
**CULTURAL COMPETENCY IN DISASTER
RESPONSE:
A REVIEW OF CURRENT CONCEPTS,
POLICIES, AND PRACTICES**

Office of Minority Health
U.S. Department of Health and Human Services

Contract # HHSN2639999000291
Task Order # C-2555
Task 4.1: First Responders - Environmental Scan

February 2008

Acknowledgments

Systems Research Applications International, Incorporated (SRA International, Inc.) would like to acknowledge the U.S. Department of Health and Human Services' Office of Minority Health for sponsoring this project and for laying the foundation for this work by developing the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care and for making significant contributions to cultural competency training for health care providers. We sincerely thank the Office of Minority Health Project Officer, Guadalupe Pacheco, for his ongoing dedication, commitment and guidance throughout the preparation of this document.

We extend our gratitude to the members of the National Project Advisory Committee (NPAC) and Consensus-Building Panel who generously lent their expertise through expert surveys and interviews. We would especially like to thank those individuals who have helped us extensively by offering us specific materials and resources, both after reviewing the preliminary draft and at the beginning of the project as we were gathering initial materials. The Project Officer and the First Responders project staff are listed below.

Project Officer

Guadalupe Pacheco, M.S.W.
Special Assistant to the Deputy Assistant
Secretary for Minority Health
Office of Minority Health, DHHS
Project Officer

Project Staff

Ann S. Kenny, MPH, BSN, RN
Project Director
SRA International, Inc.

Billie Hubbs, BS
Health Research Associate
SRA International, Inc.

Elizabeth Graham, BA
Health Research Associate
Astute Technology

Darci L. Graves, MA, MA
Sr. Health Care Education Specialist
SRA International, Inc.

Ilana Dickman, MPH
Health Care Analyst
SRA International, Inc.

Jason Goldwater, MA, MPA
Senior Member
SRA International, Inc.

Eileen Hederman, BA
Health Research Associate
Astute Technology

NPAC Members

Dennis P. Andrulis, PhD, MPH
Center for Health Equality
Drexel University of Public Health

Reneé Joskow, DDS, MPH
Office of Health Affairs
U.S. Public Health Service

Dahna Batts, MD, FACEP
Centers for Disease Control and
Prevention
U.S. Public Health Service

Nataly Kelly
Independent Consultant

Luisa López, MSW
National Association of Social Work

Juliet Choi, JD
American Red Cross

Francis G. Lu, MD
San Francisco General Hospital

Cindy Lou Daniel
Federal Emergency Management
Agency
Department of Homeland Security

John C. Scott, MS
Center for Public Service
Communications

Edward Gabriel, MPA, AEMT-P
Walt Disney Corporation

Kenrick A. Small, JD
Office of Civil Rights

Sandy Hunter, PhD, NREMT-P
Eastern Kentucky University

Bruce Young, MSW
National Center for Post-Traumatic
Stress Disorder, Veterans Affairs

Consensus-Building Panel Members

Ritu Sahni, MD, FACEP
National Association of EMS Physicians
Oregon Health and Science University

Andy Hunt, MSW, LICSW
Substance Abuse and Mental Health Services Association (SAMHSA)
U.S. Public Health Service

Âna-Marie Jones
Collaborating Agencies Responding to Disasters (CARD)

The information presented in this report does not necessarily reflect the views and opinions of the U.S. Department of Health and Human Services, Office of Minority Health, or SRA International, Inc.

To cite information from this report, please use the following reference:

SRA International, Inc. (2008). Cultural Competency in Disaster Response: A Review of Current Concepts, Policies, and Practices. Report prepared for the Office of Minority Health. Rockville, MD: SRA International, Inc.

Table of Contents

LIST OF FIGURES	V
LIST OF ACRONYMS	VII
EXECUTIVE SUMMARY	1
PURPOSE AND METHODS	1
RATIONALE FOR CULTURAL COMPETENCY IN THE DISASTER RESPONSE ARENA	2
ORGANIZATION OF EMERGENCY AND DISASTER RESPONSE IN THE UNITED STATES	2
APPLYING THE CLAS STANDARDS AT EVERY PHASE OF DISASTER	2
CONCLUSION	4
ADDENDUMS: PROFESSION-SPECIFIC INFORMATION	4
1. INTRODUCTION	8
DEFINITION OF CULTURAL COMPETENCE	11
PURPOSE OF THE ENVIRONMENTAL SCAN	12
TECHNOLOGY AND EDUCATION FOR DISASTER RESPONDERS	13
METHODS USED TO DEVELOP THE SCAN	16
ORGANIZATION OF THE SCAN	17
2. RATIONALE FOR CULTURAL COMPETENCE IN DISASTER RESPONSE ARENA	18
WHAT IS A DISASTER?	21
CHARACTERISTICS OF DISASTERS	24
THE PHASES OF DISASTER	25
3. ORGANIZATION OF EMERGENCY AND DISASTER RESPONSE IN THE UNITED STATES	29
LOCAL EMERGENCY RESPONSE	29
STATE-LEVEL EMERGENCY AND DISASTER RESPONSE	31
NATIONAL DISASTER RESPONSE	33
DEFENSE SUPPORT TO CIVIL AUTHORITIES	35
NATIONAL VOLUNTARY ORGANIZATIONS ACTIVE IN DISASTERS (NVOAD)	36
RESPONSE TO HURRICANE KATRINA	36
4. APPLYING THE CLAS STANDARDS AT EVERY PHASE OF DISASTER	38
PREPAREDNESS	41
RESPONSE	45
RECOVERY	47
5. CONCLUSION	53
ADDENDUMS: PROFESSION-SPECIFIC INFORMATION	58
A. EMERGENCY MANAGERS	59
B. EMS PERSONNEL	67
C. SOCIAL WORKERS	74
D. THE AMERICAN RED CROSS	83
E. MENTAL HEALTH AND DISASTER MENTAL HEALTH PROFESSIONALS	87
F. U.S. PUBLIC HEALTH SERVICE COMMISSIONED CORPS	112
G. MILITARY PERSONNEL	117
H. CITIZEN CORPS	123
APPENDIX A. REFERENCES	126
APPENDIX B. SEARCH TERMS	166
APPENDIX C. DISASTER RESPONSE EXPERT SURVEY RESULTS	167
APPENDIX D. DISTANCE LEARNING RESOURCES FOR DISASTER RESPONDERS	172

RESOURCES FOR DISASTER RESPONSE AND EMERGENCY MANAGEMENT	172
RESOURCES FOR PUBLIC HEALTH AND MENTAL HEALTH PROVIDERS	177
APPENDIX E. WEB RESOURCE CENTERS FOR DISASTER RESPONSE TRAINING	184

List of Figures

Figure 1: Office of Minority Health’s Recommended National Standards for Culturally and Linguistically Appropriate Services in Health Care	10
Figure 2: Social Groups Recognized in the Definition of Cultural Competence	12
Figure 3: Recommended Elements of Web-based Courses for Disaster Responders	14
Figure 4: Format of Distance Learning Resources	15
Figure 5: Online Courses Offered through the SCPHP Web Site	15
Figure 6: U.S. Population by Race/Ethnicity, 2000.....	18
Figure 7: Foreign-Born Population by World Region of Birth.....	19
Figure 8: Fair or Poor Health by Race/Ethnicity, 2004	19
Figure 9: Classification of Potentially Traumatic Events	22
Figure 10: Disaster Phases	26
Figure 11: Three Levels of Disaster Response	29
Figure 12: EMS as a Part of the Health Care System	30
Figure 13: California Emergency Organization.....	32
Figure 14: Initial Government Involvement in Disaster Response.....	35
Figure 15: The Military and Three Pillars of Civil Support	36
Figure 16: Population Vulnerability Profile	40
Figure 17: Systems of Meaning in Illness Experience.....	46
Figure 18: Cultural Dimensions in Manifesting PTSD Symptoms and Therapy	50
Figure 19: Effects of Ethnicity on Post-Traumatic Stress	52
Figure 20: Ethnicity of Emergency Managers	60
Figure 21: Steps for Working with Vulnerable Populations.....	62
Figure 22: Community-Based Organizations and Emergency Management	63
Figure 23: Courses in Emergency Management Education.....	64
Figure 24: Promising Education Practices in Emergency Management.....	65
Figure 25: Race and Ethnicity of EMS Personnel	68
Figure 26: Techniques for Responding to 911 Calls	71
Figure 27: Core Issues in EMS Personnel Education	71
Figure 28: Components of the EMS Education System	73
Figure 29: Race and Ethnicity of NASW Members	75
Figure 30: NASW Standards for Cultural Competence in Social Work Practice.....	77
Figure 31: Culturagram for Assessing Diverse Clients	79
Figure 32: Promising Cultural Competence Practices in Social Workers Education.....	81
Figure 33: Ethnic Minorities in the American Red Cross.....	84
Figure 34: Work Experience of Psychiatrists	88
Figure 35: Principles for Cultural Competence in Disaster Mental Health Programs.....	91
Figure 36: Cultural Competence Model for Accessing Minority and Marginalized Communities Affected by Disaster	93
Figure 37: Recommendations for Culturally Competent Disaster Mental Health Research	93
Figure 38: Differences between Mental Health and Disaster Mental Health	97
Figure 39: Activities in Disaster Mental Health Response	98
Figure 40: Principles of Mental Health Disaster Response	98
Figure 41: Mental Health Interventions in Disaster Phases.....	100

Figure 42: Practical Suggestions for Working with Diverse Populations	102
Figure 43: Culturally Variable Components of Interventions in Posttraumatic Stress Disorder.....	104
Figure 44: Program for Cross-Cultural Treatment of PTSD	104
Figure 45: Multicultural Counseling Training Program Development Pyramid.....	106
Figure 46: Models of Multicultural Training in Mental Health.....	107
Figure 47: Integrating Culture in the Mental Health Education Curricula	107
Figure 48: Recommended Training Methods in Disaster Mental Health.....	109
Figure 49: Diverse Populations in Mental Health and Psychological Preparedness Education Resources.....	110
Figure 50: Commissioned Corps Active Duty Strength by Ethnicity.....	112
Figure 51: PHS Active Duty Strength by Agency/Operating Division/Program	113
Figure 52: Racial and Ethnic Diversity of U.S. Military Officers.....	119

List of Acronyms

AAMC – American Association of Medical Colleges
AFMS – Air Force Medical Service
AHRQ – Agency for Healthcare Research and Quality
AMA – American Medical Association
AMCD – Association of Multicultural Counseling and Development
AMEDD – Army Medical Department
APA – American Psychological Association
ARC – The American Red Cross
ASPH – Association of Schools of Public Health
ATA – American Translators Association
BDHR - Behavioral Health Disaster Response
BOTC – Basic Officer Training Course
CACREP – Council for Accreditation of Counseling and Related Educational Programs
CARD – Collaborating Agencies Responding to Disasters
CBO – Community-based Organization
CBT – Cognitive-Behavioral Therapy
CCCM – Cultural Competency Curriculum Modules
CCNM – Culturally Competent Nursing Modules
CCP – Crisis Counseling Program
CCSAQ – Cultural Competence Self-Assessment Questionnaire
CDC – Centers for Disease Control and Prevention
CDLHN – The California Distance Learning Health Network
CISD – Critical Incident Stress Debriefing
CLAS – Culturally and Linguistically Appropriate Services
CPHP – Centers for Public Health Preparedness
DHHS – Department of Health and Human Services
DHS – Department of Homeland Security
DLIFLC – Defense Language Institute Foreign Language Center
DMH – Disaster Mental Health
DMHS - Disaster Mental Health Services
DOD – Department of Defense
DOL – Department of Labor
DSCA – Defense Support to Civil Authorities
DSM-IV – Diagnostic and Statistical Manual of Mental Disorders, 4th Edition
EMAC – Emergency Management Assistance Compact
EMAP – Emergency Management Accreditation Program
EMD – Emergency Medical Dispatcher
EMI – Emergency Management Institute

EMS – Emergency Medical Services
EMT – Emergency Medical Technician
ESF – Emergency Support Function
FAO – Foreign Area Officer
FEMA – Federal Emergency Management Agency
GAO – Government Accounting Office
HRSA – Health Resources and Services Administration
IAEM – International Association of Emergency Managers
ICP – Incident Command Post
IHS – Indian Health Services
IIMG – Interagency Incident Management Group
IOM – Institute of Medicine
IOTC – Independent Officer Training Course
JFO – Joint Field Office
LEP – limited English proficiency
MCHB – Maternal and Child Health Bureau
MTT – Mobile Training Teams
NAED – National Academies of Emergency Dispatch
NAEMT – National Association of Emergency Medical Technicians
NASW – National Association of Social Workers
NDC – North Dakota County-level emergency managers
NEMA – National Emergency Management Association
NGO – Non-Government Organization
NHTSA – National Highway Traffic Safety Administration
NIMH - National Institute of Mental Health
NIMS – National Incident Management System
NORTHCOM – United States Northern Command
NPAC – National Project Advisory Committee
NREMT – National Registry of Emergency Medical Technicians
NRF – National Response Framework
NRP – National Response Plan
NSC – National Standard Curricula
NVOAD – National Voluntary Organizations Active in Disaster
OMH – Office of Minority Health
PFA – Psychological First Aid
PFO – Principal Federal Official
PHS – Public Health Service
PTSD – Post-Traumatic Stress Disorder
S&T – Strategic & Tactical
SAMHSA – Substance Abuse and Mental Health Services Administration

SCPHP – South Central Public Health Partnership
SEMS – Standardized Emergency Management System
TRADOC – United States Army Training and Doctrine Culture Center
USFA – United States Fire Administration
USNS – United States Naval Ship
VTT – Video Tele-Training
WICHE – Western Interstate Commission for Higher Education
WMD – Weapons of Mass Destruction

Executive Summary

To help achieve its mission of “improving the health of racial and ethnic minority populations through the development of effective health policies and programs that help to eliminate disparities in health,” the Office of Minority Health (OMH) has contracted with Systems Research Applications International, Incorporated (SRA International, Inc.) to develop and test a curriculum to effectively equip disaster responders in cultural and linguistic competency. This curriculum will be grounded in the national disaster response structure identified in the National Response Plan (NRP) and its successor, the draft National Response Framework (NRF), as well as in the principles outlined in the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care issued in December 2000. The curriculum will build on the current work of the *Cultural Competency Curriculum Modules (CCCM)* for physicians and *Culturally Competent Nursing Modules (CCNM)* for nurses released by OMH in 2004 and 2007, respectively. Cultural competence training geared toward disaster response partners (including, but not limited to: first responders, disaster response professionals, community members, and members of state and local government) will help them develop the knowledge, skills, and attitudes to facilitate interaction with disaster survivors and improve the quality of disaster relief services to affected minority communities.

Purpose and Methods

This Environmental Scan is an integral part of developing a cultural competency curriculum for disaster responders. The Scan was created to determine whether current information on the concepts, policies, and teaching practices regarding cultural competence provide an adequate base for developing the curriculum, and, if so, to summarize and synthesize this information into a usable form. We discuss the emergency support functions (ESF) outlined in the National Response Plan (NRP) and three main themes of the CLAS standards (culturally competent care, language access services, and organizational supports) as they apply to disaster response.

The development process for the Environmental Scan consisted of gathering information between December 2006 and January 2008 through literature and Internet searches, reviews of relevant education and training resources, and interviews and email contacts with experts in the disaster response field. (For additional information, see “Methods used to Develop the Scan” in Chapter 1.) A central goal was to ensure a broad perspective by collecting information from a variety of sources. The primary methods for literature searches included Web-based databases such as PubMed, EBSCO, ProQuest, and PILOTS. We also used reference lists from prominent reports (i.e., National Health Disparities Report, 2005; National Cultural and Linguistic Service Standards, 2000), documents, and published articles. A complete list of search terms is provided in Appendix B and results from email surveys of subject matter experts are provided in Appendix C.

Rationale for Cultural Competency in the Disaster Response Arena

This section discusses the definitions of disasters and their characteristics, and identifies the multiple models and phases of disaster. The definitions of disaster evolved from focusing on their physical characteristics and their impact on the environment to the impact on the social fabric of affected communities. The key characteristics of disasters highlighted in the research literature include the scope of impact, speed of onset, duration of impact, and social preparedness. Other characteristics referenced in the literature are predictability and recurrence of disasters (Quarantelli, 1986; Mileti, 1999).

Organization of Emergency and Disaster Response in the United States

This section provides an overview of disaster response in the U.S., discussing local, state and national levels of response, as well as how they intertwine. It also includes a section with specific emphasis on Hurricane Katrina¹.

Responses to disasters are often hierarchical in nature. At all levels of disaster response, government efforts are supported by volunteers and non-government organizations (NGOs), such as the American Red Cross. The response to emergencies and disasters begins at the local level, and when/if local resources are insufficient, these authorities can submit requests for State assistance following communication protocols described in local and State emergency response plans. At the Federal level, response to disasters are coordinated through the National Response Plan (NRP), which establishes national level policy and operational direction regarding Federal support to State and local authorities in disaster events. [The National Response Plan (NRP) was published in 2004 by the Department of Homeland Security (DHS). In September 2007, the National Response Framework (NRF) was released in draft form by the Federal Emergency Management Agency (FEMA). On January 22, 2008, the NRF was released for final publication, and will officially replace the NRP as the coordinating document for Federal level response to disasters on March 22, 2008.]

The response to Hurricane Katrina showed that despite efforts to improve the existing disaster response system nationwide, this system has serious flaws, such as lack of coordination and communication. Local, State, and Federal authorities also failed to provide effective help to minority communities that were particularly vulnerable due to limited resources, cultural barriers, and limited English proficiency.

Applying the CLAS Standards at Every Phase of Disaster

This section discusses how key target audiences (emergency managers, mass care providers, public health and medical services providers, and military personnel) can

¹ The authors recognize that Hurricane Katrina was not the only storm of note to occur during the historic 2005 Atlantic hurricane season. Storm surge from Hurricane Rita certainly contributed additional substantial damage to many of the same areas which had been previously impacted by Hurricane Katrina, and the adverse effects from each were extensive. Throughout this document, the authors refer to Hurricanes Katrina and Rita as Hurricane Katrina, unless specifically cited otherwise in the literature.

benefit from implementing the CLAS standards at each phase of a disaster. Research shows that racial and ethnic minorities are disproportionately vulnerable to and impacted by disasters throughout the continuum of disaster phases. The disparities are due to a number of reasons, including level of English proficiency, cultural insensitivities, acculturation level, immigrant status, lower incomes, fewer savings, greater unemployment, less insurance, poorer access to information, and community isolation (Andrulis, Siddiqui, & Gantner, 2007; Fothergill et al., 1999). Additionally, a growing body of evidence suggests that certain minority groups may be at a higher risk of developing post-traumatic² stress disorder (PTSD), and during the impact phase, minority, immigrant, and refugee populations may be at higher risk for negative psychological consequences based on prior experiences of traumatic events and language or cultural needs that are different from the majority (Pole, et al., 2005). The delivery of culturally and linguistically appropriate services during each phase of a disaster may help decrease the disproportional impact that disasters have on these minority groups.

With regards to CLAS Theme 1, culturally competent care, our research shows that all target audiences will benefit from recognizing the role of culture in health- and help-seeking behaviors and knowledge of factors affecting various cultures. Disaster responders need to be able to communicate with patients and their families in a culturally and linguistically appropriate manner under stressful or emotional situations to ensure optimal level of emergency care. Their training may be greatly enhanced through the introduction of a cultural and linguistic framework such as the CLAS standards.

CLAS Theme 2, language access services, can help disaster responders by introducing techniques for handling cultural and language barriers and strategies for effectively working with interpreters and bilingual staff in emergency situations. Disaster response can be enhanced by developing quality written materials in languages other than English, either in writing or in other culturally appropriate formats (audio, video, web), with the help of qualified translation and localization professionals. Disaster relief efforts will also benefit if responders are able to attend to the feelings of survivors and their families in culturally appropriate ways.

In terms of organizational supports outlined in CLAS Theme 3, disaster responders will benefit from strategic planning and analyzing barriers and enablers to meeting patients'/survivors' needs and evaluating the effectiveness of language access services provided. Disaster relief efforts will be enhanced if responder agencies partner with local community-based organizations building trust, and involving key stakeholders in disaster preparedness planning.

² The spelling of this term is inconsistent in the literature: “post-traumatic” and “posttraumatic” are both used. Therefore, for the purposes of this Scan, the term will be referenced as it appears in any original source.

Conclusion

Current research and literature collected for the present Environmental Scan reveals that there is a sufficient basis to begin developing a cultural competence curriculum for disaster responders. Audiences for the proposed curriculum vary widely in terms of their job functions, education requirements, and demographics which may suggest curriculum design options such as “branching” decision tree modules or “specialty tracks” that cover content specific to each audience. The target audiences interviewed demonstrate a wide variety of healthcare practices and required skills for their specific roles in disaster response scenarios. Therefore, recommendations from the National Project Advisory Committee (NPAC) and consensus building members, insight from the three concept papers commissioned for this project, and results from needs assessment focus groups with disaster responders will provide essential information for designing a curriculum that can meet the individual needs of these broad audiences. Despite the need for further research with respect to cultural competency and its impact on disaster response, findings presented in this Environmental Scan show that much information and many resources are available that address all three themes of the CLAS standards as they relate to disaster response.

Addendums: Profession-Specific Information

These profession-specific addendums discuss characteristics of our key target audiences, including emergency managers, social workers, emergency medical services personnel, mental health and disaster mental health professionals, military personnel, the United States Public Health Service Commissioned Corps, and volunteer organizations like the American Red Cross and the Citizen Corps. This section of the Scan also discusses recommendations for culturally competent disaster response for each target audience, highlights current education practices, and examines the role of cultural competence in disaster responders’ education.

Emergency managers provide core management and administrative support at all levels of disaster response. Cultural sensitivity and familiarity with issues related to disadvantaged and special populations within each community are identified as core skills for emergency managers. Emerging trends indicate that emergency managers will need to continue to take into consideration matters of cultural, ethnic, racial, and gender diversity when addressing the needs of disaster victims.

The focus of emergency managers’ education is State and local emergency management, roles and responsibilities of emergency managers, hazard prevention and mitigation, and disaster planning and preparedness. Additionally, emergency management curricula should also include disaster sociology, and cultural, ethnic, racial, and gender diversity since minority populations usually have higher disaster vulnerability.

Social workers focus on the human services needs of disaster victims. An increasing body of research in social work emphasizes the need for social workers to incorporate

culturally competent approaches into their practice and make treatment consistent with a client's cultural beliefs. Social work literature offers several models for incorporating cultural competence into social work practices, including the culturally diverse social work of Lum (1996), the "ethclass" model of Devore and Schlesinger (1998), and the ethnic competence model by Green (1995).

Social workers receive their education through college undergraduate, graduate, and post-graduate degree programs. The National Association of Social Workers emphasizes cultural competence as a central component of social work practice, and encourages its members to make cultural competence a part of their education and training. Cultural competence has been incorporated into college degree programs in social work and is reported to have enhanced students' awareness of issues related to culture and racism.

The American Red Cross is the largest humanitarian volunteer organization in the United States. The American Red Cross supports disaster relief efforts through blood collection, communication and resource support provided to survivors, health and safety services, and volunteer training. American Red Cross disaster services are designed to minimize the immediate suffering caused by a disaster by providing food, clothing and shelter, and medical, nursing and mental health assistance. The American Red Cross incorporates cultural awareness into their volunteer training, through their local chapters and at an organizational level through their Strategic & Tactical (S&T) Diversity Business Planning Model.

Emergency medical services (EMS) personnel are responsible for providing immediate care by stabilizing patients and removing them from the scene. It is recommended that EMS personnel have knowledge of cultural differences in response to trauma, grief, and death in order to calm fears, worries, and frustrations. It is also essential that 911 call center staff have skills in effectively working with interpreters. At the organizational level, EMS agencies would benefit from incorporating culturally and linguistically competent services as part of their mission statements and developing policies and procedures for recruiting and retaining diverse staff and supporting ongoing professional development in cultural competence.

EMS qualifications, standards, and education practices vary widely nationwide, and education and training requirements and scope of practice are different from one State to another. There is limited reciprocity between States in terms of recognizing EMS personnel certifications, and each State has its own accreditation process for EMS education programs. Therefore, one of the most pressing issues in EMS education is creating national standards of practice and a national accreditation process. At the same time, EMS agencies are strongly encouraged to implement "innovative solutions that address cultural variation, rural circumstances, and travel and time constraints" to include distance learning programs.

Mental health professionals are charged with providing support for the affected community, response personnel, and families of those directly impacted by a disaster. These professionals' main focus is to improve the mental health of individuals.

Multiculturalism and culturally competent mental health services have gained importance in the mental health professions due to shifts in demographics and the impact of cultural differences on mental health practices. Suggested strategies for working with diverse populations include creating a safe and welcoming environment, simplifying messages, and supporting messages with written materials. Practitioners can also benefit from using interpreters and gaining knowledge relevant to specific ethnic groups and incorporating this knowledge into assessment and treatment. At the same time, there is no substantial empirical evidence related to what are the key elements of cultural competence in mental health and what influence, if any, they have on clinical outcomes for racial and ethnic minorities (CMHS, 2001a).

Disaster mental health focuses on short-term interventions to help survivors cope with the aftermath of disaster, mitigate additional stressors or psychological harm, develop coping strategies, and restore survivors to an acceptable level of adaptive action. Recent research shows that there is no single, universally applicable recipe for providing disaster mental health services. Each service should be culturally relevant and respectful of the beliefs and social practices of minority populations. Principles of cultural competence in disaster mental health research include recognizing the importance of culture and respecting diversity; recruiting disaster workers who are representative of local communities; ensuring that services are accessible, appropriate, and equitable; and ensuring that services and information are culturally and linguistically competent. The Regional Coordinating Center for Hurricane Response (RCC) reports following Katrina, that “even when one intends to do good, offending people in the existing system can lead to ostracism and ability to reach goals” (Mack, Brantley & Bell, 2007).

Cultural competence training and education are considered an important indicator of cultural competence in mental health services delivery. At the same time, researchers point out the lack of consensus on the most effective methods of multicultural education and lack of guidance on how to proceed in acquiring multicultural competence. Several researchers have argued that professional training of disaster mental health professionals requires a comprehensive curriculum that should include conceptual framework of disaster mental health, practitioner guidelines, administrative guidelines, and working with special populations, to include ethnic minorities.

U.S. Armed Forces participate in disaster relief and provide support to civil authorities within the U.S. and internationally. However, disaster relief is secondary to the U.S. military mission of national defense, so the approach to cultural competence is grounded in the goals of conducting successful combat operations and gathering intelligence. Though there has been some recognition of the need to integrate cultural competency into the training for military healthcare providers, this is still a concept under review by the leadership within the military healthcare system (L. Hill, personal communication, July 23, 2007). Within the military, there are a number of methods to teach cultural competence, including briefings, handouts, books, language training, and specialized training programs, such as the Foreign Area Officer program.

The United States Public Health Service Commissioned Corps is made up of public health officers from a variety of professions, including physicians, nurses, pharmacists, dentists and scientists. The Commissioned Corps is trained and equipped to respond to public health crises and national emergencies, such as natural disasters, disease outbreaks, or terrorist attacks. Their training is grounded in a hands-on approach to disaster relief operations and response planning, which was deemed crucial in the Commissioned Corps' response to Hurricane Katrina. The Commissioned Corps has recently revised their core readiness training to include information on working with at-risk individuals during disasters, and a number of their trainings include information on cultural awareness, cultural competence, and working with diverse populations.

The Citizen Corps is a coordinated movement to guide individuals in preparedness efforts. The Citizen Corps consists of volunteer individuals from a variety of professions, backgrounds, and skill levels. A major goal of the Citizen Corps is to create safer communities with citizens who are trained to respond to emergencies when outside assistance may not be available. The Citizen Corps movement seeks for everyone to become involved in preparedness activities by linking pre-existing volunteer, preparedness and community safety initiatives (DHS, 2002). Involvement of individuals from a variety of different backgrounds and experiences is encouraged in leadership roles, through Citizen Corps Councils, and in all of the major volunteer programs.

1. Introduction

The tragedy of Hurricane Katrina³ provides fertile ground for the nation to reflect on the organization of disaster response capabilities and training of disaster responders to provide critical care and services in and immediately after a disaster. As Dr. Garth Graham, HHS Deputy Assistant Secretary for Minority Health, stated in September 2005, “Minority communities are among those most highly impacted by the terrible destruction of Hurricane Katrina,” and DHHS acknowledged the need to bring forth expertise in the areas of “cultural sensitivity, community trust and credibility” to facilitate the arduous task of relief for those communities (DHHS, 2005).

Disasters on the scale of Katrina are uncommon, but they provide insight into issues that occur every day. At all levels of the disaster response system, cultural and language barriers between survivors and responders can undermine relief efforts if not dealt with appropriately. For instance, cultural and language barriers between disaster victims and emergency personnel can delay the communication of critical information, including evacuation orders, as well as vital health education and disease prevention information in the disaster aftermath. As some researchers point out, disasters provide an opportunity where responders can “respond directly to the position of marginalized populations, potentially transforming their experience of our social safety net” (Seidenberg, 2006).

The aftermath of Hurricane Katrina revealed that minorities were disproportionately affected (Gheyntanchi et al., 2007). Minorities are also likely to be at a greater risk of largely preventable health problems associated with the disaster; for example, public health-related conditions, such as skin rashes and gastrointestinal problems from exposure to and drinking of unclean water, and carbon monoxide poisoning from generators. The Katrina response shed light on a deficiency of health care services provided to disaster survivors, specifically the disparities in the quality of health care afforded to our country’s racial and ethnic minorities.

Disparities in health care have been documented in a number of groundbreaking reports. Findings of *The Supplement to Mental Health: A Report of the Surgeon General* (CMHS, 2001a) reveal that “racial and ethnic minorities bear a greater burden from unmet mental health needs and thus suffer a greater loss to their overall health and productivity.” Findings from the 2000 Surgeon General’s report *Oral Health in America: A Report of the Surgeon General* indicated significant disparities “between racial and socioeconomic groups in regards to oral health and ensuing overall health issues” (DHHS, 2000). The 2003 report from the Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* (Smedley, Stith & Nelson, 2003), and its supplementary paper contributions such as *Racial and Ethnic Disparities in Diagnosis and Treatment: A*

³ As stated in the Executive Summary, the authors recognize that Hurricane Katrina was not the only storm of note to occur during the historic 2005 Atlantic hurricane season. Storm surge from Hurricane Rita certainly contributed additional substantial damage to many of the same areas which had been previously impacted by Hurricane Katrina, and the adverse effects from each were extensive. Throughout this document, the authors refer to Hurricanes Katrina and Rita as Hurricane Katrina, unless specifically cited otherwise in the literature.

Review of the Evidence and a Consideration of Causes (Geiger, 2003) and *The Civil Rights Dimension of Racial and Ethnic Disparities in Health Status* (Perez, 2003), brought to the forefront that minorities receive lower quality health care even when socio-economic and access-related factors are controlled. The report also showed that bias, stereotyping, prejudice and clinical uncertainty may contribute to racial and ethnic disparities in health care (Smedley et al., 2003).

A significant body of research released since the 2003 IOM report corroborates these findings. *The National Healthcare Disparities Report* prepared by the Agency for Healthcare Research and Quality states that “although varying in magnitude by condition and population, disparities are observed in almost all aspects of health care” (The Agency for Healthcare Research and Quality, 2006). The provision of health care and social services in the context of disasters presents unique challenges in the delivery of culturally and linguistically competent care, such as: temporary work environments, limited availability of resources such as interpreters, and unfamiliar surroundings and communities for non-local responders.

To help diminish disparities in health care, the Office of Minority Health (OMH) launched the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care in December 2000 (OMH, 2000). The standards were developed on the basis of an analytical review of key laws, regulations, contracts, and standards used by Federal and State agencies and other national organizations, with input from a national advisory committee of policymakers, health care providers, and researchers. Open public hearings were held to obtain input from communities throughout the nation. The standards represent the first national standards for cultural competence in health care.

The CLAS standards offer comprehensive guidance on what constitutes culturally competent service delivery. They consist of 14 guidelines and recommendations that serve to inform, guide, and facilitate implementation of culturally and linguistically appropriate services in health care. The CLAS standards are organized by three themes: Culturally Competent Care, Language Access Services, and Organizational Supports (Figure 1). They recognize that culture and language are central to the delivery of health services. The implementation of CLAS standards can be particularly beneficial in disaster response, since it is essential for responders to be sensitive to cultural and linguistic factors while serving people from all backgrounds (DHHS, 2007b; Jones et al., 2006).

Inspired by the CLAS standards, national organizations including the American Medical Association (AMA), American Association of Medical Colleges (AAMC), the Joint Commission and others have released standards to help support the provision of culturally and linguistically appropriate care. Many of these standards promote the education and training of health care providers in culturally appropriate care.

Increasingly, national experts are looking to cultural competency training as a means to reduce disparities in health care. Evidence suggests that the most effective cultural competence training helps providers develop new knowledge, skills, and attitudes in order to effectively treat minority and immigrant populations (Smedley et al., 2003).

