.

The Crisis Counseling Assistance and Training Program (CCP) is one of the Federal Government's major efforts to provide mental health services to people affected by disasters. Created in 1974, this program is currently administered by the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMSHA), and the Federal Emergency Management Agency (FEMA). The Program provides supplemental funding to States for short-term crisis counseling services to survivors of federally declared disasters. Crisis counseling services provided through the Program include outreach, education, community networking and consultation, public information and referral, and individual and group counseling. The CCP emphasizes specialized interventions and strategies that meet the needs of special populations such as racial and ethnic minority groups.

The purpose of this guide is to assist States and communities in planning, designing, and implementing culturally competent disaster mental health services for survivors of natural and human-caused disasters of all scales. It complements information previously published by FEMA and CMHS on disaster mental health response and recovery. FEMA provided the funding for this guide as part of the agencies' ongoing effort to address the needs of special

**No one who experiences
or witnesses a disaster
is untouched by it.**

populations in disaster mental health response and recovery. *Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations* is part of a series of publications developed by CMHS.

In developing this guide, CMHS recognized that cultural competence is a complex subject—one that has varying terminologies, opinions, expectations, models, and paradigms. The authors sought to identify common concepts and to suggest guiding principles and recommendations for primary and behavioral health care providers working with disaster survivors in multicultural communities. Although it is the hope of CMHS that readers will find the guide useful, the authors also recognize that it is by no means intended to provide comprehensive information on cultural competence.

The guiding principles are based on standards, guidelines, and recommendations established by SAMHSA, the Office of Minority Health, and the Health Resources and Services Administration in the U.S. Department of Health and Human Services (DHHS), although the guiding principles do not necessarily represent these agencies' specific views. *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General* (DHHS, 2001) informed our efforts to ensure consistency with fundamental practice and theory.

To produce this guide, the authors invited input from State and local disaster mental health coordinators and consultants as well as from reviewers at the national, State, and community levels. The publication also incorporates information gathered through an extensive literature review. Vignettes from CMHS grant applications and grantee reports illustrate the range of promising practices, experiences, and challenges of State and local disaster mental health programs nationwide. As work on the guide continued, CMHS became increasingly aware that the principles and values underlying cultural competence parallel those historically espoused by disaster mental health service providers.

This publication is a first step toward developing a framework for the design of culturally competent disaster mental health programs. It also is the hope of CMHS that the information it provides will improve understanding and increase the ability of State, local, and community mental health and human service administrators, planners, trainers, and other staff to respond sensitively and effectively to the needs of all disaster survivors.





Introduction

BACKGROUND AND OVERVIEW

Disasters affect hundreds of thousands of people in the United States annually. Between 1993 and 1998, the American Red Cross responded to more than 322,000 disaster incidents in the United States and provided financial assistance to more than 600,000 families (American Red Cross, 2000). In 1997 alone, the Federal Emergency Management Agency (FEMA) responded to 43 major disasters in 27 States and three western Pacific Island territories (FEMA, 2000). In recent years, human-caused disasters have been a major challenge. Such events include the 1992 civil unrest in Los Angeles, the 1995 bombing of the Alfred P. Murrah Federal Building in Oklahoma City, and the September 2001 terrorist attacks on the World Trade Center in New York and the Pentagon in Arlington.

Disaster crisis counseling is a specialized service that involves

Because of higher birth and immigration rates, the Hispanic population is growing faster than any other ethnic minority group.

rapid assignment and temporary deployment of staff who must meet multiple demands and work in marginal conditions and in unfamiliar settings such as shelters, recovery service centers, and mass care facilities. The major objective of disaster mental health operations is to mobilize staff to disaster sites so that they can attend to the emotional needs of survivors. In the past, these responses tended to be generic; little or no effort was made to tailor resources to the characteristics of a specific population. With time and experience, however, service providers and funding organizations have become increasingly aware that race, ethnicity, and culture may have a profound effect on the way in which an individual responds to and copes with disaster. Today, those in the field of disaster mental health recognize that sensitivity to cultural

differences is essential in providing mental health services to disaster survivors.

Integrating cultural competence in the temporary structure and high-intensity work environment of a disaster relief operation is a challenge. Increasing cultural competence, not a one-time activity, is a long-term process that requires fundamental changes at the institutional level. Because both culture and the nature of disasters are dynamic, these changes must be followed by ongoing efforts to ensure that the needs of those affected by disaster are met.

The primary purpose of this guide is to provide background information, guiding principles, recommendations, and resources for developing culturally competent disaster mental health services. Disaster mental health providers and workers can use and adapt the guidelines set forth in this document to meet the unique

characteristics of individuals and communities affected directly or indirectly by a full range of natural and human-made disasters.

Designed to supplement information already available through CMHS, SAMHSA, and other sources, *Developing Cultural Competence in Disaster Mental Health Programs* highlights important common issues relating to cultural competence and to disaster mental health. It provides guidance for improving cultural competence in support of disaster mental health services.

The following issues are key to the recommendations set forth in this guide:

- Cultural competence requires system-wide change. It must be manifested at every level of an organization, including policy making, administration, and direct service provision. Therefore, for disaster mental health services to

**Precise definitions of the terms
“race,” “ethnicity,” and “culture”
are elusive.**

be effective, cultural competence must be reflected in disaster mental health plans. For additional information on building mental health systems capacity for disaster mental health response and recovery, readers may wish to review *Disaster Response and Recovery: A Strategic Guide* (DHHS, Rev. ed, in press).

■ Cultural competence requires an understanding of the historical, social, and political events that affect the physical and mental health of culturally diverse groups. Issues such as racism, discrimination, war, trauma, immigration patterns, and poverty—which reinforce cultural differences and distinguish one cultural group from another—must be considered (Hernandez and Isaacs, 1998). For a descriptive summary of historical background, patterns, and events, as well as detailed demographic

and health profiles of individual cultural groups, readers may wish to refer to *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General* (DHHS, 2001) and to *Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups* (DHHS, 2000b).

■ Precise definitions of the terms “race,” “ethnicity,” and “culture” are elusive. As social concepts, these terms have many meanings, and those meanings evolve over time (DHHS, 2001). This guide espouses a broad definition of culture that includes not only race and ethnicity but also gender, age, language, socioeconomic status, sexual orientation, disability, literacy level, spiritual and religious practices, individual values and experiences,

and other factors. This guide uses the phrases “cultural groups” and “racial and ethnic minority groups”¹ to refer to the Nation’s diverse, multicultural groups and individuals.

■ The operational definition of cultural competence provided in this guide is based on the principles of cultural competence described in *Towards a Culturally Competent System of Care* (Cross et al., 1989). Many Federal, State, and local public mental health systems, as well as organizations in the private sector, have adopted the principles presented in this document.

¹The major racial and ethnic minority groups referred to in this publication are African Americans (blacks), American Indians and Alaska Natives, Asian Americans, Native Hawaiian and Other Pacific Islanders, and Hispanic Americans (Latinos). The authors recognize that opinions about which labels are appropriate differ and acknowledge that heterogeneous subpopulations exist within each of these populations. These categories, which were established by the Office of Management and Budget in 1997, are used because they are widely accepted and used by service providers in the public and private sectors.

Organization of This Guide

This guide includes two sections and six appendices.

SECTION ONE explores the nature of culture and disaster. It begins by defining culturally related terms, discussing diversity within racial and ethnic minority groups, and describing cultural competence. It then discusses cultural competence in the context of disaster mental health services. Section One also presents the Cultural Competence Continuum and a list of questions to address in a disaster mental health plan. Readers seeking more detail about crisis counseling or disaster response and recovery may refer to other CMHS/FEMA publications. For example, the *Training Manual for Mental Health and Human Service Workers in Major Disasters* (DHHS, 2000e) provides a comprehensive overview of and essential information on training concepts on crisis counseling, including a training curriculum. *Disaster Response and Recovery: A Strategic Guide* (DHHS, Rev. ed., in press) also is a useful resource.

SECTION TWO sets forth nine guiding principles for culturally competent disaster mental health services and related recommendations for developing these services. It also presents the key concepts of disaster mental health; important considerations when working with people of other cultures; staff attributes, knowledge, and skills essential to the development of cultural competence; and a cultural competence self-assessment for disaster crisis counseling programs. In addition, Section Two provides suggestions for working with refugees and guidelines for using interpreters.

The appendices provide additional information that may be useful in developing cultural competence in disaster mental health.

APPENDIX A is an annotated bibliography of cultural competence resources and tools. Many of these resources provide detailed information about individual populations' histories, immigration patterns, and experiences with stress and trauma.

APPENDIX B lists disaster mental health technical assistance resources and publications available through CMHS. Some of these materials discuss the needs and provision of services for special populations.

APPENDIX C lists online resources that provide community-specific demographic and statistical information.

APPENDIX D lists Federal, private-sector, professional, and other organizations with cultural competence expertise.

APPENDIX E is a glossary of terms associated with disaster mental health and cultural competence.

APPENDIX F is a Cultural Competence Checklist for Disaster Crisis Counseling Programs. Based on concepts discussed throughout this guide, the checklist covers essential principles for ensuring a culturally competent disaster mental health program.

Culture and Disaster

S

ince its founding, the United States has been a nation of diversity. In the years to come, fertility and mortality rates, immigration patterns, and age distributions within subgroups of the population will contribute to an increasingly diverse national population (Day, 1996). Data from the 2000 U.S. Census reveal that Hispanics have replaced African Americans as the second largest ethnic group after whites.² Because of higher birth and immigration rates, the Hispanic population is growing faster than any other ethnic minority group (DHHS, 2001). The population of Asian Americans is also growing and is projected to continue growth throughout the first half of the 21st century, primarily because of immigration (DHHS, 2001). As shown in Table 1-1, by 2010, Hispanic Americans will comprise 14.6 percent of the U.S. population, African Americans will comprise 12.5 percent, Asian Americans will comprise 4.8 percent, and Native Americans will comprise less than 1 percent (U.S. Department of Commerce, 2000).

These demographic changes have given the United States the benefits and richness of many cultures, languages, and histories. At the same time, the Nation's growing diversity has made it more important than ever for health and

human service providers—including disaster mental health service providers—to recognize, understand, and respect the diversity found among cultural groups and subgroups. Service providers must find ways to tailor their services to individuals' and communities' cultural identities, languages, customs, traditions, beliefs, values, and social support systems. This recognition, understanding, respect, and tailoring of services to various cultures is the foundation of cultural competence.

UNDERSTANDING CULTURE

Culture influences many aspects of our lives—from how we communicate and celebrate to how we perceive the world around us. Culture involves shared customs, values, social rules of behavior, rituals and traditions, and perceptions of human nature and natural events. Elements of culture are learned from others and may be passed down from generation to generation.

Many people equate race and ethnicity with culture; however, the terms “race” and “ethnicity” do not fully define the scope and breadth of culture. Race and ethnicity are indeed prominent elements of culture, but there are important distinctions between

² This publication uses the term “whites” to denote non-Hispanic white Americans.

TABLE 1-1

Percentage Distribution of the Population By Race and Hispanic Origin

(Includes foreign and native-born populations)

Year	Race				Hispanic/Latino Origin*
	White	Black/African American	American Indian/Alaska Native**	Asian and Pacific Islander	
1995	73.6	12.0	0.7	3.3	10.2
2000	71.4	12.2	0.7	3.9	11.8
2010	67.3	12.5	0.8	4.8	14.6
2050	52.8	13.2	0.8	8.9	24.3
2100	40.3	13.0	0.7	12.6	33.3

* Persons of Hispanic/Latino origin may be of any race. Groups listed under "Race" are not of Hispanic origin.

** Includes American Indians, Alaska Natives, and Aleuts.

Source: U.S. Department of Commerce, Bureau of the Census. (2000). Projections of the resident population by race, Hispanic origin, and nativity: Middle series, 1999 to 2100. Washington, DC: U.S. Department of Commerce.

these terms. For example, many people think of "race" as a biological category and associate it with visible physical characteristics such as hair and skin color.

Physical features, however, do not reliably differentiate people of different races (DHHS, 2001). For this reason, race is widely used as a social category. Different cultures classify people into racial groups on the basis of a set of characteristics that are socially important (DHHS, 2001). Often, members of certain social or racial groups are treated as inferior or superior or given unequal access to power and other resources (DHHS, 2001).

"Ethnicity" refers to a common heritage of a particular group. Elements of this shared heritage include history, language, rituals, and preferences for music and foods. Ethnicity may overlap with race when race is defined as a social category. For example, because Hispanics are an ethnicity, not a race, ethnic subgroups such as Cubans and Peruvians include people of different races (DHHS, 2001).

"Culture" refers to the shared attributes of a group of people. It is broadly defined as a common heritage or learned set of beliefs, norms, and values (DHHS, 2001). Culture is as applicable to groups of whites, such as Irish Americans or German Americans, as it is to

racial and ethnic minorities (DHHS, 2001). People can share a culture, regardless of their race or ethnicity. For example, people who work for a particular organization, people who have a particular physical or mental limitation, or youth in a particular social group may share cultural attributes.

A culture can be defined by characteristics such as:

- National origin;
- Customs and traditions;
- Length of residency in the United States;
- Language;
- Age;

- Generation;
- Gender;
- Religious beliefs;
- Political beliefs;
- Sexual orientation;
- Perceptions of family and community;
- Perceptions of health, well-being, and disability;
- Physical ability or limitations;
- Socioeconomic status;
- Education level;
- Geographic location; and
- Family and household composition.

Did You Know . . .

Mental Health: Culture, Race, and Ethnicity—
A Supplement to Mental Health:
A Report of the Surgeon General
(DHHS, 2001) notes that:

- Approximately 12 percent of the U.S. population—34 million individuals—identify themselves as African American.
- Six percent of all blacks in the United States today are foreign-born. Most of those who are foreign-born come from the Caribbean.
- Since 1983, more than 100,000 refugees have come to the United States from African nations.
- The U.S. Census Bureau estimates that 4.1 million American Indians and Alaska Natives (Indians, Eskimos, and Aleuts) lived in the United States in 2000, representing less than 1.5 percent of the total U.S. population.
- Alaska Natives comprise approximately 4 percent of the combined American Indian and Alaska Native population.
- By the year 2020, the combined Asian American and Pacific Islander population will reach approximately 20 million, or about 6 percent of the total U.S. population.
- Approximately 35 percent of Asian Americans and Pacific Islanders live in linguistically isolated households. For some Asian American ethnic groups—including Hmong, Cambodian, Laotian, Vietnamese, Korean, and Chinese American households—the rate is much higher than this percentage.
- By the year 2050, Latinos will constitute nearly one-fourth of the U.S. population, and nearly one-third of persons under 19 years of age will be Hispanic.
- Nearly two-thirds of Hispanic Americans were born in the United States.
- Nearly two-thirds of Latinos are persons of Mexican origin, and the remaining one-third are primarily persons of Puerto Rican, Cuban, or Central American origin.

Culture changes continuously. For example, immigrants to the United States bring with them their own beliefs, norms, and values, but through the process of acculturation gradually learn and adopt selected elements of the dominant culture. An immigrant group may develop its own culture while becoming acculturated. At the same time, the dominant culture may change as a result of its interaction with the immigrant group (DHHS, 2001).

DIVERSITY AMONG AND WITHIN RACIAL AND ETHNIC MINORITY GROUPS

Four racial and ethnic minority groups—African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanic Americans—accounted for approximately 30 percent of the U.S. population in the year 2000 and are expected to account for nearly 40 percent of the U.S. population by 2025 (DHHS, 2001). Although there are important differences among these four groups, there also is broad diversity within each group. In other words, people who find themselves in the same racial or ethnic group—either by census category or through self-identification—do not always have the same culture. Examples follow:

- American Indians and Alaska Natives may belong to more than 500 tribes, each of which has a different cultural tradition, language, and ancestry (DHHS, 2001).
- Asian Americans and Pacific Islanders may identify with any of 43 subgroups and speak any of 100 languages and dialects (DHHS, 2001).

■ Hispanics may be of Mexican, Puerto Rican, Cuban, Central and South American, or other heritage (DHHS, 2001).

Furthermore, the broad category labels are imprecise (DHHS, 2001). For example, people who are indigenous to the Americas may be called Hispanic if they are from Mexico or American Indian if they are from the United States (DHHS, 2001). In addition, many people in a particular racial or ethnic minority group may identify more closely with other social groups than with the group to which they are assigned by definition (DHHS, 2001). Finally, many people identify with multiple cultures that may be associated with factors such as race, ethnicity, country of origin, primary language, immigration status, age, religion, sexual orientation, employment status, disability, geographic location, or socioeconomic status. Table 1-2 identifies Federal Government categories for race and ethnicity.

Recognizing the limitations of the traditional broad groupings, the U.S. Census Bureau revised the categories used to report race and ethnicity in the 2000 Census. For the first time, individuals could identify with more than one group (U.S. Office of Management and Budget, 2000). The U.S. Census Bureau anticipated that this change would result in approximately 63 categories of racial and ethnic identifications (DHHS, 2001).

