

Concept Paper: Cultural Competence in Disaster Mental Health

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Purpose: To provide input to the National Project Advisory Committee (NPAC), for the design and definition of curriculum modules on culturally competent care for disaster preparedness and crisis response based on the corresponding subset of National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards.

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Purpose

The purpose of this concept paper is to assist the disaster mental health worker in defining the term “cultural competence” and understanding the concept as framed by its five essential elements. The paper seeks to increase disaster mental health responders’ awareness of their own culture and their own reactions to cultural differences in general, and as they appear in disaster settings. Finally, this paper seeks to provide disaster mental health workers with information to identify strategies for enhancing cultural competence and adapting disaster mental health practice (at the service provider level and program/policy level) for cultural differences during a disaster.

Introduction

The paper begins with defining the term “cultural competence” and exploring the concept of culture. The relationship of culture to the process of meeting basic human needs will be explored as a foundation for the importance of understanding the role of culture in disasters and the impact on mental health. A general discussion on the influences of culture in help-seeking and service provision will also be provided. The discussion will then move to emphasizing the distinction between cultural “awareness” and cultural “competence,” with the primary idea that “competence” implies the ability to take action and to adapt and improve through practice and skill development. To further understand cultural competence beyond the mere definition, an exploration of the five elements of cultural competence will be provided as the basic building blocks that disaster mental health workers must be aware of as they make the commitment to culturally competent service provision. The paper will conclude with an outline of specific cultural competence strategies in disaster mental health based on the SAMHSA

recommendations and the application of the CLAS Standards. Implications and examples will be provided to illustrate key recommendations.

Defining Cultural Competence

More than thirty years ago, the term “cultural competence” was not yet coined. Similar terms of “cultural awareness,” “cultural diversity,” “culturally appropriate,” “diversity awareness,” and others were found in the literature. In today’s field of health and human services, as well as the education system, the term “cultural competence” is pervasive in the professional literature and grant and contract language, as well as government regulations and credentialing bodies. As of this paper’s publication, a Google search of the term yielded nearly one million results. While it seems that many embrace the terminology, the danger is that “cultural competence” is used in ways that lend it to being nothing more than a buzzword. The cynical see it as just another “flavor of the month” policy effort by government and ethnic minority advocates, while those who champion the concept see it as a framework for change and service improvement.

Over the past 10-15 years the overuse and misuse of the term “cultural competence” has led to the original intent of the term and its meaning being lost on the majority of people. The term is too often diluted to the point of being viewed as a “checkbox” that is required to satisfy funding agencies or to appease ethnic minority community leaders. In fact, the term “cultural competence” was first used in the late 1980’s primarily as a result of an effort to identify and define the actions and attitudes that were needed to improve the social services provided to ethnic minority groups in the United States. The concept is just as relevant, if not more relevant today. The cultural diversity of the nation has continued to grow and the U.S. Surgeon General’s Report

Mental Health: Culture, Race and Ethnicity – A Supplement to Mental Health: A Report of the Surgeon General (DHHS 2001b) shows that disparities in health care and over-representation of ethnic minorities in the justice and child welfare systems continue to persist (DHHS, 2001b).

The seminal work that defined and provided a structure for the concept of cultural competence was a monograph published in 1989 by the Georgetown University Child Development Center through a contract with the Department of Health and Human Services as part of the Child Adolescent Service System Program (CASSP). *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed: Volume I* was written by a group of experienced ethnic minority mental health service providers and program developers who saw the problems of a children's service system that was geared as a one size fits all approach which left ethnic minority children and families inadequately or inappropriately served. In their monograph, Terry Cross, Barbara Bazron, Karl Dennis and Marisa Isaacs defined and detailed the concept and framework for systematic changes that would result in a culturally competent model of service delivery.

The Cross et al monograph and its concepts will form the framework of this paper's use of the term "cultural competence." The basic definition, at the individual level is "the state of being capable of functioning effectively in the context of cultural differences" (Cross et al., 1989). However, as well-intended and skilled in cross-cultural work as individuals may be, they must function within the broader environment of a program or service system. Therefore, it is also essential to define cultural competence at the program/systems level as "a set of congruent practice skills, attitudes, policies and

structures which come together in system, agency, or among professionals that enable that system agency or those professionals to work effectively in cross cultural situations” (Cross et al., 1989).

Since the Cross et al monograph was originally published, there have been many efforts to refine or further the definition of cultural competence as a term. Efforts to answer the question in the field of “What does cultural competence mean?” and “What does it look like?” have been taken on by individuals, programs, and agencies of various sizes and scopes.

The Federal government’s Office of Minority Health draws on the work of Cross et al. to define cultural competence on the page titled “What is Cultural Competency” on their Web site (<http://www.omhrc.gov>) as: *a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.*

The Georgetown University National Center on Cultural Competence (NCCC) has the mission to increase the capacity of health and mental health programs to design, implement, and evaluate culturally and linguistically competent service delivery systems. The NCCC is perhaps the most true to furthering the original concept of cultural competence as developed by Cross et al., and the focus is at the organizational level. The

organization's Web site states that "Cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum" (NCCC, 2007). The Web site further clarifies that cultural competence requires organizations which:

- *Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally.*
- *Have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge and (5) adapt to diversity and the cultural contexts of the communities they serve.*
- *Incorporate the above in all aspects of policy making, administration, practice, service delivery and involve systematically consumers, key stakeholders and communities.* (NCCC, 2007)

Contrary to the cynics and doubters in the field, the concept of cultural competence *can* be moved beyond a buzzword or something that is merely an abstract theory. The original monograph was filled with specific examples of how the concept and the term could be applied at the individual and program levels, if the understanding and commitment to implementation is consistently applied in a systematic way.

What is "culture"?

To truly understand cultural competence, it is important to break down the term and develop a practical understanding of culture. It is beyond the scope of this paper to provide a detailed anthropological or sociological definition of culture, so the intent is to discuss what culture means in more pragmatic way. The term "culture" means many things to different people. Newspapers often have a section called "Culture" that is dedicated to covering topics like the arts, theater, or travel, but that is not the meaning of culture with which service workers are concerned. According to *Webster's Dictionary*,

the definition of “culture” is “a) the integrated pattern of human knowledge, belief, and behavior that depends upon man's capacity for learning and transmitting knowledge to succeeding generations; b) the customary beliefs, social forms, and material traits of a racial, religious, or social group; and c) the set of shared attitudes, values, goals, and practices that characterizes a company or corporation.” (Merriam-Webster, 2007a).

Webster's Dictionary provides a formal definition of culture that serves as the frame for what is most relevant for service workers. To identify more practical ideas and views of culture, it is helpful to ask the question, “What does culture mean to you?” In asking that question over the years in doing countless cultural competence workshops across the country, there are some common responses that are usually offered in answer to that question: food, dress, traditions, language, ceremonies, religion, housing, communication patterns, sense of family, etiquette, art, song, dance, among others. Another practical question that is helpful to ask in developing a working definition of “culture” is, “If you travel out of your community and go to another community or another country, what are some of the things you notice that tell you that you are in a different culture from your own?” The answers to that question are many of the things that are most relevant to understanding how important culture is, especially in terms of how it relates to providing services in a disaster setting.