To help providers develop cultural competence, the Office of Minority Health (OMH) at DHHS spearheaded the development of several educational programs. The *Cultural Competency Curriculum Modules* (CCCMs) launched on December 6, 2004, are intended for physicians and designed to help them build cultural and linguistic competencies required to improve the quality of care for minority, immigrant, and ethnically diverse communities. On March 16, 2007, OMH launched the *Culturally Competent Nursing Modules* (CCNMs) in order to help nurses provide culturally appropriate services to racial and ethnic minority populations. With the realities of September 11th and Hurricane Katrina, OMH made the decision to expand the continuing education opportunities to include persons involved in disaster preparedness and crisis response.

<p>Culturally Competent Care</p> <p>1. Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.</p> <p>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.</p> <p>3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in CLAS delivery.</p>
<p>Language Access Services</p> <p>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 LEP at all points of contact and in a timely manner during all hours of operation.</p> <p>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.</p> <p>6. Health care organizations must ensure 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).</p> <p>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.</p>
<p>Organizational Supports</p> <p>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 CLAS.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>14. Health care organizations are encouraged to make available regularly 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.</p>

Figure 1: Office of Minority Health's Recommended National Standards for Culturally and Linguistically Appropriate Services in Health Care

Therefore, OMH contracted with Systems Research Applications International, Incorporated (SRA International, Inc.) to create an E-learning program to help disaster

responders develop cultural and linguistic competencies. This Environmental Scan serves as the first step in the development process of this tool. Cultural competency training targeting disaster responders will greatly impact the quality of disaster relief services provided to minority populations. The proposed curriculum will help disaster responders develop skills for effectively interacting with minority populations and enhance the quality of services.

Among the audiences that could benefit from the cultural competence curriculum are emergency managers, EMS personnel, social workers, mental health practitioners, the U.S. Public Health Service Commissioned Corps, the U.S. military, and volunteer relief organizations such as the American Red Cross. Each of these groups has specific functions in disaster response as outlined in the National Response Plan (NRP), published in 2004 (DHS, 2004a) and discussed in further detail in Section 3 of the Scan. The emergency support functions (ESF) outlined in the NRP provide a framework for organizing the information within the Scan.

Definition of Cultural Competence

Derived from the field of medical anthropology, the concept of cultural competence has been employed in many fields of health care delivery and disaster response. The first published mention of the term “cultural competence” was by Cross and colleagues (Cross et al., 1989). For the purposes of this project, we adopt the definition used in the CLAS Standards (OMH, 2001):

Cultural and linguistic competence is 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.

In this definition of cultural competence, social groups encompass not only race, ethnicity, and religion, but also gender, sexual orientation, age, disability, and socioeconomic status. Linguistic minorities include not only people with limited English proficiency (LEP), but also people with low literacy skills and the deaf and hearing impaired (Figure 2).

Social Groups

- Race
- Ethnicity
- Religion
- Gender
- Sexual orientation
- Age
- Disability
- Socioeconomic status

Linguistic Minorities

- Limited English proficiency
- People with low literacy skills
- Deaf and hearing impaired

Figure 2: Social Groups Recognized in the Definition of Cultural Competence**Purpose of the Environmental Scan**

This Environmental Scan is an integral part of developing a curriculum on cultural competence for disaster responders. The Scan was created to determine the state of the literature and resources on the concepts, policies, and teaching practices for disaster responders as they pertain to the provision of culturally competent services. Furthermore, the Scan was necessary to determine if the available information provided an adequate base for developing curriculum and if so, to summarize and synthesize that information into a usable form.

The Scan provides background information on the applicability and relevance of culturally and linguistically appropriate services in disaster response preparedness. In addition, the Scan contextualizes the large variability of disaster types and target audiences, as well as the diversity of disaster responder roles and personnel. Information contained in the Scan also provides a baseline understanding of the CLAS standards and cultural competency to the National Project Advisory Committee (NPAC), subject matter experts who will work closely with project staff to guide the development of the curriculum.

The three-tier disaster response system in the U.S. that includes local, State and Federal response operations forms the starting point for this curriculum development initiative. Local emergency response starts with emergency medical services (EMS) personnel. When local resources are insufficient for dealing with emergencies and disasters, local authorities can submit requests for State assistance following communication protocols described in local and State emergency response plans. At the federal level, response to disasters is coordinated through the NRP published in 2004 (DHS, 2004a). The plan establishes the national level policy and operational direction regarding Federal support to State and local emergency managers in disaster events.

The NRP establishes the emergency support functions (ESF), or functional areas of disaster response that consist of teams from each Cabinet department providing direct services to the affected population (Neuby, 2006). Three ESFs are most relevant to the target audiences for this curriculum: ESF #5, Emergency Management, focuses on the

core management and administrative functions in support of disaster response; ESF #6, Mass Care, Emergency Assistance, Housing and Human Services, addresses the non-medical mass care, housing needs, and human services of disaster victims; and ESF #8, Public Health and Medical Services, focuses on public health and medical care needs (DHS, 2004a).

The 14 CLAS standards (Figure 1) serve as a suggested framework for development of this curriculum. Directed primarily at health care organizations, they represent a comprehensive set of recommendations for implementing culturally and linguistically appropriate services at all organizational and individual provider levels. The CLAS standards encompass three interdependent themes that are parts of the interrelated and overall construct of cultural competence as outlined below.

Themes of CLAS Standards as Applied to Disaster Response:

1. Culturally Competent Care refers mainly to the relationship between responders and disaster survivors and the delivery of culturally competent care to survivors and their families by individual responders.
2. Language Access Services focus on facilitating communication during all phases of a disaster (preparedness, response, recovery). Specifically educating community members prior to an event and then assisting the responders' role following the disaster to ensure appropriate language access services for survivors.
3. Organizational Supports focus on policies and procedures to help responders and response teams provide effective services to the survivors.

A culturally competent disaster response requires language access services for LEP patients and support by the organization at large. Organizational supports ensure that disaster responders receive supports that they need in providing consistent culturally and linguistically appropriate services on an ongoing basis.

Technology and Education for Disaster Responders

Technology has been an important factor in education, and many researchers recognize its role in enhancing the quality of learning experiences and access to learning materials. Web-based training offers great potential in terms of overcoming geographical constraints in training delivery and means to meet the growing need for disaster management education (Young et al., 2006; Neal, 2004). Distance learning also enhances training by using current

Web-based instruction provides a means to increase access to students interested in disaster degree program, especially among those who may be non-traditional students and/or who do not live near a university with a degree program. Thus, the wide range of flexibility offered through web-based learning can provide one important means to meet the growing need of disaster management education.

Neal. 2004

and emerging technologies for management and delivery of training “when and where it is needed” (DOD, 2005b). Despite the promise of distance and e-learning programs to educate in disaster response, most of the programs which currently exist do not place a

strong focus on cultural competency. The literature illustrates a strong need for disaster preparedness and crisis response continuing education programs that focus on cultural competency, are interactive, and engage participants in active learning.

A growing number of educational programs in emergency response are delivered through the Web in the form of distance learning modules, courses, or Webcasts. Educators note that creating a distance learning course is a process that requires different approaches. Analyzing his online teaching experience in disaster management, Neal (2004) argues that a mere posting of learning materials on the course Web site and creating online assessment tools does not create an online virtual course. Green (2004) pays attention to careful instructional design of online courses, since “simply typing out text for students to read on the screen achieves the same level of compliance as assigning them reading material.” According to Fischer (2003), memorizing key facts and roles of emergency managers is the lowest level of learning, and online courses should engage higher levels of learning, active learning and promote communication between students and the instructor. Another important component of distance learning courses design is narrow focus of instructional content, since courses with broad scope do little to prepare students for dealing with situations occurring in emergency response (DHHS, 2007).

Other authors point out that many online courses lack interactive activities, and suggest developing interactive exercises specific to mental health preparedness and disaster mental health (CPHP, 2005). Increased interactivity of education software engages students, makes them more active, and helps students internalize learning materials (Fischer, 2003). Interactivity could be enhanced through online interactive tools such as discussions. Content presentation could be enhanced by video vignettes.

- Interactive content presentation
- Use of instructional video
- Assessment tools
- Case studies
- Discussions

Figure 3: Recommended Elements of Web-based Courses for Disaster Responders

Sources: Neal, 2004; Green, 2004; Fischer, 2003; CPHP, 2005

Our review of a sample of thirty-two distance learning resources that are offered as a part of continuous education related to emergency response indicates that less than half of them (46%) present instructional content interactively (Figure 4; see Appendix D for additional information). Seven of the courses reviewed utilize rich educational opportunities offered by instructional video, and ten of the courses reviewed engage higher order learning processes through case studies (see Appendix D). In terms of topics, cultural competence is covered in detail in six courses, and eight courses cover it marginally. Only one course specifically addresses the CLAS standards, and one course mentions them briefly.

Resource Format	Number of resources
Interactive distance learning courses	15
Webcasts	8
Courses based on downloading text reading materials and online assessments	5
Non-interactive audio/video based courses	4

Figure 4: Format of Distance Learning Resources

Source: Courses listed in Appendix D

One option for using technology for education is Web-based resource collections and databases. For instance, the Resource Center of the Centers for Public Health Preparedness contains 1,127 resources for first responders to include EMS personnel. The primary focus areas of this and other similar centers are emergency preparedness, terrorism, and weapons of mass destruction (WMD). Only sixty-five of these resources are related to cultural competence and include distance learning courses, Webcasts, and resources (CPHP, n.d.).

Another promising practice in continuing education is the use of State- or university-based online training catalogues and learning management systems to provide access to nationwide learning opportunities from academic, government, and private providers. The majority of courses offered through these systems relate to disaster response, emergency management, and terrorism. Through one such system, the South Central Public Health Partnership (SCPHP) Web site, the majority of courses are on WMD, chemical terrorism, bioterrorism, agroterrorism, and epidemiology. Out of seventy-eight online courses, three courses focus on diversity and cultural competency and two courses focus on special needs populations and disasters (Figure 5).

Topic	Number of courses
Agroterrorism	4
Bioterrorism	4
Chemical terrorism	6
Communication	15
Diversity and cultural competence	3
Environmental health	3
Epidemiology	9
General public health	5
Public health management and policy	14
Risk assessment	5
Special needs populations and disasters	2
Weapons of mass destruction	8
Total	78

Figure 5: Online Courses Offered through the SCPHP Web Site

Source: South Central Public Health Partnership, n.d.

Other similar systems include *The California Distance Learning Health Network* (CDLHN), which was created as a result of collaboration between four universities in California in 1995 and offers access to courses and Webcasts on bioterrorism, nursing, mental health, culture, and community programs, and *The Center for Public Health Preparedness* at Ohio State University, which focuses on the needs of special populations to include major ethnic groups within the U.S., as well as resources on language barriers to hospital access and overcoming language barriers (CPHP Ohio, n.d.). The topics

covered in distance learning centers and Resource centers are discussed in more detail in Appendices D and E.

Methods used to Develop the Scan

The Environmental Scan consisted of gathering information between December 2006 and January 2008 through literature searches, Internet searches, review of relevant training and education materials, and interviews and email contact with experts in the field. Our main objective during the gathering phase was to ensure a broad perspective on the issue of cultural competence and disaster response by collecting information from a variety of sources. The sources focused on materials related to teaching cultural competence to disaster responders, including the content of specific cultural competency curricula, conceptual frameworks for cultural competence, policy and accreditation standards, and other information pertaining to the CLAS themes. Sources of information for the Scan included the following categories:

1. **Published literature** – Peer-reviewed journal articles, editorials and opinion pieces in peer-reviewed journals, books and reports on cultural and linguistic competence, theories, frameworks, practices, surveys, as well as other research that focused on first responders, emergency preparedness and disaster response.
2. **Disaster responders training programs** – Information on courses and curricula in disaster response and cultural competence, program information, and course syllabi.
3. **Federal, State, and local disaster response agencies** – Policy and legal information, certification standards, and contracting requirements.
4. **Public and private disaster response organizations** – Internal institutional guidelines, policies, training materials, accreditation standards, and reports.

The primary search methods included using Web-based databases such as PubMed, EBSCO, ProQuest, and PILOTS for literature searches. Key words included: “first responders,” “cultural competence,” “intercultural communication,” “medical first responders,” “EMS,” “EMT,” “emergency management,” “disaster preparedness,” “emergency preparedness,” “NIMS,” “paramedic,” “disaster outreach,” “evacuation orders,” “public communication,” “public disaster relief,” “vulnerable populations,” and “multicultural counseling” (a complete list of search terms is listed in Appendix B). We also used reference lists from prominent reports, documents, and published articles.

We performed Internet searches using the Google search engine for terms related to “cultural competence curricula,” “cultural diversity,” and “emergency responders.” We also searched online training course catalogues and databases of online training resources, for instance the Resource Center of the Centers for Public Health Preparedness for information on the Web-based educational resources for disaster preparedness and crisis response.

Another major source of information for the Scan was an email survey of experts in the field of disaster response and from data gathered during expert interviews conducted in June - August 2007. The results of the survey are summarized in Appendix C.

Organization of the Scan

This report is divided into six main sections: Introduction, Context and Rationale for Cultural Competency in the Disaster Response Arena, Organization of Emergency and Disaster Response in the United States, Applying the CLAS Standards at Every Phase of Disaster, Conclusion, and a section on profession-specific roles and responsibilities in disaster preparedness and crisis response are included as Addendums.

Following the Executive Summary and Introduction, the Context and Rationale for Cultural Competency in the Disaster Response Arena section discusses the definitions of disaster, disaster characteristics, and disaster phases. The section on Organization of Emergency and Disaster Response in the U.S. highlights local, state and federal emergency response, as well as volunteer and military defense support. It also examines each through the lens of response efforts to Hurricane Katrina.

The next section, Applying the CLAS Standards at Every Phase of Disaster, describes the three themes of the CLAS standards (culturally competent care, language access services, and organizational supports) as they apply to disaster responders. It provides an overview of research related to culturally-specific responses to disasters, disaster impacts, and vulnerabilities at each phase of a disaster event.

The Profession-Specific Addendums discuss job functions, standard training requirements, and job functions of disaster responders who will benefit from training in cultural competence. The key target audiences include emergency managers, EMS personnel, social workers, mental health practitioners, the U.S. Public Health Service Commissioned Corps, the Citizen Corps, volunteer relief organizations such as the American Red Cross, and the military. This section also discusses recommendations for culturally competent disaster response and current education practices for each target audience. The final section concludes our review by summarizing the main findings relevant to this project.

2. Rationale for Cultural Competence in Disaster Response Arena

The CLAS standards recommend that the delivery of culturally and linguistically appropriate services include: culturally competent care, which involves a set of knowledge, skills, and attitudes at the practitioner level; language access services, which are a culmination of resources, procedures, and activities coming together to support communication for LEP and low-literacy consumers; and organizational supports which are integrated throughout an organization via planning, assessments, data collection and other activities.

The growing diversity of the U.S. population makes it especially important to provide culturally competent services to racial and ethnic groups⁴. According to the 2000 Census, racial and ethnic minorities comprised almost one-third of the U.S. population (U.S. Census Bureau, 2001; Figure 6). As of 2003, according to the U.S. Census Bureau, 11.7 percent or 33.5 million people in the U.S. were foreign-born (Larsen, 2004; Figure 7). Also according to the 2000 Census, forty-seven million people aged five and over (18 percent of the population) spoke a language other than English at home (Shin, 2003).

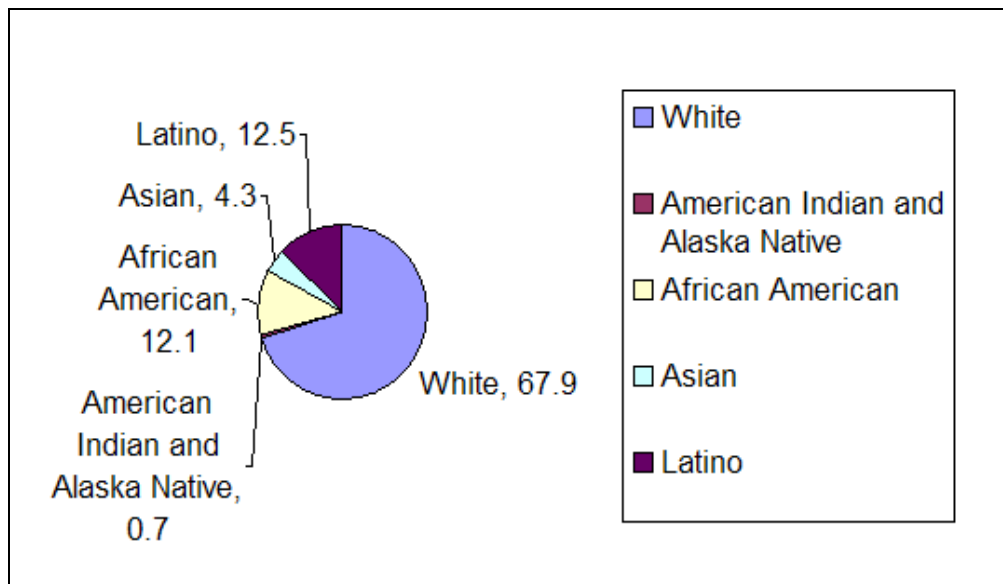


Figure 6: U.S. Population by Race/Ethnicity, 2000

Source: U.S. Census Bureau, 2001

⁴ Racial and ethnic categories appear in the Environmental Scan as they do in their original source. When not cited from a specific source, categories for race and ethnicity are based on the United States Census Bureau's *Racial and Ethnic Classifications Used in Census 2000 and Beyond*, available online at <http://www.census.gov/population/http://www/socdemo/race/racefactcb.html>.

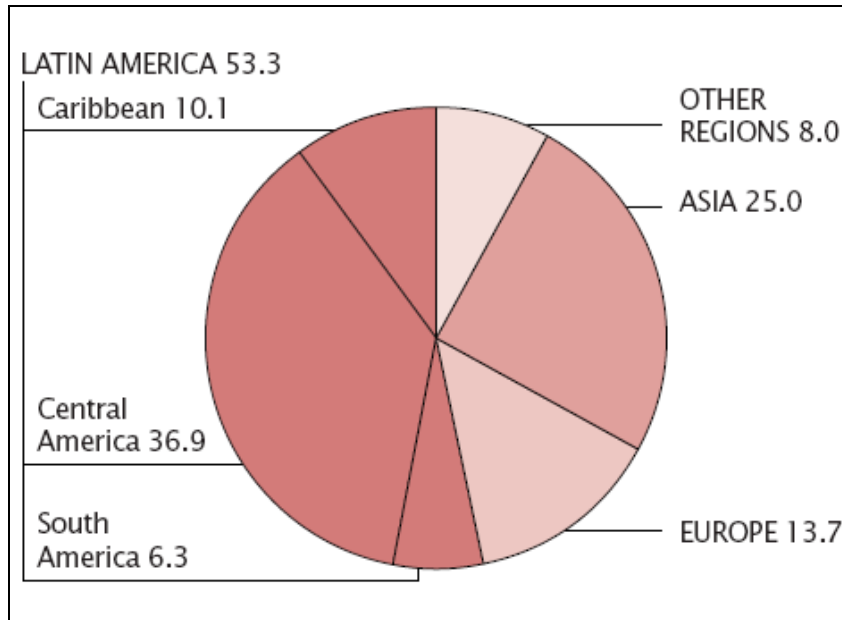


Figure 7: Foreign-Born Population by World Region of Birth
Source: Larsen, 2004

With the increasing diversity of the U.S. population, health care providers need to concentrate on the escalating concern of racial and ethnic disparities in health and health care. According to data collected by the National Center for Health Statistics at the Centers for Disease Control and Prevention (2006b), a greater percent of minorities assess their health as fair or poor as compared to White Americans (Figure 8).

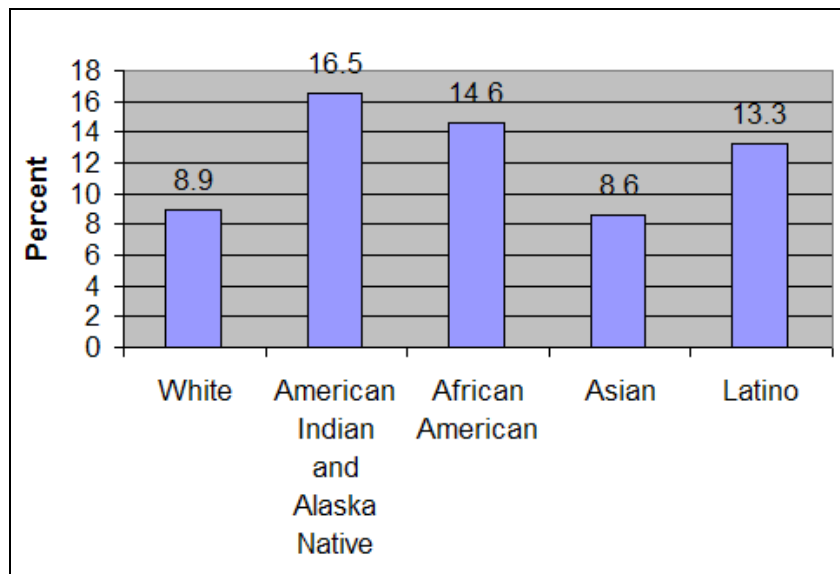


Figure 8: Fair or Poor Health by Race/Ethnicity, 2004
Source: CDC, 2006b

One contributing factor to disparities in health outcomes and status of racial and ethnic groups may be disparities in the health care they receive. Causes of these disparities could include provider variables such as provider bias or discrimination as well as patient

variables such as mistrust of the health care system or refusal of treatment (Baldwin, 2003). Programmatic variables such as a lack of interpreters and culturally and linguistically appropriate health information may also contribute to racial and ethnic health disparities (Yang & Kagawa-Singer, 2007). As a result, minorities are more likely to experience a lower quality of services and are less likely to receive routine medical procedures than are White Americans (Smedley et al., 2003).

Disaster response poses specific challenges in the provision of culturally competent services to minority populations. Disaster responders encompass several professional groups that provide a variety of services to populations affected by disasters. These groups may include emergency managers who provide logistical support for emergency relief operations, individuals who work for state, local, or federal governmental organizations (such as the Federal Emergency Management Agency (FEMA)), mass care providers who help with housing and social services (including social workers, disaster mental health professionals, and the American Red Cross), public health and medical services providers (including emergency medical services (EMS) personnel who may be the first to arrive at the scene), and the military. Each of these groups may have different levels of training in cultural competence and working with minority populations. Further, during disaster response, structures and supports for culturally competent services may not be available in ways that practitioners are used to. SAMHSA researchers (2003) state that disaster services involve: “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.” Moreover, responders themselves may be disaster victims experiencing high levels of personal stress and therefore also in need of help. As part of a survey distributed for our data collection process, Kelly (2007), an expert in interpretation and training of disaster responders, commented that there is a lack of availability of adequate stress debriefing opportunities for responders after a disaster. Furthermore, although interpreters often report vicarious emotional trauma after interpreting in disaster and emergency situations, interpreters (especially volunteer interpreters), do not typically receive stress debriefings as part of their training (Valero-Garcés, 2005).

Chan and colleagues (2004) state that “ultimately, disasters are characterized by many people trying to do quickly what they do not ordinarily do, in an environment with which they are not familiar.” Thus, even practitioners who are far along in the cultural competency development process may experience unique challenges in culturally and linguistically appropriate service delivery when participating in the context of disaster response. However, researchers in the field of disaster mental health have noted that response planning can help to provide order, and thus offers value in terms of healing to victims and responders (Everly, n.d.).

Cultural competence is especially critical in disaster response given research findings showing that ethnic minorities are disproportionately affected by disasters. For example, some of the ethnic minorities in the Katrina disaster area included Vietnamese, Mexican, Honduran, and Indian, and about forty percent were recent immigrants that arrived in the 1990s. Twenty-four percent of the minority population lived below the poverty line and

encountered multiple losses (Batalova, 2005). Additionally, many recent immigrants had to face language barriers and unique immigration-related issues such as loss of documentation to prove their legal status, thus making them ineligible for Federal assistance (Wasem, 2005).

What is a Disaster?

The literature offers a number of definitions for the term disaster. Quarantelli (1986), one of the leading experts in disaster research, notes that the earliest definitions of disaster focus on the physical characteristics of disasters and their impact on the environment. Over time, the concept of disaster has evolved to take on a more social orientation (Quarantelli, 1986). Mileti (1999) proposed a system theory of disasters and showed that disaster losses result from an interaction of three systems: earth physical system, human systems (population, culture, technology, social class), and the constructed system (buildings, roads, bridges, public infrastructure). Each of these systems is dynamic, and as human and constructed systems are becoming increasingly complex, susceptibility to disaster losses is going to increase (Mileti, 1999).

Other researchers point out psychological effects of disasters. McFarlane and Norris (2006), for instance, define a disaster as “a potentially traumatic event that is collectively experienced, has an acute onset, and is time-delimited.” This definition encompasses a number of important ideas, the first being the concept of trauma. The DSM-IV defines a traumatic event as one in which both of the following were present: “(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others, and (2) the person’s response involved intense fear, helplessness, or horror.” McFarlane and Norris (2006) note that disasters are potentially traumatic, in other words, not every disaster will cause death or injury to others, but all disasters will have the potential to do so.

Research into disaster mental health offers another definition of disaster that is related to “severe disruption, ecological and psychological, that greatly exceeds the coping capacity of the affected community” (De Girolamo & McFarlane, 1996). This definition implies that what one community perceives as disaster may not be a disaster in another community. This definition also points to the complexity of disasters, and an event may be a disaster along some dimensions (ecological, psychological, or social) without being a disaster along others (De Girolamo & McFarlane, 1996).

Existing definitions of disaster emphasizes that these events are collectively experienced, and have made important distinctions between individually and collectively experienced events. Individually experienced potentially traumatic events can include interpersonal violence, injury or illness, or household emergencies such as fires (McFarlane & Norris, 2006). Both early and current literature identify that disasters are described by “mass collective stress” that impacts many people simultaneously (McFarlane & Norris, 2006; Kinston & Rosser, 1974; Bolin, 1986; Quarantelli, 1986).

Disasters are characterized by specific temporal dimensions, including acute-onset and time-limited impact with a relatively clear beginning and end (McFarlane & Norris, 2006). Barkun (1974) has argued that much of the force of disasters is due to their acute-onset and “sudden manner in which it assaults unprepared societies, institutions, and psyches.”

Figure 9 illustrates a classification of potentially traumatic events, ordered by individual and collective experience and threat type. Under this typology, disasters are encompassed by collectively experienced acute threats, including: natural disasters, technological accidents, and episodes of mass violence.

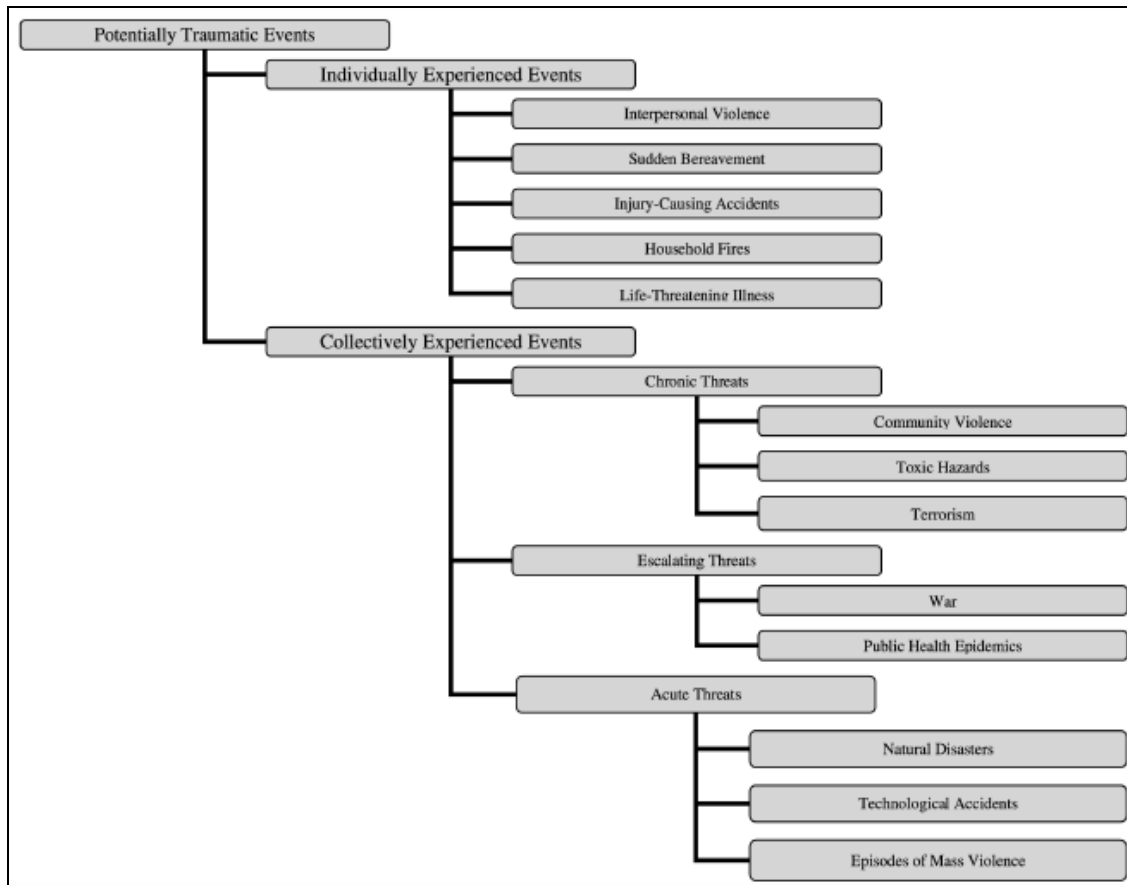


Figure 9: Classification of Potentially Traumatic Events

Source: McFarlane and Norris, 2006

Another classic definition by Fritz (1961), an expert in disaster research, also stresses the characteristics of disasters occurring in a specific time and place and occurring in a social context:

Disasters are concentrated in time and space, in which a society or a relatively self-sufficient subdivision of society, undergoes severe danger and incurs such losses to its members and physical appurtenances that the social structure is disrupted and the fulfillment of all or some of

the essential functions of the society is prevented
(Quarantelli & Tierney, 1979).

Several authors define disasters through disaster response and the balance between demands and capabilities of a community in crisis. Quarantelli (1986) states that from this perspective, a disaster occurs when the “demands for action exceed the capabilities for response in a crisis occasion” and that it “typically requires non-routine and emergent collective behavior;” Waeckerle and colleagues (1994, 1996) state that disaster events overwhelm a community’s emergency response capacity; and Noji describes that disasters create an imbalance between the supply of available resources and the need for those resources. Research has noted that the primary difference between emergencies and disasters is that disasters exceed local emergency response capabilities whereas emergencies can be managed by local resources and authorities (Everly, n.d.; FEMA, 2005). Auf der Heide (1989, 1996) has also stated that disasters bring about unique logistical difficulties such as evacuation, overloaded communication channels, and the coordination of unsolicited volunteers.

Some disaster response organizations and academic panels have taken a more quantitative approach to defining disaster. For example, the International Federation of Red Cross and Red Crescent Societies define disaster as an event that causes more than 10 deaths, affects more than 100 people, or leads to an appeal for assistance by those affected (Bravata et al., 2004). The Institute of Medicine (IOM) describes the term disaster as “a low-probability but high-impact event that causes a large number of individuals to become ill or injured” (IOM, 2007).

Disasters can be naturally occurring or man-made. The IOM identifies that man-made events can be intentional, such as terrorist attacks, or unintentional such as train wrecks, plane crashes, and fires (IOM, 2007). Other researchers have subdivided human-caused disasters into technological accidents and mass violence, defined thus:

Technological accidents are disasters caused by neglect, carelessness, callousness, or failures of technology, such as mass transportation accidents or dam collapses, whereas mass violence refers to disasters caused by intent or malevolence, such as shooting sprees or peacetime terrorist attacks (McFarlane & Norris, 2006).

The literature reports that survivors can have unique psychological reactions to natural and man-made disasters (DeWolfe, 2000). For example, in the case of human-caused disasters, “survivors grapple with deliberate human violence and human error as causal agents” whereas in the case of natural disasters, “the causal agent is seen as beyond human control” (DeWolfe, 2000). Green and Soloman (1995) note that some disasters occur or are worsened through an interaction of natural and human factors, such as increased damage from flooding because of faulty planning or warnings. Recent research explored the complexities of disasters, and suggests a view of disasters not as isolated phenomena, but as “interactions within or between complex, dynamic systems” (Sarewitz

& Pielke, 2001). The authors use the 2000 Manila garbage avalanche to illustrate the interaction between economic factors leading to shantytowns on top of a garbage dump and seasonal monsoon rains coming together to create a disaster with 160 casualties (CNN.com, 2000).