Appendix C lists additional resources offering statistical and demographic data on racial and ethnic populations and subpopulations.

TABLE 1 - 2

Federal Government Categories for Race and Ethnicity

The U.S. Office of Management and Budget (1997) announced revised standards for Federal data on race and ethnicity. The new categories for race are:

American Indian or Alaska Native refers to a person having origins in any of the original peoples of North and South America, including Central America, and who maintains tribal affiliation or community attachment.

Asian refers to a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American refers to a person having origins in any of the black racial groups of Africa.

Hispanic or Latino refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

Native Hawaiian and Other Pacific Islander refers to a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White refers to a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Some Other Race was included for those who identify with one or more races.

CULTURAL
COMPETENCE:
SCOPE AND
TERMINOLOGY

We use many terms to refer to concepts associated with cultural competence and with interactions between and among people of different cultures including “cultural diversity, cultural awareness, cultural sensitivity, multiculturalism, and transcultural services.” Although the differences in the meanings of these terms may be subtle, they are extremely important. For example, the term “cultural awareness”

suggests that it may be sufficient for one to be cognizant, observant, and conscious of similarities and differences among cultural groups (Goode et al., 2001).

“Cultural sensitivity,” on the other hand, connotes the ability to empathize with and understand the needs and emotions of persons of one’s own culture as well as those of others and to identify with emotional expressions and the problems, struggles, and joys of someone from another culture (Hernandez and Isaacs, 1998).

The term “cultural competence” suggests a broader concept than “cultural sensitivity” implies. As previously defined in this section, the word “culture” refers to the shared attributes—including beliefs, norms, and values—of a group of people (DHHS, 2001). The word “competence” implies the capacity to function effectively, both at the individual and organizational levels. “Competence” is associated with “culture” to emphasize that being aware of or sensitive to the differences between cultures is not sufficient. Instead, service providers must have the knowledge, skills, attitudes, policies, and structures needed to offer support and care that is responsive and tailored to the needs of culturally diverse population groups.

Many people and organizations have developed definitions of cultural competence. The following definition blends elements of definitions used by SAMSHA (DHHS, 2001), the Health Resources and Services Administration (DHHS), the Office of Minority Health (DHHS, 2000a), and definitions found in the literature (Bazron and Scallet, 1998; Cross et al., 1989; Denboba, 1993; Evans, 1995; Roberts et al., 1990; Taylor et al., 1998):

Cultural competence is a set of values, behaviors, attitudes, and practices within a system, organization, program, or among individuals that enables people to work effectively across cultures. It refers to the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic,

ongoing, developmental process that requires a long-term commitment and is achieved over time.

Cross and colleagues (1989) note that culturally competent organizations and individuals:

- Value diversity;
- Have the capacity for cultural assessment;
- Are aware of cross-cultural dynamics;
- Develop cultural knowledge; and
- Adapt service delivery to reflect an understanding of cultural diversity.

At the individual level, cultural competence requires an understanding of one’s own culture and worldview as well as those of others. It involves an examination of one’s attitudes, values, and beliefs, and the ability to demonstrate values, knowledge, skills, and attributes needed to work sensitively and effectively in cross-cultural situations (Goode et al., 2001).

At the organizational and programmatic levels, cultural competence requires a comprehensive, coordinated plan that cuts across policymaking, infrastructure building, program administration and evaluation, and service delivery. Culturally competent organizations and programs acknowledge and incorporate the importance of culture, assess cross-cultural relations, are aware of dynamics that can result from cultural differences and ethnocentric attitudes, expand cultural knowledge, and adopt services that meet unique cultural needs (DHHS, 2000d).

THE CULTURAL COMPETENCE CONTINUUM

Cultural competence is not a matter of being politically correct or of assigning one person to handle diversity issues, nor does it mean simply translating materials into other languages. Rather, it is an ongoing process of organizational and individual development that includes learning more about our own and other cultures; altering our thinking about culture on the basis of what we learn; and changing the ways in which we interact with others to reflect an awareness and sensitivity to diverse cultures.

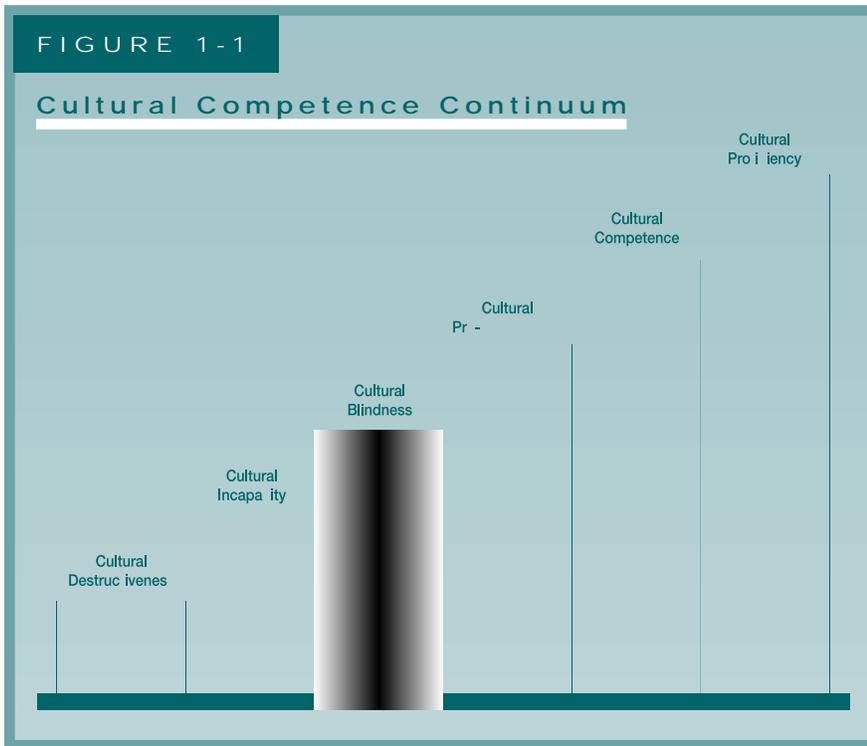
The Cultural Competence Continuum depicted in Figure 1-1 was developed by Cross et al. (1989) for mental health professionals. Today, many other public health practitioners and community-based service providers also find it a useful tool. The continuum assumes that cultural competence is a dynamic process with multiple levels of achievement. It can be used to assess an organization’s or individual’s level of cultural competence, to establish benchmarks, and to measure progress.

Cultural Destructiveness

The negative end of the continuum is characterized by cultural destructiveness. Organizations or individuals in this stage view cultural differences as a problem and participate in activities that purposely attempt to destroy a culture. Examples of destructive actions include denying people of color access to their natural helpers or healers, removing children of color from their families on the

FIGURE 1-1

Cultural Competence Continuum



The continuum includes six stages: cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competence, cultural competence, and cultural proficiency (Cross et al., 1989).

basis of race, and risking the well-being of minority individuals by involving them in social or medical experiments without their knowledge or consent. Organizations and individuals at this extreme operate on the assumption that one race is superior and that it should eradicate “lesser” cultures.

Cultural Incapacity

Organizations and individuals in the cultural incapacity stage lack the ability to help cultures from diverse communities. Although they do not intentionally seek to cause harm, they believe in the superiority of their own racial or ethnic group and assume a paternalistic posture toward “lesser” groups. They may act as agents of oppression by enforcing racist policies and maintaining stereotypes. Employment practices

of organizations in this stage of the continuum are discriminatory.

Cultural Blindness

Cultural blindness is the midpoint of the continuum. Organizations and individuals at this stage believe that color or culture makes no difference and that all people are the same. Individuals at this stage may view themselves as unbiased and believe that they address cultural needs. In fact, people who are culturally blind do not perceive, and therefore cannot benefit from, the valuable differences among diverse groups. Services or programs created by organizations at this stage are virtually useless to address the needs of diverse groups.

Cultural Pre-competence

Culturally pre-competent organizations and individuals begin

to move toward the positive end of the continuum. They realize weaknesses in their attempts to serve various cultures and make some efforts to improve the services offered to diverse populations. Pre-competent organizations hire staff from the cultures they serve, involve people of different cultures on their boards of directors or advisory committees, and provide at least rudimentary training in cultural differences. However, organizations at this stage run the risk of becoming complacent, especially when members believe that the accomplishment of one goal or activity fulfills the obligation to the community. Tokenism is another danger. Organizations sometimes hire one or more workers from a racial or ethnic group and feel that they have done all that is necessary.

Cultural Competence

Culturally competent organizations and individuals accept and respect differences, and they participate in continuing self-assessment regarding culture. Such organizations continuously expand their cultural knowledge and resources and adopt service models that better meet the needs of minority populations. In addition, they strive to hire unbiased employees, and seek advice and consultation from representatives of the cultures served. They also support their staff members’ comfort levels when working in cross-cultural situations and in understanding the interplay between policy and practice.

Cultural Proficiency

Culturally proficient organizations hold diversity of culture in high

Cultural Competence Necessary from Project Initiation

After the Great Flood of 1993 devastated the economy of rural Minnesota, the State developed a program of supportive services, including crisis counseling for rural residents. Ethnic populations affected by the flood included Hispanics, African Americans, Southeast Asians (Vietnamese, Hmong, Laotians), and Somalians. Some of these populations were relatively new to rural Minnesota, and they were not well integrated into the communities. Trust between cultures was tenuous at best, and many of the minority groups were somewhat socially isolated.

The crisis counseling project faced barriers of language, culture, and mistrust that had to be overcome in order to provide services. The challenge was difficult. Virtually all coordinators and outreach workers initially hired were white and middle class. While a concerted effort was made to provide culturally competent services once the program got underway, the final project report, with great candor, concluded that success in providing services to the various ethnic populations was spotty. It stated that the project might have been more effective had a focus on cultural competence been integrated into the program from the beginning.

Minnesota Final Report, 1994

esteem. They seek to add to the knowledge base of culturally competent practice by conducting research, developing new therapeutic approaches based on culture, and publishing and disseminating the results of demonstration projects. Culturally proficient organizations hire staff members who are specialists in culturally competent practice.

Achieving cultural competence and progressing along the continuum do not happen by chance. Policies

and procedures, hiring practices, service delivery, and community outreach must all include the principles of cultural competence. For these reasons, a commitment to cultural competence must permeate an organization before a disaster strikes. If the concepts of cultural competence and proficiency have been integrated into the philosophy, policies, and day-to-day practices of the mental health provider agency, they will be much easier to incorporate into disaster recovery efforts.

CULTURAL COMPETENCE AND DISASTER MENTAL HEALTH SERVICES

Culture as a source of knowledge, information, and support provides continuity and a process for healing during times of tragedy (DeVries, 1996). Survivors react to and recover from disaster within the context of their individual racial and ethnic backgrounds, cultural viewpoints, life experiences, and values. Culture offers a protective system that is comfortable and reassuring. It defines appropriate behavior and furnishes social support, identity, and a shared vision for recovery. For example, stories, rituals, and legends that are part of a culture's fabric help people adjust to catastrophic losses by highlighting the mastery of communal trauma and explaining the relationship of individuals to the spiritual. Despite the strengths that culture can provide, responses to disaster also fall on a continuum. Persons from disadvantaged racial and ethnic communities may be more vulnerable to problems associated with preparing for and recovering from disaster than persons of higher socioeconomic status (Fothergill et al., 1999).

Because of the strong role that culture plays in disaster response, disaster mental health services are most effective when survivors receive assistance that is in accord with their cultural beliefs and consistent with their needs (Hernandez and Isaacs, 1998). As disaster mental health service providers seek to become more culturally competent, they must recognize three important social and historical influences that can

affect the success of their efforts. These three influences are the importance of community, racism and discrimination, and social and economic inequality.

The Importance of Community

Disasters affect both individuals and communities. Following a disaster, there may be individual trauma, characterized as “a blow to the psyche that breaks through one’s defenses so suddenly and with such brutal force that one cannot react to it effectively” (DHHS, Rev. ed. in press). There also may be collective trauma—“a blow to the basic tissues of social life that damages the bonds attaching people together and impairs the prevailing sense of community” (DHHS, Rev. ed., in press). Cultural and socioeconomic factors contribute to both individual and community responses to the trauma caused by disaster.

The culture of the community provides the lens through which its members view and interpret the disaster, and the community’s degree of cohesion helps determine the level of social support available to survivors. In other words, a community that is disrupted and fragmented will be able to provide less support than a cohesive community.

A classic example is presented by sociologist Kai Erikson, who studied the impact of the devastating 1972 flood in Buffalo Creek, West Virginia (Erikson, 1976). The flood led to relocation of the entire community. Erikson describes a “loss of community,” in which people lost not only their sense of connection with the locale but also the support

of people and institutions. Results of this community’s fragmentation included fear, anger, anxiety, and depression.

Other studies have emphasized positive effects that can result from disaster experiences in communities that perform a protective role and cushion the stress of the disaster (Dynes et al., 1994). Compared with nondisaster-related suffering, which is isolating and private, the suffering of disaster survivors can be collective and public (Dynes et al., 1994). However, devastating disasters can have positive outcomes. They can bring a community closer or reorient its members to new priorities or values (Ursano, Fullerton et al., 1994). Individuals may exhibit courage, selflessness, gratitude, and hope that they may not have shown or felt before the disaster.

Community often is extremely important for racial and ethnic minority groups, and it may dramatically affect their ability to recover from disaster. For example, a racial or ethnic minority

community may provide especially strong social support functions for its members, particularly when it is surrounded by a hostile society. However, its smaller size may render it more fragile and more subject to dispersion and destruction after a disaster. Members of some racial and ethnic minority groups, such as refugees, previously have experienced destruction of their social support systems, and the destruction of a second support system may be particularly difficult (Beiser, 1990; Van der Veer, 1995).

Racism and Discrimination

Many racial and ethnic minority groups, including African Americans, American Indians, and Chinese and Japanese Americans, have experienced racism, discrimination, or persecution for many years. Both legally sanctioned and more subtle forms of discrimination and racism are an undeniable part of our Nation’s historical fabric. Despite improvements in recent decades, evidence exists that racial

Disaster Projects Confront Distrust

Several disaster crisis counseling projects supported by the Federal Government have had to address the distrust of ethnic minority groups and their reluctance to use available resources. For example, following the 1994 California earthquake, the disaster crisis counseling project found that many immigrants’ distrust of government posed a barrier to their use of disaster services. Likewise, some of the survivors of a hurricane in Alabama were immigrants from Asian Communist countries who did not trust any government and were not accustomed to receiving Government assistance.

California Final Report, 1995 • Alabama Final Report, 1999

Damage from Mississippi Tornadoes Unequal

In the late 1950s, several tornadoes struck rural Mississippi. The only persons killed were black. A subsequent study found that many people in the black community had great difficulty in coming to terms with this disaster. They did not understand how a just God could discriminate in such a fashion between white and black.

Perry and Perry, 1959

discrimination persists in housing rentals and sales, hiring practices, and medical care. Racism also takes the form of demeaning comments, hate crimes, and other violence by institutions or individuals, either intentionally or unintentionally (DHHS, 2001).

As a result of past or present experiences with racism and discrimination, racial and ethnic minority groups may distrust offers of outside assistance at any time, even following a disaster. They may not be accustomed to receiving support and assistance from persons outside of their own group in non-disaster circumstances. Therefore, they may be unfamiliar with the social and cultural mechanisms of receiving assistance and remain outside the network of aid.

Particularly during the “disillusionment phase” of the disaster, when intragroup tensions are typically high, racial and ethnic minority groups can face the brunt of anger and even blame from members of the larger culture. Such psychological assaults and experiences with racism and discrimination can result in increased stress for individuals and groups.

Social and Economic Inequality

Poverty disproportionately affects racial and ethnic minority groups. For example, in 1999, 8 percent of whites, 11 percent of Asian Americans and Pacific Islanders, 23 percent of Hispanic Americans, 24 percent of African Americans, and 26 percent of American Indians and Alaska Natives lived in poverty (DHHS, 2001). Significant socioeconomic differences also exist within racial and ethnic minority groups. For example, although some subgroups of Asian Americans have prospered, others remain at low socioeconomic levels (O’Hare and Felt, 1991).

Social and economic inequality also leads to reduced access to resources, including employment; financial credit; legal rights; and education, health, and mental health services (Blaikie et al., 1994). Poor neighborhoods also have high rates of homelessness, substance abuse, and crime (DHHS, 2001).

Poverty makes people more susceptible than others to harm from disaster and less able to access

help (Bolin and Stanford, 1998). Low-income individuals and families typically lose a much larger part of their material assets and suffer more lasting negative effects from disaster than do those with higher incomes (Wisner, 1993). Often, disadvantaged persons live in the least desirable and most hazardous areas of a community, and their homes may be older and not as sound as those in higher income areas. For example, many low-income people live in apartment buildings that contain unreinforced masonry, which is susceptible to damage in a disaster (Bolton et al., 1993).