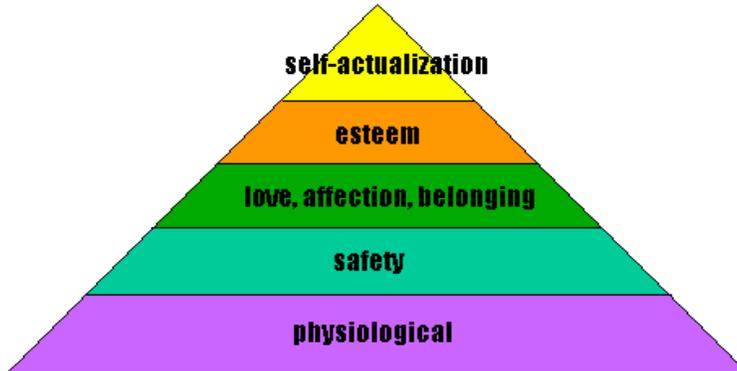
Human Needs and Culture

There is a paradox in the human condition where there is an understanding that at one level people are all the same (we share the same basic biology, and we all have the same basic human needs), yet there are also many differences that frequently result in clashes between different groups. The question then is, “If we are all the same, how can

we be so different, and why do those differences matter?” If culture is manifested in differences in food, dress, traditions, language, communication patterns, concepts of family, and religion, then practically speaking, “culture” can be viewed as one group of people’s preferred way of meeting their basic human needs. In other words, we all share the same basic human needs, but the way we understand those human needs and the way we prefer to have them met may be very different.

In 1943, psychologist Abraham Maslow developed his Hierarchy of Needs, which has become a well known model for discussing human needs. While it is not the only such model for describing human needs, it is commonly taught in basic psychology classes in college and health classes in high schools, and also frequently used in popular culture. A discussion about different theoretical opinions related to the validity of Maslow’s Hierarchy and alternative models is beyond the scope of this paper. Maslow’s Hierarchy is not used in the context of this paper as a sort of gospel truth, but is used because it provides a commonly used framework of how culture is related to a group’s preferences for meeting basic human needs. The following figure represents the pyramid that is typical of many authors’ depiction of Maslow’s Hierarchy and identifies the categories of basic human needs: physiological needs, safety needs, love needs (affection, belonging), esteem needs, and self-actualization needs (Maslow, 1943). The basic pyramid is augmented on the outside by proposing examples of common elements of culture that are related to the fulfillment of those needs. These elements are drawn from typical “brainstorming” sessions during cultural competence workshops where the participants are asked to identify what are some things they think of when they hear the word “culture.”

Figure 1: Maslow's Hierarchy of Needs as related to culture



An example of how a basic need is universal, yet different groups of people have different preferences in meeting those needs, can be seen through examining the basic psychological need of hunger. All people need food to fulfill this basic need, yet given a choice of foods, a Caucasian Midwestern U.S. farmer may prefer steak and potatoes; a farmer in Mexico may prefer beans and tortillas; a farmer in Vietnam may prefer a bowl rice or noodle soup; an African American farmer in the South may prefer barbequed pork and collard greens; and an American Indian farmer may prefer fry bread and stew. These group preferences for meeting the basic human need for food are readily seen by outside observers and sampling or appreciating those differences are fairly easy (as manifested by the number of ethnic food restaurants across the country and the spread of American fast food around the world). However, the group preferences for meeting other basic human needs such as safety, love, and belonging, or self-actualization is not always as easy to see, and is often more difficult to sample or appreciate, especially in a disaster response setting. Differences in preferred ways to meet the need for belonging can be seen through family relationships such as nuclear family, extended family, multi-generational family, group or clan societies, and so on. Self-esteem and self-actualization are often met by

concepts of spirituality and ceremony, which is often one of the most challenging areas of need to share or have appreciation of differences. While it may be fairly easy to sample different ethnic foods and have an appreciation of differences, the idea of sampling different spiritual practices or ceremonies is not so easy.

A group's preferences for meeting their human needs (their culture) has serious implications for providing services in a disaster setting where the normal structure to meet basic human needs is disrupted or destroyed. In disasters people tend to have a strong desire to for their core cultural preferences to meet needs, so the need for disaster mental health workers to be vigilantly aware of the group's preferences for meeting those basic human needs is essential to ensuring that the interactions and interventions support and build on the preferences of the group being served. Examples of differences to be aware of are the desire for "comfort foods", looking for trust in others from people "like me," and a desire for familiarity of surroundings and symbols that convey meaning in a time of crisis.

Potential areas for a "cultural bump" in disaster settings

Differences between the cultures of a community coping with a disaster and the cultures of the disaster responders can result in what cultural competence trainers often call a "cultural bump" (Cross, 1993). A cultural bump is what happens when someone expects a particular behavior, but receives something different when interacting with persons from another culture. A common source of a cultural bump is the handshake or greeting. In the mainstream American culture, a firm handshake accompanied by direct eye contact is a sign of a respectful greeting, and a firm handshake and eye contact is expected in return. In many Native American cultures, a respectful handshake may be

offered with a very gentle grip or simple offer of the hand with no grip at all accompanied by a downward gaze or brief eye contact. In those cultures, a similar gesture is expected in return as a sign of a respectful greeting. When people from these two different cultures exchange a greeting, there is likely to be a cultural bump. The potential interpersonal dynamics that develop from that interaction are what will be described later as “the dynamics of difference” (Cross et al., 1989).

The cultural bumps that disaster mental health workers are most likely to encounter will include examples like those above in the area of greetings and engaging in rapport building. There will also be different cultural concepts of physical health, wellness, mental health, grief, healing, and different help-seeking attitudes and behaviors. Differences in how illness, disease, injury, disasters and their causes are perceived and explained by a particular group may also provide challenges to the assumptions of disaster workers. Many indigenous cultures have spiritual explanations for disasters and disease, which may be foreign to disaster workers who may view those beliefs as merely superstitions. Differences in individual and group behavior and coping strategies of community members and their attitudes toward, and expectations of, disaster responders may also provide disaster workers with potential cultural bumps. It is important to be aware of the service delivery structure and style of the responder, whose culture and values may not be congruent with the community being served. All of these cultural bumps are opportunities to develop and improve on the cultural competence of the individual or system, especially when viewed within the framework of the five elements of cultural competence as will be defined later. Cultural bumps should be expected, as should the response and adaptation to those bumps.

The “Golden Rule” – a license for ethnocentrism?

The western world often talks about the Golden Rule. It has become part of the general culture as the expectation for good behavior and is seen as something to strive for. The Golden Rule is typically stated as “Do unto others as you would have others do unto you.” On the surface, this is an admirable effort at promoting the morals of good behavior and compassion for others. Upon further review and examination, the value is to treat others the way that you want to be treated. There is an underlying ethnocentric assumption that the way you would like to be treated is the same as the way that others would like to be treated. From a broad perspective of values this is probably true. Everyone wants to be treated with respect, and everyone wants to feel loved, but the way people would like to be shown respect and love may be widely different. This reminds us of the previous discussion of basic human needs and the differences between a group’s way of meeting those basic human needs.

A simple example of how differences in the way people would like to be treated can be seen in the example that is often used in cultural competence training sessions, where the question is asked, “What is the best treatment for the common cold?” When asked in a large group of people, there will be a variety of answers given: rest, hot tea, orange juice, chicken soup, herbal remedies, and Vicks VapoRub, among others. Clearly there is no “right” answer to the question, but it serves to demonstrate how there are differences in meeting the basic human needs of health and wellness. It also provides a powerful metaphor for approaches to disaster relief.

The Golden Rule approach would promote the idea that if my preference for treating the common cold was chicken soup, then my best effort at providing help and comfort to my friend John who has a cold would be to go to his house and offer him a

nice bowl of homemade chicken soup. I may be unaware that even though John appreciates the offer of chicken noodle soup, when he was growing up and had a cold, his mother slathered him in Vicks VapoRub. Based on his history and family culture, what my friend really wanted to feel help and comfort from was that soothing heat from the menthol. Being the polite friend that he is, John accepted my soup. While he may have appreciated my offer of help, accepted the soup and tried it, it left him feeling somewhat unfulfilled, because he felt that it was not what he really needed.