Characteristics of Disasters

The SAMHSA *Training Manual for Mental Health and Human Service Workers in Major Disasters* (DeWolfe, 2000) notes that “disasters are not uniform events” and each event has “intrinsic unique elements” that can influence the impact of the disaster on survivors. Quarantelli (1986) states that “cumulative research and theory in the disaster area show there are many sociobehavioral features which are not disaster-specific but are manifested across many different types of disaster agents. In his classic 1970 book, *Communities in Disaster*, Barton identified four basic characteristics of disasters which allow the observer to make comparisons across events. These characteristics include: scope of impact, speed of onset, duration of impact, and social preparedness. Other recent works have referenced the predictability and recurrence of disasters as key characteristics of these events (DeWolfe, 2000).

Scope of impact refers to whether disaster impact is narrow or widespread (Perry & Mushkatel, 1986). One way of quantifying scope of impact is the impact ratio of a disaster – the proportion of the population that is affected directly by the disaster. McFarlane and Norris (2006) note that the impact ratio can have consequences for the mental health and recovery of survivors. SAMHSA (2003) has reported that “when a disaster affects a significant proportion of a community’s population, few individuals may be available to provide material and emotional support to survivors.”

Disasters can be described as centripetal or centrifugal (Lindy & Grace, 1986). Centripetal disasters affect extant communities and “pose a risk to all those who live and work in these communities and may affect social and community functioning as well as psychological functioning” (McFarlane & Norris, 2006). In centripetal disasters, the entire community shares the impact but the disaster “unites residents in the recovery process” (Call & Pfefferbaum, 1999).

Centrifugal disasters impact groups of people who are temporarily clustered together. McFarlane and Norris (2006) note that:

Centrifugal disasters differ from centripetal disasters in two important ways: (1) they are highly concentrated and localized; and (2) they strike a group who happen to be congregated often by chance. Mass transportation accidents, office tower explosions, and nightclub fires are good examples of centrifugal disasters.

Speed of onset refers to the time period between threat detection and its impact on the social system and is usually classified as sudden or gradual (Perry & Mushkatel, 1986).

Disasters vary in the amount of warning that individuals receive before the event strikes. Earthquakes or terrorist attacks usually hit with no warning, where there may be some warning period for events such as floods or hurricanes. The literature finds that “when there is no warning, survivors may feel more vulnerable, unsafe, and fearful of future unpredicted tragedies” (DeWolfe, 2000).

Duration of impact is the time period that elapses between the initial onset of the disaster and when the risk has subsided (Perry & Mushkatel, 1986). However, the end point of a disaster can sometimes be ambiguous. For example, earthquake aftershocks and recurring flooding and landslides may continue for a period of time, thereby extending anticipation, fear, and threat felt by survivors (DeWolfe, 2000). McFarlane and Norris (2006) state that some post-disaster environments, such as those posing risks for epidemics or where income-earning infrastructure and housing are destroyed, have substantial consequences for recovery because they disrupt the development of a sense of safety.

Perry and Mushkatel (1986) describe social preparedness as “the extent to which a community has devoted resources and personnel to the preparedness phase of emergency management.” Social preparedness is a continuum ranging from high levels of preparedness, characterized by effective, in-place response plans and resources to low levels of preparedness, marked by communities without response plans or appropriate resources (Perry & Mushkatel, 1986). Among the factors that may shape a community’s level of preparedness are the predictability and recurrence of disasters in that area.

Quarantelli (1986) has noted that there are times when communities can predict possible disasters and times when these crises are unexpected. For example, individuals, households, and communities located in high-risk areas such as flood plains, “tornado alley,” or regions prone to hurricanes likely have some awareness of their potential involvement in a disaster. In other cases, such as the Mount St. Helens eruption or the Three Mile Island nuclear accident, predictability of the event was low. Research has found that when predictability is high, “there is greater sensitivity to danger cues, willingness to act upon them, and less trauma in evacuations” (Quarantelli, 1981).

The potential for recurrence of hazards is an important and related dimension of disasters that can impact survivors’ emotional distress and recovery. SAMHSA has noted that the “real or perceived threat of recurrence of the disaster or associated hazards can lead to anxiety and heightened stress among survivors” (DeWolfe, 2000). Other research has indicated that when prior disaster experiences have been made routine and “incorporated into ongoing attitudes and behaviors” then disaster occasions may be less disruptive and disturbing (Quarantelli, 1986).

The Phases of Disaster

The literature offers many models of disaster phases. A four-phase description of disasters encompasses preparedness, response, recovery, and mitigation. An extended eight-category model includes risk perception, preparedness behavior, warning

communication and response, physical impacts, psychological impacts, emergency response, recovery, and reconstruction (Fothergill et al., 1999; Perry & Mushkatel, 1986).

Other descriptions of disaster phases may include: warning/threat, impact, rescue/heroic, remedy/honeymoon, inventory, disillusionment, and reconstruction/recovery (DeWolfe, 2000; SAMHSA, 2003). SAMHSA researchers caution that “the characteristics of the disaster, as well as those of the community and its...residents, affect the duration and nature of the seven phases” and that “the phases do not necessarily move forward in linear fashion; instead they often overlap and blend together” (SAMHSA, 2003). SAMHSA further distinguishes that “each person and community brings unique elements to the recovery process” that can impact their experience of disaster (DeWolfe, 2000).

A description of disaster phases will be provided in this Section using the extended eight-category model. (The Section which focuses on the application of the CLAS Standards at every phase of a disaster uses a more generalized framework of prepare, respond and recover.) Figure 10 offers a graphic representation of the phases of disaster and their hypothesized community psychosocial affect level. Also illustrated here are the concepts of trigger events and anniversary reactions which can bring about stressful reminders and recovery setbacks to survivors (Beaton, 2006).

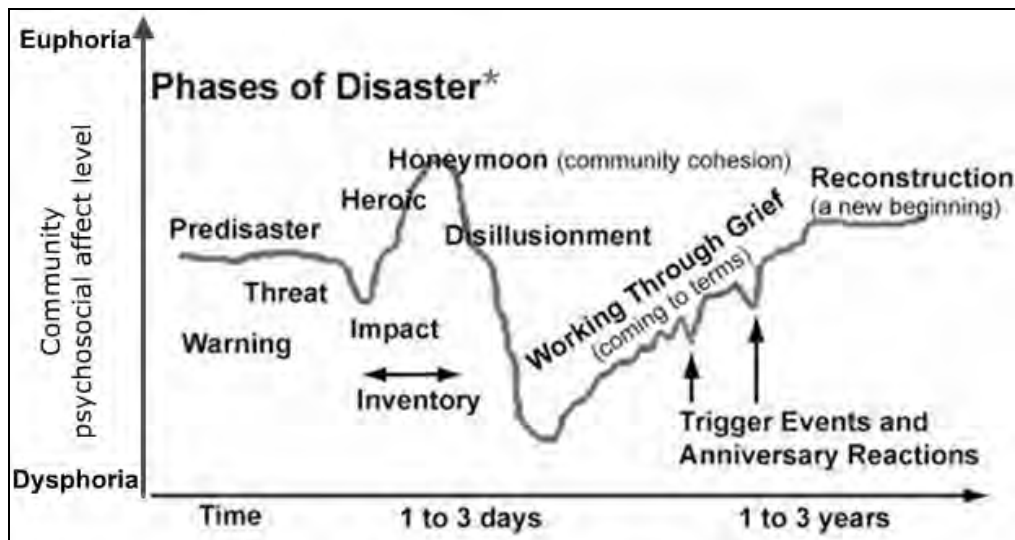


Figure 10: Disaster Phases
Source: DeWolfe, 2000

Fothergill and colleagues (1999) state that “preparedness is the stage of a disaster involving all pre-event preparation activities and mitigation efforts in advance of a specific warning.” Preparedness behavior can involve a number of activities for both households and responding authorities, including: stocking emergency supplies, making structural improvements to homes and other buildings, purchasing disaster-specific insurance, developing evacuation plans, training and response drills, and other educational efforts.

The warning or threat phase occurs for disasters where there is warning hours or days in advance, such as in the case of hurricanes and floods (SAMHSA, 2003). During this period, individuals may be exposed to warnings and information about risks, either through formal or informal networks (Perry & Mushkatel, 1986). Warnings may be disseminated through formal networks such as emergency broadcasts or tornado sirens, or through informal networks such as neighborhood meetings. Formal warning communications may include instructions such as evacuation information. Some models of the warning process also include the public's response to the warnings they receive, with evidence that minority populations may interpret these warnings with more skepticism of personal danger and lower perceived risk than other groups (Perry, Lindell, & Greene, 1982).

The impact phase occurs when the disaster actually strikes and can vary from the escalation of a threat, such as a flood, to an unexpected and unpredictable event such as an explosion (SAMHSA, 2003). Impacts are both physical and psychological (Fothergill et al., 1999). Physical impacts can include mortality, injury, and economic losses and psychological impacts can include fear, anxiety, emotional stress, trauma, and post-traumatic stress disorder (PTSD).

The emergency response phase occurs in the first hours, days, and even up to one week following the impact of a disaster (Fothergill et al., 1999). Findings from SAMHSA researchers (2003) and others describe a rescue or heroic phase as part of the immediate disaster response where "individuals' activity levels are generally high and oriented toward rescue operations, survival, and perhaps evacuation" and "people generally work together to save lives and property." Adrenaline-induced rescue behaviors to save lives and protect property are common behaviors during the rescue or heroic phase of a disaster (DeWolfe, 2000).

A community may then enter a "honeymoon" phase, characterized by optimism and where the community pulls together and assistance becomes available (SAMHSA, 2003). During this phase, a community may bond as a result of shared experiences and giving and receiving community support (DeWolfe, 2000).

SAMHSA describes that the honeymoon phase may be followed by an inventory phase where survivors "recognize the limits of help and begin to assess their futures." Fatigue is common during this period, where survivors face financial pressure and stress associated with relocation or living in a damaged home (DeWolfe, 2000). During this post-disaster phase, initial optimism may be replaced by discouragement.

A disillusionment phase, characterized by high levels of stress, helplessness, and anger, may occur when survivors recognize the reality of loss and the limits of outside relief (SAMHSA, 2003). When disaster assistance personnel begin to pull out of an area, survivors may have feelings of abandonment and resentment (DeWolfe, 2000).

Recovery and reconstruction after a disaster may take years. Structural rebuilding occurs during this period and may result in housing shortages, particularly if the disaster

disproportionally damaged low-income housing (SAMHSA, 2003). Fothergill and colleagues (1999) describe the recovery process as “a time of returning to ‘normality’ and of rebuilding, allocating resources, finding housing and repairing lifelines in a community.” As survivors witness the construction of new residences and other infrastructure, additional stress and grief may be present as victims readjust to their surroundings (DeWolfe, 2000).

Fothergill and colleagues (1999) note that reconstruction can bring opportunity for change in a community. The SAMHSA *Training Manual for Mental Health and Human Service Workers in Major Disasters* (DeWolfe, 2000) states that:

When people come to see meaning, personal growth, and opportunity from their disaster experience despite their losses and pain, they are well on the road to recovery. While disasters may bring profound life-changing losses, they also bring the opportunity to recognize personal strengths.

3. Organization of Emergency and Disaster Response in the United States

Response to emergencies and disasters starts at the local level and may evolve to State- or Federal-level response operations. Each of these levels, shown in Figure 11, is discussed in detail in this section of the Scan.

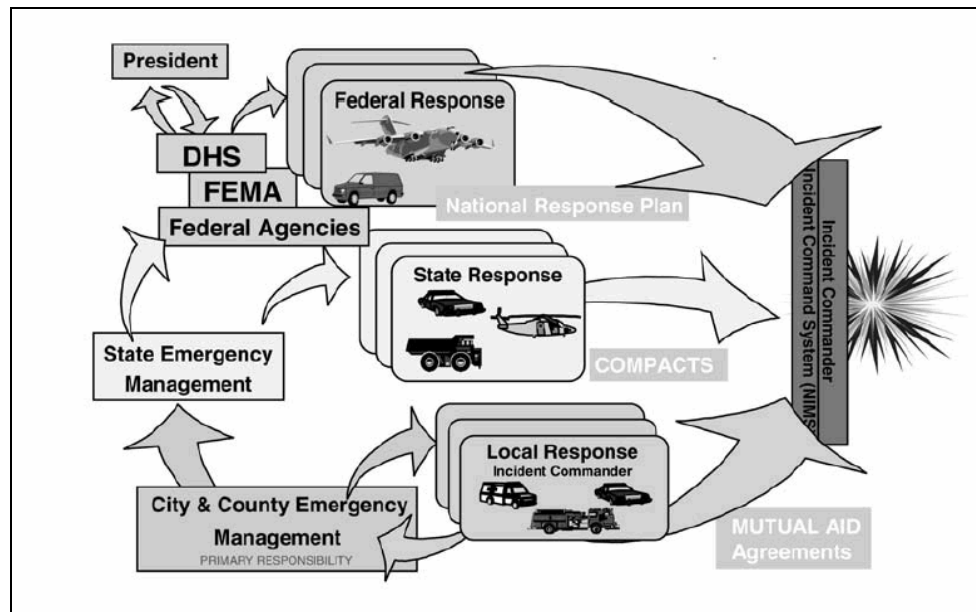


Figure 11: Three Levels of Disaster Response

Source: DOD, 2005b

Local Emergency Response

Local emergency response may start with emergency medical services (EMS) personnel arriving at the scene after being dispatched by a 911 call center. EMS personnel stabilize patients and transport them to an appropriate clinical center based on their condition. Fire and rescue may also be the first on the scene, as was the case in New York City following the September 11, 2001 terrorist attacks.

There is great variability in EMS systems across the country. A recent report released by the Institute of Medicine (IOM, 2007) shows that half of the EMS systems are organized and delivered through local fire departments, and other service providers include private companies and hospital-based systems. There is also great variety in 911 call centers that are managed by multiple agencies: police, fire departments, or local governments (IOM, 2007). To provide more effective care to LEP populations, the agencies receiving 911 calls across the U.S. often establish partnerships with agencies that provide interpretation services. In some counties, interpreter services are mandatory for all 911 call centers, but some cities and counties have limited or no telephonic interpreting or language communication services available (Futty, 2007; Kelly et al., 2006). There are also efforts to help EMS personnel effectively communicate with diverse patients by developing

foreign language reference books with information on culturally specific patient behaviors (e.g., Dees, 2006).

One of the most critical problems that EMS systems are facing is limited coordination between EMS personnel and other providers, resulting in patients being unable to receive optimal care (IOM, 2007; Cook, 2001). Another common problem, as the General Accounting Office (2003) found, is emergency department overcrowding that results in frequent patient diversion to other hospitals. Hospitals with emergency departments have limited surge capacity, or ability to “rapidly expand acute medical care capabilities” to treat increased number of patients that could potentially result from disasters with mass casualties (Shover, 2007; Rabkin, 2005). Additionally, as the IOM report (2007) demonstrates, first responders are not adequately trained to deal with disasters and do not receive appropriate support. Moreover, EMS providers are often excluded from disaster preparedness planning efforts (IOM, 2007).

To address the problems facing EMS, the National Highway Traffic Safety Administration (NHTSA) in collaboration with the Health Resources and Services Administration (HRSA) developed a vision of the EMS transformation into community-based services integrated into the health care system through research, appropriate legislation, medical direction, public education, training, public access, and clinical care (Figure 12, NHTSA, 1996). The IOM report recommends enhancing coordination and planning, accountability, medical research, disaster training, communication, and funding in order to achieve minimal delays in service delivery (IOM, 2007; see also Rabkin, 2005).

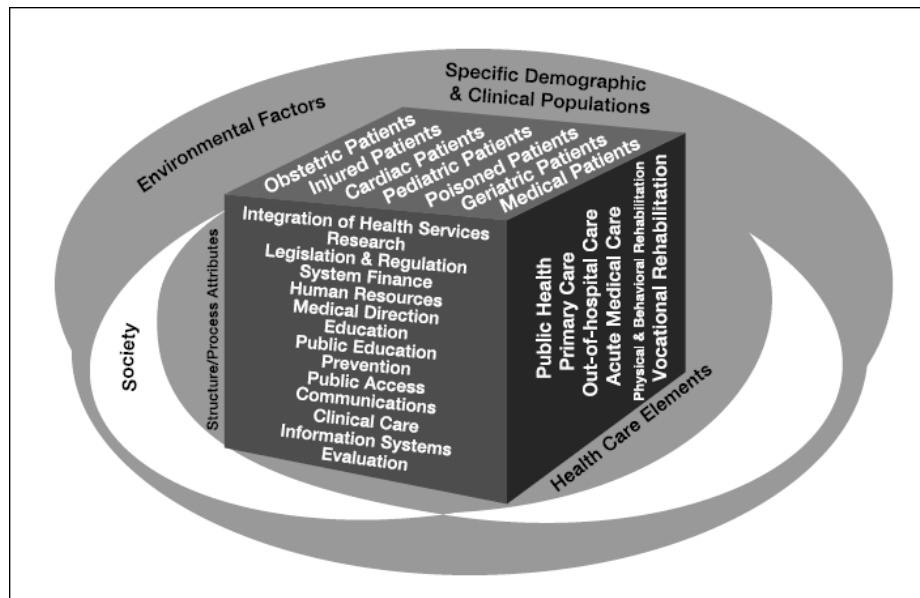


Figure 12: EMS as a Part of the Health Care System
Source: NHTSA, 1996

Another recommendation for EMS is partnerships between emergency management agencies, law enforcement, and emergency medical services as suggested by the Centers for Disease Control and Prevention (CDC). Partnerships can help address the needs of special populations (to include LEP persons) during disaster response operations (Centers

for Disease Control and Prevention, 2006a; see also Centers for Disease Control and Prevention, n.d.).

Since local communities are often the first to respond to disasters, some authors suggest a community-based approach to disaster response. For example, the Collaborating Agencies Responding to Disasters (CARD) model in the San Francisco Bay area, California, supports organizations serving special populations to include LEP and culturally isolated individuals. As opposed to the “traditional” disaster response model that focuses on short-term results, mass care, and external support, the CARD community-based model emphasizes long-term goals, individual culturally-specific interventions, and internal community support (Jones, 2005).

State-level Emergency and Disaster Response

When local resources are insufficient for dealing with emergencies and disasters, local authorities can submit requests for State assistance following communication protocols described in local and State emergency response plans (Shover, 2007; State of Alaska, 2004; State of California, 2005). State emergency response plans also establish protocols for collaborating with Federal agencies, though there is resistance among some States to federalize emergency response. For instance, Mr. Jeb Bush, the former Governor of Florida, stated that “federalizing emergency response to catastrophic events would be a disaster as bad as Hurricane Katrina” (NGA, 2005; NEMA, 2005).

States differ in terms of organizing their disaster response. For instance, the State of California uses the Standardized Emergency Management System (SEMS) for managing response to multi-agency and multi-jurisdiction emergencies. SEMS consists of five organizational levels which are activated as necessary: field response, local government, operational area, region, and State (Figure 13, State of California, 2005).

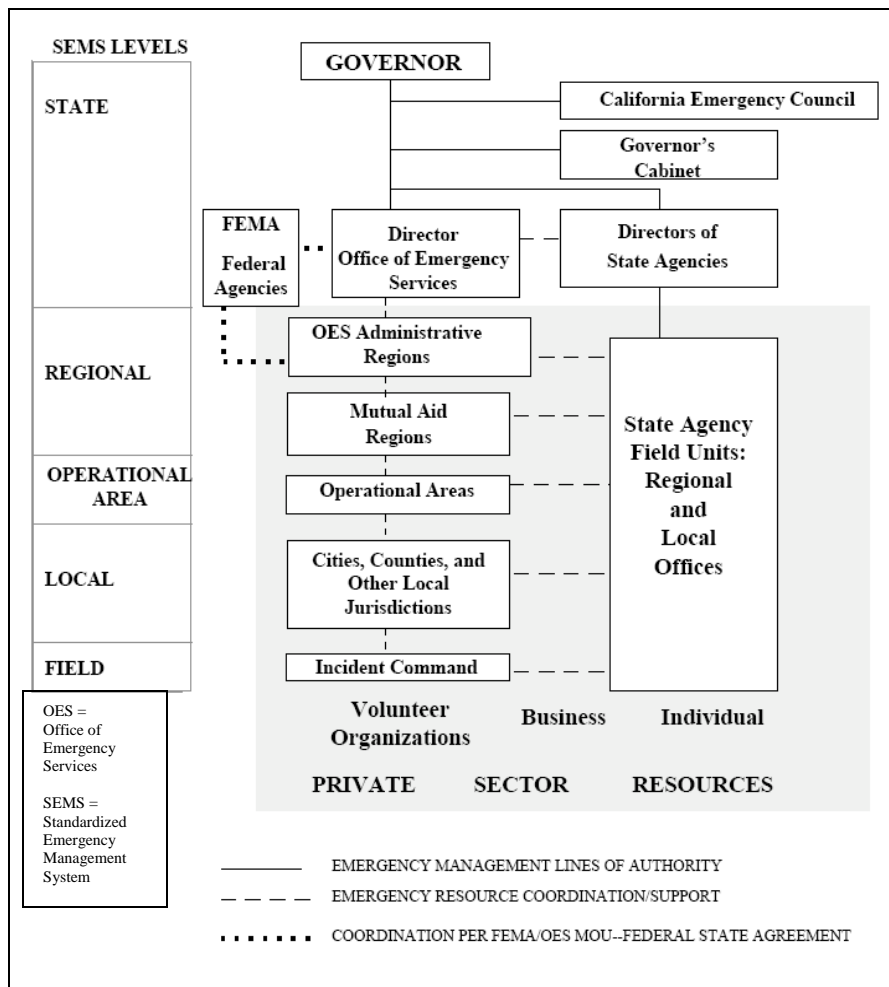


Figure 13: California Emergency Organization

Source: State of California, 2005

In Alaska, the State Emergency Response Plan focuses on three levels of government (local, state, and Federal), and emphasizes that local officials direct local disaster response operations (State of Alaska, 2004). Similarly, the Commonwealth of Virginia emphasizes the key role of local authorities (counties and independent cities) in disaster response (Virginia Department of Emergency Management, 2004).

In the event of disaster, States support each other through the Emergency Management Assistance Compact (EMAC) between 49 participating States that is managed by the National Emergency Management Association (NEMA). Through EMAC, States affected by disaster can receive immediate assistance, for instance by deploying the National Guard to disaster areas, without the need for the Federal government to declare a disaster (IOM, 2007; Bowman, Kapp, & Belasco, 2005).

National Disaster Response

In October 2007, President George W. Bush issued Homeland Security Presidential Directive #21, which presents a National Strategy for Public Health and Medical Preparedness, and emphasizes the importance of a nationally coordinated disaster response (The White House, 2007). At the Federal level, response to disasters is currently coordinated through the Department of Homeland Security's National Response Plan (NRP). The NRP was published in 2004 and will be replaced in 2008 by the finalized National Response Framework (NRF), which was released in draft form in September 2007 and will go into effect on March 22, 2008. The NRP is an all-discipline, and all-hazards approach to domestic emergency management. The plan establishes the national level policy and operational direction regarding Federal support to State and local emergency managers in disaster events (DHS, 2004a; see also DOD, 2005a). The NRP is operationalized through the National Incident Management System (NIMS) that enables Federal, State, local, and tribal governments, the private-sector, and NGOs to collaborate in order to "prevent, prepare for, respond to, and recover from disasters regardless of cause, size, or complexity" (DHS, 2004a).

According to the NRP, the first stage of response is setting up management structures, including the Interagency Incident Management Group (IIMG), Principal Federal Official (PFO), Joint Field Office (JFO), and Incident Command Post (ICP) (Figure 14). After management structures are in place, the JFO, in collaboration with the Regional Resource Coordinating Center (RRCC) and PFO, decide which Emergency Support Functions (ESF) are necessary to activate. ESFs are functional areas of disaster response and consist of teams from each Cabinet department that provide direct services to an affected population (Neuby, 2006). For instance, ESF #5, Emergency Management, focuses on the core management and administrative functions in support of disaster response and is coordinated by Department of Homeland Security (DHS) and its Federal Emergency Management Agency (FEMA). ESF #6, Mass Care, Emergency Assistance, Housing and Human Services, addresses the non-medical mass care, housing, and human services needs of disaster victims and is coordinated by DHS and the American Red Cross. The U.S. Department of Health and Human Services (DHHS) coordinates ESF #8, Public Health and Medical Services, which focuses on public health and medical care needs (DHS, 2004a).

ESF #5 coordinates all emergency management activities for the Federal government at all stages of disaster (preparedness, response and recovery) (DHS, 2004a). ESF #5 provides both managerial and administrative support functions for the National and Regional Response Coordination Centers (NRCC and RRCC, respectively), as well as the Joint Field Office (JFO). The NRCC is in charge of monitoring potential and developing incidents. During a disaster, the RRCC coordinates regional emergency management operations until the JFO has been set-up. Once the JFO has been established, coordination of emergency management operations falls under the JFO (DHS, 2004a).

ESF #6 includes three primary functions (Mass Care, Housing and Human Services) and provides support to State, local, and tribal governmental and non-governmental organizations (NGOs) (DHS, 2004a). Part of the ESF #6 scope of work includes the provision of economic assistance and other services to assist individuals, households and families impacted by “Incidents of National Significance” (DHS, 2004a). The Mass Care function involves the coordination of Federal assistance, shelter, food, emergency first aid, and the bulk distribution of emergency relief items. The American Red Cross is the primary agency for mass care under ESF #6, and as such, coordinates Federal mass care efforts in support of State and local efforts. The Housing function focuses on both short and long term housing solutions to address the needs of victims in affected areas. The Human Services function implements programs and provides services, such as coordinating a system for victim recovery efforts, and coordinating and identifying individuals with special needs within impacted areas (DHS, 2004a).

ESF #8 contains the National Disaster Medical System (NDMS), which is a federally-sponsored system designed to provide a coordinated national medical response to disaster areas through teams, supplies and equipment (DHHS, 2007c). NDMS houses a variety of specialized teams, including Disaster Medical Assistance Teams (DMATs) which are rapid-response groups of professional medical personnel who are deployed to disaster sites with adequate supplies and equipment to sustain themselves and provide care for 72 hours until other resources (Federal or otherwise) can be mobilized (DHHS, 2007d). The DMAT set-up has been referenced as a model for response by Australian first responders following the tsunami (Pearce, Mark, Gray, & Curry, 2006).

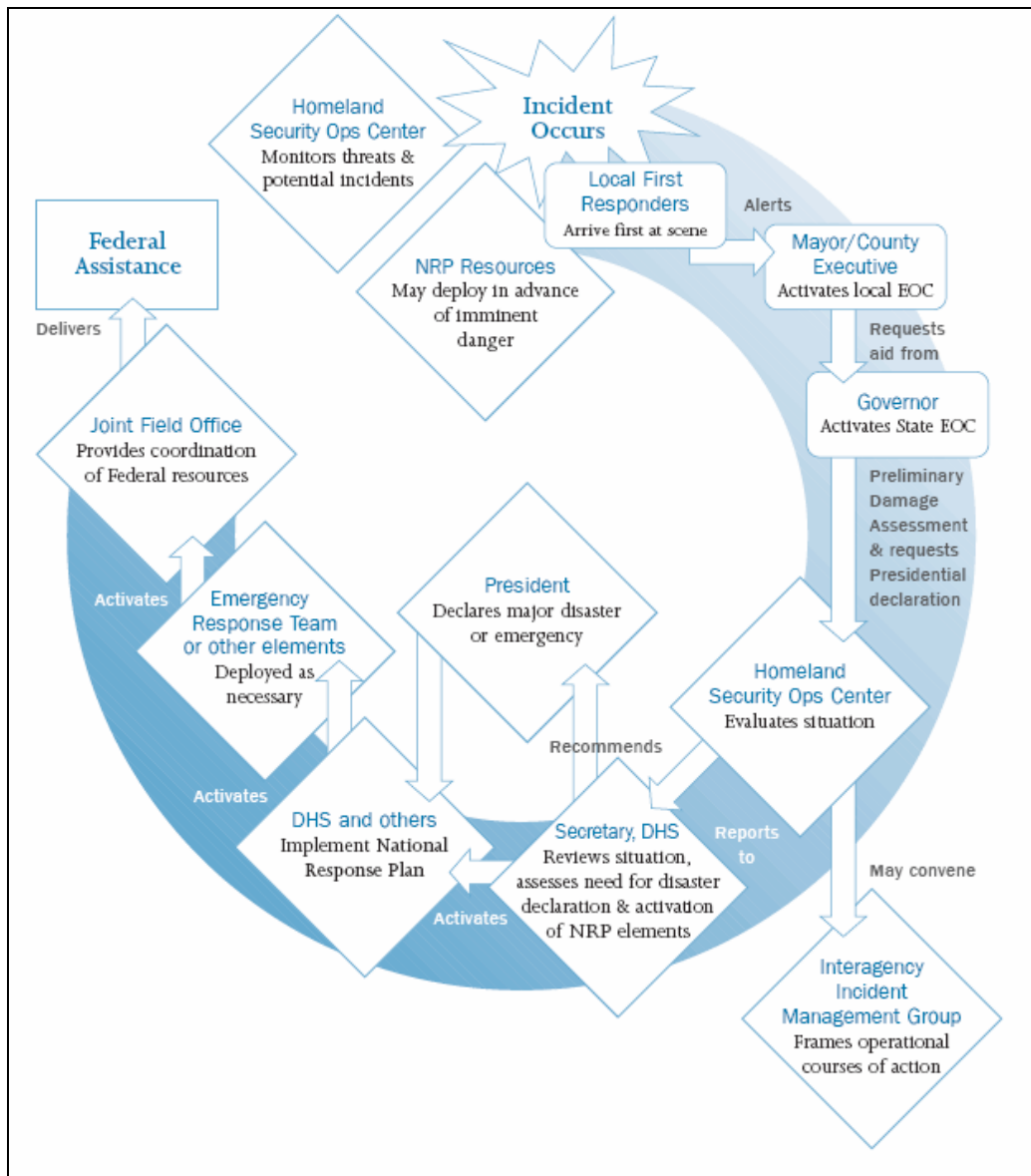


Figure 14: Initial Government Involvement in Disaster Response
 Source: DHS, 2004a

Defense Support to Civil Authorities

The U.S. military provides support to civil authorities at all three levels of response using the Defense Support to Civil Authorities (DSCA) protocol when directed by the President (Figure 15, DOD, 2005a). Support may include assisting with immediate response, providing equipment and materials, and deploying personnel with subject matter expertise in emergency response. Military support may also take the form of providing assistance to law enforcement and assisting in the restoration of law and order (DOD, 2005a). The vast majority of defense support is provided through the states via the National Guard that “provides an organized, well-trained pool of manpower that is thoroughly familiar with local conditions and geography” (DOD, 2005b).

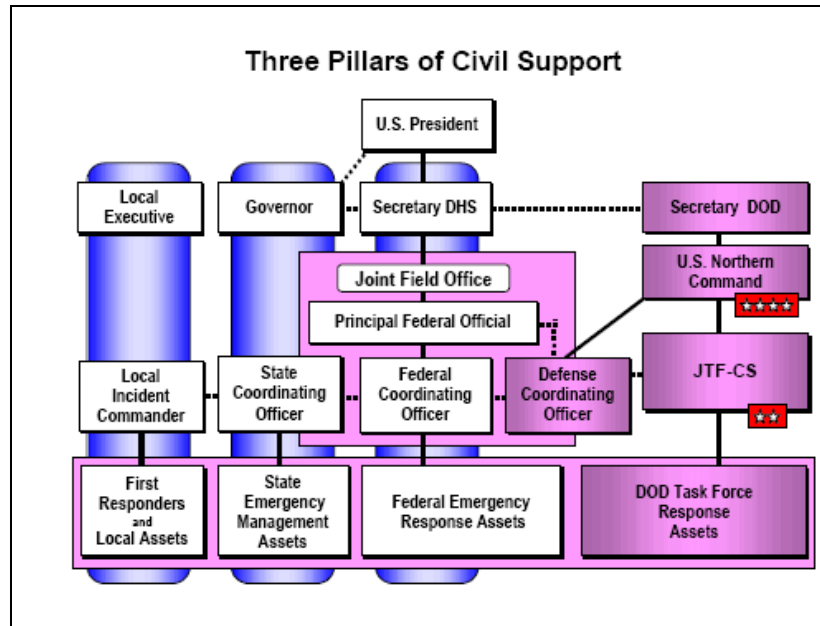


Figure 15: The Military and Three Pillars of Civil Support
Source: DOD, 2005a

National Voluntary Organizations Active in Disasters (NVOAD)

At all levels of disaster response, local, State, and national efforts are supported by volunteers and non-government organizations (NGOs) organized through the National Voluntary Organizations Active in Disaster (NVOAD), a consortium of more than thirty recognized national organizations of volunteers active in disaster relief (DHS, 2004a). As detailed in the National Response Plan (NRP), NGOs provide mass shelter, emergency food, counseling and other support services to assist disaster survivors in recovery efforts (DHS, 2004a). NGOs work with local, state, tribal and Federal governments to provide assistance.