Although disaster relief activities can help ameliorate some of the damage rendered by a disaster, some groups cannot readily access such services. Negative perceptions derived from pre-disaster experiences may serve as a barrier to seeking care. Lack of familiarity with sources of community support or lack of transportation are common barriers for many immigrants and unwillingness to disclose their immigration status is a major barrier.

Middle-class disaster survivors are more likely than lower-income people—including those from other cultures—to know how to complete forms, communicate adequately, talk to the “right” people, or otherwise maneuver within the system. Thus, they may be more likely to receive aid than survivors with fewer means or those from different cultures (Aptekar, 1990). On the other hand, affluent groups may find it difficult to accept assistance from mental health and

social service agencies. They may fear a loss of control and find it humiliating to accept emergency assistance such as clothing, food, loans, and emotional support from disaster workers.

In some instances, people of lower socioeconomic status exhibit strong coping skills in disaster situations because they have seen difficult times before and have survived. In other instances, the loss of what little one had may leave an individual feeling completely hopeless.

Tornadoes Destroy Homes in Sioux Nation

In 1999, tornadoes ravaged the Oglala Sioux Nation in South Dakota. Housing units are scattered throughout this vast reservation; one home may be 10 to 20 miles from the nearest neighbor or community. Many roads on the reservation are unimproved. Only 10 percent to 15 percent of the homes have telephone service. Because of the lack of adequate housing, multiple family units reside in one dwelling. In some situations, 20 family members live in a two-bedroom home with no running water or sewage system. Outouses are commonplace.

South Dakota Application, 1999

DISASTER PHASES AND RESPONSES

Survivors' reactions to and recovery from a disaster are influenced by a number of factors, including:

- The disaster's unique characteristics, such as its size and scope, and whether it was caused by human or natural factors (see Table 1-3);
- The affected community's unique characteristics, including its demographic and cultural make-up and the presence of pre-existing structures for social support and resources for recovery; and
- The individual's personal assets and vulnerabilities that either reduce or exacerbate stress (DHHS, 2000e).

Despite the differences in disasters, communities, and individuals, survivors' emotional responses to disaster tend to follow a pattern of seven "disaster phases" (National Institute of Mental Health, 1983; DHHS, 2000e):

- Warning or threat;
- Impact;
- Rescue or heroic;
- Remedy or honeymoon;
- Inventory;
- Disillusionment; and
- Reconstruction or recovery.

The characteristics of the disaster, as well as those of the community and its individual residents, affect the duration and nature of the seven phases. The phases do not

Disaster Resurfaces Emotional Reactions to Prior Stressors

Flooding occurred in Clovis, California, in 1995, when a canal and ponding basins overflowed. Many families, mostly Hmong, who lived near the canal were displaced. The Hmong population is a low-income community with immigrants from Southeast Asia who have a history of war and severe losses. Many were suffering from Post-Traumatic Stress Syndrome prior to the flood. The flood increased financial stress and anxiety, and exacerbated their existing symptoms.

California Final Report, 1995

necessarily move forward in linear fashion; instead, they often overlap and blend together. Furthermore, individuals may experience a given phase in different ways (DHHS, 1999), and different cultural groups may respond differently during these phases. Below are brief descriptions of each phase, including examples of responses of different cultural groups during each phase.

For further information about disaster characteristics and phases, refer to the *Training Manual for Mental Health and Human Service Workers in Major Disasters* (DHHS, 2000e).

TABLE 1-3

Characteristics of Disasters

Researchers have identified several common characteristics of disasters that are particularly important when discussing emotional distress and recovery (Bolin, 1985; DHHS, 2000a, p. 6). These characteristics are as follows:

- **Intensity of the impact:** Disasters that wreak intense destruction within a short period of time are more likely to cause emotional distress among survivors than are disasters that work their effects more slowly.
- **Impact ratio (i.e., the proportion of the community sustaining personal losses):** When a disaster affects a significant proportion of a community's population, few individuals may be available to provide material and emotional support to survivors.
- **Potential for recurrence of other hazards:** The real or perceived threat of recurrence of the disaster or of associated hazards can lead to anxiety and heightened stress among survivors.
- **Cultural and symbolic aspects:** Changes in survivors' social and cultural lives and routine activities can be profoundly disturbing. Both natural and human-caused disasters can have symbolic implications.
- **Extent and types of loss sustained by survivors:** Property damage or loss, deaths of loved ones, injury, and job loss all affect emotional recovery.

about risks and in the credence they place on such information. For example, Hispanics are more likely than non-Hispanics to use social networks for disaster information (Blanchard-Boehm, 1997; Perry and Mushkatel, 1986) and to believe information obtained through these networks (Perry and Lindell, 1991) than are members of other groups. Furthermore, some marginalized communities do not have adequate or functioning warning systems. When disaster warning information is not provided in multiple languages or is not closed-captioned, people who do not understand English or who are deaf or hard of hearing may not receive adequate warning.

Impact Phase

The impact phase occurs when the disaster actually strikes. This phase can vary from the slow, low-threat buildup associated with some types of floods to the violent and destructive outcomes associated with tornadoes and explosions. Depending on the characteristics of the disaster, reactions range from confusion, disbelief, and anxiety (particularly if family members are separated) to shock or hysteria.

Rescue or Heroic Phase

In the rescue or heroic phase, individuals' activity levels are typically high and oriented toward rescue operations, survival, and perhaps evacuation. People generally work together to save lives and property; pre-existing tensions between racial and ethnic or cultural groups are set aside. However, if family members are separated, anxiety may be heightened.

Warning or Threat Phase

The warning or threat phase occurs with hurricanes, floods, and other disasters for which there is warning hours or days in advance. Lack of warning can make survivors feel vulnerable, unsafe, and fearful of future unpredicted tragedies. The perception that they had no control over protecting themselves or their loved ones can be deeply distressing.

Racial and ethnic groups sometimes differ in the ways in which they receive information

Remedy or Honeymoon Phase

During this phase, optimism may reign as the community pulls together and government and volunteer assistance become available. The interactions between relief workers and survivors from different cultures can be very important and can influence people's long-term perceptions of the disaster relief effort. Perceptions and beliefs about how healing occurs also may influence recovery. Frequently, however, disaster workers who have had no orientation to local cultures and lack sensitivity to them are brought in to help out during this phase. Such workers may exacerbate, rather than mitigate, cultural differences.

Inventory Phase

During the inventory phase, survivors recognize the limits of help and begin to assess their futures. They become exhausted because of multiple demands, financial pressures, and the stress of relocation or living in a damaged home. Initial optimism may give way to discouragement and fatigue. This also is a time characterized by high levels of grief and loss. Families who lose loved ones will grieve and cope in different ways.

Disillusionment Phase

The disillusionment phase occurs when survivors recognize the reality of loss and the limits of outside relief. This phase is characterized by a high level of stress that may be manifested in personally destructive behavior, family

discord, and community fragmentation. Obtaining assistance from relief agencies can be extremely difficult, and survivors may feel helpless and angry. Hostility between neighbors and among groups is common, and tensions may erupt among different cultural, racial, and ethnic groups.

Reconstruction or Recovery Phase

The final phase, reconstruction or recovery, may last for years. This phase involves the structural rebuilding of the community as well as the integration of changes occasioned by the disaster into

one's community and one's life. A common problem is a lack of housing, particularly if the disaster destroyed much of the low-income housing stock. In such situations, the private market typically hinders rebuilding of low- and moderate-income rental units (Fothergill et al., 1999). Therefore, housing shortages and rent increases disproportionately affect racial and ethnic minority groups (Bolin and Stanford, 1991; Peacock and Girard, 1997). It is not unusual for local political issues to create friction and fragmentation in the impacted community during the disparate reconstruction progress and buyouts between neighboring counties.

REPORT

Civil Unrest Causes Emotional Problems for Refugees

The civil unrest and fires in Los Angeles that came in the wake of the Rodney King verdict affected a community inhabited by many refugees from Central America and Asia. For immigrants who came from war-torn countries, the Los Angeles disturbances reactivated fears and emotions associated with their homeland. Many experienced increased agitation, depression, confusion, and recollections of prior bereavements.

California Final Report, 1994

CULTURAL COMPETENCE AND DISASTER MENTAL HEALTH PLANNING

Providing culturally competent mental health services to survivors requires action before, during, and after a disaster. The disaster mental health plan, which should be part of a State or community emergency management plan, can help ensure an efficient, coordinated response to the mental health needs of the affected population (DHHS, Rev. ed., in press). These plans specify roles, responsibilities, and relationships among agencies and organizations in responding to a community's mental health needs following a disaster (DHHS, Rev. ed., in press).

Disaster Strikes a Highly Diverse Community

On January 17, 1994, a major earthquake struck Los Angeles and Ventura Counties. The Northridge earthquake was the largest and most violent to hit an urban area in the United States since the 1906 San Francisco quake. The post-disaster recovery effort provided mental health services to 1.9 million persons, representing myriad ethnic groups, special populations, and lifestyles.

The size and scope of the two affected counties, as well as the ethnic diversity of their residents, constituted a challenge to disaster mental health providers. For example, Ventura County is home to many undocumented migrant farm workers, the majority of whom do not speak English and are mistrustful of government at any level. Language and cultural barriers had to be overcome for persons from several Asian cultures as well. The diverse population in the affected areas also included other special populations, such as physically challenged persons and runaway youth, two groups that required special outreach strategies.

The disaster mental health program staff recognized from the beginning of the project the need to develop and provide culturally relevant and linguistically appropriate services, covering a multitude of cultures and languages.

California Final Report, 1995

Well-designed disaster mental health plans enhance coordination and minimize chaos, thereby helping to ensure that survivors receive assistance in a timely, helpful, and culturally sensitive manner should a disaster occur. Disaster mental health plans that identify and address diverse needs within a community can save valuable time and avert many problems. In the absence of such planning, disaster relief is disorganized, especially in the immediate aftermath. Confusion and inefficiency can prevail when

survivors attempt to gain access to services.

Successful program planners recognize that creating culturally competent environments requires more than recruiting bilingual and bicultural mental health workers, sponsoring a single diversity management class, sending a few employees to a cultural competence workshop, or hiring a “token” racial or ethnic minority group representative. Rather, cultural competence must be a part of the program values; included in the program’s mission statement; and encouraged in attitudes, policies, and practices at every level.

To develop a culturally competent disaster mental health plan, planners must:

- Assess and understand the community’s composition;
- Identify culture-related needs of the community;
- Be knowledgeable about formal and informal community institutions that can help meet diverse mental health needs;
- Gather information from and establish working relationships with trusted organizations, service providers, and cultural group leaders and gatekeepers; and
- Anticipate and identify solutions to cultural problems that may arise in the event of a disaster.

Table 1-4 presents questions that should be addressed in the mental health plan. For further information about disaster mental health planning, refer to *Disaster Response and Recovery: A Strategic Guide* (DHHS, Rev. ed., in press).

TABLE 1-4

Questions to Address in a Disaster Mental Health Plan

Community demographic characteristics

- Who are the most vulnerable persons in the community? Where do they live?
- What is the range of family composition (i.e., single-parent households)?
- How could individuals be identified and reached in a disaster?
- Are policies and procedures in place to collect, maintain, and review current demographic data for any area that might be affected by a disaster?

Cultural groups

- What cultural groups (ethnic, racial, and religious) live in the community?
- Where do they live, and what are their special needs?
- What are their values, beliefs, and primary languages?
- Who are the cultural brokers in the community?

Socioeconomic factors

- Does the community have any special economic considerations that might affect people's vulnerability to disaster?
- Are there recognizable socioeconomic groups with special needs?
- How many live in rental property? How many own their own homes?

Mental health resources

- What mental health service providers serve the community?
- What skills and services does each provider offer?
- What gaps, including lack of cultural competence, might affect disaster services?
- How could the community's mental health resources be used in response to different types of disasters?

Government roles and responsibilities in disaster

- What are the Federal, State, and local roles in disaster response?
- How do Federal, State, and local agencies relate to one another?
- Who would lead the response during different phases of a disaster?
- How can mental health services be integrated into the government agencies' disaster response?
- What mutual aid agreements exist?
- Do any subgroups in the community harbor any historical or political concerns that affect their trust of government?

Nongovernmental organizations' roles in disaster

- What are the roles of the American Red Cross, interfaith organizations, and other disaster relief organizations?
- What resources do non-government agencies offer, and how can local mental health services be integrated into their efforts?
- What mutual aid agreements exist?
- How can mental health providers collaborate with private disaster relief efforts?

Community partnerships

- What resources and supports would community and cultural/ethnic groups provide during or following a disaster?
- Do the groups hold pre-existing mutual aid agreements with any State or county agencies?
- Who are the key informants/gatekeepers of the impacted community?
- Has a directory of cultural resource groups, natural helpers, and community informants who have knowledge about diverse groups been developed?
- Are the community partners involved in all phases of disaster preparedness, response, and recovery operations?

Guiding Principles and Recommendations

D

Developing cultural competence requires a concerted effort by disaster mental health planners and front-line workers. Successful programs share common practices that are defined by nine guiding principles. These principles, listed here, have been identified by CMHS.

This section discusses each of the nine guiding principles and suggests ways to integrate them into disaster mental health planning and crisis counseling programs. The guiding principles, in many ways, overlay the Key Concepts of Disaster Mental Health (DHHS, 2000e), presented in Table 2-1. The Cultural Competence Checklist for Disaster Crisis Counseling Programs, presented in Appendix F, summarizes key content in a convenient form for use in program planning.

GUIDING PRINCIPLES FOR CULTURAL COMPETENCE IN DISASTER MENTAL HEALTH PROGRAMS

Principle 1: Recognize the importance of culture and respect diversity.

Principle 2: Maintain a current profile of the cultural composition of the community.

Principle 3: Recruit disaster workers who are representative of the community or service area.

Principle 4: Provide ongoing cultural competence training to disaster mental health staff.

Principle 5: Ensure that services are accessible, appropriate, and equitable.

Principle 6: Recognize the role of help-seeking behaviors, customs and traditions, and natural support networks.

Principle 7: Involve as “cultural brokers” community leaders and organizations representing diverse cultural groups.

Principle 8: Ensure that services and information are culturally and linguistically competent.

Principle 9: Assess and evaluate the program’s level of cultural competence.

PRINCIPLE 1:
RECOGNIZE THE
IMPORTANCE OF
CULTURE AND
RESPECT DIVERSITY

Culture is one medium through which people develop the resilience that is needed to overcome adversity. Following a disaster, culture provides validation and influences rehabilitation. However, when daily rituals, physical and social environments, and relationships are disrupted, life becomes unpredictable for survivors. Disaster mental health workers can help reestablish customs, rituals, and social relationships and thereby help survivors cope with the impact of a disaster. When doing so, these workers need to recognize that diversity exists within as well as across cultures (Cross et al., 1989). In disasters, individuals within a given cultural group may respond in very different ways; some will be receptive to disaster relief efforts, while others will not. Older adults and young people within a particular culture may react to losses or seek help in different ways, depending on their degree of acculturation. Disaster mental health workers also must be aware of and sensitive to issues stemming from biculturalism; these issues include conflict and ambivalence related to identity and the need to function in cross-cultural environments (Hernandez and Isaacs, 1998).

Recognizing the importance of culture and respecting diversity require an institution-wide commitment. To meet this commitment, disaster mental health workers must understand their own

TABLE 2-1

Key Concepts of Disaster Mental Health

The following concepts should be adopted by all disaster mental health providers, including those serving culturally diverse survivors. The concepts can also help administrators and service providers set program priorities. The concepts deviate in some ways from those on which mental health work has traditionally been based. However, their validity has been confirmed again and again in disasters of various types that have affected a broad range of populations (DHHS, 2000a).

- No one who sees a disaster is untouched by it.
- There are two types of disaster trauma—individual and community.
- Most people pull together and function adequately during and after a disaster, but their effectiveness is diminished by the effects of the event.
- Stress and grief in disasters are normal reactions to abnormal situations.
- Many emotional reactions of disaster survivors stem from problems of daily living brought about by the disaster.
- Disaster relief assistance may be confusing to some survivors. They may experience frustration, anger, and feelings of helplessness related to Federal, State, and private-sector disaster assistance programs.
- Most people do not see themselves as needing mental health services following a disaster and will not seek such services.
- Survivors may reject disaster assistance of all types.
- Disaster mental health assistance is often more practical than psychological in nature.
- Disaster mental health services must be tailored to the culture of communities where they are provided.
- Mental health workers should set aside traditional methods, avoid mental health labels, and use an active outreach approach to intervene successfully in disaster.
- Survivors respond to active, genuine interest, and concern.
- Interventions must be appropriate to the phase of the disaster.
- Social support systems are crucial to recovery.

Concerns About Child Care Heightened by Bombing

Following the 1995 bombing of the Alfred P. Murrah Federal Building in Oklahoma City, local mental health agencies mobilized to provide services to the survivors. One Latino child perished in the Murrah Building and several Latino children were wounded at the YMCA day care center. Mental health workers realized that they would have to address the concerns and guilt of Latino parents regarding child care because in this culture individuals generally resist using babysitters or placing their children in day care.

