Developing Cultural Competence in Disaster Mental Health Programs

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (SAMHSA)

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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.

*Editor's Note: This Chapter is comprised of excerpts from the US Department of Health and Human Services Guide, "Developing Cultural Competence in Disaster Mental Health Programs" (DHHS Pub. No. SMA 3828)[1]. For the full guide and much more detail, please **visit www.samhsa.gov**.*

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 (SAMHSA), 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
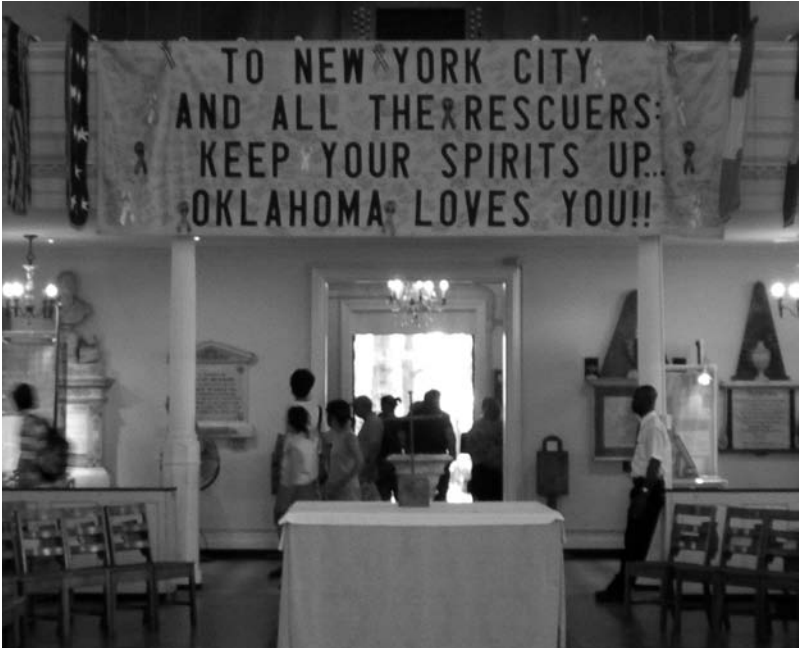
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The major objective of disaster mental health operations is to mobilize staff to disaster sites so that they can attend to the emotional needs of survivors.

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 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.[2]

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 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.[3]

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 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.

> Elements of culture are learned from others and may be passed down from generation to generation.

TABLE 2-2[4]

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.

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

...People who find themselves in the same racial or ethnic group— either by census category or through self identification...

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.

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.

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).

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

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 SAMHSA (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 a 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 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.

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 basis of race, and risking the wellbeing 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.

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 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.

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 is a dynamic process with multiple levels of achievement.

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

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.

Culturally Proficient organizations hold diversity of culture in high 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.

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

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 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 nondisaster circumstances. Therefore, they may be unfamiliar with the social and cultural mechanisms of receiving assistance and remain outside the network of aid.
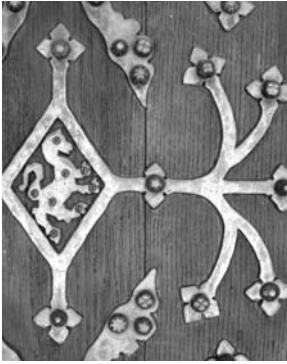
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Poverty makes people more susceptible than others to harm from disaster and less able to access help.

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.

> Disaster mental health plans that identify and address diverse needs within a community can save valuable time and avert many problems.

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).

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).[5]

TABLE 1-4

Questions to Address in a Disaster Mental Health Plan[6]		
Community demographic characteristics	**Mental health resources**	**Nongovernmental organizations' roles in disaster**
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	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?	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? n How can mental health providers collaborate with private disaster relief efforts?
Cultural groups	**Government roles and responsibilities in disaster**	**Community partnerships**
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 socio-economic groups with special needs? How many live in rental property? How many own their own homes?	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?	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?

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GUIDING PRINCIPLES AND RECOMMENDATIONS[7]

This SAMHSA Guide goes on to discuss each of nine guiding principles for cultural competence in disaster mental health programs and suggests ways to integrate them into disaster mental health planning and crisis counseling programs.

Editor's Note: The nine guiding principles are included here to identify them for you. For a fuller description of these principles and additional material, please consult the full SAMHSA document as referenced at the beginning of this chapter.

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.

This Chapter has the following Appendices:

Appendix A: Cultural Competence Resources and Tools

Appendix B: Disaster Mental Health Resources from the Center of Mental Health Services

Appendix C: Sources of Demographic and Statistical Information

Appendix D: Sources of Assistance and Information

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/Under-represented 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.

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

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

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/

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 assis-tance 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 Counse-ling 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

Appendix D: Sources of Assistance and Information

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.

Appendix D: Sources of Assistance and Information

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 CommitteeCRWRC)
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

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[1] 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.

[2] DHHS Pub. No. SMA 3828. Rockville, MD, pp. 1-2.

[3] Ibid, p4-5.

[4] Ibid., p. 25.

[5] Ibid., pp. 8-20.

[6] Ibid., p. 21.

[7] Ibid., p. 22.