To carry the metaphor further, if I developed a program to serve people with the common cold, I would develop it based on my wonderful homemade chicken soup therapy. I would then take my intervention anywhere that the common cold was a problem and may even distribute truckloads of my soup to every neighborhood with common cold problems. In this scenario, many people would be very satisfied with the chicken soup intervention, but in my good intentions I may be unaware that large numbers of people are taking my chicken soup and leaving it in their refrigerators or pantries; others take it and proceed to throw it away after they realize it does not provide them the help and comfort that I promised it would, then they find their own remedies; still others refuse to even come to the chicken soup distribution center that has become a well oiled machine, because they have heard from others that it does not work and you're better off finding your own remedy.

The lesson of this metaphor is that disaster response systems often utilize a one size fits all approach like the "everyone gets chicken soup" remedy in order to promote efficiency and standardization. Especially in disaster mental health, it is important to acknowledge the diversity that people will have in seeking their own preferences to get

their mental/emotional needs met following a disaster. Culturally competent disaster mental health demands that the responders quickly assess how the members of the local community prefer to receive disaster mental health services, determine what those services should actually look like to meet the needs of the community culture, and adapt to meet those needs. For example, a typical system that is set up for disaster survivors is for them to go to a centralized location, wait in line, fill out paperwork, wait in a holding area, get assessed by a health professional or triage nurse, then be referred to a mental health professional to speak to individually while sitting on chairs inside a tent or other shelter setting and then be given a handful of brochures on coping with disaster and provided with the suggestion to come back to the location in a few days for a follow-up visit. Like the “chicken soup program”, this method may meet the needs of a large number of people, but there will also be many people who will feel uncomfortable in accessing services through such a system. There may be significant differences in culture that either limit people from attempting to access services, or with those that access such service, but feel mistreated, or disrespected by an approach that is incongruent to their cultural needs. Any of the steps outlined in the typical scenario above may be modified and adapted to better meet the needs of a particular community or cultural group.

Examples of some adaptation for a specific culture may be to de-centralize a response effort by setting up satellite locations in areas where certain cultural groups naturally seek help, such as churches in many African American communities. Another option is to assess the appropriateness of home-visiting or outreach as the primary means of providing services. If paperwork is a cultural or linguistic barrier for a certain group, then efforts should be made to eliminate, reduce or provide hands-on assistance in filling

out any necessary paperwork for disaster aid. Other adaptations can be made once careful observation of the group's behavior and with input from community members who are familiar with a group's preferences in help-seeking.

Cultural Awareness or Cultural Competence?

It is important to take the time to distinguish between “cultural awareness” and “cultural competence.” In the field of disaster mental health, the terms are often used interchangeably or the term cultural competence is eschewed, because there is a mistaken belief that it is a judgmental and implies that there is a level of cultural “incompetence”. Of course, no one wants to be considered incompetent, so the awareness concept appears more accepting and tolerant. However, the important difference between the terms is the implication for taking action in relationship to cultural differences. **Awareness** is defined by *Webster's Dictionary* as “having or showing realization, perception, or knowledge; implies vigilance in observing or alertness in drawing inferences from what one experiences” (Merriam-Webster, 2007b). On the other hand, **competence** is defined by *Webster's Dictionary* as “the state of being competent; having the capacity to function or develop in a particular way; *specifically*: having the capacity to respond (emphasis added)” (Merriam-Webster, 2007c). Awareness is important, but it does not imply doing anything or acting in a certain way. Competence requires awareness, but also implies the ability to take action and respond. Cultural competence is a more accurate and preferable description of the skills that are needed by professionals and programs to interact effectively where there are cultural differences. Cultural awareness is important, but not enough in itself. If you were going to have heart surgery, you would clearly want your surgeon to not just have “surgical awareness,” you would want to be assured that they

have a level of “surgical competence” so that when they open your chest you would have confidence that they could deal with what is needed to be able to perform the surgery successfully. We should strive for the same in dealing with cultural differences in disaster mental health settings.

“Competence” as a continuum of ability and skills

Disaster mental health responders must have a basic level of competence in their ability to apply mental health skills in a disaster setting. This requires background training and experience in applying those basic skills. Training often includes disaster exercise drills, seminars, in the field learning opportunities and after action reviews. It is generally understood and expected that disaster mental health workers will continue to enhance their skills through such methods. The public expects that disaster responders are technically competent to do their jobs and proficient in the execution of their role during disasters. Cultural competence introduces another level of skill that must also be developed by disaster mental health workers. They must not only be competent at their technical skill in providing mental health service or developing programs, but also be competent in the ability to adapt those practices when faced with the challenges of cultural differences in communities that have experienced disaster.

As has been stated earlier, competence is not a simple checkbox. Competence is a commitment to developing and refining a set of skills, and those skills fall on a continuum. There are many every day skills that people have basic competence in and within those skills there exists a wide range of levels of competence. An example of a common skill is the ability to ride a bicycle. When presented with a challenge to ride on a bike from point A to point B, most adults say they would be able to do that with little

problem (so long as the distance was short and the terrain flat). Most adults have already gone through the initial steps of learning the skill of riding a bike as a child when they had support from a caring adult and the use of training wheels. Though their skills may be rusty, they admit to a basic level of competence in bike riding within the limits of their ability. Now think of Lance Armstrong or the X-Games trick riders, or the neighbor down the street who takes their mountain bike out for long rides. Through dedicated practice and desire to improve their skills, those people have moved beyond basic competence to an advanced level of competence in bicycle riding that is specialized in one particular area. Like any advanced athlete or professional, they were not content to be able to check the box that says “I can ride a bike.” In cultural competence, disaster mental health providers should strive for the same level of advanced competence in dealing with cultural differences.

In the general field of health care, the concept of “competencies” is not new. Licensure and accreditation standards often require “core competencies,” or “clinical competencies” that must be demonstrated by employees of a health organization and assessed in a systematic manner by the organization on a regular basis. There are many specific definitions of competency assessment in health care, and each organization must determine their own take on the concept and its application. The basic premise is that the knowledge, skills, abilities and behaviors needed to carry out a job can be measured and assessed and that it should be part of ongoing organizational evaluation and monitoring (Wright, 1998). Wright identifies the three basic types of skills to be assessed and verified in competencies: 1) critical thinking, 2) clinical/technical skills, and 3) interpersonal skills.

Critical thinking refers to areas such as problem solving, creativity, ethics, planning, learning, and clinical reasoning. **Clinical/technical skills** refer to such areas such as cognitive skills, knowledge, technical/clinical understanding of particular interventions, and ability to follow protocols. **Interpersonal skills** refer to communication, conflict management, facilitation, collaboration skills, team skills, delegation, and adaptability. There are several methods for agencies and individuals to assess and verify levels of competency for particular skills. The process begins with a specific measurable or observable competency statement, which is then verified through several different methods that can be adapted to measure critical thinking, clinical/technical skills, and interpersonal skills. Verification methods include post-tests, return demonstrations, observation, case studies, exemplars, peer review, self-assessment, discussion groups, presentations, mock events, and Quality Improvement monitors (Wright, 1998).