Oklahoma Application, 1995

Indigenous Outreach Workers Provide Community-Appropriate Services in Guam

In the aftermath of the 1997 super-typhoon, Paka, the Territory of Guam partnered with the University of Guam College of Life Sciences to provide culturally appropriate crisis counseling services. Strategies such as paying special attention to racial tensions, matching workers to the population served, and providing training on culturally respectful interactions helped the outreach workers gain entry to the island's diverse population.

The demographics of the staff mirrored that of the community, and the mental health providers were an integral part of the community. Culture-specific training provided a forum for interacting with representatives of helping agencies on the island and from neighboring Saipan. Outreach tools and strategies included a monkey hand puppet used to engage children, a program for hotel workers, and a program for seniors that used symbolism and activities to encourage recovery. Broadcast and print media, as well as personal conversations, were used to educate the public about the project and the emotional effects of disaster.

Guam Site Visit Report, 1998

cultures and world views; examine their own attitudes, values, and beliefs about culture; acknowledge cultural differences; and work to understand how cultural differences affect the values, attitudes, and beliefs of others. Table 2-2 examines important considerations mental health workers should keep in mind when dealing with people from other cultures.

PRINCIPLE 2: MAINTAIN A CURRENT PROFILE OF THE CULTURAL COMPOSITION OF THE COMMUNITY

No one knows when or where disaster will strike. For this reason, a predisaster assessment of a community's composition and familiarity with cultural traditions and customs during times of loss, trauma, and grief can provide invaluable knowledge in the event of a disaster. The range of cultural diversity—ethnic, religious, racial, and language differences among subgroups—should be assessed and described in a comprehensive profile of the community. A comprehensive community profile describes the community's composition in terms of:

- Race and ethnicity;
- Age;
- Gender;
- Religion;
- Refugee and immigrant status;
- Housing status (i.e., number of single-parent households, type of housing, rental versus ownership, number of persons per household);
- Income and poverty levels;
- Percentage of residents living in rural versus urban areas;
- Unemployment rate;
- Languages and dialects spoken;
- Literacy level;
- Number of schools; and
- Number and types of businesses.

TABLE 2-2

Important Considerations When Interacting with People of Other Cultures

Giger and Davidhizar's "transcultural assessment and intervention model" was developed to assist in the provision of transcultural nursing care. It is currently used by several other health and human services professions. The model identifies five issues that can affect the interactions of providers and service recipients. These issues, adapted below to apply to disaster crisis counseling, illustrate the importance of acknowledging culture and of respecting diversity. A complete description of the model can be found in *Transcultural Nursing: Assessment and Intervention* (Giger and Davidhizar, 1999).

Communication: Both verbal and nonverbal communication can be barriers to providing effective disaster crisis counseling when survivors and workers are from different cultures. Culture influences how people express their feelings, as well as what feelings are appropriate to express, in a given situation. The inability to communicate can make both parties feel alienated and helpless.

Personal Space: "Personal space" is the area that immediately surrounds a person, including the objects within that space. Although spatial requirements may vary from person to person, they tend to be similar among people in a given cultural group (Watson, 1980). A person from one subculture might touch or move closer to another as a friendly gesture, whereas someone from a different culture might consider such behavior invasive. Disaster crisis counselors must look for clues to a survivor's need for space. Such clues may include, for example, moving the chair back or stepping closer.

Social Organization: Beliefs, values, and attitudes are learned and reinforced through social organizations, such as family, kinships, tribes, and political, economic, and religious groups. Understanding these influences will enable the disaster crisis counselor to more accurately assess a survivor's reaction to disaster. A survivor's answers to seemingly trivial questions about hobbies and social activities can lead to insight into his or her life before the disaster.

Time: An understanding of how people from different cultures view time can help avoid misunderstandings and miscommunication. In addition to having different interpretations of the overall concept of time, members of different cultures view "clock time"—that is, intervals and specific durations—differently. Social time may be measured in terms of "dinner time," "worship time," and "harvest time." Time perceptions may be altered during a disaster. Crisis counselors acting with a sense of urgency may be tempted to set timeframes that are not meaningful or realistic to a survivor. The result may be frustration for both parties.

Environmental Control: A belief that events occur because of some external factor—luck, chance, fate, will of God, or the control of others—may affect the way in which a survivor responds to disaster and the types of assistance needed. Survivors who feel that events and recovery are out of their control may be pessimistic regarding counseling efforts. In contrast, individuals who perceive that their own behavior can affect events may be more willing to act (Rotter, 1966). Disaster crisis counselors need to understand beliefs related to environmental control because such beliefs will affect survivors' behavior.

Information about the values, beliefs, social and family norms, traditions, practices, and politics of local cultural groups, as well as the history of racial relations or ethnic issues in the community, should be included in the community profile, because these cultural characteristics may take on additional significance in times of stress (DeVries, 1996). This information should be gathered with the assistance of and in consultation with community cultural leaders (“key informants”) who represent and understand local cultural groups.

Other sources of data incorporated in the community profile include the city hall or the county commissioner’s office, as well as the resources listed in Appendix C. Finally, information included in the community profile should be updated frequently, because such data can change rapidly.

PRINCIPLE 3: RECRUIT DISASTER WORKERS WHO ARE REPRESENTATIVE OF THE COMMUNITY OR SERVICE AREA

Disaster mental health programs are most effective when individuals from the community and its various cultural groups are involved in service delivery as well as in program planning, policy, and administration and management. Recruiting staff whose cultural, racial, and ethnic backgrounds are similar to those of the survivors helps ensure a better understanding of both the survivors and the community and increases the likelihood that survivors will be willing to accept assistance. For example, if American Indian or Alaska Native populations have experienced a disaster, tribal leaders, elders, medicine persons, or holy persons might be recruited

to serve as counselors or in some other capacity. The community profile can be reviewed when recruiting disaster crisis counseling workers to ensure that they are representative of the community or service area.

If indigenous workers are not immediately available, coordinators can attempt to recruit staff with the required racial or ethnic background and language skills from other community agencies or jurisdictions (DHHS, Rev. ed. in press).

Recruitment based solely on race, ethnicity, or language, however, may not be sufficient to ensure an effective response. People who are racially and ethnically representative of the community are not necessarily culturally or linguistically competent. The ability to speak a particular language is not necessarily associated with cultural competence. For example, a well-educated, Spanish-speaking Hispanic professional may not understand the problems and cultural nuances of an immigrant community whose members are living in poverty (DHHS, 2000d).

Table 2-3 highlights the attributes, knowledge, and skills essential to development of cultural competence that should be considered when recruiting disaster mental health staff.

Migrant Farm Workers Employed as Outreach Workers

In 1998, El Niño caused a series of storms that devastated many California communities. The storms affected a large number of migrant farm workers, including many in Ventura County. The migrant workers were unwilling to seek help because of cultural proscriptions and language barriers. Some were illiterate.

To improve its ability to assist the migrant workers, Ventura County’s disaster crisis counseling project hired peer farm laborers. These workers, who had contacts and credibility within the migrant community, enabled the project to establish a unique communication model to reach farm laborers. The peer counselors went into labor camps and met with the victims of the rains and their indigenous leaders. Local residents noted that these were the first “government” workers in recent memory to be allowed in the farm workers’ camp.

California Final Report, 1998

TABLE 2-3

Staff Attributes, Knowledge, and Skills Essential to Development of Cultural Competence

Personal Attributes

- Genuineness, empathy, and a capacity to respond flexibly to a range of possible solutions
- Acceptance and awareness of cultural differences and cross-cultural dynamics
- Willingness to work with survivors of different cultures
- Ability to articulate one's own values, stereotypes, and biases and to identify how they may accommodate or conflict with the needs of culturally diverse disaster survivors
- Openness to learning about the cultures of diverse groups

Knowledge

- History, tradition, values, and artistic expressions of culturally diverse disaster survivors
- Help-seeking behaviors, informal helping supports, and natural healing practices of survivors of various cultures
- Role of language, speech patterns, and communication styles in culturally distinct communities
- Psychosocial stressors relevant to diverse groups (e.g., migration, acculturation stress, legal and illegal discriminatory patterns, racism, and socioeconomic status)
- Community resources (e.g., agencies, informal helping networks) and their availability to special populations

Skills

- Ability to discuss cultural issues and to respond to culturally-based cues
- Ability to assess the meaning of culture for the disaster survivor
- Ability to interview and assess survivors on the basis of their personal, psychological, social, cultural, political, or spiritual models

(Adapted from: Benedetto, 1998; DHHS, 1998)

PRINCIPLE 4:
PROVIDE ONGOING
CULTURAL
COMPETENCE
TRAINING TO
DISASTER MENTAL
HEALTH STAFF

Cultural competence is an essential component of disaster mental health training programs. Training should be provided to help mental health workers acquire the values, knowledge, skills, and attributes needed to communicate and work in a sensitive, nonjudgmental, and respectful way in cross-cultural situations. Such training should be provided to direct services staff, administrative and management staff, language and sign-language interpreters, and temporary staff.

Cultural competence training programs work particularly well when they are provided in collaboration with community-based groups that offer expertise or technical assistance in cultural competence or in the needs of a particular culture. Involving such groups not only enables program staff to gain firsthand knowledge of various cultures, but also opens the door for long-term partnerships (Hernandez and Isaacs, 1998).

Training should cover basic cultural competence principles, concepts, terminology, and frameworks. For example, training should include discussion of:

- Cultural values and traditions;
- Family values;
- Linguistics and literacy;

Innovative Program Developed for Seniors

Following civil unrest in Los Angeles in 1993, a crisis counseling program was developed to assist the community. One element of this program was peer counseling with senior adults, including a group of elderly Samoans. No mental health professionals from the Samoan population could be found to help address the needs of these monolingual older adults in South Bay. Project staff worked with the head of the Samoan Council of Chiefs to offer a first-of-its-kind peer counselor training delivered via simultaneous translation. It worked beautifully. Twenty Samoans became deeply committed to counseling seniors in their community.

California Final Report, 1994

- Immigration experiences and status;
- Help-seeking behaviors;
- Cross-cultural outreach techniques and strategies; and
- Avoidance of stereotypes and labels (DHHS, 2000e).

Even if the initial training period is of limited duration, participants should have an opportunity to examine and assess values, attitudes, and beliefs about their own and other cultures. Self-assessment helps identify areas where skills need to be developed (DHHS, 1998). Training should stress that people of a given cultural group may react quite differently to disaster, depending on their level of acculturation.

Cultural competence training is a developmental process. Ongoing education—through in-service training and regularly scheduled meetings with project staff to discuss cultural competence

issues—is essential (Hernandez and Isaacs, 1998).

PRINCIPLE 5:
ENSURE THAT
SERVICES
ARE ACCESSIBLE,
APPROPRIATE,
AND EQUITABLE

Survivors are not always receptive to offers of support. For example, some members of cultural groups may be reluctant to take advantage of services because of negative past experiences. Undocumented immigrants may not seek services because they fear deportation. Such individuals may be reluctant or refuse to move to temporary shelters, to accept State or Federal assistance, or to discuss information that they think could be used against them.

Inequitable treatment following disasters may reinforce mistrust of the public services and disaster assistance systems. Following the 1989 Loma Prieta earthquake in California, shelter services in the

more affluent neighborhoods had more community volunteers than survivors. The mayor visited the disaster site in these areas. Less affluent neighborhoods had fewer volunteers, and some volunteers made remarks that the survivors felt were offensive. The mayor did not visit these areas (Dhesi, 1991). Moreover, food and meal preparation in shelters was not culturally appropriate following the earthquake, and many Latinos reported that they became sick from eating the food prepared by the Anglo relief workers (Phillips, 1993).

In studies of Hurricane Andrew's aftermath, racial and ethnic minority group survivors were less likely to have insurance than were white survivors because of practices that exclude certain communities from insurance coverage at affordable rates. Survivors from minority groups were also more likely to receive insufficient settlement amounts (Peacock and Girard, 1997). Concerns related to gender also were investigated after Hurricane Andrew. Many non-English-speaking women of color, especially single women, were subjected to dishonest practices of construction contractors (Enarson and Morrow, 1997).

The delivery of appropriate services is a frequent problem. Racial and ethnic discrimination, language barriers, and stigma associated with counseling services have a negative effect on many individuals' access to and utilization of health and mental health services (Denboba et al., 1998). Families who participated in focus groups reported problems with cultural

and ethnic biases and stereotypes, offensive communication and interactions based on such biases and stereotypes, lack of cross-cultural knowledge, and lack of understanding of the values of various cultural groups (Malach et al., 1996).

Disaster mental health programs must take special care to exercise culturally competent practices. They should make efforts to ensure that staff members speak the language and understand the values of the community. Providing food that has cultural significance can be important. Involving cultural group representatives in disaster recovery committees and program decision making (for example, as members of planning boards or other policy-setting bodies) can help ensure that disaster services are accessible, appropriate, and equitable.

Culturally sensitive outreach techniques also can help ensure that services are accessible and appropriate to all survivors. For example, outreach workers should:

- Allow time for and devote energy to gaining acceptance, take advantage of associations with trusted organizations, and be wary of aligning their efforts with those of agencies and organizations that are mistrusted by cultural groups;
- Determine the most appropriate ways to introduce themselves;
- Recognize cultural variations in expression of emotion, manifestation and description of psychological symptoms, and views about counseling; and

Hurricane Response Designed to Be Culturally Competent

Hurricane Hortense struck Puerto Rico in 1996 with devastating impact. The disaster crisis counseling program was designed to be particularly sensitive to the Puerto Rican culture. For example, recognizing that this culture encourages strong ties with friends and neighbors, the program provided group debriefing sessions.

The project also used cultural celebrations to advance its goals. For example, the festival of the Three Kings Day, which occurs in early January, was used as an opportunity for special outreach in which project staff went door to door “giving asaltos”—a tradition of singing Christmas carols and giving donated gifts—as a way to identify needs and provide information and social support. The project also used dramatization to inform persons in the community about disaster phases and disaster planning.

Puerto Rico Final Report, 1997

- Assist in eliminating barriers by carefully interpreting facts, policies, and procedures.

Table 2-4 addresses special considerations that should be taken into account when counseling refugees.

PRINCIPLE 6:
RECOGNIZE
THE ROLE OF
HELP-SEEKING
BEHAVIORS,
CUSTOMS AND
TRADITIONS,
AND
NATURAL SUPPORT
NETWORKS

Culturally competent disaster mental health services proactively respond to the culturally defined needs of the community. Disruption of many aspects of life and the need to adapt to difficult circumstances cause stress and

anxiety in many survivors. In some cases, these problems can be as difficult as the disaster itself. Effective response requires familiarity with help-seeking behaviors; customs and traditions related to healing, trauma, and loss; and use of natural support networks of various cultural groups.

Help-Seeking Behaviors

Different cultures exhibit different help-seeking behaviors. In many cultures, people turn to family members, friends, or cultural community leaders for help before reaching out to government and private-sector service systems. They may prefer to receive assistance from familiar cultural community leaders or groups rather than unfamiliar service systems. In most communities, churches and other places of worship play a role similar to that of an extended family, and

Special Considerations When Working with Refugees

Refugees may differ from each other and from native populations on several dimensions, including:

Language: Refugees frequently do not speak English well, if at all. This issue presents communication challenges throughout all phases of a disaster.

Culture: Refugees have their own cultures. Because they are new to the United States, they usually are less well-versed in Western culture than are immigrants, who have had more time to understand it.

Economic marginalization and differences: When they arrive in the United States, many refugees can barely manage economically. Many are supporting relatives left at home. On the other hand, some refugees—especially those with education and highly sought skills—find well paying jobs quickly. Thus, although poverty is common among refugees, not all refugees are poor.

Fractured social relations: The communities of origin of many refugees have failed to provide needed security. In addition, many refugees have experienced personal attacks by representatives of their community or the larger society. Some become so disillusioned by this experience that they are reluctant to form new community bonds. In addition, refugees often face within-group schisms. Preexisting ethnic, religious, and political divisions of the society of origin are frequently reinstated in refugee communities formed in the new country.

Some refugees solve the problem by restricting new relationships to the safest ones, for example, by forming or joining small groups of people who emigrated from the same geographic area. When a disaster forces relocation, it can break up this small community and make recovery more problematic (Athey and Ahearn, 1991).

The negative experiences of many refugees also make them suspicious of government. They may be reluctant to seek out or accept assistance following a disaster. Undocumented migrants may fear deportation, but even refugees who have achieved legal status may fear that accepting assistance following a disaster will put them at risk of

deportation. Thus, refugees often are the last group to obtain assistance following disaster.

Experience of traumatic stressors and of loss: Refugees often have experienced horrific events that cause symptoms of Post-Traumatic Stress Disorder. They may have lost family members, their homes, and their possessions, and some have been deprived of sufficient food or water, lacked medical care, or lived in inadequate housing for long periods of time. A disaster can lead to the emotional re-experiencing of these events (Van der Veer, 1995). On the other hand, some refugees may have gained strength and resilience from their previous experiences and bring that strength to the new disaster.