The American Red Cross is the largest volunteer relief organization and disaster mental health services provider in the U.S. The American Red Cross is usually the first NGO on the scene, collaborating with affected communities and local government agencies and providing shelters, supplies, first aid, medical monitoring and mental health interventions (Bowenkamp, 2000; Weeks, 1999; Saunders, 2007).

Response to Hurricane Katrina

Response to Hurricane Katrina showed that, despite efforts to improve the existing disaster response system, serious flaws remain. Overall, the services were delivered effectively, though impaired by poor coordination and lack of communication (U.S. House of Representatives, 2006). For instance, several command structures were operating on the disaster scene simultaneously (two within FEMA, and two military commands – the Louisiana National Guard and the U.S. Northern Command (NORTHCOM) (U.S. House of Representatives, 2006; Gheyntanhi et al., 2007).

On August 30, 2005, DHS declared Katrina an “Incident of National Significance” and invoked NRP. This was one day after Katrina landfall, and several days after the States of Louisiana and Mississippi declared the state of emergency on August 26 and 27 respectively. According to Bowman and colleagues (2005), this could have slowed down the arrival of much needed DOD support to the region affected by disaster. There were deficiencies on the local level as well, for instance the Mayor of New Orleans was hesitant to issue a mandatory evacuation order despite pressures from the Federal agencies (Gheytanchi et al., 2007).

Additionally, critical elements of the NRP were executed late, ineffectively, or not at all, and command structures were often missing (U.S. House of Representatives, 2006). FEMA was unable to act on additional challenges such as evacuation, search and rescue, and public health. Local agencies and volunteers were overwhelmed by the magnitude of the disaster; many volunteers and professionals were not prepared to deal with disaster situations; and the hospitals were lacking the surge capacity resulting in poor triage and long lines to get assistance (L. Adams, 2007; IOM, 2007; Saunders, 2007; DHHS, 2007).

Local, State, and Federal authorities also failed to provide effective help to vulnerable populations, or “social groups with limited resources and high relative risk of morbidity and premature mortality” (Saunders, 2007). Minority communities in the Katrina area were particularly vulnerable since about one-fourth of their population were living below the poverty line and lost everything during the disaster (Batalova, 2005).

As Chandler and Gamboa (2005) argue, State and Federal governments did not provide appropriate warning to immigrant communities and did not assist them in evacuating from the disaster area. Language barriers were an issue, especially a lack of significant public information in languages other than English (Chandler & Gamboa, 2005). Another issue raised by researchers and investigators was the low education level among some minority populations that prevented them from properly filling out the required assistance paperwork and receiving help in a timely manner (Democracy Now, 2005).

The U.S. House of Representatives found that, based on census data, the victims of Hurricane Katrina were roughly proportionate in terms of ethnicity, sex, and wealth to the area’s population prior to landfall (U.S. House of Representatives, 2006). However, the deficiencies in Federal disaster response led many minority representatives to believe that racial inequality remained a major problem in America and that issues of race and class were central to evacuation experiences (U.S. House of Representatives, 2006). A survey conducted by the Washington Post, the Kaiser Family Foundation, and Harvard University in September 2005 among 680 randomly selected adult evacuees residing in Houston revealed that sixty-one percent of responders (predominantly black) felt that the Federal Government did not care about them (The Washington Post et al., 2005). Sixty-eight percent of respondents thought that the Federal government would have responded more quickly if more people trapped in the floodwaters were wealthier and white rather than poorer and black (The Washington Post et al., 2005).

4. Applying the CLAS Standards at Every Phase of Disaster

The CLAS Standards, in conjunction with other federal policies, provide a framework with which organizations can develop, implement and execute interventions for crisis situations which are culturally and linguistically competent. This section of the Scan offers examples of how the CLAS Standards fit in at every phase of a disaster. We discuss the three major themes of the CLAS standards – culturally competent care, language access services, and organizational supports – as they relate to our target audiences.

Racial and ethnic minorities are disproportionately vulnerable to and impacted by disasters throughout the continuum of disaster phases, making CLAS implementation all the more important at each stage of a disaster (Andrulis et al., 2007; Fothergill et al., 1999; Carter-Pokras, Zambrana, Mora & Aaby, 2007). Persons with disabilities, such as deaf, hard of hearing, and visually disabled persons, all have unique needs during times of disaster. The CLAS Standards can enhance planning for disaster response for the increasingly diverse U.S. population and can be implemented during and following a disaster, as well.

Availability of culturally competent care (Standards 1-3) and appropriate language access services for persons with limited English proficiency (Standards 4-7) can be crucial in times of disaster and can be implemented by any of our target audiences, including emergency managers, EMS personnel, and relief workers. Standards 8-14 provide recommendations for organizational supports in culturally competent practice, such as strategic planning (Standard 8), ongoing organizational assessments (Standard 9), ongoing collection of race/ethnicity and language data (Standard 10), maintaining an epidemiological profile of the community served (Standard 11), developing culturally and linguistically appropriate cross-cultural conflict resolution strategies (Standard 13) and community partnerships and outreach (Standards 12 and 14), which can be utilized to better assist during any phase of disaster preparedness and crisis response.

The CLAS Standards also recommend that health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in CLAS delivery (Standard 3). In the aftermath of Hurricane Katrina, training related to cultural competence in disaster response grew in visibility and importance as reports surfaced about differential response efforts for underserved and minority communities. The key issues raised by researchers and educators are integrating cultural competence into disaster response training for each stage of an emergency event, maintaining training efforts, and refining knowledge, attitudes and skills related to cultural competence (Andrulis et al., 2007; Andrulis, 2006).

Research indicates a number of reasons why minority communities are exposed to greater risk from disasters, including: language, housing patterns, building construction, community isolation, and cultural insensitivities (Fothergill et al., 1999). Other factors of high risk reported in the literature include acculturation level, immigrant status, English proficiency, experience of emotional trauma, and disruption of social systems (Norris &

Allegría, 2006; Rodriguez et al., 2006). Pole and colleagues (2005) have noted that cultural values and principles such as reluctance to admit personal stress, fatalistic attitudes, beliefs in the connection between mind and body, communicating in ways that elicit the approval of others, and faith constructs can impact survivors' responses to trauma and influence the incidence of certain types of psychological reactions to disaster, such as post-traumatic stress disorder (PTSD) among racial and ethnic minorities. Understanding these factors is one component of the delivery of culturally competent care and language access services.

Analyzing social changes in the aftermath of disasters, Nigg and Tierney (1993) found that pre-disaster community structures and relationships do not change substantially after disaster. In the case of racial and ethnic minorities, researchers have noted that pre-existing issues of racism and social stratification within communities, including unequal access to health care and negative experiences with the health care system, continue and are reinforced during disaster relief and recovery, and that problems such as poverty, unemployment, and homelessness will likely exist after the disaster if they were present before the event (Fothergill et al., 1999; Straker & Finister, 2007). These problems reflect disproportionate social vulnerabilities among minority populations.

Vulnerable populations are generically labeled as marginalized populations (Seidenberg, 2006) and populations with special needs, and often, the terms "special needs" and "vulnerable" are used interchangeably (DHHS, 2007). The Association of Schools of Public Health (ASPH) and the Centers for Disease Control and Prevention (CDC) define vulnerable populations as "any individual, group or community whose circumstances create barriers to obtaining or understanding information, or the ability to react as the general population has been requested to proceed during all phases of emergency management" (DHHS, 2007).

Social vulnerabilities have not received sufficient attention in disaster response literature because they are hard to measure and quantify. As Cutter points out, social vulnerability is partially a product of social and racial inequalities that increase exposure of various groups to harm and affect their ability to respond and recover after the disaster (Cutter, 2006; Fothergill et al., 1999). Minority populations usually have higher social vulnerability in disasters and "are most likely to live in dangerous areas and substandard housing, and are least able to deal with the adverse effects of droughts, tornadoes and other hazards" (McEntire, 2004; SAMHSA, 2003). Minority populations may also be more likely to depend on social support services and/ or not have access to sufficient support systems, such as financial resources. This and additional factors contributing to social vulnerability are outlined in Figure 16, below.

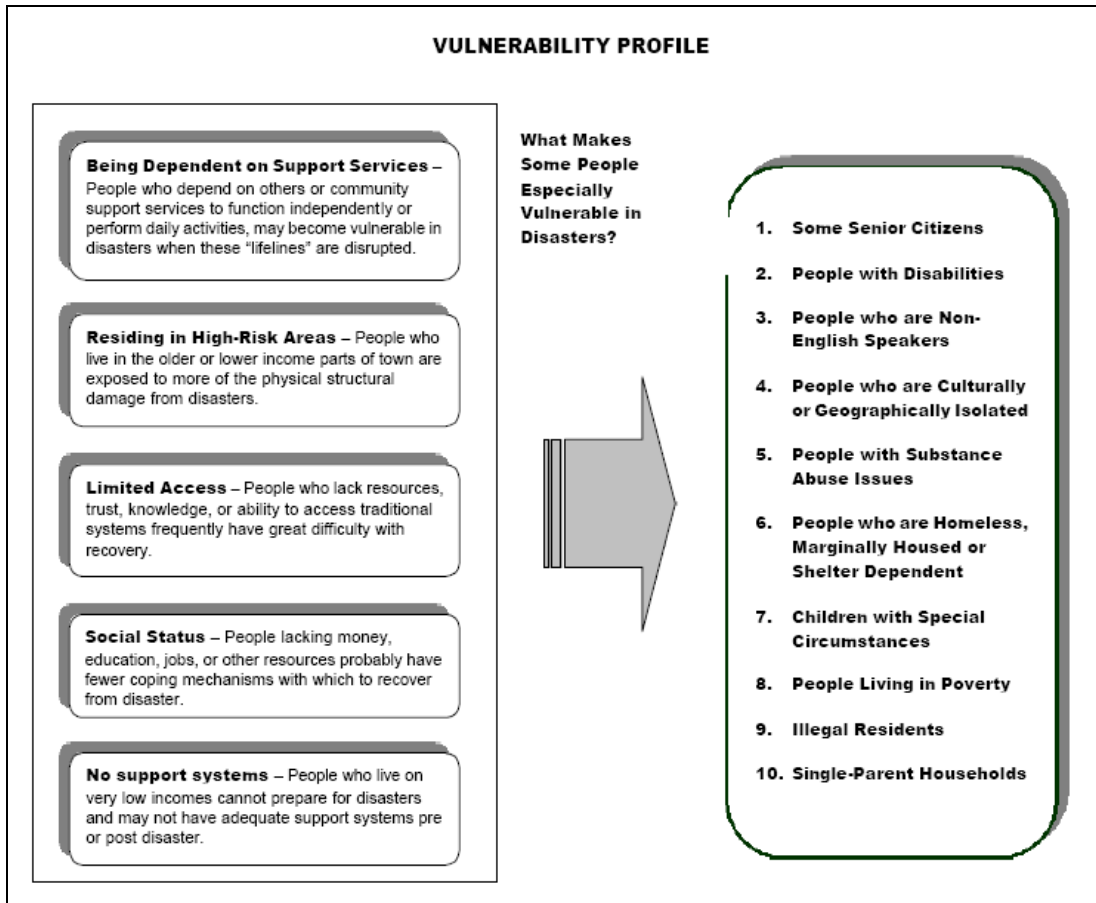


Figure 16: Population Vulnerability Profile

Source: Stengel, 2000

In looking to Hurricane Katrina as an example, Pastor and colleagues (2006) offer the following comment regarding social vulnerabilities:

The differential effects of this disaster were neither natural nor an accident. They were consistent with a pervasive continuum in which low-income and minority communities suffer from both higher socioeconomic stress and greater environmental exposures to air toxins, hazardous wastes, and other environmental disamenities.

To help explain ethnic differences in psychological response to disaster, Green (1996) and Perilla and colleagues (2002) suggest the concept of differential vulnerability that implies that ethnic minorities are disproportionately affected by disasters and associated stressors. They also examine differential exposure, or differences in the extent to which minority groups were exposed to disasters. Their research shows that minorities affected by Hurricane Andrew were more severely exposed to the disaster and had higher rates of posttraumatic stress (Perilla et al., 2002).

Recent research shows that the mental health of minority populations and their responses to disasters can be influenced by culture in a number of ways. For instance, patients describe their symptoms in a number of culturally specific ways and attribute different meaning to their mental illness. Cultural meaning of illness is known to influence how the people cope with symptoms, seek treatment, and what social support do they receive (CMHS, 2001a). Different population groups may have culturally-specific coping styles. For instance, African Americans are reported to rely more on spirituality to help cope with mental illness, and are more likely than Whites to rely on themselves in terms of handling distress (Neighbors et al., 1998; CMHS, 2001a).

Other factors that influence mental health of minority populations include culturally specific ways of seeking treatment, mistrust of clinicians, stigma imposed by some cultures on people seeking mental health treatment, and immigration experiences (CMHS, 2001a). As far as immigration is concerned, it can cause stress and depression due to the effects of acculturation. At the same time, research points out that some immigrant communities, for instance Latino immigrants, may be very resilient in the face of hardships that they face when settling in a new culture. One of factors that may contribute to the resilience is the “double frame of reference” when Latino immigrants use the inferior social and economic conditions within their home countries as a point of reference in assessing their lives in the U.S. and thus feel less distress in handling their life in the U.S. (CMHS, 2001a).

In the case of disasters, SAMHSA reminds us that “each survivor experiences a disaster through his or her own lens” and a victim’s characteristics such as culture, world view, and spiritual beliefs all contribute to how disasters are perceived and how individuals cope and engage in disaster relief efforts and recovery (DeWolfe, 2000). Culture can also serve as a support during times of tragedy and offer “a protective system that is comfortable and reassuring” as well as provide a shared vision for recovery (SAMHSA, 2003).

Research indicates that understanding culturally-specific responses to disasters is important for reaching out to disaster-affected minority communities and for the planning and delivery of disaster mental health services (Perilla et al., 2002). In the following sections, research related to vulnerabilities at each phase of disaster, and culturally-specific responses to disasters and disaster impacts are reviewed. The information presented indicates numerous instances where the CLAS Standards could be implemented by any of the groups involved in disaster preparedness and crisis response.

Preparedness

Preparedness activities enhance the ability of social units to respond when disaster occurs by developing appropriate strategies and assuring that appropriate response resources are in place prior to disaster (Tierney et al., 2001). As research shows, it is very difficult to prompt preparedness actions among the population before a threat of disaster arises (Tierney et al., 2001), yet in some cultures and religious groups preparedness activities are strongly encouraged. For instance, members of the Church of Jesus Christ of Latter

Day Saints (Mormons) are encouraged to keep a year's supply of food (Lindell & Perry, 2004).

Before receiving a specific disaster warning, households and families engage in preparedness behavior such as stocking emergency supplies, developing evacuation plans, making structural improvements to homes, and engaging in disaster education. Research has revealed that minorities are more likely to be under-prepared for disasters, less likely to be involved in preparedness activities, and are less likely to receive educational opportunities related to disaster-preparedness due to their socio-economic status, lack of English proficiency, and distrust of official media (Pastor et al., 2006; Fothergill et al., 1999; Faupel et al., 1992). Recruiting community members and engaging faith-based organizations to ensure that preparedness plans are culturally and community appropriate is one way to increase the implementation of the CLAS Standards during preparedness efforts.

Pastor and colleagues (2006) note that although minorities generally have a heightened perception of disaster risk, these populations remain under-prepared for such events. Persons with disabilities also tend to be under-prepared for disasters, often preparing an emergency supply kit, but lacking an appropriate evacuation plan that includes the identification of safety centers that provide critical services or the coordination of assistance during a disaster (Spence, Lachlan, Burke & Seeger, 2007). Wealth and language barriers are reported as factors contributing to disaster under-preparedness among minorities. With regard to financial status, the adoption of some expensive mitigation measures such as insurance, structural improvements, and simple protective measures, such as purchasing fire extinguishers, can be prohibitively costly for low income groups (Pastor et al, 2006). The Panel on the Public Policy Implications of Earthquake Prediction (1975) note that low-income groups are more likely not to receive, understand, or believe disaster warnings. Tierney (1993) notes that preparedness information was issued only in English after the Whittier-Narrows earthquake, even though the disaster zone included LEP residents.

In a 1997 report, Blanchard-Boehm found that whites were more likely than African Americans, Latinos, and Asians to make structural home improvements to mitigate earthquake damage and purchase earthquake insurance. Cost barriers were cited as an impediment to not making such investments.

Despite preparedness discrepancies among minority groups, there are organizations which aim to assist minorities in preparing for disasters. Following the Loma Prieta earthquake, an organization called the Chinatown Disaster Response Project arose to provide resources for disaster preparedness specific to the needs of the San Francisco Bay Area's Chinatown (NICOS Chinese Health Coalition, n.d.). The program trains residents to be prepared for independent survival during the first 72 hours following a disaster, through the use of classes, disaster drills, and the creation of a bilingual handbook for distribution to Chinatown residents (NICOS Chinese Health Coalition, n.d.). There are several organizations which aim to help American Indian/Alaska Natives in preparing for disasters, such as the Native American Alliance for Emergency

Preparedness in California (<http://www.naaep.com>) whose website contains numerous online disaster preparedness resources and workshops (NAAEP, n.d.).

Tierney and colleagues (2001) argue that individual decisions regarding disaster preparedness are subject to biases and errors in interpreting information related to disasters. To stimulate preparedness activities, researchers suggest viewing communicating disaster risks as a process and improving the message by enhancing its source (credibility, repetition, frequency of repetition, and channels to disseminate information) and tailoring it to the audience (Tierney et al., 2001). Communicating in this way can be done by any of the target audiences in their roles during preparedness activities. In addition, lessons learned from Hurricane Katrina cite the importance of developing a plan that is inclusive in nature, taking into account every aspect of society (Walker Jr. & Warren, 2007).

Research conducted with Latin American immigrants in the Washington, D.C. area indicated that sources of information and preferences for receipt of emergency preparedness information may differ from the general public. Respondents ranked firemen and police officers, American Red Cross personnel and individuals who are well trained with charisma among the most trusted sources of information. Participants indicated that courses or seminars were the preferred method for receiving information followed by TV/radio programs and pamphlets, flyers or manuals (Carter-Pokras, et al., 2007). While these precise results cannot be applied to all minority groups or even to all Latin American immigrants, multiple researchers have demonstrated that issues of trust and rapport with both the channels through which disaster information is disseminated and the individuals delivering these messages are of critical importance in reaching minority groups in times of crisis (Brodie, Weltzien, Altman, Blendon & Benson, 2006; Cordasco, Eisenman, Glik, Golden & Asch, 2007; Kirkpatrick & Bryan, 2007). Understanding one's community and their preferred means of gathering information can allow for more appropriate dissemination of the necessary information in times of disaster.

Warning/Threat Phase

In some cases, disasters occur without warning, such as earthquakes or explosions. In other situations, including hurricanes and floods, communities may receive warning of the event hours or days in advance. Research findings indicate that groups with prior experiences of disasters have heightened perceptions of risk associated with it, for instance refugee and immigrant groups that commonly experience pre-migration trauma as a result of natural or manmade disasters (Ton, 2004).

During warning periods, threat information may be disseminated by a variety of sources, including the mass media, friends, relatives or other social networks, or through authorities such as police and fire personnel. One source states that “racial and ethnic groups sometimes differ in the ways in which they receive information about risks and in the credence they place on such information” (SAMHSA, 2003). In particular, there is consensus in the research literature that Latinos are frequently more likely to rely on and trust social networks such as friends, relatives, or neighborhood meetings for disaster

information as opposed to more formal media warnings (Perry & Lindell, 1991; Perry & Nelson, 1991; Blanchard-Boehm, 1997; Perry & Mushkatel, 1986; Peguero, 2006). Generally, Whites often tend to rely on mass media as a source of credible information about threats more so than minorities (Perry & Lindell, 1991).

Perry and Lindell (1991) note that “the most common reaction to warning receipt is disbelief” and thus, individuals commonly engage in information-seeking behavior after receiving a warning as a means to confirm the threat. As a result, disseminating culturally and linguistically appropriate information may be beneficial to this process. Although these authors do not find a direct effect of ethnicity on compliance with evacuation warnings, minorities tend to make more contacts during the warning confirmation process than do Whites (Perry & Lindell, 1991). For many, extended families are crucial courses of confirmation related to evacuation (Lindell & Perry, 2004).

Other researchers have found racial and ethnic differences in the likelihood of evacuation in some disasters. For example, in the case of Hurricane Andrew, Gladwin and Peacock (1997) found that blacks were less likely to evacuate than other groups. In the aftermath of Hurricane Katrina, many African Americans relied on official support in terms of evacuation from affected areas. The Vietnamese population preferred to seek assistance through informal networks such as families, friends, and churches (American Psychological Association, 2006b). The Latino population was more likely to seek assistance through official channels, though confusing Federal policies related to appropriate proof of identity and immigration status prevented many victims from seeking help (Murray & Gelatt, 2005; Messias & Lacy, 2007; Muñiz, 2006). American Indians evacuated to other reservations or did not relocate at all, and were seeking support from tribes and Native organizations across the country, as well as from smaller non-profit organizations (American Psychological Association, 2006b). The CLAS Standards can be implemented to address these differences by maintaining an epidemiological profile of one’s community to better understand their needs (Standard 11), and engaging in partnership (Standard 12) and outreach activities (Standard 14).

Racial and ethnic minorities and the working poor often have access to fewer resources, which can impact communities’ response to disaster. For example, Cutter and colleagues (2006) argue that the New Orleans poor had lower compliance with evacuation orders because Katrina struck on August 29 – two days before paychecks and welfare or disability checks would arrive – and these populations had no money for transportation out of the evacuation zone. Katz and colleagues (2005) report that nearly one-quarter of New Orleans residents relied on public transportation prior to Katrina and the city’s plans to use buses and vans for evacuation proved insufficient as two hundred public vehicles were lost due to flooding (Eggler, 2005).

SAMHSA researchers note that some marginalized communities may not have access to warning systems and thus may not receive an appropriate level of threat warning (2003). At particular risk are limited English proficient populations and the deaf or hard of hearing for which warning communications may be inadequate if they are not in multiple languages or closed-captioned (SAMHSA, 2003). Aguirre (1988) argues that disaster

warning effectiveness “presupposes either a common shared language and culture or the adaptation of the warning system to a multilingual and multicultural social structure.” Though the only Spanish-language radio station in the New Orleans area did broadcast warnings and suggest evacuation, many immigrants did not receive necessary information at all (Muñiz, 2006).

Moreover, although technological innovations have transformed the capacity for warning and disaster communication, reliance on these technologies may increase the ‘digital divide,’ or a gap between social groups that have access to digital and information technology, and groups without this access. Digital divide may “accentuate existing inequalities, particularly among minorities, the elderly, and other poor segments of the population” (Rodríguez et al., 2006).

Response

The literature related to all of our target audiences recognizes the importance of knowledge related to the role of culture in help-seeking behavior and expressions of trauma in disaster response and relief efforts. Research suggests that “emergency personnel who arrive in a disaster setting to offer assistance may be culturally insensitive” (Fothergill et al., 1999; Katayama, 1992; Norris & Allegría, 2006).

The literature further indicates that improved language access services can help disaster responders overcome cultural and language barriers between survivors and responders, which have been cited as obstacles to appropriate emergency response. For example, Yelvington (1997) notes that in the aftermath of Hurricane Andrew, early relief information was provided only in English and the Latino and Haitian populations did not receive needed food and other assistance. Additionally, there have been reported cases of house tags (notices about a building’s safety status) being printed in English only, or instances in which translations did not convey the same message across languages (Phillips & Ephraim, 1992). For example, after one California earthquake, signs reading “Not Fit for Occupancy” were placed on buildings with English-speaking tenants, while signs for buildings in Spanish-speaking areas read “Entry Illegal” (Cooper & Laughy, 1994). The literature indicates the importance of hiring bilingual and bicultural members of minority communities to assure that the disaster response needs of local communities are met, and strongly recommends the use of qualified interpreters and translators for more effective verbal and written communication before, during and after a disaster.

In the response phase, survivors may experience stress reactions, and the type and intensity of these reactions vary greatly within the same disaster (Shalev, 2006; Bryant & Litz, 2006; Everly, n.d; Young et al., 1998). Chen and colleagues (2003) point out that fifty-nine percent of Chinatown residents in New York had four or more symptoms of distress after the terrorist attacks of September 11, but less than four percent received mental health treatment. In another study by Shuster and colleagues (2001) shows that stress reactions after September 11 attacks were considerably higher among non-Whites as compared to Whites (62 percent and 41 percent respectively).

Expressions of stress symptoms in ethnic minorities can be mediated by culture and can take the form of idioms of distress and culture-bound syndromes, or “clusters of symptoms much more common in some cultures than in others” (CMHS, 2001a) that are recognized within the culture as indicating personal or social difficulties (Kirmayer, 1996). In many cultures where emotional conflict and mental illness is stigmatized, people tend to de-emphasize or suppress their emotional symptoms and focus on the somatic symptoms instead (Kirmayer, 1996; see also Paniagua, 2000). Kirmayer (1996) suggests that the meaning of symptoms and the experience of illness are embedded in larger social processes and are “deeply rooted in the systems of interpretation of conventional cultural idioms, local worlds, and the larger social context” (Figure 17).

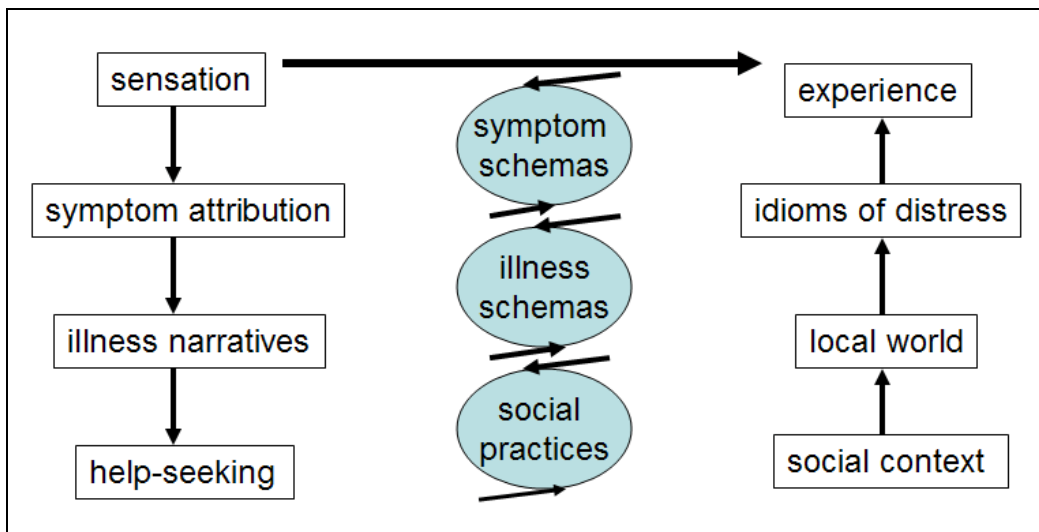


Figure 17: Systems of Meaning in Illness Experience

Source: Kirmayer, 1996

Examples of somatic expressions include *susto* that is reported by Latino population, or tiredness and weakness resulting from frightening and startling experiences (Paniagua, 2000; Saldaña, 2001; Perilla et al., 2002). Another expression of strong emotions as a reaction to stressful events is *ataques de nervios* characterized by shouting, swearing, striking out at others and falling on the ground (Romero, 2000). *Ataques de nervios*, according to researchers, are a socially and culturally acceptable cry for help within Latino communities when stress becomes intolerable (Hough et al., 1996; Green, 1996). Korean patients can report *hwa-byung*, or sensations of constriction in the chest, pain in the upper abdomen, fear of death, and tiredness resulting from the lack of balance between reality and anger (Okazaki, 2000; Saldaña, 2001; CMHS, 2001a; Iwamasa & Pai, 2003).

Survivors are not always receptive to offers of support. For example, some groups may have negative past experiences with authorities and are reluctant to seek assistance from these entities, preferring family, neighbors, churches, or the American Red Cross (Seidenberg, 2006). Some immigrants may not seek out services because of fear that their undocumented status will be discovered and they will be deported (SAMHSA, 2003). Several researchers have also noted that historically, foods provided in disaster

shelters are often unfamiliar and inappropriate for minority survivors and made them feel ill (Fothergill et al., 1999; Phillips, 1993).

Different cultures display different coping styles, or strategies to manage demands “that are perceived as taxing or exceeding one’s available resources (Myers et al., 2003). Some minority groups, for instance African Americans and Latinos, may be more likely to use religion as a powerful coping strategy. Some cultures advocate active coping, others discourage it (Myers et al., 2003). Similarly, adaptive behaviors that are accepted within one group can be rejected or treated with suspicion by another group (Case & Robinson, 2003). Effortful, active coping strategies, such as John Henryism (a prolonged, high-effort active coping with emphasis on mental vigor, commitment to hard work, and determination to succeed (James, Hartnett, & Kalsbeek, 1983)), may be inappropriate for minorities with low socio-economic status and limited resources. At the same time, some researchers argue that John Henryism may protect minority groups with higher socio-economic status from the negative health effects of race-based stressors (Bonham et al., 2004).

Culture can help promote healing and resilience for victims and can serve to validate individuals’ experiences through the disaster (DeWolfe, 2000). By helping to restore cultural customs, rituals, and physical and social environments, disaster mental health workers can support survivors in the aftermath of a disaster (DeWolfe, 2000). As Green (1996) notes, further research is needed to identify the types of variables that mediate response to disasters among minority populations, for instance community level mediators (scope of disruption), social mediators (kin and network support), individual predispositions, and formal interventions.

Recovery

The recovery phase of a disaster includes adjustment to the physical and psychological impacts of a disaster and can require both short- and long- term recovery. Physical impacts include mortality, morbidity, injury, and economic losses and psychological impacts can take a variety of forms, including: emotional stress, trauma, shock, and anxiety (Fothergill et al., 1999; DeWolfe, 2000). SAMHSA has noted that “the greater the scope, community destruction, and personal losses associated with the disaster, the greater the psychosocial effects” (DeWolfe, 2000).

Physical Impacts

In their review of the literature on the physical impacts of disaster, Fothergill and colleagues (1999) found that minorities experienced different consequences as a result of natural disasters compared to non-minorities. For example, the American Red Cross has historically found a disproportionately high rate of disaster-connected deaths among ethnic minorities (Trainer & Hutton, 1972). Needs assessments conducted among Hurricane Katrina evacuees found differences in medical needs and health related to race and socio-economic status (Ghosh, Patnaik, & Voigt, 2007; Ridenour, Cummings, Sinclair, & Bixler, 2007). Wisner and colleagues note that casualties from the 1976 Guatemala earthquake were so much more prevalent among the poor and indigenous that

the disaster was described as a “class-quake” (Wisner, 2004). Subsequent disasters, such as the 1999 earthquake in Turkey, have also been dubbed “class-quakes” because of the unbalanced death and destruction suffered by poor and underserved communities.

Higher rates of mortality, morbidity, and injury experienced by minorities after disaster may be related to the lack of safe housing, segregated residential patterns, and economic issues related to safe construction (Fothergill et al., 1999). For example, Phillips (1993) reports that the 1989 Loma Prieta earthquake devastated low-income, substandard housing in Watsonville, California, that was disproportionately inhabited by minority groups. Wagner and colleagues found that, following the collapse of the World Trade Center on September 11, 2001, residents of a low-income, largely minority community in Western Brooklyn were more likely than residents of lower Manhattan to report worsened asthma and have emergency department visits or inpatient hospitalizations post 9/11, a fact which was attributed to where they lived (Wagner, Radigan, Roohan, Anarella, & Gesten, 2005). Bolton and colleagues state that low-income individuals residing in apartment buildings containing unreinforced masonry are particularly susceptible to damage (Bolton et al., 1993). Wisner and colleagues note that low-income individuals typically lose a much larger part of their material assets and suffer more lasting negative consequences from disaster than do those with higher incomes (Wisner, 1993).

Psychological Impacts

A significant body of research finds that minority communities are increasingly susceptible to experiencing negative psychological impacts during and after disasters (Pastor et al., 2006). Minority, immigrant, and refugee populations may be at higher risk for negative psychological consequences based on prior experiences of traumatic events and language or cultural needs that are different from the majority (IOM, 2003).

Aptekar (1990) finds that class and race contribute to psychological reactions to disaster, and emphasizes the importance of a community’s or culture’s collective memories in coping with trauma associated with disaster. Additionally, minority populations with lower incomes appear to be more stressed after a disaster and are more likely to feel a sense of helplessness and greater indebtedness (Ton, 2004; Myers et al., 2003). Cultural differences of grief and loss occur because the meaning of trauma is culturally specific and culturally defined (Florida Center for Public Health Preparedness, 2004).