Going back to the bike riding example, if you were trying to demonstrate competence in mountain biking, you may develop a competency statement such as, “*Jane demonstrates the ability to successfully ride a mountain bike to the top of Bumpy Road Mountain and return safely.*” You may already know that Jane has the ability to ride a bike on a flat surface, but she may now be required to use her basic bike riding competency in a more difficult environment. This particular competency addresses several **critical thinking** skills, including Jane’s commitment to making the ride, her ability to develop a plan to make the ride, and her ability to adapt her plan based on any unexpected variables. It also addresses the **technical skills** required by asking her not to simply ride on a flat surface, but to navigate the bike on rough terrain. **Interpersonal**

skills are not specifically measured in this example, but if we made this a team activity we may add an element of interpersonal interaction to the statement. To measure or verify her competency, an appropriate method should be selected. A return demonstration would imply that a reviewer actually observes Jane make the entire bike ride; this may not be realistic, so a case study may be used where Jane would write about her successful ride. Another option may be peer review where other bike riders going up Bumpy Road Mountain provide reports and feedback about Jane's performance. To demonstrate competence in her critical thinking skills, Jane may be asked to develop a presentation to describe her journey and prepare other riders for such an experience. If necessary, the competency statement could be modified to add further objective definitions of "successfully ride" and "return safely," perhaps with a specific timeframe added. The results of the assessment would provide you and Jane with feedback necessary for her to improve her ability and give some clues about what training, conditioning, equipment or other things needed to continually increase Jane's ability to make the ride.

In applying this approach to cultural competence in disaster mental health, a specific competence may be developed around the application and adaptation of a particular disaster mental health skill or program in a culturally specific environment. For example, the process of building rapport and utilizing cultural knowledge to facilitate a helping relationship is a basic competency that could be measured by developing an individualized cultural competency statement for a particular worker that is working in with a new cultural group. A statement like, "*Jane demonstrates the ability to utilize language and behavior that builds respect and rapport among members of the XYZ*"

community through the use of cultural information from local community cultural experts,” could be developed. Jane and her supervisor could then devise a plan to verify this competency by a number of different ways, such as direct observation, feedback from XYZ community cultural experts, self-study, or any number of other ways. The feedback and verification process may also provide the opportunity to develop further training to increase the level of competency in this specific skill.

Ongoing Cultural Competence

By now it should be clear that cultural *competence* implies the ability to take action, adapt, and function in a different environment. In order to make this a reality in every day practice and in the systematic approach to disaster mental health, a *commitment* to a developmental process of quality improvement is necessary. Elements should be integrated into all aspects of disaster programs and services (policy, practices, attitudes and structure) and not viewed as a separate component.

Five Elements of Cultural Competence for the individual worker

Cross et al. (1989) identified five essential elements to cultural competence. It is useful to review these elements, because they help guide the implementation of cultural competence at the individual worker level and the program or system level.

1. Awareness and acceptance of differences
2. Awareness of own cultural values
3. Understanding and managing for the “dynamics of difference”
4. Development of cultural knowledge
5. Ability to adapt practice to fit the cultural context of the client/family

The disaster mental health worker must be aware of and accept the fact that there are cultural differences in the communities that are being served. Cultural differences are

acknowledged and there is not judgment about the differences being better or worse than the workers' own cultural values. This leads directly to the need for workers to have an awareness of their own cultural values through a process of self-examination and personal reflection. Workers will not only need to be aware of the cultural differences in the community and their own personal values, but also to understand how to manage what Cross et al. refer to as the “dynamics of difference” between their own culture or the culture of their organization and the culture of the person/community being served. This concept will be explored in the next section. The fourth element of cultural competence is the development of cultural knowledge. Clearly, it would be impossible for every disaster worker to have full working knowledge of all of the variety of cultural groups and practices in the diversity of our nation and beyond. It is important to develop specific knowledge of a particular group when the worker will be focused on that community. This knowledge should be provided by members of that community in real life situations whenever possible and not simply through reading history books or looking up information on the internet (though that can often be a springboard to learning). It is equally, if not more important, for workers to develop or identify networks of people who have specific cultural knowledge about a particular group that will be served. This is where community liaisons and cultural brokers fit in. The final element of cultural competence is to take all of the other elements and demonstrate the ability to adapt practice to fit the cultural context of the client and/or family.

The “Dynamics of Difference”

The concept of “the dynamics of difference” is the interaction that happens when people from different cultures meet and have some type of interaction (Cross et al.,

1989). In this interaction, or “cultural bump,” each person interprets the responses of others within the context of his/her own cultural experience. Those experiences tend to be generalized and given greater meaning about how someone from one culture understands or interprets another’s behavior. The dynamics that happen as a result of these cultural differences cause a broad range of reactions, behaviors and attitudes (Cross et al., 1989 & Cross, 1993) as represented by the following continuum:

Figure 2: Continuum of Reactions to Cultural Differences

*Genocide *Institutional Racism *Racism *Prejudice *Ethnocentrism *Idealism *Awareness *Understanding *Valuing Diversity

On the far end of the worst possible reaction to difference is **genocide**: those differences in culture are viewed as so terrible that the other group must be exterminated. One step away from that is the reaction of **institutional racism**: when policy and structures of a society or organization are set up so different cultures are inherently restricted to access to the rights or resources of the organization or society. **Racism** is another reaction where individuals or groups withhold access to rights or resources based solely on racial or cultural differences. **Bigotry** is a reaction that is based on generalized misjudgment about a group’s cultural behaviors with an underlying attitude the particular group is inherently inferior or bad in some way. **Prejudice** is also a reaction where attitudes and beliefs are formed based on misjudgment or misinformation about a cultural group, which is coupled with stereotyping and avoidance of the other group. **Ethnocentrism** is a reaction to difference that is based on misinterpretation based on viewing another culture’s behavior by the standards of one’s own culture and making judgments and ideas for solutions based on one’s own values. **Idealization** may also be a

dynamic based on a romanticized stereotype of another group's culture with the unrealistically view that members of that other culture have some mystical attributes (i.e. the "noble savage" view of Native Americans.) The danger in this dynamic is that members of the romanticized group are not viewed as real people with complex needs and values. **Awareness** is the dynamic where differences in culture are initially acknowledged and to some level, accepted. The reaction of **understanding** in the face of cultural differences implies a deeper perception of the nuances and meaning of those differences from the perspective of the other culture and the accompanying knowledge related to behavior and attitudes. On the most positive end of the spectrum is **valuing diversity**. This reaction to cultural difference celebrates those differences in culture and promotes the acceptance of those differences. In contrast to the common "melting pot" concept where the idea is that all cultures come together to add their own uniqueness into a new blended culture with different flavors; celebrating diversity promotes the "salad bowl" concept where the idea is that different cultures exist together, yet maintain their own unique individual structure and flavor while simultaneously adding to the overall contents of the bowl.

Disaster mental health workers and program managers should be aware of potential areas where the dynamics of difference will present challenges such as language and communication style, economic opportunity, family configuration and kinship structures, how problems are defined or solved, non-verbal communication, political and/or historical influences, and many others. For example, if the disaster mental health program is designed to provide one-on-one support to individuals who actively seek out assistance, and there is a culture that has more of a group or extended family help-seeking

preference, the community member may feel that the disaster program is disrespectful or attempting to break up the group or undermine the role of the family matriarch or patriarch. From the disaster worker point of view, they may feel that the community is not playing by the rules and is attempting to manipulate the system. Disaster mental health workers need to have skills in the ability to manage their own feelings of frustration or confusion when these types of differences occur as well as the ability to manage the interpersonal dynamics that may be presented as disrespect or lack of understanding.