Family dynamics and role changes: Another challenge for many refugee families is that of new family dynamics upon resettlement. Children may have seen their parents fearful, helpless, and stressed during the flight and—upon resettlement—anxious, powerless, and exhausted. Children may come to believe that adults are not to be trusted because they have not seen adults playing a protective and nurturing role.

Intergenerational conflict resulting from differing rates of acculturation presents another family problem. Finally, parents may feel deprived of their role as family heads when they find they must depend on children as language translators or navigators within the new culture (de Monchy, 1991).

De Monchy (1991) identifies three principles for effective service delivery with refugees:

1. Trauma experiences need to be acknowledged.
2. Refugees need to be recognized as successful survivors, and their wisdom and strengths affirmed.
3. Empowerment and the recovery of control need to be encouraged, especially for refugees who are reestablishing parental roles with their children.

survivors turn to them first for assistance.

Many survivors may be reluctant to seek help or may reject disaster assistance of all types. Some people feel shame in accepting assistance from others, including the government, and equate government assistance with “welfare.” Members of racial and ethnic minority groups, including refugees and immigrants, also may be reluctant or afraid to seek help and information from service systems because of historical mistrust of the health, mental health, and human services systems or because of fear of deportation (Aponte, Rivers, and Wohl, 1995). Other groups may prefer to suffer or even perish rather than seek help from people they mistrust. Therefore, building trusting relationships and rapport with disaster survivors is essential to effective crisis counseling.

Those who do seek help may find relief procedures confusing. Feelings of anger and helplessness and loss of self-esteem can result from survivors’ encounters with relief agencies. These feelings result from the survivors’ lack of understanding of the disaster relief system as well as government and private agencies’ often bureaucratic procedures.

Customs and Traditions in Trauma and Loss

Religious and cultural beliefs are important to survivors as they try to sort through their emotions in the

Shamans Counter Bad Luck

In 1995, northern California experienced a series of storms that led to flooding, landslides, and mud debris flow. The State implemented a FEMA-funded crisis counseling program for the victims of the storms. One group affected were Hmong immigrants, persons with a history of war and severe losses. In serving the Hmong population, the program utilized the color red in many printed materials and supplies because Hmong culture includes a belief that red symbolically wards off evil spirits. Another consideration involved the Hmong belief that floods are an omen of doom and that shaman cleansing rituals are needed to counter the bad luck that this omen portends. As a way of acknowledging and respecting this belief, the staff developed and provided a referral list of shamans in the local area.

California Final Report, 1996

aftermath of traumatic events. Beliefs may influence their perceptions of the causes of traumatic experiences. For example, in many cultures, people believe that traumatic events have spiritual causes. These beliefs can affect their receptivity to assistance and influence the type of assistance that they will find most effective. Different populations may elaborate on the cultural meaning of suffering in different ways, but suffering itself is a defining characteristic of the human condition in all societies. In most major religions, including Christianity, Judaism, Islam, Hinduism, and Buddhism, the experience of human misery—resulting from sickness, natural disasters, accidents, violent death, and atrocity—also is a defining feature of the human condition.

Different cultural groups also handle grief in different ways. Family customs, beliefs, and degree of acculturation affect expressions of grief. Disaster mental health workers must recognize that grief rituals, although diverse in nature, can help people return to a reasonable level of functioning. For example, Western tradition holds that grief should be “worked through.” This process includes acceptance of the loss; extinction of behaviors that are no longer adaptive; acquisition of new ways of dealing with others; and resolution of guilt, anger, and other disruptive emotions.

If a community remains intact after a disaster, cultural norms, traditions, and values determine the strategies that the survivors use to deal with the effects. When the entire community is affected, however, cultural mechanisms may be overwhelmed and unable to fulfill their customary functions of regulating emotions and

Alaska Villagers Helped by Tribal Elders

In 1994, severe rains in Alaska resulted in extensive flooding of the Koyukuk River. Three native villages experienced tremendous damage and residents had to be temporarily evacuated. With FEMA funding, the State of Alaska developed a disaster crisis counseling project that included among its staff professionals and paraprofessionals, Alaska Native and non-native staff, and tribal elders. Among the counselors were individuals with cultural sensitivity and respect for the wisdom of the elders. The project organized sewing circles and birchbark basket-making circles in order to use the mechanisms of the culture's social life to assist in its recovery.

Alaska Final Report, 1995

Importance of Culturally Competent Ethnic Workers

Flooding in Florida displaced many residents in 1998. One area that was flooded included a community with a high percentage of African Americans, a majority of whom were living in rental property. Unfortunately, the landlords were less than prompt, thorough, or enthusiastic in making repairs.

The disaster crisis counseling program that was developed in response to the flood employed an African American team leader from the county where most of the affected people lived. She was especially important in accessing community leaders and gatekeepers, helping identify needs of the community, and providing services.

Florida Final Report, 1999

providing identity, support, and resources (DeVries, 1996). Disaster mental health workers can support the healing process by helping rebuild the community's cultural support system. Workers will be most effective when they recognize and understand the importance of culture in the lives of disaster survivors and the beliefs, rituals,

and level of acculturation of the community in which they work.

Customs and Traditions for Healing

Many cultural groups hold beliefs about illness and healing that differ sharply from those held by Western society. People in every culture share beliefs about the causes of illness and ideas about how suffering can

be mitigated. For example, members of some cultures believe that physical and emotional problems result from spiritual wrongdoings in this life or a previous one. They believe that healing requires forgiveness from ancestors or higher spirits. Some people believe that suffering cannot be ameliorated (DeVries, 1996). Others demonstrate stress and emotional conflict through complaints about their physical health.

Traditional healers, such as local herbalists, faith healers, and acupuncturists, play important roles in recovery of mental and physical health within some cultures. In general, the work of healers is based on the principle that the body cannot be isolated from the mind, and the mind cannot be removed from its social context. Disaster mental health workers who interact with cultures in which healers play a key role in health must understand the concepts of integration of body, mind, and spirit when they provide disaster crisis counseling services to diverse populations. They must be able to integrate traditional methods of healing into service delivery (de Monchy, 1991).

Although the crisis counselor may not subscribe to certain cultural healing beliefs, he or she must acknowledge their existence and recognize their importance to some disaster survivors. At the same time, the worker must be alert for any use of dangerous healing practices, such as ingestion of harmful mixtures containing lead or other toxic substances, and take corrective measures. Reestablishing

rituals in appropriate locations is another way to help survivors in the recovery process. Symbolic gathering places, such as churches, mosques, trees, and safe places for meeting after sundown are important in some cultures and are required for certain rituals. After a disaster, survivors may lose access to symbolic places, and this loss may limit their ability to mobilize healing resources. Identifying new locations for rituals can foster social support and facilitate coping mechanisms following disaster (DeVries, 1996).

Disaster mental health workers also may help organize culturally appropriate anniversary activities and commemorations as a way to help survivors mark a milestone in the healing process. Cultural and religious traditions, including special ways of both celebrating and mourning, can be incorporated into such events and may enrich their symbolic meaning and healing potential. Any attempts to facilitate activities involving customs and traditions must be undertaken carefully and only after consultation with members of the involved cultural groups.

Natural Support Networks

In many cultures, the family or kin group is chiefly responsible for its members, and support from kin may be essential in helping individuals overcome grief and trauma. However, when disaster strikes, all members of the extended family may be affected, leaving many people without this customary support network.

Traditions concerning the role of the family, who is included in the family, and who makes decisions vary across cultures (DHHS, 2000e). Elders and extended family play a significant role in some cultures, whereas in other cultures, isolated nuclear families are the decision makers (DHHS, 2000e). Households in racial and ethnic communities are, on average, larger than white households (O’Hare, 1992); they also are more likely to be multigenerational. Asians, for example, are more than twice as likely as whites to live in extended families (O’Hare and Felt, 1991).

Disaster mental health workers must recognize that family support may not be available when entire kin groups are affected. Helping families and friends reunite is one way to ensure mutual support. Likewise, formal support groups can help assure those with limited access to relatives and acquaintances that they are not alone. Individuals who do not relate to support groups because of cultural and linguistic differences may need more individualized services.

Disaster mental health workers also must recognize that in many cultures, the individual cannot be separated from the family and community (Reichenberg and Friedman, 1996). In such cultures, unlike those of Western society, the individual does not exist apart from the group; outreach efforts focused on individuals are, therefore, neither comprehensible nor effective. For example, among some

Asian American and Pacific Islander populations, intervention strategies that diffuse the power of family relationships are especially inappropriate. Mental health workers can assess who is significant in a survivor’s family structure by asking the survivor to describe his or her home, family, and community (Managua, 1998).

PRINCIPLE 7: INVOLVE AS “CULTURAL BROKERS” COMMUNITY LEADERS AND ORGANIZATIONS REPRESENTING DIVERSE CULTURAL GROUPS

Involving “cultural brokers”—community leaders and groups that represent diverse groups—is vital to the success of disaster mental health efforts. Collaborating with organizations and leaders who are knowledgeable about the community is the most effective way of gaining information about the community. Collaboration can assist in assessing needs, creating community profiles, making contact with and gaining the trust of survivors, establishing program credibility, integrating cultural competence in training, and ensuring that strategies and services are culturally competent (DHHS, 1998).

In most communities, and in diverse communities in particular, some of the most influential individuals are cultural group

Did You Know . . .

According to 1990 census data, nearly 14 percent of the Nation's population—32 million people—speak a language other than English in their homes. More than 300 languages are spoken in the United States (Goode et al., 2001).

leaders who possess “insider” knowledge of the community and are willing and able to articulate that knowledge (Hernandez and Isaacs, 1998). These individuals, who may not be immediately visible, can include spiritual leaders, members of the clergy, teachers, civic leaders, local officials, or long-term residents who have the respect and confidence of their neighbors. They often can provide outsiders with the best insights into a local culture's values, norms, customs, conventions, traditions, and expectations (Hernandez and Isaacs, 1998).

Organizations representing various cultural groups and other special interest groups in the community should be invited to participate in disaster mental health programs. These organizations can provide valuable insight during the planning process, serve as a point of entry to the survivor community, and enhance cultural relevance of service delivery. Including individuals from various cultures on planning task forces and committees will help ensure that they concur with the selected strategies.

Should a disaster occur, community-based organizations can provide an important communication link with the cultural groups they represent. For example, churches do much more than serve the spiritual needs of the African American community. They are also the center of political, social, educational, and cultural activities. Therefore, African American ministers may play an important part in mental health outreach and recovery efforts.

Informal, culture-specific groups such as sewing circles and youth sports teams can also be sources of support to disaster survivors. The crisis counseling program staff should identify the most effective ways to work with such groups. Community-based organizations that should be involved include:

- Civic associations;
- Social clubs;
- Neighborhood groups;
- Faith-based organizations;
- Interfaith groups;
- Mutual aid societies;
- Voluntary organizations;

- Health care and social service providers; and

- Nonprofit advocacy organizations (Hernandez and Isaacs, 1998).

To ensure effective use of resources, crisis counselors should coordinate their work with that of other public and private agencies responding to the disaster. The coordinating agency should recognize unique jurisdictional situations that may arise when working with various American Indian and Alaska Native cultures. American Indian and Alaska Native tribes are federally recognized sovereign nations. Disaster mental health agencies should acknowledge the need for a partnership that includes various agencies within tribes, different levels of government, and many tribes working together to improve access to disaster assistance.

Although under the Stafford Act, a State government must request a Presidential disaster declaration on behalf of a tribe, agencies subsequently can work directly with the tribe and with existing authorities and resources to tailor disaster plans to the tribe's unique needs and jurisdictional requirements.

PRINCIPLE 8:
ENSURE THAT
SERVICES AND
INFORMATION ARE
CULTURALLY AND
LINGUISTICALLY
COMPETENT

Language can be a major barrier to service delivery. Survivors who are monolingual, limited in their English, or deaf or hard of hearing

Multiple Methods Employed to Communicate with Asian Groups

Hurricane George caused extensive damage in Alabama in 1998, leaving many people homeless and others with major losses to their homes and businesses. Included among the disaster survivors was an Asian population. The disaster crisis counseling program used several methods to reach and serve them. For example, it developed leaflets in the Cambodian, Laotian, and Vietnamese languages and distributed them to churches serving large numbers of Asian immigrants. The crisis counseling project also employed interpreters, a strategy that was viewed as highly effective in disseminating information to these groups. Finally, the project provided screening and information services to Asian adolescents in a church group.

Alabama Final Report, 1999

may be at a particular disadvantage. Emergency response programs generally have few or no staff trained to work with bilingual populations (Phillips and Ephraim, 1992). For example, most of the information provided immediately after Hurricane Andrew in Florida was available only in English (Yelvington, 1997). As a result, many Latinos and Haitians did not receive needed food, medical supplies, and disaster mental health assistance information.

“Linguistic competence” ensures accurate communication of information in languages other than English. This capability enables an organization and its personnel to communicate effectively with persons of limited English proficiency, those who are illiterate or have low literacy skills, and individuals who are deaf or hard of hearing (Goode et al., 2001). Elements of linguistic competence include the availability of trained bilingual and bicultural staff, translations of educational materials and documents, and sign-language and language interpretation services. Although linguistic competence and cultural competence involve distinct skills, they are intrinsically connected (DHHS, 1999).

Availability of Trained Bilingual and Bicultural Staff

Ideally, disaster mental health workers should be bilingual, bicultural, and from the affected community. However, in many circumstances, workers who are

bilingual but not from the affected culture and community must be hired. In such situations, communication challenges may arise, even though the disaster worker or interpreter speaks the same language as the survivors. Examples or related issues follow.

- Disaster mental health workers may be responsible for assisting survivors who have a language pattern that is different from their own. Dialects, in addition to colloquialisms and accents, can be difficult to understand and communication barriers can result.
- Words may have different meanings even among people who share a language. Rogers (1992) noted difficulty in communicating disaster information between members of the United States Army and people in a native Polynesian culture because, although they both

spoke English, the two groups did not assign a common meaning to certain words and phrases. The language differences led to frustration and a breakdown of credibility.

- Bilingual disaster survivors who primarily speak Spanish may be more withdrawn when interviewed in English rather than in Spanish. An individual’s speech pattern may be halting or disrupted and expression of affect may be reduced when the person is required to speak in a language other than his or her primary language. In such situations, the disaster worker’s assessment of the survivor’s issues and needs can be distorted. Ideally, the preferred or primary language of bilingual disaster survivors should be used in delivering outreach and other services (Aponte et al., 1995).

Program managers must be cautious in selecting bilingual staff members and interpreters. Those who are bilingual also must understand nonverbal and cultural patterns to communicate effectively. Bilingual staff members should demonstrate bilingual proficiency and undergo cultural competence training (DHHS, 2000a).

Dissemination of Educational Information

Written information should be translated³ into multiple languages, as appropriate for the community to be served. The literacy level of the target population must be considered when developing written materials. Any written materials should be supplemented with other forms of information (DHHS, 2000a). For example, messages may be conveyed by radio or through announcements at churches and other community centers. Most localities now have television stations that broadcast in the languages of various cultural groups. Although these communications media should be used, it is important to note that some people do not have access to television and may depend on radio broadcasts for information.

Crisis support programs should establish relationships with multi-cultural television stations, radio stations, and newspapers before a disaster occurs. In addition, program staff should invite television and radio station personnel to participate

in the development of a disaster communications plan.

The information needs of people who are deaf or hard of hearing also must be considered. Closed-captioned television, for example, is a critical communication tool for this population. The Federal Communications Commission requires that all emergency information presented on television be accessible to persons who are deaf or hard of hearing.

Language and Sign-Language Interpretation

Language interpretation may be used when the language barrier is so great that communication between mental health workers and survivors is not possible or when no bilingual staff can be hired. Sign-language interpretation also must be considered when developing communication strategies.

Although language interpreters may be the only viable option in some situations, hiring bilingual staff members remains the preferred solution. Van der Veer (1995) notes that an interpreter's behavior may evoke certain feelings in the disaster survivor. Factors such as the interpreter's gender, age, or level of acculturation may affect the survivor's willingness to speak openly. Disaster survivors may be ashamed of mental health problems that are considered a sign of madness or a cause for contempt in their cultures. They also may distrust interpreters who are from

the same country and speak the same language, but who have different political or religious backgrounds (Van der Veer, 1995).

Interpreters should be trained to accurately convey the tone, level, and meaning of the information presented in the original language. Without adequate training, interpreters may interpret information inaccurately or incompletely. The most common problems include changing open-ended questions into leading questions, altering the content of questions, and adding comments. Problems in interpreting answers include leaving out part of the answer, adding something to the answer, and making mistakes because of limited understanding of English (Van der Veer, 1995).

When working with refugees, mental health workers should be aware that interpreters might have experienced traumatic events similar to those experienced by the refugees. In such situations, the interpreter may want to avoid reliving unhappy or traumatic memories. Thus, the interpreter may present information inaccurately, evade certain topics, change the subject, or tell the mental health worker that the interview is too stressful for the disaster survivor (Westermeyer, 1989). Table 2-5 provides useful guidelines for using interpreters.