Minorities have less access to mental health services and are more reluctant to seek out mental health services, thus deepening the disparity in disaster psychological impacts (Pastor et al., 2006). Denboba and colleagues (1998) note that racial and ethnic discrimination, language barriers, and stigma associated with counseling services can prevent racial and ethnic minorities from receiving appropriate disaster mental health care. Additionally, as Vega and Allegría (2001) show, minority populations are more likely to use primary care providers or use informal sources of support that can be insufficient to meet survivors’ needs (Perilla et al., 2002). In many Latino and Asian cultures, communicating without establishing a personal relationship is inappropriate and unacceptable (Norris & Allegría, 2006). At the same time, minorities are as likely as

others to seek mental health services and receive care when other barriers are reduced (stigma, or mistrust) or eliminated (costs of care), as shown by the data from Project Liberty in New York (Felton, 2002).

SAMHSA (2003) points out that there are special considerations for refugees who experience disaster, in particular with regard to PTSD. Van der Veer (1995) notes that refugees have often experienced horrific events and disaster can lead to the emotional re-experiencing of these events. There is some evidence that during the California earthquakes, immigrant groups were reminded of disasters they had previously experienced in Mexico, such as the devastating Mexico City earthquake (Fothergill et al., 1999). Because of negative past experiences, refugees may also be suspicious of government and thus not seek out or accept assistance after a disaster (SAMHSA, 2003). This type of suspicion of government entities makes the provision of culturally and linguistically appropriate assistance even more important for non-governmental and volunteer groups, such as the American Red Cross or groups associated with the Citizen Corps.

Disparities in Recovery

Several sources have indicated that minorities typically have slower and more difficult recoveries after disaster due to factors such as lower incomes, fewer savings, greater unemployment, less insurance, poorer access to information, and the existence of bias in the search for long-term housing (Pastor et al., 2007; Fothergill et al., 1999). Andrusis and colleagues (2007) note that minority communities often recover more slowly after disaster because they are more likely to experience cultural barriers and receive inaccurate or incomplete information because of language barriers. Aptekar (1990) argues that upper-middle-class disaster victims are more likely to receive aid than minorities and the poor because they are more adept at maneuvering and negotiating the government and relief system and are more likely to know how to fill out standard forms.

Pastor and colleagues (2006) note that opportunities for “second disasters” are revealed during the recovery phase of disaster when rebuilding and reconstruction can exacerbate already-present inequalities. For example, one study found that housing after Tropical Storm Agnes in 1972 was allocated along racial and ethnic lines and blacks were assigned to a high-rise housing project (Fothergill et al, 1999). In another example, it was reported that non-English-speaking women of color were vulnerable to dishonest practices by construction contractors after Hurricane Andrew (Enarson & Morrow, 1997).

During the reconstruction process, market forces may hinder the development of low- and moderate-income rental units and housing shortages disproportionately impact racial and ethnic groups (SAMHSA, 2003; Bolin & Stanford, 1998). Bolin and Stanford (1998) state that communities of color can experience decline in their standard of living in the long-term after a disaster.

Though the majority of survivors recover after disasters and their symptoms reduce in the first days and weeks following the disaster (Ruzek, 2006; Housley et al., 2006), a

growing body of evidence suggests that certain minority groups may be vulnerable to anxiety disorders, depression, and post-traumatic stress disorder (PTSD) (Bryant & Litz, 2006). Risk factors for depression include racism, discrimination, as well as acculturation and challenges of economic survival (Sáez-Santiago & Bernal, 2003). Additional factors include gender, age, health status, perceived control of daily stressful events, and language difficulties (Sáez-Santiago & Bernal, 2003).

In the case of PTSD, Draguns (1996) shows that the factors that influence the manifestation of PTSD symptoms include individualism-collectivism, power distance, uncertainty avoidance, and masculinity-femininity (Figure 18).

Individualism

- Self-experience
- Self-actualization

High-Power Distance

- Wide distance between client and therapist

High-Uncertainty Avoidance

- Respect for science
- Dismissal of unverified techniques
- Stringent bureaucratic requirements

Masculinity

- Coping
- Restoration of productivity and efficiency

Collectivism

- Imperative for social integration
- Harmonious relationships

Low-Power Distance

- Cooperative, egalitarian therapy

Low-Uncertainty Avoidance

- Innovative approaches
- Experimenting with new approaches
- Low bureaucratic requirements

Femininity

- Caring
- Promoting inner satisfaction

Figure 18: Cultural Dimensions in Manifesting PTSD Symptoms and Therapy

Source: Draguns, 1996

As the research of Thiel de Bocanegra and Brickman (2004) related to Chinese immigrant workers in New York shows, factors that affect PTSD in minority populations include age, age at immigration to the United States, and prescription drug use after the attacks of September 11, 2001. Other risk factors for post-traumatic stress disorder include pre-immigration traumatic experiences such as starvation, loss of family members and property, and prolonged detainment in unsafe and overcrowded refugee camps (Abueg & Chun, 1996; Kinzie, 2001). Other stressors include post-immigration and adjustment to the new country and new culture (Abueg & Chun, 1996). For instance, up to seventy percent of refugees from Cambodia, Vietnam, and Laos meet diagnostic criteria for PTSD compared to four percent of U.S. population that are diagnosed with this disorder (CMHS, 2001a).

Researchers have found that Latinos and African Americans are more vulnerable to traumatic events and are more likely to develop PTSD than Whites (American Psychological Association, 2006a; Hough et al., 1996). Latinos have demonstrated the highest rates of PTSD after Hurricane Andrew and the September 11th terrorist attacks (Perilla et al, 2002; Galea et al., 2002, Figure 19). Pole and colleagues (2005) find that the higher incidence of PTSD among Latinos is driven by several cultural-influenced behaviors such as passive coping styles (beliefs in miracles, faith, or luck) with external loci of control, avoidance and numbing symptoms as an approach to managing distress, and wishful thinking and self-blame coping. These authors further note that less-aculturated Latinos may be at particularly high risk for PTSD.

Percentage Meeting All Symptom Criteria by Ethnicity

Low Personal Trauma

- 9 percent Non-Hispanic White
- 10 percent Non-Hispanic Black
- 10 percent Latino-Spanish

Moderate Personal Trauma

- 15 percent Non-Hispanic White
- 18 percent Non-Hispanic Black
- 31 percent Latino-Spanish

High Personal Trauma

- 21 percent Non-Hispanic White
- 38 percent Non-Hispanic Black
- 50 percent Latino-Spanish

Figure 19: Effects of Ethnicity on Post-Traumatic Stress

Source: Perilla et al., 2002

For Native Americans, PTSD is strongly related to substance abuse, anxiety, and depression (Robin et al., 1996). Research also shows that in some cases Native Americans and Alaskan Natives can be at a higher risk of PTSD due to ecological factors. A study of the *Exxon Valdez* spill in Alaska revealed that the higher risk of PTSD among Alaskan Natives was due to the fact that the spill destroyed natural resources that were not only “a means of economic sustenance, but also a way of transmitting traditional values and culture to the next generation” (Green, 1996).

In their review of the literature, Fothergill and colleagues found evidence to suggest that the reconstruction stage of a disaster can provide an opportunity for change in some communities. For example, disasters can engage communities in political dialogues about social inequities (Bolin & Stanford, 1998). The rampant media coverage of Hurricane Katrina and commentaries about the response to this disaster are a powerful example of such a phenomenon. Enarson and Morrow (1997) have also described the emergence of grass-roots community coalitions that formed after Hurricane Andrew. Fothergill and colleagues (1999) caution that while disaster can provide opportunity for collective action, “only groups engaged in such action before a disaster will be likely to engage after the disaster.”

The literature indicates that all of our target audiences will benefit from increased cultural knowledge, language access services, strategic planning, and analyzing barriers and enablers to meeting survivors’ needs. Disaster relief efforts can be enhanced if responder agencies partner with local community-based organizations, build trust, and involve them in disaster preparedness planning.

5. Conclusion

Our research into cultural competence as related to disaster response yielded several findings. First, there is a body of evidence documenting that racial, ethnic and linguistic minorities are particularly vulnerable to disasters and suffer disproportionately from the negative consequences of these events. Second, emergency responders can benefit from recognizing the role of culture in the disaster context and can improve service delivery by acquiring knowledge, skills, and attitudes to promote culturally and linguistically appropriate disaster response services. Third, cultural competency training opportunities for disaster responders are limited, with the fewest resources available to traditional EMS personnel and emergency managers. Fourth, the few programs that do exist typically do not include even basic information regarding working with limited English proficient populations. Furthermore, we found that only one resource integrates the CLAS standards as part of a comprehensive OMH cultural competency education program for responders.

Together, these main findings reinforce the importance of developing a cultural competency curriculum for disaster preparedness and crisis response that is grounded in the CLAS standards. Such a tool has the potential to improve culturally-sensitive and appropriate disaster response and facilitate a reduction in disparities in disaster vulnerability and risk.

We reviewed a wide range of resources during the development of this Scan to ensure a broad representation of information and opinions related to multiple audiences that may benefit from this forthcoming curriculum. Our sources included but were not limited to: Federal- and State- level reports and documents, peer-reviewed published literature, information from professional organizations, current training and education resources designed for relevant audiences, data sought from experts in the field, and Internet and multimedia searches.

In order to provide a comprehensive picture of available information related to cultural competence in disaster response, we focused on several research areas: investigating the rationale for cultural competency in disaster response; identifying definitions of disaster and disaster characteristics; exploring information about our target audiences and their job functions, educational requirements, and demographic characteristics; examining how the CLAS standards relate to disaster response functions; documenting the vulnerability of minorities and the underserved to disaster events; identifying culturally-specific disaster interventions; and probing the nature and availability of cultural competency training opportunities for our target audiences.

Summary of Key Findings

Minorities are disproportionately impacted by disasters.

Our first key finding – that minorities are disproportionately vulnerable to and impacted by disasters – reinforces the importance of developing tools and strategies to provide culturally and linguistically appropriate disaster response services and establishing programs that can help to reduce or eliminate the vulnerabilities and disaster response

disparities. Our research revealed that there are a number of factors that contribute to the disproportionate risk that minorities face in disasters, including: language, housing patterns, cultural and geographic isolation, cultural differences between survivors and responders, and preparedness levels of minority communities.

For instance, we found examples of disaster evacuation information not being disseminated in languages spoken in affected communities, thus delaying the receipt of important information by non-English speaking residents in disaster zones. Also, measures of disaster preparedness such as stocking emergency supplies, making structural reinforcements to homes, or purchasing certain types of insurance (i.e., earthquake or flood) can be prohibitively expensive for poorer households. Often, minorities and the underserved populations are more likely to reside in unsafe housing which exacerbates their risk to disaster. Minorities frequently have slower and more difficult disaster recovery process. Limited access to financial resources and insurance to help rebuild, reluctance to seek Federal aid, fear or mistrust of government agencies, and real or perceived discrimination from aid agencies are examples of factors that contribute to the slower disaster recoveries often experienced by minority communities.

All target audiences will benefit from recognizing the role of culture in health and cultural influences on disaster-related behaviors and experiences.

During the development of the Scan, we found evidence to suggest that all target audiences will benefit from recognizing the role of culture in health and cultural influences on disaster-related behaviors and experiences. However, there is wide variation among different disaster response and service providers as to the importance attributed to cultural competence. Traditional EMS personnel and emergency managers are just starting to integrate cultural competency training and principles into their practice, whereas social workers and disaster mental health professionals have broader background and experience with the concepts of cultural competency. For example, the National Association of Social Workers (NASW) has integrated cultural competence into their professional standards for social work. Cultural competence has been also integrated into mental health services, and through SAMHSA efforts, cultural competence is a part of guiding principles and recommendations in disaster mental health programs. The U.S. Public Health Service Commissioned Corps emphasizes the importance of cultural awareness and working with diverse groups, and has incorporated these fundamentals of cultural competence into a number of their trainings.

Despite recognition of the importance of cultural competency training, sufficient cultural competency training opportunities are lacking for a number of disaster response partners.

Our research revealed a lack of sufficient cultural competency training opportunities for traditional EMS personnel and emergency managers, but found many more resources available in the mental health and social work fields. Despite extensive literature noting the importance of emergency managers' awareness of cultural, ethnic, racial, and gender diversity, cultural competence is not sufficiently introduced into emergency managers' education programs. We were unable to locate any one undergraduate course about

cultural competency in the emergency management field, though there is a limited number of courses that cover vulnerable populations and sociology of disaster.

Guiding documents for EMS training such as the *National Standard Curricula*, *Emergency Medical Services: Agenda for the Future*, and others acknowledge the importance of diversity issues and advocacy for vulnerable populations and point to the use of technology-based distance learning programs. However, our research did not reveal any distance learning courses for first responders specifically related to cultural competency.

There are unique considerations and challenges with respect to EMS training. First, qualification standards and education practices vary widely nationwide, and education and training requirements and scope of practice are different from one state to another. Moreover, there is limited reciprocity between states in terms of recognizing certification. There is also a lack of consistency among EMS curricula, with content and instructional methodology varying from program to program.

Certain foundations of cultural competence, such as cultural awareness and working with diverse groups, have been incorporated into a number of trainings for both the American Red Cross and the Commissioned Corps. While the inclusion of these fundamentals in trainings for these groups is good, trainings could be expanded further to cover additional cultural competency fundamentals, including specific emphasis on the Language Access Services and Organizational Supports components of the National CLAS standards.

The social work and mental health fields have more highly developed research and resources with respect to the role of cultural competency in disasters; research in these fields points to the importance and effectiveness of interactive teaching methods.

The social work literature is rich in models and approaches to practice that incorporate principles of cultural competency and cultural awareness. Moreover, there is a solid literature base on methods and approaches to multicultural social work education; much of which points to the importance and effectiveness of experiential learning and interactive teaching methods.

The number of mental health education programs that include cultural diversity and multiculturalism has increased over the past two decades, and awareness of the need for multicultural training in mental health disaster response increased in the aftermath of Hurricane Katrina, an event that the American Psychological Association called a “multicultural disaster.” Similar to the social work literature, researchers exploring disaster mental health education suggest that didactic training methods are insufficient, and recommend the use of exercises such as skills practice, role-playing, and simulations. The use of video to illustrate the context of disaster response has also been noted as a best practice in disaster mental health training.

Gaps in the Knowledge

Lack of integration of the CLAS standards

We found that the three themes of the CLAS standards do apply to our target audiences and their job functions. However, there is limited reference to the CLAS standards in the published literature with respect to disaster responders. Additionally, most programs do not sufficiently prepare disaster responders to work with interpreters or provide other linguistically appropriate services. We found that only two resources specifically address the CLAS standards. One of these resources is the workbook on working with vulnerable populations developed by CDC showing that the CLAS standards can greatly benefit organizations who strive to achieve cultural and linguistic competence. Another resource is the work of Jones and colleagues that incorporates CLAS standards into disaster mental health research. Disseminating information about the standards in the disaster response context through an online curriculum could provide a useful framework for implementation and improvement of culturally and linguistically appropriate disaster response services.

Lack of evidence of effectiveness of existing trainings for target audiences

Our research reveals that there is a lack of empirical evidence related to the effectiveness of existing cultural competency programs for our target audiences. This is not a surprising finding given that there is sparse evidence concerning the effectiveness of cultural competency training programs for other health care professionals such as physicians and nurses. A key research goal in the cultural competency training field in the years to come will be conducting empirical studies to measure the effectiveness of available programs. Rigorous evaluation methodologies, such as randomized controlled trials and the incorporation of patient outcomes data, will be crucial to establishing the value and efficacy of cultural competency training programs.

Concluding Thoughts

The research presented in this Scan offers sufficient information to begin developing cultural competency curriculum modules for disaster response professionals. The proposed curriculum has the potential to make an important contribution to the disaster response education field by educating practitioners about the CLAS standards and promoting their use as a framework for enhancing culturally and linguistically appropriate disaster response services.

However, it is important to note that the audiences for the proposed curriculum vary widely in terms of their job functions, educational requirements, and demographics. Also of note is that some disaster response fields, namely social work and mental health, have higher educational requirements and more advanced tools and resources with respect to culturally and linguistically competent services as compared to traditional EMS personnel, Red Cross staff and volunteers, and emergency managers.

Therefore, recommendations from the National Project Advisory Committee, Consensus-Building members, concept papers, and needs assessment focus group results will be critical in designing a curriculum that can meet the needs and learning styles of this diverse group of different disaster response professionals.

Addendums: Profession-Specific Information

A. Emergency Managers

Characteristics of Emergency Managers

Emergency management is most commonly identified as the “management of risk in order to protect life and property through a comprehensive effort that involves non-linear activities tied to mitigation, preparedness, response and recovery” (Phillips, 2003). As outlined in the National Response Plan (NRP), these activities involve coordination of incident management efforts, issuance of mission assignments, managing resources and human capital, incident action planning, and financial management (DHS, 2004a).

To more effectively work with disaster survivors, the literature points out that emergency managers need to take a proactive risk-based approach to emergency management, focus on building disaster resistant communities as a catalyst for a safer America, emphasize social vulnerability reduction, root their practices in emergency management fundamentals, and perform strategic planning with jurisdictional stakeholders (May, n.d.; Cwiak et al., 2004).

Standards for accrediting and certifying emergency managers and accrediting disaster response agencies are determined by the International Association of Emergency Managers (IAEM) and the Emergency Management Accreditation Program (EMAP) (IAEM, 2006; EMAP, 2004). The IAEM emergency manager certification is based on three years of emergency response experience, possession of a bachelor’s degree or equivalent, 200 hours of training, self-defined contributions to the field, written responses to disaster scenarios, and a 100-item multiple choice exam (IAEM, 2006).

As researchers point out, no verification of actual performance appears to be necessary for the IAEM certification. The sample items for the multiple choice exam are not specific to any particular emergency manager’s duties and appear to be answerable using little more than common sense (Gheytanchi et al., 2007). Similar concerns exist with EMAP accreditation of disaster response agencies, and the EMAP program does not connect the accreditation and actual disaster management performance (Gheytanchi et al., 2007).

In terms of demographics, the Bureau of Labor Statistics data indicates that as of 2006, there were 11,300 specialists employed as emergency managers, with the majority (5,990 or 53 percent) employed by local government (DOL, 2007). An exploratory study of emergency managers’ demographics conducted by Cwiak and colleagues (2004) compared attendees at the International Association of Emergency Management’s (IAEM) November 2003 conference (81 respondents) and North Dakota’s county-level (NDC) emergency managers (43 respondents). Results showed a mean age of 46 years among IAEM respondents and 51 years among NDC respondents (Cwiak et al., 2004). In both groups, emergency managers were predominantly male (79 percent among IAEM and 67 percent among NDC) and overwhelmingly White (87 percent among IAEM, 95 percent among NDC; Figure 20).

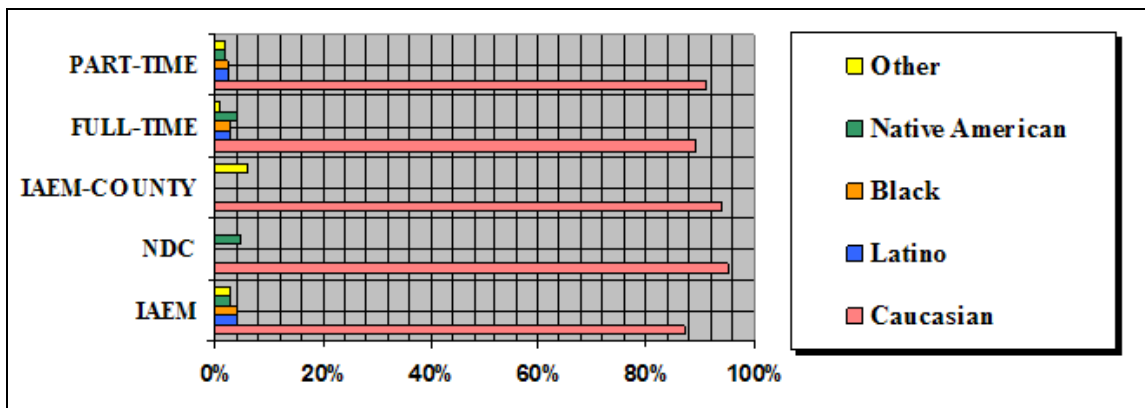


Figure 20: Ethnicity of Emergency Managers

Source: Cwiak et al., 2004

Regarding emergency managers' education, research reveals a disparity between IAEM (74 percent with a four-year degree or higher) and NDC respondents (81 percent with less than a four year degree) (Cwiak et al., 2004). However, both groups valued additional college-level courses and indicated that they needed more professional training (Cwiak et al., 2004).

The Three Areas of CLAS in Relation to Emergency Management

Emergency managers perform core management and administrative functions in support of disaster preparedness, response, and recovery. Due in part to the September 11, 2001 terrorist attacks, emergency managers enhanced their visibility and moved from a relative anonymity to being key players in disaster and mass violence response (Cwiak et al., 2004). Through programs such as the FEMA Higher Education Project, emergency management is changing from a bureaucratic and reactive field to a more dynamic, proactive, and culturally-sensitive field. Experts argue that cultural sensitivity and familiarity with the issues related to disadvantaged and special populations are important professional characteristics of emergency managers (Thomas & Milleti, 2003; Cwiak et al., 2004).

Cultural competence is vital to emergency managers, as the increasing diversity of the U.S. population brings "new occasions for misunderstanding and prejudice" that require changes in traditional assumptions about cultural differences and minority groups (Darlington, 2000). At the same time, as shown by Cwiak and colleagues (2004), emergency managers consider cultural sensitivity less important as compared to other skills such as listening and leadership (56 percent, 96 percent, and 97 percent respectively). Therefore, emergency managers may benefit from ongoing training on cultural competence that is tailored to disaster awareness and preparation (Missouri Department of Health and Senior Services, 2006). Federal and State emergency management organizations may also benefit from hiring bilingual and bicultural members of minority communities as managers at the regional level to provide more effective services (Seidenberg, 2006; SAMHSA, 2003).

Researchers recommend providing linguistically competent disaster relief services and identifying linguistic resources in the community, for instance, employees of ethnic groceries and restaurants, legal aids and attorneys, or distance learning and telemedicine technologies for translation or interpreter services (Missouri Department of Health and Senior Services, 2006). It is also recommended that emergency management agencies ensure that their written educational materials are culturally appropriate and include feedback from community members (Missouri Department of Health and Senior Services, 2006).

Regarding organizational supports for culturally competent disaster relief services, recent literature suggests that emergency managers focus on developing sustainable communities and facilitate community planning in order to make sure that diverse groups are included in disaster recovery processes (Fothergill et al., 1999; SAMHSA, 2003; Schneider, n.d.). The effectiveness of disaster response can be enhanced if emergency managers develop strategic plans and create and maintain a general directory of community assets and resources for use in an emergency (Missouri Department of Health and Senior Services, 2006; Cwiak et al., 2004). This is especially important as some minority groups refuse to seek help and reject disaster assistance because of their undocumented immigration status and doubts about eligibility for Federal relief funds (SAMHSA, 2003; Batalova, 2005). In these circumstances, resources within a community may be more likely to be utilized by those in need during and following a disaster.

The Public Health Workbook to Define, Locate, and Reach Special, Vulnerable, and At-Risk Populations in an Emergency under development by the Centers for Disease Control and Prevention (CDC) at DHHS shows that adopting the CLAS standards can greatly benefit organizations who strive to achieve cultural and linguistic competence and adopt the CLAS standards. Adoption of the CLAS standards will enable emergency managers and public health professionals to build the relationships needed to communicate with every person in their community, forge stronger relationships and partnerships, and build stronger and more effective community outreach networks (Centers for Disease Control and Prevention, 2007).

Roles of Emergency Managers during Disaster Preparedness and Crisis Response

Emergency management focuses on the core management and administrative functions in support of disaster and terrorist attack response and is coordinated by the Department of Homeland Security through FEMA (DHS, 2004a; Lakoff, 2006). Recent research shows that sociological and psychological considerations related to emergencies and disasters are a critical area of study in emergency management. These considerations include information on how people process disaster scenarios, knowledge of the psychological realities of victims, and community reactions to disasters and emergencies (Woodbury, 2005). Recent research and practice point out that

Emergency management is the management of risk in order to protect life and property through a comprehensive effort that involves non-linear activities tied to mitigation, preparedness, response and recovery.

Phillips, 2003

emergency managers should focus on building disaster resilient communities as a catalyst for a safer America and work on reducing social vulnerabilities (May, n.d.). It is also strongly recommended that Federal, State, and local emergency management entities improve cultural competency in disaster response by decentralizing organizational structures to the local level, increasing reliance on local non-government organizations (NGOs), and promoting advocacy and networking with local leaders (Seidenberg, 2006).

Emergency managers should pay special attention to social vulnerabilities. Minority populations are reported to have higher social vulnerability in disasters since they are often more likely to reside in dangerous areas and substandard housing, and to have limited resources (McEntire, 2004; see also SAMHSA, 2003).

CDC's *Public Health Workbook to Define, Locate, and Reach Special, Vulnerable, and At-Risk Populations in an Emergency* (the Workbook) provides practical advice and a step-by-step approach that can guide emergency managers and public health professionals in defining, locating, and reaching minority populations (Centers for Disease Control and Prevention, 2007; Figure 21). The Workbook shows that cultural and linguistic competence is essential for working with vulnerable populations and that services provided to these populations will benefit from adopting CLAS Standards (Centers for Disease Control and Prevention, 2007).

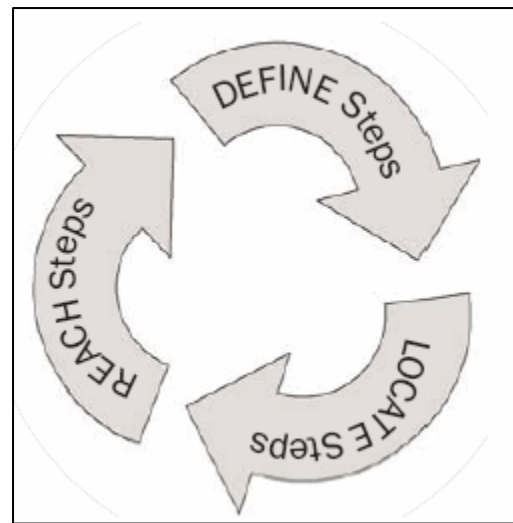


Figure 21: Steps for Working with Vulnerable Populations
Source: CDC, 2007

Emerging trends indicate that emergency managers will need to take into consideration matters of cultural, ethnic, racial, and gender diversity when addressing the needs of disaster victims (Hite, 2003). Cultural sensitivity and familiarity with the issues related to disadvantaged and special populations within each community are identified as core skills for emergency managers (Thomas & Milleti, 2003; Fothergill et al., 1999). For instance, it is important to plan the notification information in languages other than English (Fothergill et al., 1999; American Psychological Association, 2006a; Missouri Department of Health and Senior Services, 2006) and plan for providing services to ethnic communities in a timely manner and in a culturally sensitive way (Fothergill et al., 1999; SAMHSA, 2003).

It is recommended that emergency management agencies engage in community outreach and create and maintain a directory of community resources for use in an emergency (Missouri Department of Health and Senior Services, 2006). Community partnerships can be very beneficial for both emergency management agencies and local communities, since they provide the best assurance that the needs of vulnerable populations and the needs of the community for long-term recovery will be addressed. Community-based

organizations provide an ongoing human service infrastructure to people in the community and they are often the best indicators of post-disaster needs (Stengel, 2000; Figure 22). They can also help assure that social networks of underprivileged families are maintained (Seidenberg, 2006).

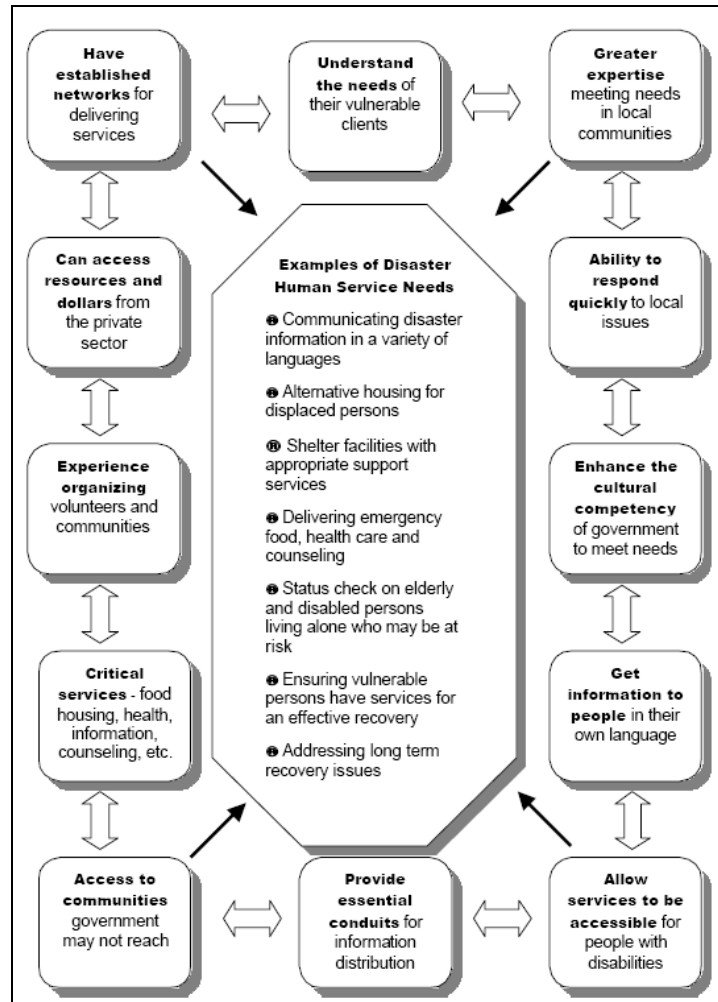


Figure 22: Community-Based Organizations and Emergency Management
Source: Stengel, 2000

Disaster Preparedness and Crisis Response Training for Emergency Managers

Emergency management, like many other disaster preparedness and crisis response professions, has grown since the terrorist attacks of September 11, 2001. The number of doctoral, master's, bachelor's, associate, and certificate programs has dramatically increased. Forty-four colleges and universities are offering degree programs in emergency management, and sixty-nine schools offer individual courses in emergency management, hazards and/or disasters without any type of certification or degree program (Hite, 2003). Seventeen percent of courses in emergency management are offered online (Darlington, 2000).

There is little to no consistency in using the words disaster, emergency, or hazard in the titles of college courses, and little to no consistency in defining emergency management. The core components (or most frequently referred to elements) of the emergency management curriculum are mitigation, preparedness, response, and recovery. Other issues covered in the emergency management courses include preparedness, planning, organizational, legal issues, terrorism, risk and hazards, management, policy, and future/challenges (Phillips, 2003).

Typical courses taught in the emergency management programs include hazard mitigation, disaster response and recovery, leadership and organizational behavior, hazardous materials, private sector issues, computers in emergency management, building disaster resilient communities, voluntary agency disaster services, crisis communications, and community disaster preparedness (Drabek, 2007). In terms of educational topics, a quantitative study by Darlington (2000) of 1,886 schools nationwide (response rate 50 percent) indicated that the focus of emergency managers' education is State and local emergency management, roles and responsibilities of emergency managers, hazard prevention and mitigation, and disaster planning and preparedness (Figure 23). Fifteen percent of courses address the sociology of disasters, and thirteen percent of courses address community and emergency management and the media. Cultural competence does not appear to be sufficiently included in emergency managers' education programs.

Topic	Percent of schools and agencies offering courses
Emergency management skills	72%
State and local emergency management	67%
Roles and responsibilities of emergency managers	58%
Hazard prevention and mitigation	53%
Disaster warning systems	42%
Information technology and emergency management	36%
Biological, toxic agent, and epidemic hazards	29%
Psychological dimensions of hazards and disasters	21%
Sociology of disasters	15%
Community and emergency management	13%

Figure 23: Courses in Emergency Management Education

Source: Darlington, 2000

Researchers and educators point out that emergency managers of the future will need to have a multi-disciplinary education that combines academic and experiential knowledge in several disciplines to include criminal justice, seismology, meteorology, chemistry, public administration, public health, public budgeting and community planning. Emergency management curricula will also need to include issues of disaster sociology and matters of cultural, ethnic, racial, and gender diversity when addressing the needs of disaster victims since minority populations usually have higher disaster vulnerability (Hite, 2003; Woodbury, 2005; McEntire, 2004; May, n.d.; Darlington, 2000).

Current education gaps include methodology of disaster research, national security and terrorism, ethical problems in field work, and program evaluation. Additionally, there are gaps in more sophisticated graduate-level planning and management education; skills for

highly complex hazards, threats, and disasters; and the need for multi-disciplinary team management to deal with human-made threats, including multiple, simultaneous terrorist assaults (Rubin, 2004; Darlington, 2000).

In terms of emergency management teaching methodologies, educators argue that traditional classroom experience needs to be combined with practical experiences. One way of gaining practical experiences could be internships (Phillips, 2003). It has also been suggested to rely more on distance learning technologies, implement advanced pedagogical approaches aimed at developing higher order thinking, and utilize Instructional Systems Design (Thomas & Milleti, 2003, Figure 24).