Five Elements of Cultural Competence at the program/systems level

The five elements that were discussed earlier at the individual worker level can also be applied at the program or system level, and are stated by Cross et al. (1989) as:

1. Valuing Diversity
2. Conducting a Cultural Self-Assessment
3. Managing for the Dynamics of Difference
4. Institutionalization of Cultural Knowledge
5. Adaptation to Cultural Diversity

While the individual elements of cultural competence have to do with a person's specific skills and attitudes, this level includes developing policies, procedures, and other systemic structures that promote cultural competence at the service level. The importance of the presence of these elements cannot be understated. Often the focus on cultural competence efforts is at the individual level, but individuals function in the framework of a greater organization, so the overall infrastructure must support the efforts of the individual worker. An organization demonstrates **valuing diversity** through seeking an ethnically, culturally, and linguistically diverse workforce and utilizing local community members that represent the diversity of the community being served. The

organization's commitment to **conducting a cultural self-assessment** is demonstrated by an organization's leadership taking a hard look in the mirror and asking tough questions about how the organization is applying the principles of cultural competence. The assessment should be ongoing and part of a greater quality improvement initiative and include feedback and input from culturally diverse populations that are being served. Managing for the dynamics of difference implies that the organization has developed policies and procedures that allow for cultural differences to be present and respected in the workforce. The **institutionalization of cultural knowledge** may include developing a cultural knowledge bank or library of information, and it also may include identifying cultural brokers and other cultural experts who have knowledge of particular communities. **Adaptation to cultural diversity** is the organization's overall ability to take their programs, policies, practices and attitudes and adapt them to work effectively with different cultural groups. Specific programs designed by and for members of cultural groups are sought out by culturally competent organizations as a means of providing access to interventions or strategies that are based on the needs and preferences of specific cultural groups. An example may be using a talking circle ceremony as a means of doing a team debriefing in an American Indian community.

The Role of Culture in Disasters

By now it should be clear that cultural differences are real and important to acknowledge, and that disaster mental health approaches should be able to fit different cultures. When a disaster happens, it has a direct impact on the culture of the community. With the idea discussed earlier that culture is a group's preferred way of

meeting its basic human needs, after a disaster the basic fabric that holds a community together is broken or destroyed. Using Maslow's Hierarchy of needs as a framework (See Figure 1 on page 5), community reactions to and coping with a disaster are also dependent on the culture of the community. Depending on the scope and scale of a disaster, any elements of the culture listed outside the pyramid in the figure on page 4 will be disrupted (food, housing, clothing, social norms, formal laws, parenting, social activities, art, ceremony, and spirituality). The disruptions that a disaster creates in the basic structure of society have a direct impact on individuals', families', and communities' ability to meet their basic human needs. This presents a variety of challenges for the disaster mental health worker to understand how communities will seek to rebuild and re-structure the elements of their culture that have been disrupted.

Following a disaster, people want to get back to normal as soon as possible, and they will seek out, or re-create, a level of familiarity based on their preferences in meeting their basic human needs. For example, "comfort food" can go a long way in helping disaster survivors recover emotionally, but there are many different ideas about what "comfort food" is in different cultural groups. Military MREs (Meals Ready to Eat) are often provided in wide-spread disasters, and while they do meet the physiological needs of hunger, they rarely provide "comfort" that individuals desire. Efforts should be made to seek information from individuals, families, and community members about what foods would provide them with comfort and familiarity. The answers may be as varied as grilled cheese sandwiches, bar-b-cue ribs, steamed rice, beans and tortillas, chicken and dumplings, a local seafood dish, chocolate, ice cream, and many others. The impact of providing such foods to a community when food supplies are disrupted would

be extremely positive and well received. Likewise there are implications for providing services which would be well received when accounting for cultural preferences in meeting other basic needs of safety, love and belonging and so on,.

The role of mental health response in disasters

Mental and emotional reactions to disaster situations are normal. As stated above, the nature of disaster disrupts the normal functioning of individuals, families, and communities by its impact on the very structures that meet basic human needs. Unlike standard mental health practice which tends to be oriented towards diagnosis and treatment of mental disorders, the field of disaster mental health presumes that people are resilient and that disasters represent a temporary interruption of their well-being.

Meyer (1994) outlined the key concepts of disaster mental health:

1. No one who sees a disaster is untouched by it.
2. There are two types of disaster trauma (individual and collective).
3. Most people pull together and function during and after a disaster, but their effectiveness is diminished.
4. Disaster stress and grief responses are normal reactions to an abnormal situation.
5. Many emotional reactions of disaster of survivors stem from *problems of living* brought about by the disaster.
6. Disaster relief procedures have been called “The Second Disaster.”
7. Most people do not see themselves as needing mental health services following a disaster and will not seek out such services.
8. Survivors may reject disaster assistance of all types.
9. Disaster mental health assistance is often more “practical” than “psychological” in nature.
10. Disaster mental health services must be uniquely tailored to the communities they serve.
11. Mental health staff need to set aside traditional [western] methods, avoid the use of mental health labels, and use an active outreach approach to intervene successfully in disaster.
12. Survivors respond to active interest and concern.
13. Interventions must be appropriate to the phase of disaster.
14. Support systems are crucial to recovery.

The role of disaster mental health response is to provide short-term support and services to individuals, families, and communities in order to attend to the emotional needs of survivors (and responders) in disaster settings. As Myer (1994) outlines above, disaster mental health services need to fit the particular phase of the disaster and should not be construed as traditional psychotherapy or mental health. The primary function of disaster mental health is to support a return to pre-disaster emotional functioning, not provide diagnosis and therapy related to reactions that result from a disaster. Attending to specific mental health crisis such as suicidal ideation, psychosis or exacerbated symptoms of survivors with histories of mental health diagnosis prior to the disaster is sometimes necessary in disaster mental health response. Such situations are typically not the norm, but are dealt with to resolve the immediate issue then to refer the individual on to a more appropriate level of services for follow-up care.

Approaches to disaster mental health services

Disaster mental health workers have a variety of tools and approaches at their disposal in addition to their background training in standard mental health practice. It is beyond the scope of this paper to provide a comprehensive review of all the disaster mental health approaches and interventions that have been developed, so three of the most common will be discussed and reviewed. One fundamental difference between disaster mental health practice and standard mental health practice in an outpatient or inpatient community setting is that disaster work is generally not a psychotherapy-based approach. Disaster mental health workers typically have a therapeutic background and clinical skills, but the short-term crisis nature of disaster response requires a different approach that utilizes those skills, applies them in a practical manner, and does not

promote a pathology model. The exception to this is where disaster mental health workers become part of a longer term disaster recovery effort and provide back-fill or augmentation to serve the client population of an existing public mental health system whose staffing has been severely disrupted through a disaster.

The American Red Cross Disaster Mental Health Model, as reviewed by Meyer (1994), is based on providing basic training to licensed mental health professionals (such as social workers, psychologists, marriage and family therapists, counselors, psychiatric nurses, and psychiatrists). In this model, mental and emotional reactions of individuals are managed as part of a larger disaster training and response effort provided by the Red Cross. Disaster mental health is integrated into other elements of a Red Cross disaster response including shelters, mass care, and family support services. Key elements are community outreach, the use of home visits, and the basic premise that emotional reactions to disaster are normal reactions to an abnormal situation and that emotional support is provided on a short-term basis. Serious mental health issues such as psychosis or bi-polar disorder are assessed, but Red Cross disaster mental health workers deal with any immediate crisis behaviors first and then attempt to connect such individuals with local community mental health resources that can provide ongoing services in the community. The emphasis in this model is to provide basic humanistic emotional support to the survivors of a disaster. Since the Red Cross Model is a general model which has not been specifically adapted for different cultural groups, the burden of implementing it in a cultural competent manner is on the individual worker or specific team providing services in various cross-cultural settings.