³ Interpretation is the oral restating in one language of what has been said in another language. Translation typically refers to the conversion of written materials from one language to another (Goode et al., 2001).

TABLE 2-5

Guidelines for Using Interpreters

The following guidelines should be considered when using language interpreters (Bamford, 1991; Gaw, 1993; Paniagua, 1998; Westermeyer, 1989):

- Before hiring interpreters, attempt to identify mental health workers who speak the language spoken by survivors and who identify with the survivors' culture.
- Hire certified, qualified interpreters who share the survivor's racial and ethnic background.
- Determine the survivor's dialect before asking for an interpreter.
- Compare the level of acculturation of the interpreter with that of the survivor. If it is not similar, effective communication may not be possible because Western values may be reflected in the interpreter's comments.
- Introduce the interpreter to the disaster survivor, and allow time for them to build trust through informal conversation.
- Take time for translation. Use a sequential mode of interpretation—that is, the disaster survivor speaks, the interpreter interprets what has been said into English, the disaster mental health worker speaks, and the interpreter speaks again.
- Do not use survivors' friends and relatives, including their children, as interpreters. The survivor may not feel comfortable expressing concerns of a personal nature to relatives and friends. Using children can reverse the hierarchical role of parents and place burdens on children. Moreover, such responsibility may require skills beyond the child's current stage of development and be too stressful for the child (DHHS, 2000c).

PRINCIPLE 9: ASSESS AND EVALUATE THE PROGRAM'S LEVEL OF CULTURAL COMPETENCE

Self-assessment and process evaluation are keys to ensuring that disaster mental health services are as effective as possible and to making maximum use of resources. Self-assessment helps programs identify organizational problems that may impede the delivery of culturally competent services. The self-assessment tool presented in Table 2-6 may be used in conjunction with the Cultural Competence Checklist for Disaster Crisis Counseling Programs, presented in Appendix F. The Cultural Competence Continuum (Figure 1-1) is another useful tool for assessing a program's level of cultural competence.

Process evaluation helps ensure that the disaster mental health program stays on course. It also can identify problems or gaps in providing culturally competent services. Involving representatives from as many cultural groups as possible in process evaluation ensures that diverse cultural groups or group perspectives are heard and understood.

The program can use a variety of techniques for collecting information for process evaluations. For example, staff might create an evaluation task force or advisory group or a discussion or focus group that includes representatives of different cultural groups. A group that includes a disaster survivor perspective, as well as



TABLE 2-6

A Cultural Competence Self-Assessment for Disaster Crisis Counseling Programs

Six elements are needed to ensure cultural competence of mental health agencies (Bernard, 1998). Programs can use these elements to assess their level of cultural competence as well.

Leadership

- Are the leaders of the program committed to cultural competence?
- Does the project manager hold staff accountable for knowledge of the provision of appropriate services to all disaster survivors?

Understanding of cultural competence

- Has the program staff developed a common understanding of cultural competence and do they clearly and frequently communicate that understanding to others?

Organizational culture

- Does the crisis counseling program promote and encourage cultural competence?
- Is the program administered by an organization with a strong commitment to and history of working toward cultural competence?
- Are policies, procedures, and systems in place for delivering interpretation, bilingual, or translation services?

Training

- Have all crisis counseling staff members been trained in cultural competence, and are they familiar with the diverse cultural and ethnic groups in the community?
- Are training programs ongoing?

- Are regular meetings convened and educational opportunities offered for staff members to discuss cultural competence issues and concerns, build cross-cultural skills, and develop strategies?

Cultural competence plan

- Has the program identified goals designed to address the mental health needs of the community in a culturally competent manner?
- Has the program explored various methods of working with disaster survivors in a way that respects and is sensitive to the needs of all groups in the community?
- Has the program established partnerships with community-based agencies that serve cultural and ethnic groups for input on needs assessment, program planning, and evaluation?
- Has the program developed a mechanism to acquire knowledge about the customs, values, and beliefs of special populations?

Managing the plan

- Has a person or group been identified to evaluate the success of the program in addressing cultural competency issues?
- Have methods been instituted to recognize innovations in serving culturally distinct groups and implement those innovations project-wide?

representatives of partner agencies, can provide qualitative information and innovative ideas that can help the crisis counseling program more effectively address the community's cultural needs. Evaluation methods should be consistent with the cultural norms of the groups being served. Evaluators should be sensitive to the culture and familiar with the culture whenever possible and practical (DHHS, 2001).

Program staff should regularly communicate process evaluation findings to key informants and cultural groups engaged in the project and in the evaluation in order to ensure their ongoing support.

Developing a culturally competent disaster crisis counseling program requires commitment and diligence. The rewards of such dedication are at the heart of the program—effective and appropriate services to help disaster survivors recover and heal.

Bilingual and Bicultural Staff Assist in Assuring Cultural Competence

Late winter storms in California in 1995 affected several ethnic groups in Fresno County. The county crisis counseling project sought to deliver services in a bilingual, bicultural manner. Staff members were assigned to match the ethnic and cultural attributes of each community; for example, Spanish-English speakers primarily concentrated in one area of the county, while Hmong-English speakers were deployed to another area. Brochures and other forms of written information were translated into both Hmong and Spanish. Interpreters were used to reach persons who spoke Punjabi, Armenian, and Chinese. The project also arranged to provide oral translations of handouts for those who were illiterate.

California Final Report, 1995

Information Dissemination for Deaf and Hard-of-Hearing Populations Improved

In September 1999, Hurricane Floyd arrived in North Carolina, causing the most devastating flooding the State had ever experienced. Outreach efforts organized through the "Hope After Floyd" program helped thousands of residents to deal with the hurricane's aftermath.

Outreach workers reported particular success in providing crisis counseling services to individuals who were deaf and hard of hearing, many of whom experienced fear and stress associated with the lack of access to information provided through television or radio. Following the disaster, project staff provided in-service training and consultation to emergency management agency officials on the needs of the deaf and hard-of-hearing populations, and worked to ensure that the Federal Communications Commission required broadcast stations to provide closed-captioned emergency information.

North Carolina Site Visit Report, 2000

References



- American Red Cross/Disaster Services. (2000). Retrieved February 2000. www.redcross.org.
- Aponte, J., Rivers, R., and Wohl, J. (1995). *Psychological Interventions and Cultural Diversity*. Boston, Massachusetts: Allyn and Bacon.
- Aptekar, L. (1990). A comparison of the bicoastal disasters of 1989. *Behavior Science Research*, 24(1-4), 73-104.
- Athey, J. L., and Ahearn, F. L. (1991). The mental health of refugee children: An overview. In F. L. Ahearn and J. L. Athey (Eds.), *Refugee Children: Theory, Research and Services* (pp. 3-19). Baltimore, MD: The Johns Hopkins University Press.
- Bamford, J. (1991). Pre-school hearing, speech, language and vision screening. *Effective Health Care* 4(2). York: NHS Centre for Reviews and Dissemination.
- Bazron, B., and Scallet, L. (1998). *The Impact of Culturally and Linguistically Appropriate Services on Access To Care in a Managed Behavioral Health Care Environment*. Fairfax, VA: The Lewin Group.
- Beiser, M. (1990). Mental health of refugees in resettlement countries. In mental health of immigrants and refugees. *Proceedings of a Conference Sponsored by Hogg Foundation for Mental Health and World Federation for Mental Health*. Austin: University of Texas.
- Benedetto, R. (1998, June). Introduction to special populations and migrant/farm workers. Training conducted at the Annual FEMA/CMHS Crisis Counseling Assistance and Training Workshop, Emmitsburg, Maryland.
- Bernard, J. A. (1998). Cultural competence plans: A strategy for the creation of a culturally competent system of care. In M. Hernandez and M. Isaacs (Eds.), *Promoting Cultural Competence in Children's Mental Health Services*. Baltimore, MD: Brookes Publishing Company.
- Blaikie, P., Cannon, T., David, I., and Wisner, B. (1994). *At Risk: Natural Hazards, People's Vulnerability, and Disasters*. New York: Routledge.
- Blanchard-Boehm, D. (1997). *Risk Communication in Southern California: Ethnic and Gender Response to 1995 Revised, Upgraded Earthquake Probabilities*. Boulder, CO: Natural Hazards Research and Applications Information Center.
- Bolin, R. (1985). Disaster characteristics and psychosocial impacts. In Sowder, B. J. (Ed.), *Disasters and Mental Health: Selected Contemporary Perspectives*. Washington, DC: U.S. Government Printing Office.
- Bolin, R., and Stanford, L. (1998). The Northridge earthquake: Community-based approaches to unmet recovery needs. *Disasters*, 22(1), 21-38.
- Bolin, R., and Stanford, L. (1991). Shelter, housing and recovery: A comparison of U.S. disasters. *Disasters*, 15(1), 24-34.
- Bolton, P. A., Liebow, E. B., and Olson, J. L. (1993). Community context and uncertainty following a damaging earthquake: Low-income Latinos in Los Angeles, California. *The Environmental Professional*, 15, 240-47.
- Cross, T. L. (1989). *Towards a Culturally Competent System of Care. Vol. I: A Monograph of Effective Services for Children who are Severely Emotionally Disturbed*. Washington, DC: Georgetown University Child Development Center.
- Day, J. C. (1996). Population projections of the United States by age, sex, race, and Hispanic origin: 1995 to 2050. U.S. Bureau of the Census, Current Population Reports, No. P25-1130. Washington, DC: U.S. Government Printing Office.
- De Monchy, J. L. (1991). Recovery and rebuilding: The challenge for refugee children and service providers. In F. L. Ahearn and J. L. Athey (Eds.), *Refugee Children: Theory, Research and Services* (pp. 163-180). Baltimore, MD: The Johns Hopkins University Press.
- Denboba, D. (1993). MCHB/DSCSHCN guidance for competitive applications: Maternal and child health improvement projects for children with special health care needs. Rockville, MD: Health Resources and Services Administration, U.S. Department of Health and Human Services.
- Denboba, D., Bragdon, J., Epstein, L., Garthright, K., and Goldman, T. (1998). Reducing health disparities through cultural competence. *Journal of Health Education*, 29(5, Suppl.), 47-53.
- DeVries, M. (1996). Trauma in cultural perspective. In B. Van der Kolk, A. D. McFarlane and L. Weisaeth (Eds.), *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society*. New York: Guilford Press.

- Dhesi, N. (1991). *The Social Impacts of the 1906 and 1989 Earthquakes*. Unpublished manuscript, University of Colorado, Boulder.
- Dynes, R. R., Tierney, K. J., and Fritz, C. E. (1994). The emergence and importance of social organizations: The contributions of E. L. Quarantelli. In R. R. Dynes and K. J. Tierney (Eds.), *Disasters, Collective Behavior, and Social Organization*. Newark: University of Delaware Press.
- Enarson, E., and Morrow, B. H. (1997). A gendered perspective: The voices of women. In W. G. Peacock, B. H. Morrow and H. Gladwin (Eds.), *Hurricane Andrew: Ethnicity, Gender, and the Sociology of Disasters*. Routledge, New York.
- Erikson, K. (1976). Loss of communality at Buffalo Creek. *American Journal of Psychiatry*, 133, 302-305.
- Evans, J. (1996). *Journey Towards Cultural Competency: Lessons Learned*. Texas Department of Health, Center on Cultural Competency. Washington, DC: Maternal and Child Health Bureau, Health Resources and Services Administration.
- Federal Emergency Management Agency (2000). FEMA/Declared Disasters/Library. February 2000. www.fema.gov.
- Fothergill, A., Maestas, E. G. M., and Darlington, J. D. (1999). Race, ethnicity and disasters in the United States: A review of the literature. *Disasters* 23(2), 156-173.
- Gaw, A. (1993). *Culture, Ethnicity, and Mental Illness*. Washington, DC: American Psychiatric Press.
- Giger, J., and Davidhizar, R. (1999). *Transcultural Nursing: Assessment and Intervention* (3rd ed.). St. Louis: Mosby Year Book.
- Goode, T., Sockalingam, S., Brown, M., and Jones, W. (2001). *Policy Brief 2: Linguistic Competence in Primary Health Care Delivery Systems: Implications for Policy Makers*. Washington, DC: National Center for Cultural Competence.
- Hernandez, M., and Isaacs, M. (1998). *Promoting Cultural Competence in Children's Mental Health Services*. Baltimore, MD: Paul H. Brookes Publishing.
- Malach, R., Nelkin, V. S., and Jones, D. A. (1996). *Family Perspectives: Cultural/Ethnic Issues Affecting CSHCN-Educational Fact Packets*. Bernalillo, NM: Southwest Communications Resources.
- National Institute of Mental Health (1983). *Training Manual for Human Service Workers in Major Disasters* (Pub. No. ADM 83-538). Washington, DC: U.S. Department of Health and Human Services.
- O'Hare, W. (1992). America's minorities—The demographics of diversity. *Population Bulletin*, 46(4). Washington, DC: Population Reference Bureau.
- O'Hare, W., and Felt, J. (1991). Asian Americans: America's fastest growing minority group (*Population Trends and Public Policy, No. 19*). Washington, DC: Population Reference Bureau.
- Paniagua, F. (1998). *Assessing and Treating Culturally Diverse Clients*. Thousand Oaks, CA: Sage Publications.
- Peacock, W. P., and Girard, C. (1997). Ethnic and racial inequalities in hurricane damage and insurance settlements. In W. G. Peacock, B. H. Morrow and H. Gladwin (Eds.), *Hurricane Andrew: Ethnicity, Gender, and the Sociology of Disasters*. New York: Routledge.
- Perry, H. S., and Lindell, M. K. (1991). The effects of ethnicity on decision-making. *International Journal of Mass Emergencies and Disasters*, 9(1), 47-68.
- Perry, H. S., and Mushkatel, A. H. (1986). *Minority Citizens in Disasters*. Athens: University of Georgia Press.
- Perry, H. S., and Perry, S. E. (1959). *Schoolhouse Disasters: Family and Community as Determinants of the Child's Response to Disaster*. Washington, DC: National Academy of Sciences, National Research Council.
- Phillips, B. D. (1993). Cultural diversity in disasters: Sheltering, housing, and long-term recovery. *International Journal of Mass Emergencies and Disasters*, 11(1), 99-110.
- Phillips, B. D., and Ephraim, M. (1992). Living in the aftermath: Blaming processes in the Loma Prieta earthquake (Working Paper No. 80.). Boulder: IBS, Natural Hazards Research and Applications Information Center, University of Colorado.
- Reichenberg, D., and Friedman, S. (1996). Traumatized children: Healing the invisible wounds of war: A rights approach. In Y. Daniel, N. S. Rodley and L. Weisaeth (Eds.), *International Response to Trauma Stress*. Amityville, NY: Baywood.

- Roberts, R., et al. (1990). *Developing Culturally Competent Programs for Families of Children with Special Needs*. Washington, DC: Georgetown University Child Development Center.
- Rotter, J. B. (1966). Generalized expectancies for internal versus external control of reinforcement. *Psychological Monographs*, 80(1), 1-28.
- Taylor, T., et al. (1998). *Training and Technical Assistance Manual for Culturally Competent Services and Systems: Implications for Children with Special Health Care Needs*. Washington, DC: National MCH Center for Cultural Competence, Georgetown University Child Development Center.
- Ursano, R. J., Fullerton, C. S., and McCaughey, B. G. (1994). Trauma and disaster. Exposure to traumatic death: The nature of the stressor. In R. J. Ursano, C. S. Fullerton and B. G. McCaughey (Eds.), *Individual and Community Responses to Trauma and Disaster: The Structure of Human Chaos* (pp. 3-27). Cambridge, UK: Cambridge University Press.
- Ursano, R. J., and McCarroll, J. E. (1994). Exposure to traumatic death: The nature of the stressor. In R. J. Ursano, C. S. Fullerton and B. G. McCaughey (Eds.), *Individual and Community Responses to Trauma and Disaster: The Structure of Human Chaos* (pp. 46-71). Cambridge, UK: Cambridge University Press.
- U.S. Department of Commerce, Bureau of the Census, Population Division (1996). *1993 States: Middle Series Projections by Sex, Race, and Hispanic Origin, with Median Age*. Washington, DC: Population Division, U.S. Bureau of the Census.
- U.S. Department of Commerce, Bureau of the Census (2000). *Projections of the Resident Population by Race, Hispanic Origin, and Nativity: Middle Series, 1999 to 2100*. Washington, DC: U.S. Department of Commerce.
- U.S. Office of Management and Budget (1997). Revisions to the standards for the classification of Federal data on race and ethnicity. Available at: www.whitehouse.gov/omb/fedreg/ombdir15.html.
- U.S. Office of Management and Budget (2000). Guidance on aggregation and allocation of data on race for use in civil rights monitoring and enforcement (OMB Bulletin No. 00-02). Available at: www.whitehouse.gov/omb/bulletins/b00-02.html.
- U.S. Department of Health and Human Services (2000a). *Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-focused Research Agenda*. The Office of Minority Health, Office of Public Health and Science, Washington, DC. Available at: www.omhrc.gov/CLAS.
- U.S. Department of Health and Human Services (1999). *Cultural Competence: A Journey*. Rockville, MD: U.S. Department of Health and Human Services (no publication number). Bureau of Primary Health Care, Health Resources and Services Administration.
- U.S. Department of Health and Human Services (1998). *Cultural Competence Monograph Series*. Cultural competence for health care professionals working with African-American communities: Theory and practice (Pub. No. 98-3238). Bureau of Primary Health Care, Health Resources and Services Administration; Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration; and the Office of Minority Health.
- U.S. Department of Health and Human Services (2000b). *Cultural Competence Standards*. In *Managed Mental Health Care Services: Four Underserved/Underrepresented Racial/Ethnic Groups* (Pub. No. SMA 00-3457). Rockville, MD: U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
- U.S. Department of Health and Human Services (1999). *Disaster Mental Health: Crisis Counseling Programs for the Rural Community* (Pub. No. SMA 99-3378). Rockville, MD: U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
- U.S. Department of Health and Human Services (1998). *Family-based or Cultural Competence Systems of Health Care*. U.S. Department of Health and Human Services (no publication number). Bureau of Primary Health Care, Health Resources and Services Administration.
- U.S. Department of Health and Human Services (2001). *Guidelines to Help Assess Cultural Competence in Program Design, Application, and Management*. U.S. Department of Health and Human Services (no publication number). Bureau of Primary Health Care, Health Resources and Services Administration.