- 
- Classroom experience
 - Internships
 - Distance learning courses
 - Case studies

Figure 24: Promising Education Practices in Emergency Management

Sources: Thomas and Milleti, 2003

College-based emergency management education is supported through government organizations, such as for the FEMA Higher Education Project (FEMA, 2003). Recommended college courses focus on emergency operations and include disaster response and recovery operations, emergency management operations, and planning. In partnership with the academic community, FEMA is developing several classroom-based BA-level courses that also focus on disaster management and include building disaster resilient communities as one of the topics (FEMA, 2003).

To facilitate information exchange, the FEMA Higher Education Project lists graduate and undergraduate course syllabi from 104 universities across the U.S., Australia, and the U.K. that offer courses on emergency response. The overwhelming majority of courses focus on homeland security, terrorism, weapons of mass destruction (WMDs), natural disasters, incident management systems, and emergency preparedness planning. None of the courses are specifically focused on cultural competence in emergency management. Six courses are offered in disaster sociology and cover the role of social factors such as vulnerable populations (which consist of primarily children and elderly adults in these resources) in emergency management. Few courses are focused on community relations in preparedness planning and disaster response.

FEMA has also facilitated the development of a national curriculum for emergency managers which began in 2003. At the workshop convened in October 2003 by the Natural Hazard Center at the University of Colorado at Boulder and the University of Colorado at Denver in partnership with the FEMA Higher Education Project, participants started to formulate a national model for an emergency/hazards management higher education curriculum and create a framework for educational opportunities. Cultural sensitivity and familiarity with the issues related to disadvantaged and special populations were some of the core skills for emergency managers at the undergraduate

level to be integrated into existing programs (Thomas & Milleti, 2003). It is also noted that sociology research should be encouraged in order to support practitioners, especially research related to mass communication models of warning; how culture, race, class, gender, and sexual orientation can affect the distribution of emergency/hazards management resources and services; disasters and development; emergency response organizations; volunteerism; and disaster convergence (Thomas & Milleti, 2003).

Continuous training for emergency managers is offered by the Department of Homeland Security through its <http://www.Firstrespondertraining.gov> Web site that offers over 200 courses and workshops, though no course specifically addresses preparedness for racially, ethnically, and/or linguistically diverse populations (DHS, 2007; Andrulis et al., 2007). FEMA also offers continuous professional education for emergency managers at the Emergency Management Institute (EMI) and National Incident Management System (NIMS) Integration Center. EMI courses focus primarily on preparedness and response for disasters, WMDs, floods, hospital emergency staff training, and human resources development.

EMI also offers courses online through its Independent Study Distance Learning Site accessible at <http://emilms.fema.gov/>. The majority of twenty-three courses offered through this site are related to emergency management with one course on Tribal Relations that includes components of culturally competent behavior and helps develop cross-cultural communication skills. Another relevant course is the Special Needs Considerations for Service and Support Providers. The course does not discuss cultural competence specifically, but can be helpful in developing effective communication strategies for working with minority and underserved communities (EMI, 2007). NIMS Integration Center training focuses primarily on the elements of the National Incident Management System and integration of government and local organizations that have a role in preventing, preparing for, responding to, or recovering from an incident (FEMA, n.d.).

B. EMS Personnel

Characteristics of EMS Personnel

The National EMS Scope of Practice Model defines four levels of EMS personnel: Emergency Medical Responders (EMR); Emergency Medical Technician (EMT); Advanced Emergency Medical Technician (AEMT); and Paramedic (National Highway Traffic Safety Administration, 2005). The Bureau of Labor Statistics defines the levels of EMS personnel as first responders, EMT-Basics (EMT-B), EMT-Intermediates (EMT-I), and Paramedics (DOL, 2006). All emergency medical systems also involve dispatchers (EMD). The ultimate power to regulate emergency medical systems lies within each State (National Highway Traffic Safety Administration, 2005).

According to the Bureau of Labor Statistics, the primary duties for emergency medical providers include basic emergency medical care when they arrive at the scene of an incident (DOL, 2006). EMRs provide initial emergency care, providing basic emergency care on the scene, and assisting with higher level EMS response during transport to the hospital. EMRs provide simple, non-invasive emergency care. EMTs have a broader scope of practice, providing care with the basic equipment found on an ambulance and acting as a link between the scene of an emergency and the emergency health care system. AEMTs function in much the same way as EMTs, but are additionally trained to use more advanced equipment on an ambulance. Paramedics are trained in all aspects of emergency pre-hospital care and advanced life support. Paramedics are also trained to provide invasive and pharmacological treatment when necessary (IOM, 2007; DOL, 2006; National Highway Traffic Safety Administration, 2005). EMD functions include monitoring the location of EMS personnel; dispatching the appropriate type and number of units in response to calls for assistance; providing medical instruction to those on the scene until help arrives; questioning each caller (sometimes with the help of interpreter) to determine the type, seriousness, and location of the emergency; and providing updates on the patient's condition to ambulance personnel, serving as a link between ambulance and hospital staff (Clawson, 1989).

In terms of training, the requirements for EMS personnel vary nationwide, in part because the *National EMS Scope of Practice Model* only serves as guidance and each State creates their own requirements (IOM, 2007; National Highway Traffic Safety Administration). Generally, EMT-B requires classroom training and clinical work in a hospital emergency room. The training emphasizes managing respiratory, trauma, and cardiac emergencies, as well as the use of emergency equipment (Bureau of Labor Statistics, 2007). Candidates must pass a written and practical exam in order to get their license. EMT-I requires 300 to 400 hours of additional instruction beyond the EMT-B coursework and includes patient assessment and the use of advanced airway devices (IOM, 2007; NAEMT, 2006). The most advanced level, EMT-P, involves up to 2,000 hours of additional didactic training and practicum time, for instance, training in advanced life support (IOM, 2007). The training for EMDs is provided mainly by private companies, as well as organizations like the National Academies of Emergency Dispatch

(NAED) that also provide certification (NAED, 2006; IOM, 2007). Most emergency medical dispatchers develop their skills on the job and through training, and it is recommended that their training includes working with interpreters (Kelly et al., 2006).

The overwhelming majority of States and territories require both a written and a practical exam for initial credentialing. All States require that licensure be renewed, typically every 2–3 years (IOM, 2007). At the national level, standards for EMTs and certification exams are administered by the National Registry of Emergency Medical Technicians. Currently, 45 states require that their EMTs meet the standards set forth by the National Registry of EMTs in order to be licensed (NREMT, n.d.).

As for EMS personnel demographics, the National Registry of Emergency Medical Technicians (NREMT) contained 192,182 EMTs as of 2004 (IOM, 2007). Yet it is difficult to know how many EMS personnel are actually employed since registration requirements vary across States and many EMS personnel are volunteers: it is estimated that in some States the number of volunteers among EMTs is above fifty percent (IOM, 2007). The National Association of Emergency Medical Technicians (NAEMT) estimates that there are roughly 800,000 EMS providers in the U.S. (Johnston, 2006).

The majority of EMS personnel (54.1 percent) are employed in rural areas and small towns (IOM, 2007). EMS personnel are younger than the civilian labor force nationwide; for instance, 48.3 percent of EMTs are younger than 34 years as compared to 37.3 percent nationwide. EMS personnel are predominantly male (sixty-five percent compared to thirty-five percent women) and predominantly White (86.1 percent compared to 67.9 percent of Whites in the total U.S. population) (IOM, 2007, Figure 25).

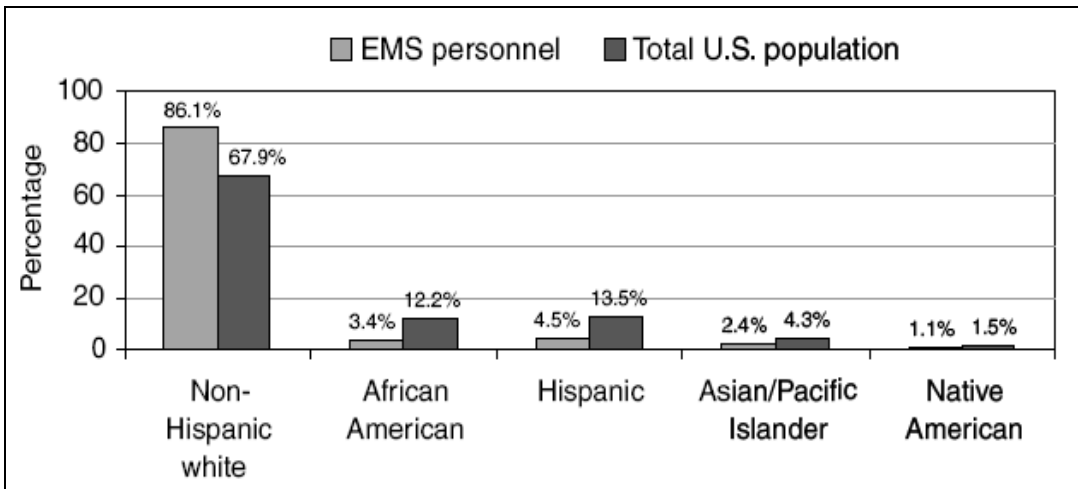


Figure 25: Race and Ethnicity of EMS Personnel
Source: IOM, 2007

The Three Areas of CLAS in Relation to EMS Personnel

EMS personnel's key priority is to provide efficient and immediate care to the critically ill and injured. It has been emphasized that the EMS personnel should provide equitable care regardless of culture, gender, age, or socioeconomic status (NHTSA, 1995; Gillespie, 1978; NAEMSP, 1993). As pointed out by the National Highway Traffic Safety Administration (NHTSA), developing patient rapport and recognizing and utilizing communication unique to diverse multicultural groups and ages within those groups are key professional characteristics of EMS personnel (NHTSA, 1998c; Bronheim, 2003). For more effective emergency response, researchers suggest that EMS agencies develop policies and procedures for recruiting and retaining diverse staff and support ongoing professional development in cultural competence (Bronheim, 2003).

Providing language access services to patients with limited English proficiency is required by the U.S. Department of Justice *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*. The Guidance requires all recipients of Federal funds to provide meaningful access to services to persons with limited English proficiency (DOJ, 2002). To comply with Federal laws, many local EMS agencies across the country are partnering with interpretation agencies, and some local authorities make interpreter services mandatory for all 911 call centers (Futty, 2007). Most states differ in how they manage language services. California, for instance, is the only state with a statewide contract for telephone interpreting for 911 services, with the services available at no additional cost to every 911 public safety answering point (New America Media, 2004).

When we got there two women were screaming and crying. Neither spoke English. I didn't even know who was the mother or if either one was the mother. We didn't know how long the infant had been unresponsive, didn't know if he had been sick. But worst of all, we had no way to comfort the women or explain to them what was happening. Since the baby died at home, in our town we had to wait for the police to arrive. It took them fifteen minutes—fifteen minutes of my feeling totally helpless.

Bronheim, 2003

Regarding organizational supports for cultural competence, EMS agencies may benefit from incorporating culturally and linguistically competent services as part of their mission statements (Bronheim, 2003). Another useful organizational strategy is community outreach. The report of the National Highway Traffic Safety Administration (NHTSA) and Health Resources and Services Administration (HRSA) *Emergency Medical Services: Agenda for the Future* suggests the vision of EMS as community-based services fully integrated into the health care system (NHTSA, 1996). In addition, mobile medical care is an effective recommendation offered by some of the recent research stemming from the aftermath of Katrina (Krol, Redlener, Shapiro & Wajnberg, 2007).

Community outreach can be an effective strategy to achieve the NHTSA vision, one example is the “Make the Right Call” campaign that is focused on timely access and appropriate utilization of the EMS system and is supported by the U.S. Fire Administration (USFA)/NHTSA/Maternal and Child Health Bureau (MCHB) (Kelly et

al., 2006). Community outreach can help EMS agencies enhance local disaster preparedness and identify populations with special needs and linguistic resources within the community to help meet patients' needs (Kelly, 2007; Centers for Disease Control and Prevention, 2007; Sahni, 2007). For more effective outreach, it is important that public education materials are available in the languages commonly spoken in the community and are developed using professional translator services (Kelly et al., 2006).

Roles of EMS Personnel during Disaster Preparedness and Crisis Response

To better serve increasingly diverse populations, it is recommended that the EMS personnel have the knowledge of cultural differences in response to trauma, grief, and death in order to calm fears, worries, and frustrations (Bronheim, 2003; Sarhill et al., 2001; Hunter, 2007; Sahni, 2007). This knowledge is especially important when obtaining a patient's consent of care or dealing with refusal of care (NHTSA, 1995). For instance, 'Do Not Resuscitate' orders that usually require a written order from a physician and patient may not be acceptable when responding to Muslim patients, since Islam holds life as sacred and belonging to God (Sarhill et al., 2001).

EMS personnel can also benefit from achieving a minimal proficiency level in a foreign language in order to communicate at a basic level with patients in that language. Efforts are underway to develop foreign language reference books for EMS personnel with information on culturally-specific patient behaviors (Dees, 2006) in the event they may not have access to interpreter services.

However, working with a qualified interpreter is considered a best practice when interacting with a LEP individual regardless of the situation. The need for clear and efficient communication is rarely greater than in an emergency setting. Individuals with limited English proficiency will often be less proficient in times of crisis. Similarly, workers with limited proficiency in a given language are also normally less proficient during times of crisis. The ability to conference in a qualified interpreter, albeit remotely, can save time and resources. When using interpreters in answering emergency phone calls, it is recommended that emergency communication centers contract with qualified interpreting service providers to ensure that dispatchers have the ability to quickly add interpreters to the line within seconds (Kelly et al., 2006; Fuddy, 2007). Very little training is available for interpreters who work in emergency settings. However, some major providers of telephone interpreting services for emergency communication centers provide training to their networks of interpreters through specialized protocols for emergency interpreting settings, along with supporting resources in print, web and DVD formats (Kelly, 2007).

Among strategies for the emergency dispatch staff of 911 call centers, authors recommend considering factors that might influence callers, for instance, fear of government and police, lack of understanding that domestic violence is illegal, or dependence on an abusive spouse who speaks English and controls immigration papers (Kelly et al., 2006). Kelly and colleagues (2006) suggest specific techniques for responding to emergency calls received from diverse populations (Figure 26). Kelly notes

that “to more effectively communicate with diverse callers, it is helpful to obtain copies of commonly used phrases in other languages and record a bilingual or multilingual ‘hold’ message” (Kelly et al., 2006).

- Conference the telephone interpreter as quickly as possible.
- Use direct speech (first person) at all times.
- Retain control of the call.
- When possible, avoid using children and other family members to interpret.
- Recognize and acknowledge cultural issues quickly and respectfully, and resume regular protocols.

Figure 26: Techniques for Responding to 911 Calls

Source: Kelly et al., 2006

Disaster Preparedness and Crisis Training for EMS Personnel

The majority of EMS personnel are educated through EMS agencies, community colleges, universities, medical centers, and hospitals. Recently, more schools are offering programs in paramedicine, providing an option for those who are interested in obtaining academic degrees specific for EMS personnel. As pointed out in the *Future of Emergency Care* report compiled by the Institute of Medicine, EMS qualifications standards and education practices vary widely nationwide, and education and training requirements and scope of practice are different from one state to another (IOM, 2007). There is limited reciprocity between the states in terms of recognizing EMS personnel certifications, and each state has its own accreditation process for EMS education programs. Therefore, one of the most pressing issues in EMS education is creating national standards of practice and a national accreditation process. Another pressing issue is assuring an appropriate and adequate level of EMS medical training; the Institute of Medicine (2007) has reported that EMS disaster preparedness training is often insufficient (Figure 27).

- Uniformity in educational standards
- Reciprocity in EMS personnel credentials between states
- Adequate medical education
- National certification of EMS personnel
- National accreditation of EMS programs

Figure 27: Core Issues in EMS Personnel Education

Source: IOM, 2007

For decades, the education of EMS personnel has been guided by the *National Standard Curricula* (NSC) developed by the National Highway Traffic Safety Administration (NHTSA) in the 1970s and revised in the 1990s. There are NSCs for First Responders, EMT-Basics, EMT-Intermediates, and EMT-Paramedics. The NSCs present minimum training requirements and assist in developing knowledge, skills, and attitudes related to first responders’ work such as patient assessment, airway, circulation, trauma, children and childbirth, and EMS operations (NHTSA, 1994; NHTSA, 1995; NHTSA, 1998b; NHTSA, 1998c). The NSCs are patient-centered, for instance pointing to the inappropriateness of judging patients “based on a cultural, gender, age, or socioeconomic

model, and to vary the standard of care rendered as a result of that judgment” (NHTSA, 1995). The EMT-I and EMT-P NSCs have objectives of valuing “the need to serve as the patient advocate inclusive of those with special needs, alternate life styles and cultural diversity” and assessing the responders’ own prejudices related to the various aspects of cultural diversity (NHTSA, 1998b; NHTSA, 1998c).

The NSCs have been referenced in many state laws and administrative rules as the basis for EMS personnel scope of practice (NYSDOH, 2002). The NSCs have also been incorporated into textbooks created for different levels of EMS personnel and accompanied by DVDs and interactive Web sites that offer opportunities to review learning materials and practice skills through scenarios and real life simulations (American Academy of Orthopaedic Surgeons, 2005a; First Responder Training, n.d.).

Despite their prevalence, the NSCs have been criticized for focusing on detailed, highly prescriptive objectives and relying on declarative learning material. Each curriculum was developed independently by different contractors who used different processes: therefore the curricula content and instructional methodology lack consistency. Additionally, the NSC revision process is time-consuming and expensive, and adherence to NSC does not itself ensure the quality of EMS personnel education (IOM, 2007; NHTSA, 2000).

To move away from the NSC-based education model, the National Highway Traffic Safety Administration proposed a new system based on National EMS Education Standards (NHTSA, 2000). In 1996, the report of the NHTSA and Health Resources and Services Administration (HRSA), *Emergency Medical Services: Agenda for the Future (Agenda)* suggested a vision for EMS as “community-based health management that is fully integrated with the overall health care system” (NHTSA, 1996; NHTSA, 1998).

EMS of the future will be community-based health management that is fully integrated with the overall health care system. It will have the ability to identify and modify illness and injury risks, provide acute illness and injury care and follow-up, and contribute to treatment of chronic conditions and community health monitoring. EMS will be integrated with other health care providers and public health and public safety agencies.

NHTSA, 1996

EMS education, according to the *Agenda*, should be built on national core content instead of the existing NSC. The *Agenda* proposed that EMS education be technology-based, employ sound educational principles and adult learning techniques, establish a program of lifelong learning, and incorporate the most current research in emergency medicine. The *Agenda* also encouraged EMS personnel to implement “innovative solutions that address cultural variation, rural circumstances, and travel and time constraints” to include distance learning programs (NHTSA, 1996). Addressing cultural differences is of special importance for the field given the Department of Transportation guidance recommending service providers become culturally competent to enhance access to services among vulnerable LEP minority populations (DOT, 2001).

Expanding on the vision for EMS education outlined in the *Agenda*, NHTSA suggested a system of education consisting of five components outlined in *Emergency Medical*

Services Education Agenda for the Future: A Systems Approach and supporting documents (NHTSA, 2000). The components of the new proposed system are outlined in Figure 28.

<i>The National EMS Core Content</i>	Provides a comprehensive list of skills and knowledge needed for EMS personnel, as well as other components of EMS practice that include cultural diversity as a part of EMS professional attitudes.
<i>The National EMS Scope of Practice Model</i>	Organizes the National EMS Core Content into four levels of practice with the minimum knowledge and skills defined for each level. It creates a mechanism to incorporate new technologies and research findings into EMS practice. The document states that EMS professionals are expected to meet the urgent health care needs of all populations to include “patients with limited access to health care due to geographic, demographic, socioeconomic, or other reasons.”
<i>The National EMS Education Standards</i>	Will take the place of the current National Standard Curricula, specifying minimum terminal learning objectives for each level of EMS practice.
<i>The National EMS Education Program Accreditation</i>	Will offer mechanism for verifying the quality of educational programs across the country and enhance the consistency of the educational program evaluation.
<i>The National EMS Certification</i>	Will offer a mechanism of assuring the entry-level competence of EMS providers through a standardized examination process

Figure 28: Components of the EMS Education System

Sources: NHTSA, HRSA, 2005; NHTSA, 2005, NHTSA, 2000

Educational programs for EMS personnel are also offered by the U.S. Fire Administration (DHS) and its National Fire Academy. The Academy is offering training courses in advanced EMS leadership issues, EMS management, and managing community health risks. These courses include simulation activities, and allow participants to rehearse new behaviors and skills. Although not addressing cultural competence, these courses can help develop community outreach strategies within EMS agencies and improve health within minority communities (USFA, 2007). The Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP) and the National Association of EMS Educators (NAEMSE) both provide programs for EMS instructors and are currently promoting diversity awareness (Hunter, 2007).

C. Social Workers

Characteristics of Social Workers

The primary functions of social workers include assisting clients in dealing with personal relationships and solving personal and family problems, and assisting clients facing life-threatening disease or social problems, including inadequate housing, unemployment, disability, or substance abuse. There are several types of specialties within social work, including: child, family and school; medical and public health; mental health and substance abuse; and planning (systems planning for the delivery of services to clients) and working on social policy that shapes the nation's service systems at all levels (DOL, 2007c). Social workers can be, and often are, members of the U.S. Public Health Service, mental health, or disaster mental health practitioners. As such, information from many of the other profession-specific addendums may be applicable to social workers, as they often work in any number of these professional fields.

Like many other professions, training for social workers varies by State and work environment. A bachelor's degree in social work is the most common minimum requirement. A degree in psychology, sociology, or related fields may be sufficient for some entry-level jobs. An advanced degree, such as a master's in social services policy or administration, may also be required. For most States, licensure requires at least 3,000 hours of clinical experience, and passing the States' open book exam (DOL, 2007c).

The National Association of Social Workers (NASW) reports that the majority of its members are females (79%) with the median age of fifty (NASW, 2003). Health social workers have a greater proportion of females (89%) (NASW, 2006). The overwhelming majority of NASW members are White (87%, 86% among health social workers) and seven percent are African Americans (Figure 29). The majority of members have a master's degree (91%) and an average of 16 years of work experience.

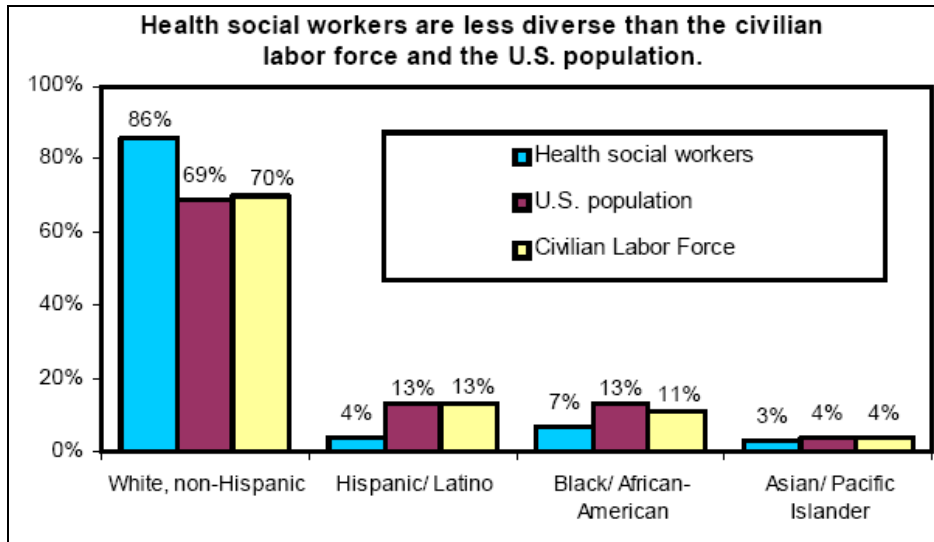


Figure 29: Race and Ethnicity of NASW Members
Source: NASW, 2006

The Three Areas of CLAS in Relation to Social Workers

As defined by the National Association of Social Workers (NASW), cultural competence in social work refers to the process by which social services respond respectfully and effectively to people of all cultures in a manner that “recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each” (NASW, 2001). Defined operationally, cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes (NASW, 2001).

An increasing body of research in social work highlights the need for social workers to include culturally competent approaches into their practice and make treatments consistent with clients’ cultural beliefs (Lum, 1996; Green, 1999; Congress & Lyons, 1992; NASW, 2001; NASW, 2007). Social workers need to possess culturally specific knowledge about the client groups they work with, including historical experiences, migration patterns, individual and group oppression, level of acculturation, socioeconomic backgrounds, life processes, as well as learning styles and cognitive skills (NASW, 2007). Social workers should also have knowledge of specific clients’ cultural customs, practices, and beliefs related to causes of illness and delivery of services. Social workers need critical skills such as culturally appropriate interviewing skills, and need to be aware of the limitations and strengths of current theories, processes and practice models, and which have specific applicability and relevance to the service needs of culturally diverse client groups (NASW, 2007). NASW also recommends that culturally competent social workers should possess genuineness, empathy, and warmth. They should accept and be open to differences among people and demonstrate willingness to learn to work with clients of different backgrounds (NASW, 2007). Researchers and practitioners also recommend recruiting a diverse workforce and providing training in

cultural competence in order to more effectively work with minority populations (NASW, 2001; NASW, 2007). Since social workers may also work with LEP patients, they also need training on appropriately working with interpreters, such as that offered by UMass Amherst online (Robert Wood Johnson Foundation, n.d.).

Through the efforts of NASW, cultural competence has been integrated into the professional standards for social work. The *Standards for Cultural Competence in Social Work* (the Standards) released by NASW in 2001 encourage social workers to maintain high quality of care provided to minority clients and develop a heightened consciousness of how clients experience their uniqueness and deal with their differences and similarities within a larger social context (NASW, 2001; Figure 30). According to the Standards, social workers should develop specialized knowledge and understanding about the history, traditions, values, family systems, and artistic expressions of major client groups served. Social workers should use appropriate methodological approaches, skills, and techniques that reflect their understanding of the role of culture in the helping process (NASW, 2001). The Standards encourage social workers to be aware of the effect of social policies and programs on diverse client populations and advocate on behalf of their clients. Social workers should also take reasonable steps to provide services and information in languages other than English in order to ensure that LEP clients are aware of available programs and can effectively participate (NASW, 2001; NASW, 2007).

- **Standard 1: Ethics and values –**
 - Social workers shall function in accordance with the values, ethics, and standards of the profession, recognizing how personal and professional values may conflict with or accommodate the needs of diverse clients.
- **Standard 2: Self-awareness**
 - Social workers shall seek to develop an understanding of their own personal, cultural values and beliefs as one way of appreciating the importance of multicultural identities in the lives of people.
- **Standard 3: Cross-cultural knowledge**
 - Social workers shall have and continue to develop specialized knowledge and understanding about the history, traditions, values, family systems, and artistic expressions of major client groups that they serve.
- **Standard 4: Cross-cultural skills**
 - Social workers shall use appropriate methodological approaches, skills, and techniques that reflect the workers' understanding of the role of culture in the helping process.
- **Standard 5: Service delivery**
 - Social workers shall be knowledgeable about and skillful in the use of services available in the community and broader society and be able to make appropriate referrals for their diverse clients.
- **Standard 6: Empowerment and advocacy**
 - Social workers shall be aware of the effect of social policies and programs on diverse client populations, advocating for and with clients whenever appropriate.
- **Standard 7: Diverse workforce**
 - Social workers shall support and advocate for recruitment, admissions and hiring, and retention efforts in social work programs and agencies that ensure diversity within the profession.
- **Standard 8: Professional education**
 - Social workers shall advocate for and participate in educational and training programs that help advance cultural competence within the profession

- **Standard 9: Language diversity**
 - Social workers shall seek to provide or advocate for the provision of information, referrals, and services in the language appropriate to the client, which may include use of interpreters.
- **Standard 10: Cross-cultural leadership**
 - Social workers shall be able to communicate information about diverse client groups to other professionals.

Figure 30: NASW Standards for Cultural Competence in Social Work Practice

Source: NASW, 2001

At the organizational level, social service delivery systems can become culturally competent through valuing diversity, conducting cultural self-assessments, being conscious of the dynamics of inter-cultural interaction, institutionalizing cultural knowledge, and developing programs and services that reflect an understanding of diversity between and within cultures (NASW, 2001).

Research into incorporating cultural competence into social work has yielded several definitions of and approaches to culturally competent services. For instance, Rounds and colleagues (1994) suggest that culturally competent social work should build on acknowledging the value of cultural diversity, conducting cultural self-assessments, recognizing and understanding the dynamics of difference in client’s and practitioner’s behaviors, acquiring cultural knowledge, and adapting social work skills to a client’s culture. According to Lum (1996), the goal of culturally competent social work is to improve the quality of socioeconomic functioning of minority populations that has been historically oppressed. Therefore, the empowerment of minority clients is one of central foci of social work that helps alleviate debilitating psychological effects of economic and cultural powerlessness (Congress, 2004; Congress, 1994; Simon, 1994; Guttiérrez & Lewis, 1999).

Researchers also emphasize the positive impact of multiculturalism on clients and social workers (Ewalt et al., 1996) and suggest several frameworks for working with diverse populations and culturally specific interventions. For instance, Chau (1990) suggests that the sociocultural dissonance existing between minority clients and practitioners can be eliminated with four cross-cultural practice processes: psychosocial adaptation, ethnic consciousness-rising, interethnic integration, and ethnic rights advocacy. Lum (1996) focuses on culturally diverse social work that “recognizes and respects the importance of difference and variety in people and the crucial role of culture in the helping relationship.” Lum’s model incorporates culturally relevant information into the five stages of the social work process (contact, problem identification, assessment, intervention, and termination). Each stage addresses specific practice issues for both minority clients and social workers and contains culturally specific social work tasks (Lum, 1996).

Devore and Schlesinger (1998) focus on an overlap between social class and group membership (ethclass, a concept coined in 1964 by Milton Gordon and defined “the

intersection of the vertical stratification of ethnicity with the horizontal stratification of social class” (Gordon, 1964)), and argue that ethclass together with understanding of human behavior and knowledge of ethnically-specific social practices of the client are crucial for understanding the clients’ ethnic reality. Green (1995) argues that “social services can and should be provided to people in ways that are culturally acceptable to them and that enhance their sense of ethnic group participation and power.” He proposes a model of ethnic competence that emphasizes cultural awareness and knowledge as a foundation for social services. Ethnically-specific knowledge has to be complemented with the analysis of practitioners’ personal meaning of cultural and racial difference. The next step in developing ethnic competence is comparative analysis of culturally different world views in order to identify the salient features of the client culture and individualize the clients in reference to inter-cultural differences. The final step in developing ethnic competence is identifying appropriate intervention strategies for minority clients based on ethnically-specific knowledge (Green, 1995).

Ho and colleagues (2003) focus on family therapy and distinctive cultural and family values of minority clients. Their approach is based on incorporating the knowledge of ethnic minority reality, the impact of external society on minority culture, minority biculturalism, ethnic differences in minority culture, and the role of language and social class in minority experiences (Ho et al., 2003).

To avoid the danger of stereotyping and overgeneralization related to diverse ethnic groups, Congress (2004) suggests assessing families from a multicultural perspective using a culturagram – a tool designed to help social workers understand culturally diverse clients. The culturagram covers ten areas that include reasons for relocation, legal status, time spent in the community, language spoken at home and in the community, health beliefs, crisis events, holidays and special events, contact with cultural and religious institutions, values about education and work, and family values (structure, power, myths, and rules) (Congress, 2004, Figure 31).

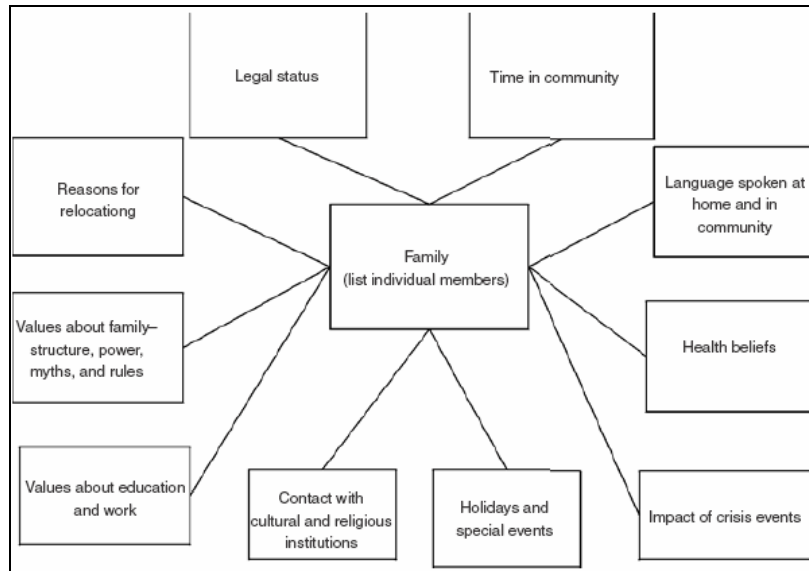


Figure 31: Culturagram for Assessing Diverse Clients

Source: Congress, 2004

Researchers point out that social workers need to be attentive to the language of their clients and the meaning of the client’s message. Green (1995) argues that multilingualism can be a barrier during cross-cultural encounters and it is the responsibility of social service providers to overcome it. The issue of shared meaning can be of special importance when working with LEP minority clients, and authors encourage social workers to achieve proficiency in a foreign language to understand some information received from the client (Green, 1995).