Psychological First Aid (PFA) is a model developed by the National Child Traumatic Stress Network and National Center for Post Traumatic Stress Disorders with the support and review of the Substance Abuse and Mental Health Services Administration (Byner, et al, 2006). A detailed curriculum was designed for use by disaster mental health workers and other responders in the immediate short-term aftermath of a disaster. It is noted by many experts in disaster mental health as the “acute intervention of choice” in disaster response. It is designed with the premise that the majority of people impacted by disaster will need only short-term emotional support, but that those who need long-term follow-up will need to be identified and served appropriately. PFA is intended to be culturally adapted and can be provided in a wide variety of disaster response settings, including community outreach teams, shelters, phone hotlines, family reception centers, hospitals and emergency rooms. The PFA model identifies eight Core Actions:

1. Contact and Engagement
2. Safety and Comfort
3. Stabilization (if needed)
4. Information Gathering: Current Needs and Concerns
5. Practical Assistance
6. Connection with Social Supports
7. Information on Coping
8. Linkage with Collaborative Services

The developers of PFA have included “culture alerts” in the curriculum, which give the provider opportunities to consider where adaptation of each of the core actions may be appropriate. For example, in the “Contact and Engagement” section, the issue of potential cultural differences around eye contact and personal space are noted, and workers are asked to “look for clues” and to “seek guidance about cultural norms from

community leaders” (Byner, et al 2006). Each of the other Core Actions will need to be adapted and customized to meet the needs of disaster survivors in the context of their own culture. Like the Red Cross Model, PFA is not a psychotherapeutic intervention. A background in therapeutic approaches or clinical licensure may be helpful, but not necessary for the provider to implement the model. The Five Elements of Cultural Competence, as described earlier, should be considered in utilizing and adapting this model in specific situations.

Critical Incident Stress Debriefing (CISD) is a model that was developed by Jeffery Mitchell in 1983 as a tool for debriefing Emergency Medical Services and other first responders following critical incidents such as serious auto accidents, school shootings, line of duty deaths, and other events that are experienced by a small number of people as a single event. Over the years CISD has been expanded in its use by practitioners to include large scale disaster response situations. “The Mitchell Model,” as it is frequently referred to, is well-known, but not without controversy with regard to its debatable efficacy. Proponents argue that poor results in research are due to the model being used in inappropriate settings or by providers that are not well trained in the model. Grey, et. al, (2002) provide a comprehensive review that deals with the controversy of the limitations of CISD as a post-disaster intervention. CISD is intended to be a one-time crisis intervention through a seven-step small group process. It is designed to assist a homogeneous group of people who have had roughly the same exposure to a traumatic event and is typically implemented within a few days after the traumatic event has occurred (Mitchell and Everly 1996).

Like the Red Cross and PFA models, CISD is not intended to be a psychotherapy intervention and proponents admit that it is limited in scope and purpose and not intended to be a stand alone process outside of an integrated package of interventions within an overall Critical Incident Stress Management (CISM) program (Mitchell and Everly 1996). The primary goals of the CISD intervention are: 1) to educate people about stress reactions and ways to cope with them, 2) to provide messages that help normalize the reactions to traumatic events, 3) to promote emotional processing and sharing of the event, and 4) to provide information about follow-up interventions and services if requested. (Grey, 2005). The model is intended to be implemented by providers that are trained and certified by the International Critical Incident Stress Debriefing Foundation.

CISM is the overall framework that is intended to support the use of CISD, but is also relevant to the other specific approaches Mitchell and Everly (1996) outlined seven elements necessary for a comprehensive, integrative, multi-component crisis intervention system:

1. Pre-crisis preparation
2. Disaster or large-scale incident, as well as, school and community support programs including demobilizations, informational briefings, "town meetings" and staff advisement
3. Defusing: a 3-phase, structured small-group discussion provided within hours of a crisis for purposes of assessment, triaging, and acute symptom mitigation
4. Critical Incident Stress Debriefing (CISD)
5. One-on-one crisis intervention/counseling or psychological support throughout the full range of the crisis spectrum
6. Family crisis intervention, and organizational consultation
7. Follow-up and referral mechanisms for assessment and treatment, if necessary

Any of the three interventions outlined above should be at the disposal of the disaster mental health worker. Depending on the role of the worker and which agency

they are affiliated with in a disaster setting, the program that the worker operates under may dictate the specific approach that is to be applied. In order to achieve cultural competence, like our fictional mountain bike rider Jane, who was asked to take her basic bike riding skills and apply them to a challenging mountain course, the disaster mental health worker must be able to take their skills in applying a certain practice and adapt it to fit within the context of cultural differences that may be encountered (the fifth element of cultural competence.) Before being able to adapt their practice, the disaster mental health worker needs the other four elements of cultural competence in place: the awareness and acceptance of difference, awareness of their own cultural values, understanding the dynamics of difference and development of cultural knowledge. A commitment to the principles of cultural competence and continual self-assessment will aide the disaster mental health worker in being able to take standard disaster mental health practice models and adapt them to work more effectively when interacting with different cultural groups.

Practical Suggestions

In providing disaster mental health services in situations or communities that are different from the disaster mental health provider's own culture, there are some practical lessons from the field. The first is since cultural competence is an ongoing developmental process, workers can expect that they will encounter cultural differences that they will be unprepared for, and that are currently too difficult for them to function effectively in based on their level of awareness, knowledge, experience or skills. This awareness of one's own cultural values and behaviors is a critically important skill in cultural competence – knowing when you are not yet ready to interact with a certain

culture that is markedly different than your own without doing more harm than good. A personal commitment to the process ensures that this self-awareness includes the ability to be open to learning. The act of unintentionally offending members of a community can provide tremendous learning opportunities given that there is the prospect to make any necessary amends for the offence and get honest feedback. It is a truism that I have observed and personally experienced that the moment you think you are culturally competent, you will encounter a culturally different situation where you realize how much more learning and experience is needed. It can be a painful and challenging process, thus requiring commitment to work through it. A trusting relationship with a mentor who is familiar with the particular culture that a worker is challenged with can help provide needed coaching and guidance in behavior. The process of improving one's cultural competence is also extremely rewarding, and once more advanced levels are achieved with certain cultural groups, the worker can begin to share their own lessons learned with others.

When interacting with a culture that is different from their own, disaster mental health workers should carefully watch and describe the natural behavior of groups they are interacting with and identify possible adaptation of practices and programs accordingly. The typical disaster mental health interventions are based on the western mainstream concepts of mental health care with a fundamental emphasis on improving or restoring the functioning and mental state of the individual. In many indigenous and ethnic communities, the cultural beliefs are more family- (including extended family or clan) and community-oriented, where the emphasis may naturally be on restoring the overall functioning and wellness of the group as a whole - not specific individuals. Such

a cultural difference would mean a significant adaptation of disaster mental health workers' basic intervention approach. An example might be encouraging or participating in a cultural group gathering or healing ceremony that brings the community together in a way that provides symbolic or spiritual intervention aimed at restoring balance and wellness to the group. Individual community members benefit personally from such activities, but the focus is on the larger group.

In a disaster response setting it is also important to quickly establish regular communications with different cultural groups in the impacted area in order to address rumor control issues which often arise. Special attention should be paid to any historic or cultural attitudes in communities about intervention from outside parties. Establishing trust and overcoming previous conceptions may present challenges in dealing with some cultural groups, especially for uniformed responders. Ongoing communication and building relationships with local community or cultural leaders helps promote inclusion and will help workers truly adapt the practices based on the specific community's needs. Disaster mental health workers should remember the chicken soup/Vaporub examples, and be sure to work with community members to find out what they feel would be most helpful to them based on their own cultural preferences.