- U.S. Department of Health and Human Services (2001). *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General* (Pub. No. SG-CRE-EXEC). Rockville, MD: U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
- U.S. Department of Health and Human Services (2000c). *Psychosocial Issues for Children and Adolescents in Disasters* (2nd ed.) (Pub. No. ADM 86-1070R). Rockville, MD: U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
- U.S. Department of Health and Human Services (2000d). *Quality Health Services for Hispanics: The Cultural Competency Component* (Pub. No. 99-21). Rockville, MD: U.S. Department of Health and Human Services. Health Resources and Services Administration, Office of Minority Health, and Substance Abuse and Mental Health Services Administration.
- U.S. Department of Health and Human Services. *Disaster Response and Recovery: A Strategic Guide* (Pub. No. SMA 94-3010R). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (Rev. ed. in press.)
- U.S. Department of Health and Human Services (2000e). *Training Manual for Mental Health and Human Service Workers in Major Disasters* (2nd ed.) (Pub. No. ADM 90-538). Rockville, MD: U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
- Van der Veer, G. (1995). Psychotherapeutic work with refugees. In R. J. Kleber, C. R. Figley, and B. P. R. Gersons (Eds.), *Beyond Trauma: Cultural and Societal Dynamics* (pp. 151-169). New York: Plenum Press.
- Watson, O. M. (1980). *Proxemic Behavior: A Cross-cultural Study*. The Hague, The Netherlands: Mouton.
- Westermeyer, J. (1989). Cross-cultural care for PTSD: Research, training, and service needs for the future. *Journal of Traumatic Stress, 2*, 515-536.
- Wisner, B. (1993). Disaster vulnerability: Scale, power and daily life. *GeoJournal 30*(2), 127-40.
- Yelvington, K. A. (1997). Coping in a temporary way: The tent cities. In W. G. Peacock, B. H. Morrow and H. Gladwin (Eds.), *Hurricane Andrew: Ethnicity, Gender, and the Sociology of Disasters*. New York: Routledge.

CRISIS COUNSELING
PROGRAM REPORTS

The Emergency Mental Health and Traumatic Stress Services Branch reviews reports from States that have received funding under the Robert T. Stafford Disaster Relief and Emergency Assistance Act. The following reports were reviewed for this publication:

- Alabama, Hurricane George, 1998
FEMA-1250-DR
- Alaska, Storms and Floods, 1994
FEMA-1039-DR
- California, Civil Unrest, 1994
FEMA-942-DR
- California, Northridge Earthquake, 1994
FEMA-1008-DR
- California, Late Winter Storms, 1995
FEMA-1046-DR
- California, Flooding, 1998
FEMA-1203-DR
- California, El Nino Storms, 1998
FEMA-1203-DR
- Florida, Severe Storms, 1999
FEMA-1204-DR
- Guam, Super Typhoon, 1997
FEMA-1193-DR
- Minnesota, Storms and Floods, 1993
FEMA-995-DR
- North Carolina, Hurricane Floyd, 1999
FEMA-1292-DR
- Oklahoma, Oklahoma City Bombing, 1995
FEMA-1048-DR
- Puerto Rico, Hurricane Hortense, 1997
FEMA-1136-DR
- South Dakota, Severe Storms, 1997
FEMA-1156-DR

Appendices



Appendix A:

Cultural Competence Resources and Tools

- American Psychological Association (1990). *APA Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations*. Washington, DC: American Psychological Association.

Offers recommendations on working with ethnic and culturally diverse populations to providers of psychological services.
- Child Welfare League of America (1993). *Cultural Competence Self-assessment Instrument*. Washington, DC: Child Welfare League of America.

A tool designed to help organizations providing family services identify, improve, and enhance cultural competence in staff relations and client service functions. The instrument, which has been field-tested, provides a practical, easy-to-use approach to addressing the major issues associated with delivering culturally competent services.
- Cohen, R. (1992). Training mental health professionals to work with families in diverse cultural contexts. *Responding to Disaster: A Guide for Mental Health Professionals*. Washington, DC: American Psychiatric Press, Inc.

Explores cultural considerations for mental health workers and disaster survivors in the immediate and longer-term aftermath of a disaster. Examines issues of loss, mourning, separation, coping, and adaptation as they relate to disaster survivors from various cultures.
- Cross, T. L. (1989). *Towards a Culturally Competent System of Care. Vol. I: A Monograph of Effective Services for Minority Children who are Severely Emotionally Disturbed*. Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center.

One of the first documents to provide practical information on operationalizing cultural competence. Provides definitions for competence, introduces the concept of a cultural competence continuum, and provides information that can be used at individual and organizational levels.
- Giger, J., and Davidhizar, R. (1999). *Transcultural Nursing: Assessment and Intervention*. St. Louis, MO: Mosby, Inc.

Provides tools that can be used to evaluate cultures' perceptions and needs related to communication, space, social organization, time, environmental control, and biological variations. Giger and Davidhizar were among the first to develop the concept of cultural competence in the nursing profession. Now in its third printing, the publication is used by a number of other disciplines.
- Goode, T. D. (1999). *Getting Started: Planning, Implementing and Evaluating Culturally Competent Service Delivery Systems in Primary Health Care Settings, Implications for Policy Makers and Administrators*. Washington, DC: Georgetown University, National Center for Cultural Competence.

A checklist that can assist programs and organizations in initiating strategic development of policies, structures, procedures, and practices that support cultural and linguistic competence.
- Health Resources and Services Administration (1998). *Health Care Rx: Access for All*. Washington, DC: Health Resources and Services Administration.

A chart book that provides a picture of the health of racial and ethnic minority Americans and the cascade of factors that limit access to health care, hamper workforce diversity, and limit culturally competent services.
- Hernandez, M., and Isaacs, M. (1998). *Promoting Cultural Competence in Children's Mental Health Services*. Baltimore, MD: Paul H. Brookes Publishing.

Provides an excellent framework for developing a culturally competent mental health system. Focuses on the need to develop organizational infrastructures that support and further cultural competence and the need to ensure that programs are meaningful at the community and neighborhood levels. Also addresses special issues related to serving culturally diverse populations. Designed for planners, program

managers, policy makers, practitioners, parents, teachers, researchers, and others who are interested in improving mental health services for families.

- Hicks, Noboa-Rios (1998). *Cultural Competence in Mental Health: A Study of Nine Mental Health Programs in Ohio*. Columbus, OH: Outcomes Management Group, Ltd.

Provides an assessment of nine culturally competent programs that were funded to encourage the provision of cultural sensitivity training to the mental health community and to develop nontraditional, culturally sensitive methods of delivering services to persons of color. Prepared for the Multi-Ethnic Behavioral Consortium of the Ohio Department of Mental Health.

- Nader, K., Dubrow, N., and Stamm, H. (1999). *Honoring Differences: Cultural Issues in the Treatment of Trauma and Loss*. Ann Arbor, MI: Brunner/Mazel.

Discusses the treatment of trauma and loss while recognizing the importance of understanding the cultural context in which the mental health professional provides assistance.

- Perkins, J., Simon, H., Cheng, F., et al. (1998). *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities*. Los Angeles, CA: National Health Law Program.

An informative discussion on linguistic issues that can impede effective service delivery. Covers the importance of language access, use of community volunteers, limitations of interpretation, linguistic barriers in mental health, and effective use of written materials.

- Substance Abuse and Mental Health Services Administration (2000). *Cultural Competence Standards in Managed Mental Health Care for Underserved/Underrepresented Racial/Ethnic Groups*. Washington, DC: Western Interstate Commission for Higher Education and Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Provides information on cultural competence guidelines, performance indicators, and potential outcomes in the areas of triage and assessment,

care planning, treatment plans, treatment services, communication styles, and cross-cultural linguistic and communication support.

- Substance Abuse and Mental Health Services Administration (2000). Cultural strengths and challenges in implementing a system of care model in American Indian communities. *Systems of Care: Promising Practices in Children's Mental Health* (2000 Series, Vol. 1). Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

Examines promising practices of five American Indian children's mental health projects that integrate traditional American Indian helping and healing methods with the systems of care model.

- U.S. Department of Health and Human Services (1992-1999). *Cultural Competence Series*.

Monograph series sponsored by Bureau of Primary Health Care, Health Resources and Services Administration; Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration; and Office of Minority Health.

- Van der Veer, G. (1995). *Psychotherapeutic Work with Refugees*. New York: Plenum Press.

Suggests that the trauma that a refugee experiences in a disaster may not be an isolated incident, but part of a series of ongoing traumatic events. Stresses that overcoming cultural difference is essential in working with traumatized refugees and that such work requires creatively adjusting a variety of existing techniques.

Appendix B:

Disaster Mental Health Resources from the Center for Mental Health Services (CMHS)

The following publications and videos on disaster response and recovery planning for special populations were developed by the Emergency Mental Health and Traumatic Stress Services Branch of CMHS. To download these documents or order copies, please visit the Substance Abuse and Mental Health Services Administration (SAMHSA) Web site at www.samhsa.gov.

PUBLICATIONS

- ADM 86-1070R *Psychosocial Issues for Children and Adolescents in Disasters*
- ADM 90-538 *Training Manual for Mental Health and Human Service Workers in Major Disasters, Second Edition*
- SMA 94-3010R *Disaster Mental Health Response and Recovery: A Strategic Guide (May not be available; revised edition in press)*
- SMA 95-3022 *Psychosocial Issues for Children and Families: A Guide for the Primary Care Physician*
- SMA 96-3077 *Responding to the Needs of People with Serious and Persistent Mental Illness in Times of Major Disaster*
- SMA 99-3323 *Psychosocial Issues for Older Adults in Disasters*
- SMA 99-3378 *Crisis Counseling Programs for the Rural Community*

VIDEOS

- ESDRB-2 Children and Trauma: The School's Response
- OM 00-4070 Voices of Wisdom: Seniors Cope with Disaster
- OM 00-4070S Voices of Wisdom: Seniors Cope with Disaster (Spanish Version)
- OM 00-4071 Hurricane Andrew: The Fellowship House Experience

GENERAL MATERIALS

CMHS Program Guidance Series

Appendix C:

Sources of Demographic and Statistical Information

The following World Wide Web resources offer demographic and statistical information useful for developing disaster mental health community profiles:

STATISTICS ABOUT IMMIGRATION PATTERNS

**Immigration and Naturalization Service,
U.S. Department of Justice:**

[http://uscis.gov/graphics/shared/aboutus/
statistics/index.htm](http://uscis.gov/graphics/shared/aboutus/statistics/index.htm)

NATIONAL, STATE, AND COUNTY STATISTICS AND DEMOGRAPHIC DATA BY AGE, RACIAL, ETHNIC, AND LINGUISTIC SUBGROUPS

U.S. Bureau of the Census:

www.census.gov/population/www/index.html

UNEMPLOYMENT INFORMATION BY GENDER, RACE, AND AGE

Bureau of Labor Statistics:

<http://stats.bls.gov/>

DEMOGRAPHIC INFORMATION BY ZIP CODE

PeopleSpot:

[http://peoplespot.com/statistics/
demographics.htm](http://peoplespot.com/statistics/demographics.htm)

GENERAL INFORMATION

**Government Information Sharing Project,
Oregon State University:**

<http://govinfo.kerr.orst.edu/index.html>

**National Center for Health Statistics,
Centers for Disease Control and Prevention:**

www.cdc.gov/nchs/

Federal Healthfinder®:

www.healthfinder.gov/

Appendix D:

Sources of Assistance and Information

FEDERAL GOVERNMENT ORGANIZATIONS AND RESOURCES

Federal Emergency Management Agency (FEMA)

FEMA coordinates with other State and Federal agencies to respond to presidentially declared disasters. It provides disaster assistance for individuals, businesses (through the Small Business Administration), and communities (through the Robert T. Stafford Disaster Relief and Emergency Assistance Act).

Federal Emergency Management Agency
Human Services Division
500 C Street, SW
Washington, DC 20472
Phone: 202-566-1600
www.fema.gov

Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA)

Through an interagency agreement with FEMA, CMHS provides consultation and technical assistance for the Crisis Counseling Assistance and Training Program. Publications and videotapes on disaster human response are available through SAMHSA's National Mental Health Information Center.

Center for Mental Health Services
Emergency Mental Health and Traumatic Stress
Services Branch
5600 Fishers Lane
Room 17C-20
Rockville, MD 20857
Phone: 301-443-4735
Fax: 301-443-8040
www.samhsa.gov

SAMHSA's National Mental Health
Information Center
P.O. Box 42557
Washington, DC 20015
Phone: 1-800-789-2647
Fax: 301-984-8796
TDD: 1-866-889-2647
www.mentalhealth.samhsa.gov/

Federal Communications Commission (FCC)

445 12th Street, SW
Washington, DC 20554
Phone: 202-418-1771 or 1-888-225-5322
TTY: 202-418-2520 or 1-888-835-5322
Fax: 202-418-0710 or 1-866-418-0232
www.fcc.gov

Health Resources and Services Administration (HRSA)

Office of Minority Health
5600 Fishers Lane
Room 14-48
Rockville, MD 20857
Phone: 301-443-3376 or 1-888-275-4772
www.hrsa.gov

Indian Health Service (IHS)

Office of Public Health
The Reyes Building
801 Thompson Avenue
Suite 400
Rockville, MD 20852-1627
Phone: 301-443-3024
www.ihs.gov

National Institute on Deafness and Other Communication Disorders (NIDCD)

31 Center Drive
MSC 2320
Bethesda, MD 20892
Phone: 301-496-7243
www.nidcd.nih.gov

NIDCD Information Clearinghouse

1 Communication Avenue
Bethesda, MD 20892
Phone: 1-800-241-1044
TTY: 1-800-241-1055
www.nidcd.nih.gov

Office for Civil Rights

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F
Hubert H. Humphrey Building
Washington, DC 20201
Phone: 202-619-0257 or 1-877-696-6775
www.hhs.gov/ocr

Office of Public Health and Science

U.S. Office of Minority Health Resource Center

U.S. Department of Health and Human Services
P.O. Box 37337
Washington, DC 20013-7337
Phone: 301-443-5084 or 1-800-444-6472
Fax: 301-251-2160
www.omhrc.gov

Rural Information Center Health Service

National Agricultural Library
10301 Baltimore Avenue
Room 304
Beltsville, MD 20705-2351
Phone: 301-504-5547 or 1-800-633-7701
Fax: 301-504-5181
TDD/TTY: 301-504-6856
www.nal.usda.gov/ric

NATIONAL ORGANIZATIONS

American Red Cross (ARC)

ARC has chapters in most large cities and a State chapter in each capital city. Every local Red Cross chapter is charged with readiness and response responsibilities in collaboration with its disaster partners. Disaster services include preparedness training, community education, mitigation, and response. ARC chapters help families with immediate basic needs (food, clothing, and shelter) and provide supportive services and longer-term interventions. Contact the local chapter for assistance or the chapter in your State capital.