When using interpreters, it is important that they have specialized interpreter training and training related to the protocol of home visitation and adaptive behavior assessment (Fradd & Wilen, 1990). Interpreters need to be briefed before the meeting to explain the purpose, plans and expectations for the session. During the meeting, the social worker should closely monitor the verbal and nonverbal interactions of all parties involved and intervene as necessary. After the meeting, it is recommended to have a debriefing session with the interpreter to exchange information and clarify what transpired during the meeting. During the debriefing, the interpreter can also provide information on the client’s level of English proficiency and cultural factors that influence the client’s behavior (Fradd & Wilen, 1990; Green, 1995).

Roles of Social Workers during Disaster Preparedness and Crisis Response

When responding to disasters, social workers need to be able to help survivors manage tremendous changes in their lives in a sensitive and culturally appropriate manner (Buckwalter, Smith, Zevenbergen, & Russell, 1999; Puig & Glynn, 2003). To do so, social workers need to know as much as possible about the local communities and social and family hierarchies and differences, and use a cultural guide or mediator to guide them through intricacies of local culture (Puig & Glynn, 2003; Nigg, 1995).

Social workers also need to be able to balance macro and micro issues, or the social system as a whole and issues relevant to individual families and communities, since “community recovery is not an outcome but rather a social process that begins before disaster occurs and encompasses decision-making related to restoration and reconstruction activities” (Nigg, 1995). As Nigg and Tierney (1993) argue, pre-disaster community structures and relationships do not change substantially after the disaster; therefore they need to be taken into consideration in emergency preparedness and social work (Nigg & Tierney, 1993).

Social workers may be among the numerous volunteers who assist during a disaster. A social worker may provide a number of services, including disaster mental health services, assistance with PTSD, and generally helping guide survivors back to what they perceive as normal. As was illustrated immediately following Hurricane Katrina, social work volunteers are often among the most needed personnel following a disaster (NASW, 2005). The goals of disaster mental health (short-term interventions to help survivors cope with the aftermath of disaster, mitigate additional stressors or psychological harm, develop coping strategies, and restore the person to an acceptable level of adaptive action) can also be addressed by social workers (MDMH, 2006).

Disaster Preparedness and Crisis Response Training for Social Workers

Social workers receive their education through college undergraduate, graduate, and post-graduate degree programs. The National Association of Social Workers emphasizes cultural competence as a central component of social work practice, and encourages its members to make cultural competence a part of their education and training (NASW, 2001; NASW, 2007). Cultural competence has been sufficiently incorporated into college degree programs in social work, and is reported to have enhanced students awareness of issues related to culture and racism (Colvin-Burque et al., 2007). At the same time, as Boyle and Springer (2001) point out, there is still a gap in evaluating the effectiveness of cultural competence education in social work and measuring the level of cultural competence in social service practitioners. While social workers are increasingly trained in cultural competence, they are not necessarily trained in its relevance to disasters.

Social workers who are interested in disaster response may benefit from disaster specific training, such as Critical Incident Stress Management (CISM) which is offered through the International Critical Incident Stress Foundation, Inc. (ICISF), or a basic community response course offered by the National Organization of Victim Assistance (NOVA) (Robb, 2004). Most workshops and training programs offered by the ICISF and NOVA meet continuing education requirements for social workers (Robb, 2004).

Authors point out that multicultural social work graduate and post-graduate education should be supported by hiring diverse faculty and providing social supports for the students (Lum, 1996). Recommended curriculum should include social systems theory, comparative social values, the development of ethnic and racial identity, issues related to

immigration, the impacts of institutional racism on minority populations, and components of appropriate field delivery systems (Lum, 1996).

As an approach to multicultural social work education, Green (1995) suggests situated learning, or the acquisition of relevant knowledge within the context of social relationships, or the community of practice (Lave & Wenger, 1991). This approach allows students to gain cultural competence through expertly guided performances and social interactions as opposed to lectures, training films, or role plays that can enhance teaching but “will never lead anyone to real cultural awareness or ethnic competence” (Green, 1995). Green distinguishes between building cultural knowledge and cultural awareness, and suggests activities to support both domains. Awareness-raising activities involve carefully constructed case studies that stimulate critical examination of students’ identity, racism, and help-seeking behaviors. Knowledge-building activities include observation of minority social service agencies, describing culturally specific sequences of events, analyzing linguistic clues provided by the clients, and genograms, or exploratory family genealogies that highlight key family events (Green, 1995).

Authors also suggest specific techniques for developing cross-cultural counseling skills. Chau (1990), for instance, developed an ethnic self-profiling exercise to help students explore their values and attitudes and become more introspective about their cultural values. This exercise entails selecting concepts related to cultural diversity and entering them in a table according to the students’ level of comfort with this word. The students then discuss common themes in their responses in small groups and reflect on their socialized attitudes and behaviors. To enhance students’ cultural sensitivity, Chau also recommends using media depicting social justice, reading of cross-cultural material, using case studies and role plays to examine problems that the minorities face and develop practice skills (Chau, 1990).

Ronnau (1994), an expert in family-centered services and teaching cultural competence, offers a variety of strategies and activities to help future social workers develop cultural competence skills. These include resource papers about cultures, asking students to serve as guides to their own culture, informing students of cultural awareness activities on campus and in the community, and integrating cultural information across a curriculum.

- Resource papers
- Cultural guides
- Cultural awareness activities
- Immersion programs

Figure 32: Promising Cultural Competence Practices in Social Workers Education

Sources: Griswold et al. 2007; Puig & Glynn, 2003; Ronnau, 1994.

Promising educational practices in social work education include immersion, or an experiential learning activity through academic-community partnerships that results in clinical encounters between students and diverse patients. Immersion programs help expand students’ awareness, deepen their self-reflection, and heighten cultural humility

(Griswold et al. 2007). Immersion programs also allow the application of the academic content to the context of real life situations, and facilitate a better understanding of the context where the skills are applied. Additionally, immersion reinforces learning by making it relevant to specific communities (Puig & Glynn, 2003).

D. The American Red Cross

Characteristics of the American Red Cross

The American Red Cross is the largest charity and volunteer-based organization that provides disaster relief services. The American Red Cross is part of the International Red Cross and Red Crescent Movement, a network of 186 national societies throughout the world (American Red Cross, 2007d). The American Red Cross supports disaster relief efforts through blood collection, communication and resource support provided to survivors, health and safety services, and volunteer training.

The American Red Cross responds to more than 70,000 disasters every year, whether the disaster is a fire in a home, an industrial accident affecting thousands, or mass casualty natural disaster such as a flood or earthquake (American Red Cross, 2007c). Different local chapters of the American Red Cross form the cornerstone of the organization's response to a disaster, initiating their response when a disaster occurs in their area. If the disaster exceeds the response capacity of any given chapter and the surrounding community, the American Red Cross will activate and work in partnership with a broader network of people, resources, and organizations (American Red Cross, 2007d). The American Red Cross collaborates with other non-profit groups, such as the American Psychological Association (APA), in its disaster response efforts, and requires all volunteers to undergo official American Red Cross disaster response training (American Red Cross, 2007c).

American Red Cross disaster services are designed to minimize the immediate suffering caused by a disaster by providing food, clothing and shelter, and medical, nursing and mental health assistance (American Red Cross, 2007d). Red Cross disaster services may be provided as mass care, individual assistance, or some combination of the two. Mass care assistance involves any combination of three integrated elements: 1) individual or congregate temporary shelters; 2) fixed or mobile feeding operations; and 3) distribution of relief supplies. Individual assistance is provided on an individual or family basis through the purchase of necessary items and/or services or referrals to agencies and organizations that offer assistance at no charge to disaster victims (American Red Cross 2007d).

The American Red Cross Disaster Services Program is a nationwide system of disaster planning, preparedness, community disaster education and mitigation, chapter readiness and disaster response throughout the U.S. and its territories. The program delivers high-quality services in a uniform and consistent manner, due in part to requirements that all volunteers must undergo official disaster response training (American Red Cross, 2007c). The required disaster response training includes Core Disaster Courses on the American Red Cross mission, community services, emergency assistance, shelter operations, and volunteer orientation. Other courses include disaster mental health services overview,

fundamentals of disaster assessment, logistics, public affairs, collaboration, psychological first aid, serving people with disabilities, mass casualty disasters, and WMD and terrorism (Flower, 2007).

The American Red Cross has more than one million volunteers and over 800 chapters across the U.S. (Salmon, 2005). The large majority of volunteers are White, for instance, only five percent of Red Cross volunteers are African American compared to thirteen percent in the U.S. population. Four percent of volunteers are Asian as compared to four percent of Asians in the U.S. population, and two percent of volunteers are Latino compared to fourteen percent in the U.S. population (Salmon, 2005; Figure 33).

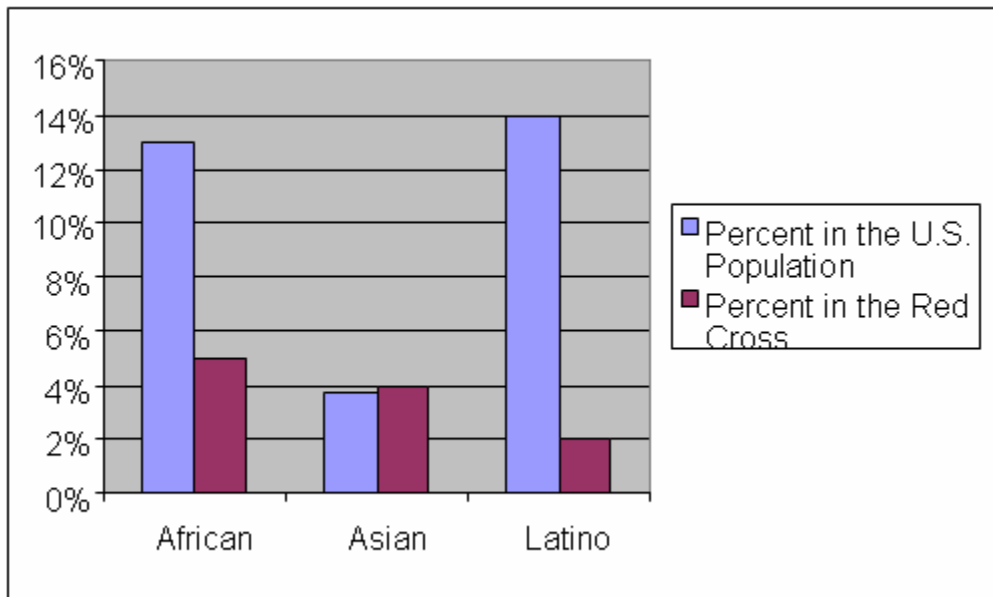


Figure 33: Ethnic Minorities in the American Red Cross

Source: Salmon, 2005

The Three Areas of CLAS in Relation to the American Red Cross

The American Red Cross and its local chapters have long realized the value of culturally competent services and are taking steps to provide these services. As an example, they are now providing language assistance to minority populations with limited English proficiency. In 2005, the American Red Cross launched a new Spanish-language Web site <http://www.cruzrojaamericana.org> that is tailored specifically to the needs of Latino communities and is intended to be a primary source of information on disaster response to Latino communities (American Red Cross, 2005). Another example of their community outreach initiatives is the Seattle Red Cross Chapter that established the Language Bank with 440 volunteers who speak seventy-four languages and handle over 4,000 cases each year, for instance negotiating with apartment managers, communicating with citizenship and immigration services, and helping in emergency situations such as residential fires (American Red Cross, 2004).

Culturally competent services are supported by the American Red Cross organizational policies, such as the Strategic & Tactical (S&T) Diversity Business Planning Model developed in 2001 (American Red Cross, 2003; American Red Cross, 2007a). Individual chapters also develop diversity plans, for instance the American Red Cross Mid-Michigan Chapter adopted a diversity plan to continuously develop the cultural sensitivity of its staff and volunteers. The objectives of this plan include attracting and retaining a diverse paid and volunteer workforce, delivering services that are appropriate and available to all, and providing diversity-related enrichment opportunities to the workforce (American Red Cross Mid-Michigan Chapter, 2003).

To enhance the quality of its services, the American Red Cross and its chapters actively partner with community and faith-based organizations (American Red Cross, 2006b). Most recently, the American Red Cross trained over 170 community relations liaisons to ensure that all demographic groups within the communities are fully served (Agee-Aldridge, 2007). The American Red Cross also partners with private organizations and businesses such as Home Depot in order to educate communities on the importance of disaster preparedness and minimize the loss associated with disasters. The goal of the three-year partnership with Home Depot is to educate one million people on disaster preparedness (American Red Cross, 2007a).

Roles of the American Red Cross during Disaster Preparedness and Crisis Response

To more effectively respond to national disasters, the American Red Cross developed the *American Red Cross Strategic & Tactical (S&T) Diversity Business Planning Model* that was distributed to local chapters in 2001. The model identifies four phases from creating an infrastructure and developing organizational competency to integrating diversity into unit strategic and business plans (American Red Cross, 2003; American Red Cross, 2007b).

Despite these efforts, Hurricane Katrina response efforts revealed a gap between Red Cross responders (who were predominantly White) and minority victims. Some examples of these gaps included the cultural misperceptions of the evacuees and the lack of interpreters to help victims make themselves understood to responders. To close this gap, the American Red Cross launched aggressive an outreach campaign to diversify its vast volunteer network where minorities are underrepresented (Salmon, 2005).

To build on the lessons learned from Hurricane Katrina and to provide more efficient care to minority population, the American Red Cross Board of Governors established a Catastrophic Disaster Task Force in 2006 (American Red Cross, 2006a). The American Red Cross partnered with minority faith-based organizations such as the African Methodist Episcopal Church to train pre-selected participants on the skills needed to operate Red Cross shelters or support disaster relief operations. To date, nearly 500 people have been trained and certified as American Red Cross volunteers or received information on working with the American Red Cross during times of disaster (American Red Cross, 2006b). The American Red Cross is also partnering with the American

Translators Association to develop to a nationwide volunteer network of professional interpreters (American Translators Association, 2006).

To celebrate the diversity of the U.S. population, local chapters of the American Red Cross hold annual events such as Asian-Pacific Islander Month, Black History Month, Women's History Month, Older American's Month, Gay and Lesbian Pride Month, and Latino Heritage Month hosted by the California chapter (American Red Cross Southern California Region, 2003). These events raise cultural awareness of the American Red Cross staff and honor the rich histories and contributions of diverse populations (American Red Cross Southern California Region, 2003).

Disaster Preparedness and Crisis Response Training for the American Red Cross

The American Red Cross requires all volunteers (including mental health volunteers) to go through specialized training, and this training is provided online or through local Red Cross chapters. The online training, *Introduction to Disaster Services Training*, consists of three modules that cover the American Red Cross services, disaster preparedness, and volunteer opportunities within the American Red Cross (for additional details on this course, see Appendix D).

Some Red Cross training courses are offered through blended learning approach, when students complete the knowledge portion of the course online and then complete practice and assessment in a classroom session facilitated by a certified Red Cross instructor through an authorized training provider or local Red Cross chapter (American Red Cross, 2002).

Volunteers can also take optional training on specific topics, for instance Disaster Relief Services, Community Relations, Family Relations, Call Center Operations, and First Aid. Examples of local chapter programs include Oregon Trail Chapter and Northwest Florida Network that provide training on effective service delivery, disaster assessment, disaster health services, disaster mental health, logistics in disaster areas, mass casualties in disasters, and shelters (American Red Cross of Northwest Florida, 2007; American Red Cross Oregon Trail Chapter, 2003).

To provide better services to diverse communities, the American Red Cross established a partnership with the American Translators Association to develop to a nationwide volunteer network of professional interpreters (American Translators Association, 2006). Although the American Red Cross provides a wide variety of disaster training courses, those on Community Relations are the most relevant to cultural competence.

E. Mental Health and Disaster Mental Health Professionals

Characteristics of Mental Health Professionals

The primary focus of mental health professionals is to improve psychosocial functioning of the clients. Mental health professionals may include psychologists, psychiatrists, and social workers. (Please see the social worker addendum for additional information specific to this profession.) Psychologists help mentally and emotionally disturbed clients adjust and deal with personal crises, such as the death of a loved one or divorce (DOL, 2007b). In disaster response, mental health professionals provide grief support, notification of death to family members, or crisis intervention in order to comfort and reassure victims (Hartsough & Myers, 1985). Psychologists usually require a doctoral degree for employment as an independent licensed clinical or counseling psychologist. A doctoral degree is also required for teaching, research, clinical, and counseling positions in universities, health care services, elementary and secondary schools, private industry, and government.

Psychologists in independent practice or those who offer any type of patient care – including clinical, counseling, and school psychologists – must meet certification or licensing requirements in all States and the District of Columbia. Licensing laws vary by State and by type of position, but require licensed or certified psychologists to limit their practice to areas in which they have developed professional competence through training and experience (DOL, 2007b).

In 2002, the American Psychological Association (APA) reported that its members were almost equally male and female (forty-nine percent female). Their members had a median age of forty-nine years and averaged more than fifteen years of work experience. The majority of members (ninety-one percent) have doctorate degrees.

Psychiatrists serve as the primary caregivers in the area of mental health who assess and treat mental illness through a combination of psychotherapy, psychoanalysis, hospitalization, and medication. Psychiatrists undergo the same basic education requirements as physicians, including undergraduate school, graduate medical school, and a residency specializing in psychiatry. After completing their education and training, psychiatrists must pass written and oral board examinations to receive their degree (American Psychiatric Association, 2007).

In terms of demographics, the Department of Labor (DOL) estimates the number of psychiatrists as 22,440 as of 2004 (DOL, 2004). The Annual Psychiatrist Salary and Employment Survey conducted in 2006 indicates that nearly 70% of psychiatrists surveyed are male (69 percent) and that 61% have more than ten years of practice (LocumTenens.org, 2006; Figure 34).

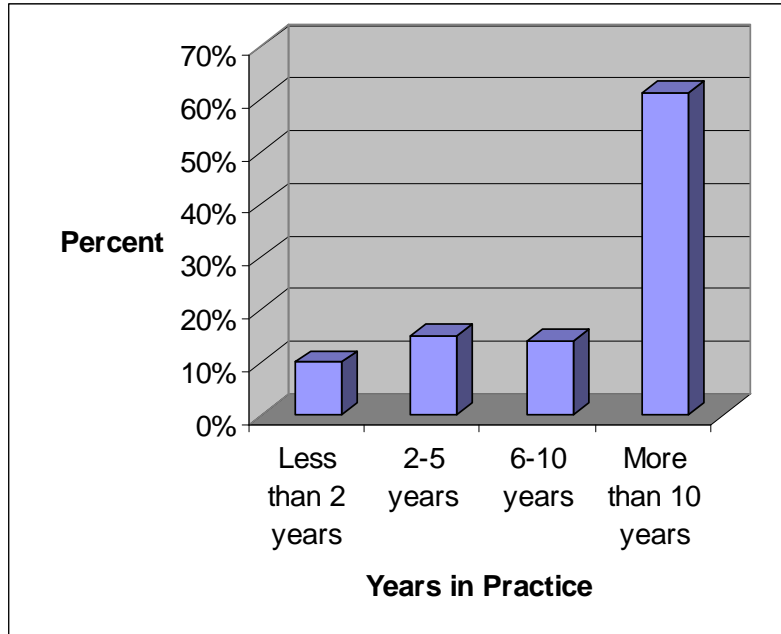


Figure 34: Work Experience of Psychiatrists
 Source: LocumTenens.org, 2006

According to the American Psychiatric Association’s Psychiatry Resident Census conducted in 2004-2005, the majority of medical residents in psychiatry are White (49.7 percent) with an increasing number of Asian residents (26.2 percent) (American Psychiatric Association, 2005). As King and colleagues (1999) show, psychiatrists tend to have most experience working with White patients, and less experience working with the immigrants or patients from a number of ethnic backgrounds, particularly Asian-Americans, Asians, Latinos, Native Americans, Pacific Islanders, and persons of Middle Eastern descent (King et al., 1999).

The Three Areas of CLAS in Relation to Mental Health Professionals

Cultural competence has become an important component of mental health services. Sue and Sue (2003) define cultural competence in mental health as “the ability to engage in actions or create conditions that maximize the optimal development of client and client systems.” They define multicultural counseling competence as “the counselor’s acquisition of awareness, knowledge, and skills needed to function effectively in a pluralistic democratic society (ability to communicate, interact, negotiate, and intervene on behalf of clients from diverse backgrounds), and on a organizational/societal level, advocating effectively to develop new theories, practices, policies, and organizational structures that are more responsive to all groups” (Sue & Sue, 2003).

Sue and Sue use a multidimensional model of cultural competence (MDCC) that includes: culture and race-specific attributes of cultural competence (Dimension 1), components of cultural competence (Dimension 2), and foci of cultural competence (Dimension 3) (Sue

& Sue, 2003; see also Hong et al., 2000). The model is based on a 3 (Awareness, Knowledge, and Skills) x 4 (Individual, Professional, Organizational, and Societal) x 5 (African American, Asian American, Latino American, Native American, and European American) factorial combination, and allows for the systematic development of cultural competence in a number of areas (Sue & Sue, 2003).

Some authors recommend broadening the concept of cultural competence and suggest that mental health professionals need to become “context competent.” Context competence takes into account not only cultural origins and race/ethnicity, but also history, family, religion, politics, economics, community, prejudice, and discrimination that form the context of clients’ perceptions of their health and the health of their families and communities (Yali & Revenson, 2004).

There is no conclusive evidence of the efficiency of cultural competence programs in the mental health field. As *A Supplement to Mental Health: A Report of the Surgeon General* points out, cultural competence has been promoted “largely on the basis of humanistic values and intuitive sensibility rather than empirical evidence” and that the empirical evidence on the effectiveness of these programs is missing (DHHS, 2001). The report of the President’s New Freedom Commission on Mental Health also points out that research “on putting the concept of cultural competence into practice and measuring its effectiveness is lacking” (President’s New Freedom Commission, 2003). The Commission recommends tailoring services for diverse populations and providing “access, enhanced quality, and positive outcomes of care.” The Commission also recommends mental health research in order to develop culturally competent treatments, services, care, and support, as well as increasing cultural competence of providers (President’s New Freedom Commission, 2003).

No empirical data are yet available as to what the key ingredients of cultural competence are and what influence, if any, they have on clinical outcomes for racial and ethnic minorities.

DHHS, 2001

Recent research suggests that culturally competent mental health professionals should be knowledgeable about the ethnic, linguistic, and cultural background of their clients (Flores & Carey, 2000; Hong & Ham, 2000). They should be aware that cultures have varieties and that there is more variety within cultures than between them (DHHS, 2001). Mental health practitioners should have an understanding of the American sociopolitical system and its effects on marginalized groups and awareness of institutional barriers that prevent minorities from receiving care (Sue & Sue, 2003; Saldaña, 2001).

An important factor that stimulated cultural competence in mental health was the development of thirty-one Multicultural Counseling Competencies commissioned by the Association of Multicultural Counseling and Development (AMCD) in 1992. The competencies are organized in three domains (counselor awareness of own assumptions, values, and biases; understanding the worldview of the culturally different client; and developing appropriate intervention strategies and techniques), and each domain includes relevant beliefs and attitudes, knowledge, and skills (Sue et al., 1992; Arredondo & Toropek, 2004).

In terms of culturally competent skills, authors suggest that mental health practitioners are able to generate a wide variety of verbal and non-verbal responses to match the styles of diverse patients. They should be aware of their helping style and its limitations and advocate on behalf of their patients when appropriate (Sue & Sue, 2003). Mental health practitioners should have the ability to assess the meaning of ethnicity for diverse clients and distinguish between the symptoms of intra-psychic stress and stress arising from social structure. They should also be able to use interpreters and interviewing techniques to accommodate linguistically diverse clients (Saldaña, 2001).

Recent research points out that developing organizational cultural competence is a long process, and cannot be achieved in a short period of time (NCTSN, 2007). Organizational steps to achieve cultural competence include creating a supporting organizational structure, clarifying values and philosophy, tracking community demographics, and assessing patients' satisfaction (NCTSN, 2007). The *Cultural Competence Standards in Managed Mental Health Care for Four Underserved/ Underrepresented Racial/Ethnic Groups* (the Standards) developed by the Western Interstate Commission for Higher Education (WICHE) Mental Health Program recommends sixteen guiding principles for cultural competence in mental health organizations. These principles include natural support, collaboration and empowerment, feedback, quality, and data-driven systems. The cultural competence standards include a cultural competence plan, governance, benefit design, outreach, quality improvement, information support, staff training and development, and standards related to clinical practice. The Standards provide recommendations on staff knowledge, skills, and attitudes to deliver appropriate care (WICHE, 1997).

Several authors who are experts in the field of Organizational Development and related fields suggest frameworks for incorporating cultural competence into organizational practices. Cox (1993) proposes organizational transformation based on the interplay of the climate for diversity, individual outcomes, and organizational effectiveness. His model has three states: monolithic, pluralistic, and multicultural, and each state is influenced by the interplay between the climate for diversity, individual (employee) outcomes, and organizational effectiveness. Arredondo (1996) suggests a data-driven model of stages and tasks focused on multiculturalism and diversity. The stages of this model include planning for a diversity initiative, a self-study, and an evaluation of measurable objectives. This approach has served as the basis for conducting applied research in more than fifty organizations such as social and mental health agencies, colleges, and the private sector (American Psychological Association, 2003b).

Siegel and colleagues (2003) provide a framework for an integrated approach to organizational cultural competence and propose performance measures for assessing organizational cultural competency in behavioral health. Performance measures cover six domains (needs assessment, information exchange, services, human resources, policies and planning, and outcomes) and three organizational levels (administrative, service delivery, and individual); for each domain and three levels there are indicators of success (Siegel et al., 2003).

The California Institute for Mental Health (2002) suggests effective engagement of clients and communities as a core component of culturally competent organizations, since diverse clients' and community input is a vital element in the development, implementation, and evaluation of culturally competent mental health services. To enhance cultural competence, organizations should make sure that all workers understand the role of cultural competence in their work (California Institute for Mental Health, 2002).

CLAS in Disaster Mental Health

In disaster mental health (DMH), the knowledge of the client's culture provides mental health professionals with "an entree and/or point of departure" to the treatment (Doherty, 1999). SAMHSA researchers propose principles of cultural competence in disaster mental health research that include recognizing the importance of culture and respecting diversity, recruiting disaster workers who are representative of local communities, ensuring that services are accessible, appropriate, and equitable, and ensuring that services and information are culturally and linguistically competent (Figure 35).

- | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ol style="list-style-type: none">1. Recognize the importance of culture and respect diversity.2. Maintain a current profile of the cultural composition of the community.3. Recruit disaster workers who are representative of the community or service area.4. Provide ongoing cultural competence training to disaster mental health staff.5. Ensure that services are accessible, appropriate, and equitable.6. Recognize the role of help-seeking behaviors, customs and traditions, and natural support networks.7. Involve as "cultural brokers" community leaders and organizations representing diverse cultural groups.8. Ensure that services and information are culturally and linguistically competent.9. Assess and evaluate the program's level of cultural competence. |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Figure 35: Principles for Cultural Competence in Disaster Mental Health Programs

Source: SAMHSA, 2003

Researchers suggest that making treatment relevant to local culture could vastly improve the probability of success in appropriate interventions (Doherty, 1999). To provide more effective disaster relief services, it is important to recruit workers who represent local communities. At the same time, recruitment based on race and ethnicity may not be efficient, since the ability to speak a specific language does not mean that a person is culturally competent (SAMHSA, 2003). Ongoing training for DMH personnel is also essential, especially if it is provided in collaboration with community-based groups (SAMHSA, 2003).

To develop cultural competence, mental health workers need to be aware of their own values, biases, attitudes and prejudices, be flexible, creative, and respectful in their intervention strategies, and demonstrate willingness to work with clients of different backgrounds and embrace cultural differences (MDMH, 2006; Carter, 2007; Sue & Sue, 2003; Brewer & Brown, 1998; Kramer, 1999; Pedersen, 1994; Saldaña, 2001). Disaster mental health workers should have in mind the importance of community, racism and

discrimination, as well as social and economic inequality for minority clients (MDMH, 2006). Disaster mental health professionals should also be able to display respect and compassion to survivors, build rapport with survivors, maintain a calm presence in survivors' communities, actively listen to survivors' stories, allow silence, attend nonverbally (i.e., eye contact, head nodding, etc.), reflect feelings, and allow expression of emotions (MDMH, 2006).

Researchers suggest several organizational measures to provide disaster mental health services to diverse communities, for instance, incorporating cultural competence into a program's values and mission statement, and encouraging culturally competent attitudes, policies, and practices at every level (SAMHSA, 2003). Process evaluation can help mental health organizations determine the effectiveness of cultural competence plans, organizational leadership, and the effectiveness of cultural competence training (SAMHSA, 2003). Organizations should also develop disaster mental health plans in order to enhance coordination and minimize chaos and help ensure that survivors receive assistance in a timely, helpful, and culturally sensitive manner. Disaster mental health plans that identify and address diverse needs within a community can save valuable time and avert many problems (SAMHSA, 2003; Gard & Ruzek, 2006).

When planning disaster response, mental health organizations may benefit from maintaining community profiles and identifying specific populations with limited resources (SAMHSA, 2003; Speier, 2006; Gard & Ruzek, 2006; Compton et al., 2005). Community outreach is an important organizational strategy, since people who need help the most are least inclined to look for help (Ruzek, 2006; Myers, 1994b; Myers & Wee, 2003). Outreach should be based on population demographics and should be culturally-specific (Naturale, 2006). For instance, many Asian cultures do not have a word for and concept of trauma as it is understood in the West, and may not understand outreach programs to address traumatic experiences (Naturale, 2006).

Regarding research into disaster mental health, literature shows that the evidence base regarding effective mental health treatments for minorities is poor (DHHS, 2001; Norris & Algría, 2005). To fill the evidence gap in disaster mental health research, Jones and colleagues (2006) suggest a "cultural competence model for accessing minority and marginalized communities affected by disaster." Their model is based on cultural competence and the CLAS standards and emphasizes that the relationship between the disaster and outcomes is mediated by resources (for instance, trust, access, and cultural/linguistic capabilities). The authors hypothesize that if resources are provided to minority communities in a culturally competent manner, the outcomes for minority communities will improve (Jones et al., 2006, Figure 36).

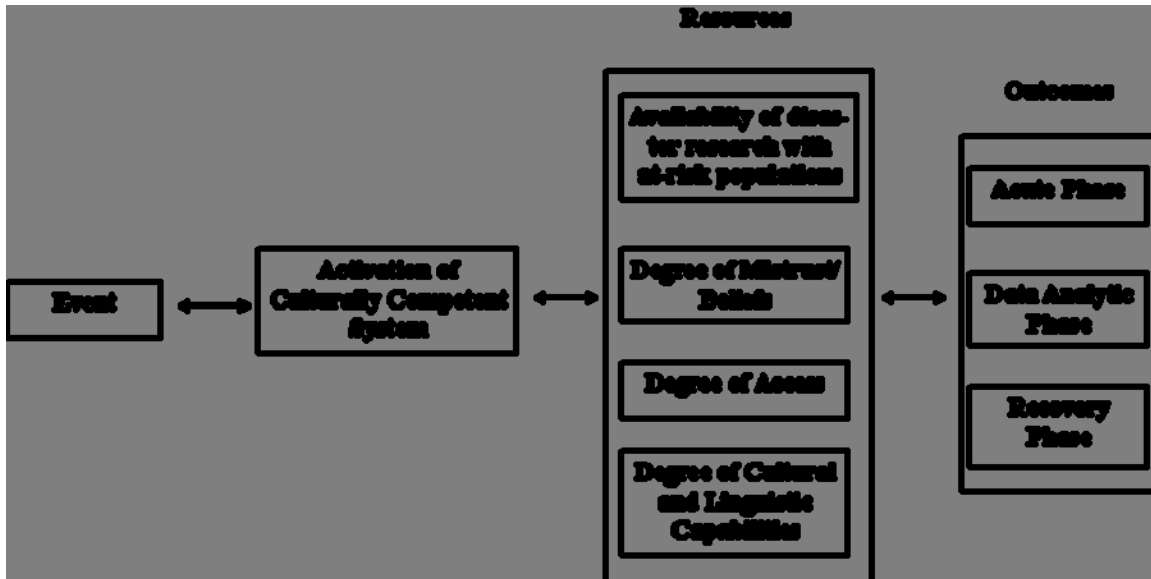


Figure 36: Cultural Competence Model for Accessing Minority and Marginalized Communities Affected by Disaster

Source: Jones et al., 2006

Based on the CLAS Standards, Jones and colleagues propose several recommendations on conducting research in disaster mental health in a culturally competent manner (Figure 37).