Guiding Principles for Cultural Competence in Disaster Mental Health Programs

In 2003, the Substance Abuse Mental Health Services Administration (SAMHSA) within the Department of Health and Human Services (DHHS) published *Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations*. This document provided an overview of the concept of cultural competence and made nine important recommendations for disaster mental health

programs. These principles are related to the National Standards on Culturally and Linguistically Appropriate Services (CLAS), which are promoted by all agencies within DHHS, specifically by the Office of Minority Health. These general principles for the recommendations have been discussed throughout this document, but are outlined as follows and include the correlating CLAS Standards (see Appendix A).

1. Recognize importance of culture and respect diversity.

This principle has been identified throughout this document and is related to the basic elements of cultural competence.

2. Maintain a current profile of the cultural composition of the community (in alignment with CLAS Standards 10 and 11).

This recommendation applies to the pre-disaster planning phase, and to some extent, the early phase of intervention. The profile would include information that would assist disaster mental health workers in preparing for cultural differences that they may encounter. It should include such things as the breakdown of the population's race and ethnicity, age, gender, religion or spiritual practices, refugee or immigration status, income, housing, rural vs. urban population rates, unemployment, languages and dialects spoken, number of schools and number and type of businesses. Much of this information would be available through internet searches and would provide key data to guide intervention efforts.

3. Recruit disaster workers who are representative of the community or service area (in alignment with CLAS Standard 2).

Community representatives that can be involved in the disaster mental health relief efforts can provide key knowledge and experience that will help bring the

hard data that is gathered to form the community profile to life. Community members can provide deeper understanding of the community from a grassroots, on-the-ground perspective that improves the likelihood of the community acceptance of the intervention and mental health responders. Community members also provide important feedback for making adjustments and adaptation to standard operating procedures.

4. Provide ongoing cultural competence training to disaster mental health staff (in alignment with CLAS Standard 3).

Disaster mental health responders are typically required to receive training related to their professional licensure or credentialing in order to maintain their practice, or their status as a disaster mental health provider. Training on cultural competence should be provided on a regular basis. Such training should be personalized and include a variety of methods beyond simple didactic workshop presentations, and there should be individualized training and performance improvement plans that will assist disaster mental health workers in increasing their cultural competence in specific areas. Training should be provided during pre-disaster planning, while on-site at the disaster location, and following a worker's return after the disaster.

5. Ensure that services are accessible, appropriate and equitable (in alignment with CLAS Standard 1).

During the actual disaster response, individual workers and leadership must be willing and able to adapt the practices to ensure that mental health services are accessible both in the physical location of services (people being able to get to a

place where services are provided, or services being delivered through outreach to where people naturally live or gather), and in the procedures to receive services (paperwork, number of steps needed to get to help, etc.). The appropriateness of services has been addressed in this paper as being able to adapt the practices to fit the cultural context of the individual, family or community. Such services should also be equitable – meaning that services are delivered to the right people at the right time at the right level.

6. Recognize the role of help-seeking behaviors, customs and traditions, and natural support networks (related to CLAS Standard 1).

The value behind this recommendation has also been discussed throughout this paper in terms of finding ways to serve the community in a way that their preferred methods of meeting their basic human needs are respected and drives the provision and adaptation of services.

7. Involve as “cultural brokers” community leaders and organizations representing diverse cultural groups (related to CLAS Standard 2).

The fourth element of the cultural competence model is to institutionalize cultural knowledge (Cross et al., 1989). This recommendation supplies the structure for developing cultural knowledge that is specific to different communities. Cultural brokers are key to understanding the every day reality of how culture has been impacted by a disaster and how culture can be viewed as a strength to draw on in developing interventions that will promote a return to functioning.

8. Ensure that services and information are culturally and linguistically competent (in alignment with CLAS Standards 1 and 4-7).

This paper has not specifically mentioned the need to be linguistically competent, since the focus has been on the broader concept of culture. However, all of the same ideas and principles apply to linguistic competence as with cultural competence. Or to paraphrase the basic cultural competence definition from Cross et al (1989), linguistic competence can be viewed as the ability to function effectively in the context of *language* differences. Written materials and signage should be translated into a variety of languages that are spoken in the community. Interpretation and translation services should be available for workers to communicate with those who do not share the same language and bilingual disaster mental health workers should be utilized in a way that allows them to use their language skills. Linguistic competence also refers to the reading level of written material, which should be written in a level that is readable to those who may have lower functioning literacy. The use of technical/medical terminology and acronyms in writing and in conversation should also be avoided to promote linguistic competence.

9. Assess and evaluate the program's level of cultural competence (in alignment with CLAS Standard 9).

The concept of assessing and measuring cultural competence was discussed at the level of the individual worker in the section on “Competence as a Continuum of ability and skills” earlier in this paper. Assessment should be ongoing, and never a one time event. Tools for evaluating the cultural competence of organizations that can be applied to a disaster mental health program on the whole are available

through a variety of sources including several tools available through the National Center on Cultural Competence.

Additional Guidelines for Planning and After Action Review

In addition to the recommendations above, which relate to certain Federal CLAS Standards, many of the other CLAS Standards also have implications in disaster mental health programs. Most of the Standards below can be viewed as being related to an After Action Review, or lessons learned process in the post-disaster setting, which the SAMHSA document did not specifically address in the nine principles/recommendations.

CLAS Standard 8 (See Appendix A) refers to the development of a strategic plan and specific goals of the organization to implement culturally competent services. This standard forwards the concept that builds an infrastructure around the elements of cultural competence as they are applied to disaster mental health programs. Each of the five organizational level elements of the cultural competence model can be written into the plan as a framework: valuing diversity, conducting a cultural self assessment, managing for the dynamics of difference, institutionalization of cultural knowledge and adaptation to cultural diversity (Cross et al., 1989). Policies, procedures, job descriptions, and other elements of the plan can all be built in a way that promotes and enhances cultural competence.

CLAS Standard 12 (See Appendix A) refers to a process of participatory community involvement in planning and after action review. This concept is related to many of the topics and concepts highlighted in this paper, that community members who are familiar with and part of a particular cultural group should be involved, ideally in the planning and preparation stage for pre-disaster planning, and also in any after action

review process. Community members should be able to provide feedback to the leaders of the disaster mental health response program about what worked as was planned, what worked when adapted, what did not work at all and any other information that would help to improve the quality of services provided.

CLAS Standard 13 (See Appendix A) refers to implementing conflict and grievance resolution processes that are culturally and linguistically competent. Such process should provide real-time feedback during the disaster response that identifies, prevents and resolves any cross-cultural conflicts or complaints by community members about the services being provided. This standard is related to the anticipation of cultural bumps and the concept of managing for the dynamics of difference. Training, preparation and adaptation practices by disaster mental health workers will help to prevent many potential conflicts. A culturally competent workforce will still experience cultural bumps, but will be better able to manage those at the lowest possible level and avoid large-scale cross-cultural disasters in interactions that need to be resolved through a formal conflict resolution process. Such a process must still be in place and must be provided in a way that community members with cultural differences can resolve any serious complaints in a way that will promote cultural understanding.

CLAS Standard 14 (See Appendix A) implies the need for public information to be provided on progress and successful innovations in the disaster mental health response program. This recommendation offers the opportunity for the leaders of the program to gather information and feedback and produce documentation either in the form of an after action review/lessons learned document, or through periodic status reports in ongoing disaster response.