American Red Cross National Headquarters
2025 E Street, NW
Washington, DC 20006
Phone: 202-737-8300 General Information
Phone: 202-303-4498 Public Inquiry
Phone: 703-206-7460 Disaster Services
www.redcross.org

PROFESSIONAL PRIVATE- SECTOR ORGANIZATIONS AND RESOURCES

African American Mental Health Research Center Institute for Social Research

University of Michigan
426 Thompson
Room 5118
Ann Arbor, MI 48106
Phone: 734-763-0045
Fax: 734-763-0044
<http://rcgd.isr.umich.edu/prba>

American Psychological Association

750 First Street, NE
Washington, DC 20002-4242
Phone: 202-336-5510 or 1-800-374-2721
TDD/TTY: 202-336-6123
www.apa.org

Cross Cultural Health Care Program

270 S. Hanford Street
Suite 100
Seattle, WA 98134
Phone: 206-860-0329
Fax: 206-860-0334
www.xculture.org

National Alliance for Hispanic Health

1501 16th Street, NW
Washington, DC 20036
Phone: 202-387-5000
www.hispanichealth.org

National Asian American and Pacific Islander Mental Health Association

1215 19th Street
Suite A
Denver, CO 80202
Phone: 303-298-7910
Fax: 303-298-8180
www.naapimha.org

National Association for Rural Mental Health

3700 W. Division Street
Suite 105
St. Cloud, MN 56301
Phone: 320-202-1820
Fax: 320-202-1833
www.narmh.org

National Association of Social Workers

750 First Street, NE
Suite 700
Washington, DC 20002-4241
Phone: 202-408-8600 or 1-800-638-8799
www.naswdc.org

National Center for American Indian and Alaska Native Mental Health Research

University of Colorado Health Sciences Center
Department of Psychiatry, North Pavilion
4455 E. 12th Avenue
Campus Box A011-13
Denver, CO 80220
Phone: 303-724-1414
Fax: 303-724-1474
www.uchsc.edu/sm/ncaianmhr

National Center for Cultural Competence

Georgetown University Center for
Child and Human Development
3307 M Street, NW
Suite 401
Washington, DC 20007-3935
Phone: 202-687-8635 or 1-800-788-2066
Fax: 202-687-8899
TTY: 202-687-5503
<http://gucchd.georgetown.edu>

National Indian Health Board

101 Constitution Avenue, NW
Suite 8-B09
Washington, DC 20001
Phone: 202-742-4262
Fax: 202-742-4285
www.nihb.org

National MultiCultural Institute

3000 Connecticut Avenue, NW
Suite 438
Washington, DC 20008-2556
Phone: 202-483-0700
Fax: 202-483-5233
www.nmci.org

National Rural Health Association

One West Armour Boulevard
Suite 203
Kansas City, MO 64111-2087
Phone: 816-756-3140
www.nrharural.org

STATE AND LOCAL GOVERNMENT AGENCIES

Departments of Mental Health

Contact the State agency responsible for mental health services. A State disaster mental health coordinator may be designated to manage the Crisis Counseling Program. The main office will be located in your State's capital city.

Emergency Services

The emergency services agency is the lead agency delegated by the State's governor to carry out day-to-day emergency management responsibilities. Contact the Office of Emergency Services in your capital city.

UNIVERSITY AND MEDICAL UNIVERSITIES

Academic practitioners with general training in stress, coping, and counseling often express interest in offering assistance to communities that have experienced a disaster. Undergraduate and graduate students are usually very interested in serving as crisis counselors. Caution is advised to ensure that survivors are treated appropriately and not enlisted into research studies or given treatments designed for traditional psychiatric disorders. Contact your local university's departments of psychiatry, psychology, or social work.

RELIGIOUS ORGANIZATIONS

Churches, synagogues, other faith-based organizations, and interfaith organizations are valuable resources for identifying and serving disaster survivors. Often, they are the most productive and rapid responders for immediate basic needs. Most denominations have some kind of disaster relief program. Contact the district office for major denominations in your area.

MEDIA

Television, radio, and newspapers can provide a list of resources and supports in major disasters.

VOLUNTARY ORGANIZATIONS

The National Voluntary Organizations Active in Disasters (NVOAD) has made disaster response a priority. Member organizations provide effective services and avoid service duplication by coordinating response efforts. Member organizations include:

- Adventist Community Services (ACS)
- American Red Cross (ARC)
- American Relay League, Inc. (ARL)
- AMURT (Ananda Marga Universal Relief Team)
- Catholic Charities USA (CC)
- Christian Disaster Response, AECCGC
- Christian Reformed World Relief Committee (CRWRC)
- Church of the Brethren (CB)
- Church World Service (CWS)
- The Episcopal Church (EC)
- Friends Disaster Service (FDS)
- Inter-Lutheran Disaster Response (ILDR)
- Mennonite Disaster Service (MDS)
- Nazarene Disaster Response (NDR)
- The Phoenix Society (PS)
- The Points of Light Foundation (PLF)
- Presbyterian Church, USA (PC)
- REACT International, Inc. (REACT)
- The Salvation Army (SA)
- Second Harvest National Network of Food Banks (SHNNFB)
- Society of St. Vincent de Paul (SSVP)
- Southern Baptist Convention (SBC)
- United Methodist Church Committee of Relief (UMCOR)
- Volunteers of America (VOA)
- World Vision (WV)

ADDITIONAL RESOURCES

Building Cultural Competence: A Blueprint for Action

Washington State Department of Health
Maternal and Child Health Community
and Family Health
New Market Industrial Campus, Building #7
P.O. Box 47880
Olympia, WA 98504-7880
Phone: 360-236-3504 or 206-389-3052
Fax: 360-586-7868

The Diversity Journal

Harvard Pilgrim Health Care
Office of Diversity
Brookline, MA 02146-7229
Phone: 617-730-7710
Fax: 617-730-4695

A Practical Guide for the Assessment of Cultural Competence in Children's Mental Health Organizations

The Technical Assistance Center for the
Evaluation of Children's Mental Health System
Judge Baker Children's Center
295 Longwood Avenue
Boston, MA 02115
Phone: 617-232-8390
Fax: 617-232-4125

Appendix E:

Glossary

This glossary defines terms often used in the disaster mental health response field and terms that may be useful in understanding cultural competence. The definitions for cultural competence terms are based on standards used by the Federal Government and by national and community-based systems of care.

Acculturation

The process by which an individual or group adopts the identity, customs, and values of another culture.

Center for Mental Health Services (CMHS)

A center within the Substance Abuse and Mental Health Services Administration (SAMHSA). CMHS advises the Federal Emergency Management Agency (FEMA) on disaster mental health issues. SAMHSA is part of the U.S. Department of Health and Human Services (DHHS).

Competence

The capacity to function effectively.

Crisis Counseling Assistance and Training Program *(commonly referred to as the Crisis Counseling Program)*

A program funded by the Federal Emergency Management Agency through the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Public Law 93-288 as amended by Public Law 100-707). The Crisis Counseling Program supports the provision of crisis counseling to individuals and groups who have been affected by a major disaster or its aftermath, educational activities and public information on disaster mental health issues, and disaster mental health consultation and training.

Crisis Counselor (Outreach Worker)

An individual who provides crisis counseling services and ideally is from the community, cultural, or ethnic group that is to receive those services. Crisis counselors are members of, familiar to, and recognized by their own communities. They may be spouses of community leaders, natural leaders in their own right, or individuals who have a nurturing role in their communities. Crisis counselors may include retired persons, students, and

community volunteers. They may or may not have formal training in counseling or related professions, and they may be paraprofessionals or professionals.

Cultural Competence

A set of values, behaviors, attitudes, and practices that enables an organization or individual to work effectively across cultures; the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services as well as of staff who are providing such services.

Culture

The shared attributes of a group of people; a common heritage or learned set of beliefs, norms, and values.

Emergency Mental Health and Traumatic Stress Services Branch

The branch within the Division of Program Development, Special Populations and Projects, CMHS, that provides disaster mental health technical assistance to FEMA and the State Mental Health Authority on the Crisis Counseling Assistance and Training Program.

Ethnicity

The common heritage of a particular group of people; includes shared history, language, rituals, and preferences for music and foods.

Federal Emergency Management Agency

The lead Federal agency in disaster response and recovery; provides funding for crisis counseling grants to State mental health authorities following presidentially declared disasters.

Formative Evaluation

Data-based description of the trends of the program over time.

Healers

Persons who have cultural knowledge and training to relieve people of their physical and emotional afflictions according to their cultural beliefs. Healers may use physical approaches, spirituality, herbs, and other techniques.

Interpretation

The oral restating in one language of information that has been stated in another language (Goode et al., 2001). An interpretation should convey the tone, level, and meaning of the information on which it is based.

Key Stakeholder

One who has a primary interest in the success of the program.

Linguistic Competence

The capacity of an organization or individual to communicate effectively with persons of limited English proficiency, those who are illiterate or have low literacy skills, and individuals who are deaf or hard of hearing.

Major Disaster

According to Section 102 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, “any natural catastrophe (including any hurricane, tornado, storm, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought) that in the determination of the President causes damage of sufficient severity and magnitude to warrant major disaster assistance under this Act to supplement the efforts and available resources of States, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby.”

National Voluntary Organizations Active in Disaster (NVOAD)

A group of voluntary organizations that have made disaster response a priority. State VOADs perform a similar function at the State level by directing local organizations and governments to area resources.

Outreach

A method for delivering crisis counseling services to disaster survivors; consists primarily of direct contact with survivors in their natural environments.

Paraprofessional

A person who works as a crisis counselor and has a bachelor's degree or less in a specialty that may or may not be related to counseling. Paraprofessionals have strong intuitive skills, know how to relate well to others, possess good judgment and common sense, and are good listeners. They may or may not be indigenous workers. In times of disaster, they provide outreach, counseling, education, information, and referral services. They work with individuals, families, and groups. Effective crisis counseling programs train paraprofessionals in how to work with people who are experiencing the psychological sequelae of disasters.

Process Evaluation

Changes in the program based on findings/reports from program date.

Professional

A person who has an advanced degree (master's level or higher) in psychology, social work, counseling, or a related profession. Professionals have experience in the mental health or counseling fields as well as the expertise needed to provide clinical supervision and training to crisis counselors. Typically, a professional coordinates and supervises the local outreach team associated with a crisis counseling program. He or she may provide crisis services directly or offer consultation and support to crisis counselors. Professionals clinically evaluate clients to determine whether their needs exceed the scope of the crisis counseling program. They may work directly with individuals, families, and groups whose problems are unusually challenging or complex.

Professionals often need training on the ways in which crisis counseling for disaster survivors differs from traditional mental health or counseling practice.

Race

A category describing people according to a set of characteristics that are socially important but that are not necessarily defined by visible physical features (DHHS, 2001).

Racial and Ethnic Minority Group

A collective, heterogeneous group of people who identify as African American, American Indian and Alaska Native, Asian American and Pacific Islander, or Hispanic American (DHHS, 2001, p. 5).

Refugee

A person who, because of fear of being persecuted for reasons of race, religion, nationality, or political opinion, is residing outside the country of his or her nationality and is unable or unwilling to avail himself or herself of the protection of that country; also, a person who, not having a nationality and being outside the country of his or her former habitual residence, is unable or unwilling to return to that country.

Special Population

A targeted group in a disaster-impacted community or area with needs that require specific attention by the crisis counseling program. Special populations include children, adolescents, older adults, elderly persons, members of ethnic and cultural groups, migrant workers, disaster relief workers, persons who are severely mentally ill, persons with disabilities, and homeless persons. Other special populations may be unique to the area being served by the crisis counseling program.

Stafford Act (Robert T. Stafford Disaster Relief and Emergency Assistance Act)

The legislation (Public Law 93-288 as amended by Public Law 100-707) that enables Federal emergency response and services to be provided following a disaster. Section 416 authorizes the President to provide crisis counseling assistance and training for disaster survivors following presidentially declared disasters.

State Mental Health Authority (SMHA)

The lead State government organization for providing mental health services. Because this organization may be a department, division, or branch, depending on the State government system, CMHS and FEMA use the abbreviation "SMHA" to denote the lead mental health organization.

Substance Abuse and Mental Health Services Administration

A component of DHHS. SAMHSA comprises three centers: CMHS, the Center for Substance Abuse Prevention, and the Center for Substance Abuse Treatment. CMHS provides technical assistance to FEMA for the Crisis Counseling Assistance and Training Program.

Translation

Written conversion of written materials from one language to another (Goode et al., 2001).

Appendix F:

Cultural Competence Checklist for Disaster Crisis Counseling Programs

Cultural competence should be integrated into a community emergency mental health management plan before a disaster actually occurs. When disaster strikes, certain principles must be followed to ensure a culturally competent disaster crisis counseling program. The following checklist can assist in developing cultural competence in disaster crisis counseling programs. You also can use this checklist as an informal program assessment tool. For this purpose, use the check boxes to insert a numerical ranking from 1 to 3, with 1 reflecting the cultural pre-competence stage of development (good intentions, no actions yet); 2 representing the cultural competence stage (importance recognized, some actions underway); and 3 denoting the cultural proficiency stage (effective program in place). The terminology used to describe these phases was drawn from the Cultural Competence Continuum developed by Cross and colleagues (1989).

Recognize the importance of culture and respect diversity.

- Complete a self-assessment to determine your own beliefs about culture.
- Encourage staff to complete self-assessments in order to understand their own cultures and worldviews; examine their own attitudes, values, and beliefs about culture; and acknowledge cultural differences.
- Assess capabilities of the counselors to understand and respect the values, customs, beliefs, language, and interpersonal style of the disaster survivor.
- Seek evidence that you/staff respect the importance of verbal and nonverbal communication, space, social organization, time, and environment control within various cultures.

Maintain a current profile of the cultural composition of the community.

- Develop and periodically update a community profile that describes the community's composition in terms of race and ethnicity, age, gender, religion, refugee and immigrant status, housing status, income and poverty levels, percentage of residents living in rural versus urban areas, unemployment rate, language and dialects, literacy level, and number of schools and businesses.
- Include in the profile information about the values, beliefs, social and family norms, traditions, practices, and politics of local cultural groups, and historical racial relations or ethnic issues.
- Gather information in consultation with community cultural leaders who represent and understand local cultural groups.

Recruit disaster workers who are representative of the community or service area.

- Review the community profile when recruiting disaster crisis counseling workers and attempt to recruit workers from the ethnic and cultural groups included among the survivors.
- If workers from the community or service area are not available, recruit others with backgrounds and language skills similar to those of local residents.
- Assess disaster workers' personal attributes, knowledge, and skills as they relate to cultural competence.

Provide ongoing cultural competence training to disaster mental health staff.

- Offer ongoing cultural competence training (e.g., in-service training and regularly scheduled meetings) to service providers, administrators and managers, language and sign interpreters, and temporary staff.
- Involve community-based groups with expertise in cultural competence or in the needs of specific cultures.
- Allot time for training participants to examine and assess their values, attitudes, and beliefs about their own and other cultures.

Ensure that services are accessible, appropriate, and equitable.

- Identify and take steps to overcome reluctance of ethnic groups to use services because of mistrust of the system or previous inequitable treatment.
- Identify and take steps to eliminate service barriers that occur as a result of racial and ethnic discrimination, language barriers, transportation issues, and the stigma associated with counseling services.

- Involve representatives of diverse cultural groups in program committees, planning boards, and policy-setting bodies and in decision making.
- Identify and use strategies to address specific concerns of refugees who had negative experiences that make them suspicious of government intervention.

Recognize the role of help-seeking behaviors, customs and traditions, and natural support networks. Identify and use strategies to:

- Identify cultural patterns that may influence help-seeking behaviors.
- Build trusting relationships and rapport with disaster survivors.
- Recognize that survivors may find traditional relief procedures confusing or difficult.
- Recognize individual cultures' customs and traditions related to healing, trauma, and loss, and identify how these customs and traditions influence an individual's receptivity to and need for assistance.
- Acknowledge cultural beliefs about healing and recognize their importance to some disaster survivors.
- Help survivors reestablish rituals; organize culturally appropriate anniversary activities and commemorations.
- Recognize that outreach efforts focused only on the individual may not be effective for people whose cultures are centered around family and community.
- Determine who is significant in survivors' families and social spheres by listening to their descriptions of the home, family, and community.

Involve community leaders and organizations representing diverse cultural groups as cultural brokers.

- Collaborate with trusted leaders (e.g., spiritual leaders, clergy members, and teachers) who know the community.
- Invite organizations representing cultural groups and other special interest groups in the community to participate in disaster mental health program planning and service delivery.

- Collaborate with community-based organizations to communicate with the cultural groups they represent.
- Identify effective ways to work with informal culture-specific groups.
- Coordinate with other public and private agencies in responding to the disaster.

Ensure that services and information are culturally and linguistically competent.

- Identify indigenous workers who speak the language of the survivors; use interpreters only when necessary.
- Identify trained interpreters who share the disaster survivors' cultural backgrounds.
- Determine the dialect of the disaster survivor before asking for an interpreter.
- Assess the level of acculturation of the interpreter in relation to that of the disaster survivors.
- Establish a plan for providing written materials in languages other than English and at the literacy level of the target population.
- Provide means to reach people who are deaf or hard of hearing.
- Consult with cultural groups in the community to determine the most effective outreach activities.
- Use existing community resources (e.g., multicultural television and radio stations) to enhance outreach efforts.

Assess and evaluate the program's level of cultural competence.

- Continuously assess the program to identify and correct problems that may impede the delivery of culturally competent services.
- Incorporate process evaluation into the crisis counseling program.
- Involve representatives of various cultural groups in process evaluation.
- Communicate process evaluation findings to key informants and cultural groups engaged in the program.







**U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
5600 Fishers Lane
Rockville, MD 20857
DHHS Publication No. SMA 3828
Printed 2003**