Next Steps

Individual disaster mental health workers and disaster mental health program managers are encouraged to utilize the information throughout this document to improve services for diverse cultural groups who may experience a disaster. The primary concept of cultural competence and its five elements provide a basic framework for organizing the efforts and the implementation of CLAS Standards. An initial step in utilizing this document is to do a self-assessment related to cultural competence in general and specifically around disaster mental health skills. Excellent practical self assessment tools on cultural competence for both individuals and organizations can be accessed on the website for the National Center on Cultural Competence. Beyond the technical details of doing a self-assessment, it is important to remember that it takes a strong personal commitment to the developmental process in order to enhance cultural competence. To follow up on that commitment and self-assessment, a specific cultural competence action plan is necessary both at the individual and program/agency level.

Implications for Training Disaster Mental Health Workers

Disaster mental health workers come from a variety of different clinical and professional backgrounds. Many disaster mental health workers have primary roles as community mental health providers, and then assume the role of “disaster mental health worker” when volunteering or being deployed to a disaster setting. As a result, the work force training is typically focused on their primary professional standards and the interest or clinical specialty of the provider (i.e. social worker, psychologist, family therapist, psychiatrist, or psychiatric nurse). To increase knowledge and skills for the disaster response role, mental health professionals typically seek training that is intrinsically

motivated or required by their sponsoring program or agency that utilizes them as disaster mental health responders. Disaster mental health training is typically focused on response models such as the Red Cross Model, Psychological First Aid, CISD, or other advanced applications related to specific disaster scenarios (natural disasters, bio-hazards, acts of terrorism, and so on.)

In a cultural competence training model for disaster mental health workers, ideally there should be two levels of training. The first level is a broad-based training provided to all workers that is designed to develop knowledge and practical skills about the cultural competence model, and to provide shared opportunities, or small learning communities, where workers can discuss their new learning and work on broad implications. The second level should build on the first, but be more focused on individual workers and based on personal cultural competence training plans that are developed in cooperation with peers and/or agency leaders.

Suggestions for group training

The first level (group training) can be provided in a number of ways and will need to be customized based on the program or agency that is sponsoring the training of its workforce. The important thing to remember is that cultural competence training must be part of an ongoing quality improvement effort and written into the policies of the organization, and the SAMHSA recommendations and CLAS Standards may be used a guideline. Group training must be more than a once or twice a year workshop. The primary objective of this level of group training is to get everyone “on the same page,” so there is a shared understanding of the basic language and concepts of cultural competence and policies are developed that support direct services.

One possible framework for cultural competence training at the program or agency level would be to provide mandatory training based on the concepts outlined in this paper. Each of the sections of this paper could be developed into workshop sessions. Ideally, such training would be a combination of didactic lecture utilizing PowerPoint presentations, large group brain storming, small group discussion activities, role plays, and other interactive methods. The trainers or facilitators should be familiar with the topic and group facilitation to provide expertise in both the content of the cultural competence framework and to set the tone of open learning that promotes true sharing among participants. If necessary, large groups may be offered didactic lectures, but they should be divided up into smaller groups for interactive sessions that foster open discussion. The length of the training can vary depending on the needs of the program or agency, but ideally such training should be between 4-8 hours to cover the topic in depth and held at least quarterly. This is significantly more than many programs or agencies allow for cultural competence training, but will help to build familiarity with the concepts and promote positive changes. This type of training is ideally provided face-to-face in a group session with participants who have an ongoing working relationship and basic sense of trust in each other.

When possible, workshop sessions should be built into an organizational structure that promotes an ongoing dialog about cultural competence. Programs or agencies can support small learning communities or discussion groups which allow small groups of workers to have open and honest discussions about their work and how it relates to the application of their behavior, attitudes, and specific skills. Organizations can further support ongoing training by developing training committees or work groups that are

given a role to impact overall policy and practice decisions of the agency related to serving in culturally diverse communities.

Suggestions for individual training

The second level of training should be more focused on the individual learning process and build on the first level described above by solidifying the foundation of the concepts of cultural competence and applying it on a personal level. Individual workers should conduct a thorough and honest cultural competence self assessment, with input from peers and supervisors. Cultural competence goals should be integrated into an individual's professional development plan that is often required a part of the overall quality improvement by organizations. Keeping the five elements of cultural competence (Cross et al., 1989) in mind, personalized training should be developed to improve workers awareness of cultural differences, awareness of their own culture and attitudes, the dynamics of difference that present challenges to them personally, developing cultural knowledge about various groups and developing networks to enhance knowledge, then finally training and opportunities to work on the adaptation of specific practices among different cultural groups.

Individual training should be ongoing and include the development of specific competency statements as discussed in the section of this paper. Training methods should include a variety of activities that address competencies in the area of critical thinking, clinical/technical, or interpersonal skills as related to functioning effectively in cross-cultural situations. Attending workshops, participating in Web-based training and other ways to develop individual knowledge of particular ethnic group or cultural adaptation of an intervention are the most common forms of training. Another more

interactive method is cross-cultural immersion experiences. Such activities would provide opportunity for a worker to go to a cultural event, community gathering or other means of experiencing a cultural that is different than the workers own. Going to an American Indian pow-wow, an African American church social, a Mexican-American soccer tournament, a Chinese New Year celebration, or attending a church service or ceremony of a particular culture group are only some examples of cultural immersion experiences. After participating in an event like this, in order to maximize the learning, a debriefing with someone familiar with the culture should occur to help understand differences and interpret the meaning of any differences that the worker notices. A worker may be asked to write a brief report on their observations and their own personal reactions, and then include any implications for their work with the group they experienced. Since cultural competence is a skill that must be developed, an ongoing process of challenging yourself to step outside of your own cultural comfort zone and to gain personal experience with other cultures is critical.

Conclusion/Review

The purpose of this concept paper is to assist the disaster mental health worker in understanding the term “cultural competence” simply as *the ability to function effectively in the context of cultural differences*. In this paper, culture is practically defined as *a particular group’s preferred way of meeting basic human needs*. The cultural competence concept is framed by its five essential elements, 1) awareness and acceptance of difference, 2) awareness of one’s own cultural values, 3) understanding the dynamics of difference, 4) developing cultural knowledge, and 5) ability to adapt practice to fit the cultural context of the client/family. The paper provides the opportunity for workers to

increase awareness of their own culture and their own reactions to cultural differences in general, but particularly as they may be apparent in disaster settings. The role of disaster mental health and disaster mental health approaches are discussed and outlined and specific recommendations for direct service practice and program development/management level were identified.

Cultural competence is attainable. It is measurable. It is often a difficult and challenging process that takes personal commitment at the local and leadership level. Cultural competence is a journey, not an end. Disaster mental health workers bring many skills with them on that journey. Some of these skills they will need, some they will not need, and some they will need to significantly adapt. They will also need to learn new skills in order to continue the journey successfully. As with any journey, there is the temptation to say “are we there, yet?” This paper has hopefully provided a basic road map to help ensure that the worker stays on the journey. Along the journey celebrate your success and learning, but also remember, that the moment you think you are “there,” you will quickly discover that you still have a ways to go, because the journey of cultural competence is one that lasts a lifetime.

Appendix A

The CLAS Standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served.

The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations as follows: CLAS **mandates** are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7).

CLAS guidelines are activities recommended by OMH for adoption as mandates by Federal, State, and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13).

CLAS recommendations are suggested by OMH for voluntary adoption by health care organizations (Standard 14).

Standard 1

Health care organizations should ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2

Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3

Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Standard 4

Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5

Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6

Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family

and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7

Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Standard 8

Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9

Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Standard 10

Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records,

integrated into the organization's management information systems, and periodically updated.

Standard 11

Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12

Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Standard 13

Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Standard 14

Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

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