1. Ensure that all participants are treated respectfully in a manner compatible with their culture, health beliefs and practices, and preferred language.
2. Include, retain, and promote individual representatives of the traumatized community into the research team.
3. Ensure that all members of the research team receive ongoing education and training in culturally and linguistically appropriate service delivery and research.
4. Offer and provide language assistance capabilities, including bilingual members and interpreter services to all participants with limited English proficiency, at no cost.
5. Develop, implement, and routinely assess a written strategic plan outlining goals, policies, and systems of accountability to engage culturally and linguistically appropriate research.
6. Use culturally and linguistically appropriate measures and assess participants' satisfaction with measures.
7. Establish collaborative partnerships with traumatized communities where individuals representative of these communities are involved in the designing and implementing of research initiatives.

Figure 37: Recommendations for Culturally Competent Disaster Mental Health Research

Sources: Jones et al., 2006

Multiculturalism and culturally competent mental health services have gained importance in the mental health professions due to shifts in demographics and the impact of cultural differences on mental health practices (Saldaña, 2001). Additionally, as shown in *A Supplement to Mental Health: A Report of the Surgeon General* (DHHS, 2001), “racial and ethnic minorities bear a greater burden from unmet mental health needs and thus suffer a greater loss to their overall health and productivity” (DHHS, 2001). The report argues that “the provision of culturally and linguistically appropriate mental health

services is a key ingredient for any programming designed to meet the needs of diverse racial and ethnic populations” (DHHS, 2001). Researchers also point out the lack of literature related to the mental health of ethnic minorities. For instance, Bernal and colleagues (2003) have found that less than one percent of works on psychology during the past forty years references racial and ethnic minority considerations.

In recognition of the increased importance of the role of culture in mental health practices, the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV, American Psychological Association, 1994) discusses culturally-specific idioms of distress and “culture-bound syndromes” and provides recommendations on incorporating culture into mental health treatment. The DSM-IV recommends inquiring about patients’ cultural identity, exploring cultural explanations of illness, considering cultural factors related to the psychosocial environment and levels of functioning, critically examining cultural elements in the patient-provider relationship, and rendering an overall cultural assessment for diagnosis and care (American Psychological Association, 1994).

At the same time, several authors have questioned the cross-cultural validity of the DSM-IV, since it does not reflect on the mind-body interaction often observed in non-Western cultures (Lewis-Fernandez & Kleinman, 1995; Stamm & Friedman, 2000; Carter, 2007). The authors also recommend developing cross-culturally sensitive instruments for assessing the minority patients and assure their equivalence in terms of content, language, concepts, methods, and standards for determining normality and abnormality (Keane et al., 1996).

Roles of Mental Health Professionals during Disaster Preparedness and Crisis Response

Recent research reveals several barriers for effective delivery of mental health services to minority populations. These barriers include but are not limited to poverty (Brown, Ojeda, Wyn, & Levan, 2000), lack of health insurance and high costs of care (Jacobsons & Buckner, 2007;

Multiculturalism is a pervasive force in modern society that acknowledges the complexity of culture.

Pedersen, 1991

Manson, 2004), lack of connection between providers and communities, discriminatory policies and mistrust, and limited education of minority populations (DHHS, 2001; Jacobsons & Buckner, 2007; Saldaña, 2001). Additional factors that contribute to disparities in mental health include immigration history, acculturation and acculturative stress experienced by minority populations, and stigma experienced by those seeking mental health by some cultures (Jacobsons & Buckner, 2007; Saldaña, 2001; Al-Krenawi & Graham, 2000; Sanchez & Gaw, 2007).

Language barriers and monoculturalism of providers constitute another important issue. Limited English proficiency of clients can lead to their inability to verbalize thoughts and feelings and focus on pronouncing English words rather than conveying meaningful content (Jacobsons & Buckner, 2007; Sue & Sue, 2003; Council of National Psychological Associations for the Advancement of Ethnic Minority Interests, 2003). Communication difficulties are often viewed by mental health professionals as proof of a

mental disorder and thus lead to a misdiagnosis (Council of National Psychological Associations for the Advancement of Ethnic Minority Interests, 2003). Cultures manifest mental disorders in a variety of ways, and “patients from one culture may manifest and communicate symptoms in a way poorly understood in the culture of the clinician” (DHHS, 2001; Lin & Cheung, 1999). Sue and Sue (2003) found that clinicians often fail to understand culturally specific expression of symptoms and impose their cultural standards on minority populations.

Another factor contributing to disparities in mental health is different meaning attributed to mental illness by different cultural groups that has consequences in terms of whether people are motivated to seek treatment (DHHS, 2001). Mental health services may contain hidden barriers, such as a lack of concordance between ethnicity and gender between therapist and client. Several authors indicated that ethnicity and gender match between therapists and clients, as well as language and ethnicity match are important variables affecting the utilization of treatment by minority populations (Flaskerud & Liu, 1991; Al-Krenawi & Graham, 2000). Sue and Sue (2003) point out that counseling is a White middle-class activity, and therapists expect some degree of openness, sophistication, and emotional and behavioral expressiveness from their clients. Therefore, the LEP clients who fail to verbalize their thoughts may face prejudice and can be misdiagnosed. Additionally, Euro-American mental health treatment focuses on the individual, whereas many non-Western cultures emphasize collectivist values (Sue & Sue, 2003).

Researchers point out that there are also several barriers to disaster mental health services for minority populations. Often, minorities delay seeking treatment until the symptoms are severe or never seek treatment at all (Norris & Allegría, 2005; Norris & Allegría, 2006). Another barrier is mistrust caused by cultural misunderstanding, misdiagnosis, and undocumented immigrant status. Limited English proficiency and absence of bilingual or culturally competent disaster mental health workers are also a serious problem for diverse populations (DHHS, 2001; Norris & Allegría, 2005; Norris & Allegría, 2006). Interpretation may also be hindered by a lack of disaster specific or mental health specific training (Bolton & Weiss, 2001).

Often, minority clients avoid seeking disaster mental health services due to the stigma imposed on people with mental illnesses in their cultures, and further research is recommended in order to suggest effective ways of diminishing the stigma of seeking mental health services (Norris & Allegría, 2005; Gibson et al., 2006). In some cultures, it is believed that clinical wisdom comes with age, and clients can mistrust young clinicians (Al-Krenawi & Graham, 2000). Clinician’s gender can also be a barrier, since clients from cultures with patriarchal orientation may have difficulties with getting directions from female practitioners (Al-Krenawi & Graham, 2000). Geography can also be a barrier, since minority clients often reside in rural areas where mental services are limited or missing (Stamm & Friedman, 2000; Norris & Allegría, 2005).

During times of disaster, these barriers may be particularly challenging to overcome. However, a number of recommendations exist for working with diverse patients and can be applied in any situation.

Standard recommendations for mental health strategies for diverse populations include creating a safe and welcoming environment through bilingual phone services and receptionists, population-specific magazines in the waiting room, and other signage (Vasquez, 2006). These strategies will be difficult to accommodate in times of emergency, however there are still means to provide culturally competent services. Mental health practitioners should respect the personal space of their clients and follow the cultural norms for eye contact, interruption and turn-taking behaviors, gesturing, and facial expressions (Saldaña, 2001). Practitioners should be aware that their communication behaviors (erect posture, prolonged eye contact, assertiveness) can be perceived as aggressiveness by some cultures (Saldaña, 2001).

For more effective communication, mental health professionals should simplify their message, support it with written materials, and keep instructions short and relevant to the lives of the client (Saldaña, 2001). Since language barriers often lead to misdiagnosis, it is important that the client receives the message in his or her own language and that the assessment instruments are in the clients' native languages. Some authors caution, though, that some assessment instruments may be culturally inappropriate, in other words, the assessment questions may be incomprehensible, unacceptable, or culturally irrelevant (Manson, 1997). To address these issues, Arnold and Matus (2000) provide specific recommendations on cultural equivalency of existing diagnostic instruments.

Authors also suggest trying to maintain best practice techniques for effective work with interpreters, during both crisis and non-crisis times for instance avoiding using family and friends, as well as secretarial, custodial, and domestic staff as interpreters. During interpreted sessions, mental health professionals should be talking directly to the client and maintain eye contact, use short simple sentences, speak slowly, and avoid jargon (Saldaña, 2001). Other recommendations include emphasizing confidentiality and making sure that the interpreter and the client speak the same dialect and are comfortable with each other (Saldaña, 2001; SAMHSA, 2003).

Among other strategies for effective work with diverse clients, authors recommend incorporating the client's explanatory model into treatment (Council of National Psychological Associations for the Advancement of Ethnic Minority Interests, 2003; American Psychological Association, 2003b). Mental health practitioners should also place the clients in the context of their family, social history, immigration status, availability of community resources, work history, and level of acculturation (Saldaña, 1995; American Psychological Association, 2003b; DHHS, 2001; Vasquez, 2006). They should take into consideration the identity development process of minority populations and explore how it affects their beliefs and behaviors (American Psychological Association, 2003b; Atkinson, Morten, & Sue, 1998; Brewer & Brown, 1998).

Multicultural mental health often requires nontraditional approaches to work with diverse

clients (American Psychological Association, 2003b), for instance community outreach and participation in culturally diverse and culture-specific activities (Arredondo et al., 1996). To incorporate the community into treatment, De La Cancela and colleagues (1998) suggest the community health psychology model that includes multiple bio-psycho-politico- and social contexts into our understanding of human behavior. According to this model, systems of health care must be shaped by a wider perspective of the communities and services provided must be inclusive, systemic, culturally competent, and comprehensive in its approach (De La Cancela et al., 1998).

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.

SAMHSA, 2003

Researchers point out that disaster mental health (DMH) is different from traditional mental health treatment since it focuses on short-term interventions to help survivors cope with the aftermath of disaster, mitigate additional stressors or psychological harm, develop coping strategies, and restore the person to an acceptable level of adaptive action (MDMH, 2006, Figure 38).

“Traditional” Mental Health	Disaster Mental Health
<ul style="list-style-type: none"> • Office-based • Safe, secure environment • Long-term treatment • Focus on diagnosis and treatment of a mental illness • Impact the baseline of personality and functioning • Encourage insight into past life experiences and their influence on current problems • Psychotherapeutic focus • Focus on present and past • Conducted by mental health professionals 	<ul style="list-style-type: none"> • Community-based • Proximity to stressors • Short-term interventions • Focus on assessment of strengths and coping skills • Restore people to pre-disaster levels of functioning • Validate the appropriateness of reactions to the event and its aftermath and normalize the experience • Psycho-educational focus • Focus on present and future • Conducted by paraprofessionals and mental health professionals

Figure 38: Differences between Mental Health and Disaster Mental Health

Sources: MDMH, 2006; CMHS, 2000; CMHS, 2001; Mitchell, 2003

Ruzek highlights five models of providing mental health support to populations affected by disasters: combat psychiatry, disaster mental health services (DMHS), worker support in high-risk occupations, rape counseling, and cognitive-behavioral interventions (Ruzek, 2006). This section of the Scan will focus on DMHS, worker support, and cognitive-behavioral interventions as most relevant to the Scan.

The first model, DMHS, focuses on supporting normal people having normal reactions to abnormal events and offering emotional support and basic pragmatic assistance and aiding in adaptive coping (Myers & Wee, 2003; Ruzek, 2006; Young, 2006). Recent research shows that there is no single, universally applicable recipe for providing DMHS due to differences between cultures in which a disaster occurs (Ehrenreich, 2001; see also

Young et al., 1998). Therefore, it is recommended that DMHS are tailored to the needs of affected communities and assist in re-establishing the social equilibrium in affected communities in terms of customs, traditions, rituals, family structure, gender roles, and social bonds (MDMH, 2006; Ehrenreich, 2001; Myers & Wee, 2003; Myers, 1994b; Gard & Ruzek, 2006; NCTSN, 2006). It is also recommended that DMHS match the phases of disaster (as outlined in Section 2 of the Scan).

DMHS usually include outreach and survivor engagement in order to enhance safety, stabilization of survivors, providing practical assistance, reducing distress, linking survivors to social resources, providing information on coping support, and linking survivors to other services (Gard & Ruzek, 2006; NCTSN, 2006; Figure 39). Each of these actions needs to be sensitive to culture, ethnic, religious, racial, and linguistic diversity (NCTSN, 2006).

1. Outreach and survivor engagement.
2. Survivor education.
3. Social support.
4. Brief crisis therapy.
5. Assessment and follow-up.
6. Referral to mental health treatment.

Figure 39: Activities in Disaster Mental Health Response

Source: Gard and Ruzek, 2006; NCTSN, 2006

Principles of DMHS derive from combat psychiatry and include proximity (close to person's operational area), immediacy (deliver help soon), and expectancy (expectations of positive outcomes should be established at the beginning) (Ruzek, 2006; see also Carter, 2007). Other principles, as illustrated in Figure 40, that are important in times of crisis include brevity and simplicity of messages, the ability to be flexible and innovative with the process, and ultimately pragmatic in the services provided (Mitchell & Everly, 2006).

- No one who sees a disaster is untouched by it.
- There are two types of disaster trauma – individual and community.
- Most people pull together and function during and after a disaster, but their effectiveness is diminished.
- Disaster stress and grief reactions are normal responses to an abnormal situation.
- Many emotional reactions of disaster survivors stem from problems of living brought about by the disaster.
- Most people do not see themselves as needing mental health services following disaster and will not seek such services.
- Survivors may reject disaster assistance of all types.
- Disaster mental health assistance is often more practical than psychological in nature.
- Disaster mental health services must be uniquely tailored to the communities they serve.
- Mental health workers need to set aside traditional methods, avoid the use of mental health labels, and use an active outreach approach to intervene successfully in disaster.
- Survivors respond to active, genuine interest, and concern. Interventions must be appropriate to the phase of the disaster. Social support systems are crucial to recovery.

Figure 40: Principles of Mental Health Disaster Response

Source: MDMH, 2006

DMHS can be delivered in the form of Psychological First Aid (PFA) and Crisis Counseling Program (CCP) developed by FEMA. PFA is strongly recommended by SAMHSA and the American Red Cross in order to reduce stress reactions caused by traumatic events and to stimulate short- and long-term adaptive functioning and coping (Young, 2006; Johnstone, 2007). Core actions of PFA include contact and engagement, safety and comfort, stabilization, information gathering on current needs and concerns, practical assistance, connection with social supports, providing information on coping, and linking to collaborative services. Each of these actions should be culturally sensitive and respect beliefs and social practices of minority populations, including appropriate types of physical and social contacts, gender roles, eye contact, personal space, and family structure (NCTSN, 2006). Additionally, following Hurricane Katrina and the use of the American Red Cross National Call center to deliver disaster-oriented mental health services, research indicates that PFA seems to work well with telephone hot-lines, which have been a key component of crisis-oriented mental health for over 50 years (Combs, 2007).

Like PFA, CCP has been developed by FEMA (Young et al., 2006) and is aimed at short-term mental health interventions that help reduce dysfunction and distress. CCP focuses on individual and community recovery through empowerment, skill building, and education face-to-face contact with survivors in their natural environments (CMHS, 2001). The key concepts of crisis counseling include active listening, validation of survivors' responses, education related to normal reactions to abnormal events, education about coping, providing information related to referral services, and moving survivors to the next step in recovery (Bryant & Litz, 2006). It has been recently recommended that CCP focuses more on community resilience and fosters natural support networks in the affected communities (Norris et al., 2006).

Researchers agree that DMHS should take into considerations the needs of vulnerable populations to include racial and ethnic minorities (NIMH, 2002) and should be timed appropriately to match disaster phases (Myers, 1994a; Ehrenreich, 2001; Ørner et al., 2006). At the same time, there is no consistency in identifying disaster phases and selecting appropriate interventions. While Ørner and colleagues' model describes the impact and rescue phases, their primary focus is more individualized and task oriented, allowing the survivors to dictate the pace rather than the model (Ørner et al., 2006). Young and colleagues (1999) focus on three phases of disaster (emergency, early post-impact, and restoration). The consensus workshop convened by the National Institute of Mental Health (NIMH) in 2002 identifies five phases (pre-incident, impact, rescue, recovery, and return to life) (NIMH, 2002). Figure 41 compares two of the emergency response phase models as they describe states, responses and interventions.

Young et al., 1999

Emergency (immediate period after disaster strikes)

- Goals: Crisis assistance
- Role of mental health professionals: Pragmatic interventions aimed at protecting, directing, connecting, triage, acute care, death notification.

Early post-impact (0-8/12 weeks)

- Goals: Facilitating psychological and interpersonal stabilization among survivors
- Role of mental health professionals: Support rescue workers (debriefing, defusing, stress management), address practical and emotional needs of survivors, provide opportunities to discuss traumatic experiences and emotional reactions, help coping with stress reactions.

Restoration (starting during weeks 8-12)

- Goals: Treating symptoms
- Role of mental health professionals: Identifying individuals and families with persistent symptoms, interventions in clinical settings.

NIMH, 2002

Pre-incident (before disaster)

- Goals: Preparation, improve coping
- Role of mental health professionals: Prepare

Impact (0–48 hours)

- Goals: Survival, communication
- Role of mental health professionals: Basic needs, Psychological First Aid, monitoring the impact on environment, technical assistance, consultation, training.

Rescue (0–1 week)

- Goals: Adjustment
- Role of mental health professionals: Needs assessment, triage, outreach, fostering resilience and recovery.

Recovery (1–4 weeks)

- Goals: Appraisal/planning
- Role of mental health professionals: Monitoring recovery environment

Return to life (2 weeks–2 years)

- Goals: Reintegration
- Role of mental health professionals: Treatment

Figure 41: Mental Health Interventions in Disaster Phases

Source: Young et al., 1999; NIMH, 2002

The second model of disaster mental health, worker support in high-risk occupations, targets the needs of response workers who may develop symptoms of depression, panic, and generalized anxiety (Centers for Disease Control and Prevention, 2004). Disaster worker support can take forms of task rotation, peer support system, stress debriefing, employee assistance, and stress management training (Ruzek, 2006). Stress debriefings, such as the Critical Incident Stress Debriefing, CISD can be an especially effective technique since it helps survivors review their personal experiences of a traumatic event (Friedman, 2006).

There is no consensus on using CISD; some authors argue that it is effective in addressing the needs of disaster relief workers and can help address cross-cultural differences between workers and local communities (Young et al., 1999; Weaver, 1995). Stress debriefing can be especially beneficial for multilingual disaster workers if conducted in their native languages (Kelly, 2007). At the same time, the National Institute of Mental Health has discouraged the use of CISD since it does not prevent the development of PTSD (NIMH, 2002; Gard & Ruzek, 2006; Gibson et al., 2007; Walsh, 2007; Housley et al., 2006). Authors also point out the limits of talk therapy as applied to different cultures (Marsella & Christopher, 2004; Cokley, Cooke, & Nobles, 2005). For

instance, many cultures do not use cognitive mediation using words and concepts but rather rely on intuitive, emotional, and religious mediation (Marsella & Christopher, 2004). Instead of CISD, some authors suggest Critical Incident Stress Management – an integrated, comprehensive, multi-component program that includes a wide range of interventions – pre-crisis support through education, on-scene support through individual, group, and environmental interventions (Mitchell & Everly, 2006).

Another technique used in supporting disaster workers is defusing, or short stress-relieving informal meetings to explore the traumatic event, discuss signs and symptoms, and develop coping mechanisms (Gard & Ruzek, 2006; Friedman et al., 2006). Usually, defusing goes through four phases that include fact finding, inquiring about thoughts, inquiring about feelings, and support and reassurance (Young et al., 1999; Friedman et al., 2006). It is recommended that defusing sessions include the discussion of cross-cultural difference, since cross-cultural differences between workers and community are reported among stressors (Young et al., 1999; Weaver, 1995).

The third model in disaster mental health is cognitive-behavioral interventions, or a diverse set of theoretical orientations, methodologies and clinical interventions (Vera et al., 2003). Cognitive-behavioral interventions focus on specific behaviors, thoughts, and emotions, and can be thus especially beneficial for minority clients who may misunderstand abstract theoretical models that are sometimes used in therapy (Vera et al., 2003). Another advantage of cognitive-behavioral therapy for minority clients is that it allows to provide their own interpretations of traumatic events in the framework of their culture (Vera et al., 2003).

Cognitive-behavioral interventions can consist of brief (4-5 sessions) treatments that include education, relaxation techniques, imagery and *in vivo* exposure, and cognitive restructuring offered at least ten days after traumatic exposure (Ruzek, 2006; Gibson et al., 2006). Cognitive restructuring teaches survivors to identify and evaluate evidence for negative automatic thoughts, as well as help evaluate negative automatic thoughts about trauma, self, the world, and the future. It is known to help reduce incidence, duration, and severity of acute stress disorder, PTSD, and depression in disaster survivors (NIMH, 2002; Gibson et al., 2006). This technique can be effective when working with minority populations to help them reframe the meaning of the loss of material possessions in the context of survival and the resiliency of the human spirit (Cokley, Cooke, & Nobles, 2005). At the same time, limited provider resources make it impossible to deliver this service to a large amount of people following a disaster. As a substitute and alternative, it is recommended to provide supportive counseling to stabilize stressors (Bryant & Litz, 2006).

Several authors argue that the key principle of multicultural interventions in disaster mental health should be restoring the social functioning and social fabric of affected minority communities (Norris & Allegría, 2005; Norris & Allegría, 2006; Ørner et al.,

Disasters represent a complex cultural encounter in which the cultures of the victims, the helpers, and the emergent crisis can come into conflict. It is a situation in which acculturation pressures are being imposed and negotiated by all parties.

Marsella & Christopher, 2004

2006). To provide culturally competent disaster relief services, mental health professionals need to go beyond traditional methods and embrace novel approaches to meeting community needs, for instance community action based on the public health approach (Norris & Allegría, 2005; Solomon, 2003; SAMHSA, 2003).

To improve access to DMHS and eliminate barriers, it is important to provide accessible, community-based local services at low cost, since minority populations may not have insurance to pay for services (Norris & Allegría, 2005). Many minority disaster survivors are known to seek help from their families, therefore mental health disaster responders must work collaboratively with communities and programs should employ ethnic minority practitioners. By assuming the facilitator or consultant role, mental health practitioners can help communities make informed choices and recognize that these choices are owned by the community (Norris & Allegría, 2005). Mental health professionals should also rely on bilingual and bicultural community members in order to enhance credibility of services, engage in community outreach and community education (SAMHSA, 2003).

- Learn from local leaders, social service workers, and community members from the cultural group about values, family norms, traditions, community politics, etc., ideally before a disaster strikes.
- Involve mental health staff and community outreach workers who are bilingual and bicultural whenever possible. Involve trusted community members to enhance credibility.
- Allow time and devote energy to gaining acceptance, be wary of aligning your efforts with agency/organizations that are mistrusted by the communities you're trying to reach. Take advantage of association with valued and accepted organizations.
- Be dependable, non-judgmental, genuine, respectful, well informed, and credible to the community. Listen for verbal and non-verbal cues and modify efforts accordingly.
- Determine the most appropriate and acceptable ways to introduce yourself, and define your program and services to be culturally sensitive.
- Recognize cultural variation in expression of emotions, manifestation, and description of psychological symptoms, mental health problems, and view of "counseling."
- Provide community education information in multiple languages and via radio, TV, and church announcements if there is low literacy level.
- Focus on problem-solving and concrete solutions. Be action-oriented and empower clients through education and skill building.
- Assist in eliminating barriers to help: interpret facts, policies, and procedures; and, provide advocacy and resource assistance in dealing with barriers.

Figure 42: Practical Suggestions for Working with Diverse Populations

Source: MDMH, 2006

Researchers point out that context-specific multidisciplinary, multifaceted, and culturally sensitive strategies are essential in building community resilience and facilitating post-disaster recovery (Watson et al., 2006; Landau & Saul, 2004). Walsh (2007) developed a multi-systemic resilience-oriented approach that allows contextualizing distress, addressing impacts on the family, and strengthening interpersonal and collective recovery after the trauma (Walsh, 2007). Mental health professionals can facilitate healing

We do not know the full range of psychological reactions in the acute phase regarding symptom profiles and functional impairments; how to weigh age, gender, and cultural differences; what measurable acute post-traumatic phenomenological, diagnostic, psychological, and biological factors will let us distinguish resilient survivors from those vulnerable to develop PTSD and other psychiatric problems; and the best methods and instruments to evaluate posttraumatic distress and monitor affected individuals over time.

Friedman et al., 2006

and resilience by encouraging individuals, families, and communities to engage in shared acknowledgment of reality of traumatic effect, shared experiences of loss and survival, reorganization of family and community, and reinvestment in relationships and life pursuits in order to stimulate community growth (Zinner & Williams, 1999; Walsh, 2007; Tedeschi et al., 1998).

When providing DMHS, it is important to match clients and providers ethnically (Sue & Sue, 2003; Loo, 2007; Naturale, 2006). At the same time, as Sue (1998) shows, a more important factor in successful outcomes is “cognitive match” between the client and the practitioner, or similarity in the client and practitioner explanatory models (Sue, 1998). It is also important to assess clients using broader cultural categories, for instance information on contextual and cultural variables such as prior trauma exposure, level of acculturation, country of origin, and English proficiency (Norris & Allegría, 2005; Stamm & Friedman, 2000).

One example of culturally specific therapy is the concept of “posttraumatic psychocultural therapy” which is based on probing the experiential world of a veteran with respect to historical traditions of African Americans that may link to the combat-related trauma (Manson, 1997). Another example is The Three-Way Mirror model, which allows survivors to reflect on their pretrauma, trauma, and posttrauma experiences in order to integrate traumatic experiences into life narrative and develop new integrated self-representation (Gusman et al., 1996).

Mental health practitioners may benefit from integrating traditional healing practices into disaster mental health treatment and develop partnerships with community healers (Stamm & Friedman, 2000; SAMHSA, 2003). Efforts to include traditional healers into mental health treatment programs were successful when working with African American and Native American veterans diagnosed with PTSD (Manson, 1997).

When using interpreters to communicate with disaster-affected minority populations, researchers caution to pay attention to potential problems such as accuracy of interpretation, editorializing, privacy, level of expertise, misunderstanding or abuse in the role of interpreter, using children, and interpreters’ refusal to interpret some information because of perceived cultural insult (Stamm & Friedman, 2000; SAMHSA, 2003; Ehrenreich, 2001; Bolton & Weiss, 2001). Interpreter behavior can also evoke certain feelings in disaster survivors, and factors such as an interpreter’s gender, age, or level of acculturation can influence the survivor’s willingness to communicate openly (SAMHSA, 2003; Miller et al., 2005).

Despite the benefits of using interpreters in cross-cultural mental health encounters, an exploratory study of Miller and colleagues (2005) shows that there is limited understanding of how the use of interpreters can influence the outcome of therapy or its process. Authors argue that interpreting in mental health is different from medical interpreting since it entails an ongoing relationship with the client and involves the process of “highly charged emotional material related to trauma and loss” (Miller et al., 2005). Effective therapy requires a therapeutic alliance between a therapist and the client

and, as the authors show, an interpreter is an important part of this alliance since he or she is a witness to the client's experience (Miller et al., 2005). It is common for clients to initially form a stronger relationship and attachment to the interpreter than the mental health practitioner, and the client-interpreter relationship often starts before the treatment begins. Therefore, the authors argue that the traditional role of the interpreter as conduit or "black box" is inappropriate in mental health clinical encounters (Miller et al., 2005).

When dealing with stress symptoms or mental disorders following a disaster, mental health professionals need to be sensitive to the cultural perspectives of their patients and therapy experiences where the cultures differ (Draguns, 1996, Figure 43). For instance, mental health professionals need to address the issues of racism and prejudice in minority clients when treating PTSD, since these issues may intensify the client's experiences and cultural mistrust and provide a source of chronic stress that produces susceptibility to PTSD (Jenkins, n.d.; see also Grieger et al., 2007; Pole et al., 2005; Allen, 1996). At the same time, Zoellner and colleagues (1999), who explored African American and White women's responses to PTSD treatment, show that further research is needed in terms of ethno-cultural factors in the treatment of PTSD. According to these authors, there are no ethnic differences in outcomes of cognitive-behavioral therapy in White and Black females who were victims of assault (Zoellner et al., 1999).

- Use of interpretations and their rationale and basis.
- Extent and nature of verbal interaction between client and therapist.
- Role of verbal communication.
- Role differentiation between client and therapist.
- Respective weights of physical and somatic and psychological distress.
- Role of ritual in psychotherapy.
- Use of metaphor, imagery, myth, and storytelling in psychotherapy.
- Nature of relationship between therapist and client.

Figure 43: Culturally Variable Components of Interventions in Posttraumatic Stress Disorder

Source: Draguns, 1996

When providing cross-cultural treatment of PTSD, researchers recommend adopting a comprehensive program in order for the treatment to be most optimal (Kinzie, 2001). The program suggested by Kinzie (2001) contains nine components (Figure 44).

- Ability to treat major psychiatric disorders in addition to PTSD.
- Addressing the language needs of the patients.
- Easy access.
- Establishing credibility with minority communities and refugees.
- Linkages and continuity with all services.
- Integrating both physical and mental disorders.
- Feedback mechanism for the patients.
- Staffing with clinicians capable of handling wide variety of disorders.
- Training for bilingual mental health workers.

Figure 44: Program for Cross-Cultural Treatment of PTSD

Source: Kinzie, 2001

Disaster Preparedness and Crisis Response Training for Mental Health Professionals

Mental health providers go through specialized education that includes undergraduate college education and an advanced graduate and/or post-graduate degree. As emphasized by the Center for Mental Health Services (CMHS), disaster mental health providers require specialized training, since a background in crisis intervention or mental health services does not prepare a mental health professional for issues encountered in communities during the months following a disaster (CMHS, 2000; CMHS, 2001; NIMH, 2002; see also Young et al., 1999; Rogers, 2007).

To prepare mental health practitioners for work in disaster areas, CMHS recommends training focused on an overview of disasters, phases of reactions to disaster, adult reactions to disaster, disaster mental health interventions, children in disaster; and special populations in disaster (CMHS, 2000). Another training topic of great importance is the Crisis Counseling Program (CCP) developed by FEMA (Young et al., 2006). CCP is focused on short-term mental health interventions conducted by counselors or trained paraprofessionals. CCP also focuses on individual and community recovery through empowerment, skill building, and education. The model encourages counselors to provide help outside offices (e.g., schools, churches, etc.), and be proactive (CMHS, 2001).

Specific disaster mental health training is critical for all professional and paraprofessional personnel associated with a disaster mental health recovery program. This training can guide crisis counseling project development so that the wisdom gathered from twenty-five years of disaster mental health intervention is reflected in program services.

CMHS, 2000

Young and colleagues (2006) argue that professional training of disaster mental health professionals requires a comprehensive curriculum that should include covering conceptual framework of DMH services, mental health practitioner guidelines, administrative guidelines, and special populations that include ethnic minorities, displaced workers, injured, bereaved, children, and emergency and mental health workers (Young et al., 2006). A similar approach was suggested by the consensus workshop on early psychological interventions following mass violence convened by NIMH in 2001 (NIMH, 2002): it does not include minorities into high-risk populations, but emphasizes the need for mental health training in cultural issues (NIMH, 2002).

Numerous researchers have pointed out the benefits of acquiring cross-cultural competence in mental health and counseling in order to maximize the development of minority clients (Sue et al., 1992; Sue & Sue, 2003; Norris & Alegria, 2005; SAMHSA, 1998). Therefore, cultural competence training and education are considered an important indicator of cultural competence in mental health care services delivery (Siegel et al., 2003). At the same time, researchers point out the lack of consensus on the most effective methods of multicultural education and lack of guidance on how to proceed in acquiring multicultural competence (Frier & Ramsey, 2005; Collins & Arthur, 2007).

An important factor that stimulated cultural competence in mental health education was the development of thirty-one Multicultural Counseling Competencies commissioned by the Association of Multicultural Counseling and Development (AMCD) in 1992. Responding to the efforts by AMCD and other professional associations, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) revised its training standards to include issues of social and cultural diversity and suggested experiential learning activities to help develop multicultural counseling skills (Council for Accreditation of Counseling and Related Educational Programs, 2001). Examining how CACREP standards contribute to cultural competence, Holcomb-McCoy and Myers conducted a survey that revealed training effectiveness in raising self-perceived cultural competence in 46 percent of respondents. At the same time, survey respondents reported that their multicultural training was inadequate (Holcomb-McCoy & Myers, 1999).

A variety of philosophical concepts related to culture and cultural competence generated a variety of training models used in mental health. An example of including culture into training programs is a multicultural counseling training program development pyramid suggested by Ridley and colleagues (1994; Figure 45). The foundation of the pyramid is training philosophy that should be focused on multiculturalism. The training philosophy supports the development of ten learning objectives that, in turn, provide the foundation for developing matching ten instructional strategies (for instance, didactic methods, experiential activities, introspection, technology-enhanced learning). Program designs should provide students with multicultural experiences, for instance developing a single multicultural course or series of courses. At the top of the pyramid is the evaluation to demonstrate the effectiveness of the training program (Ridley et al., 1994).

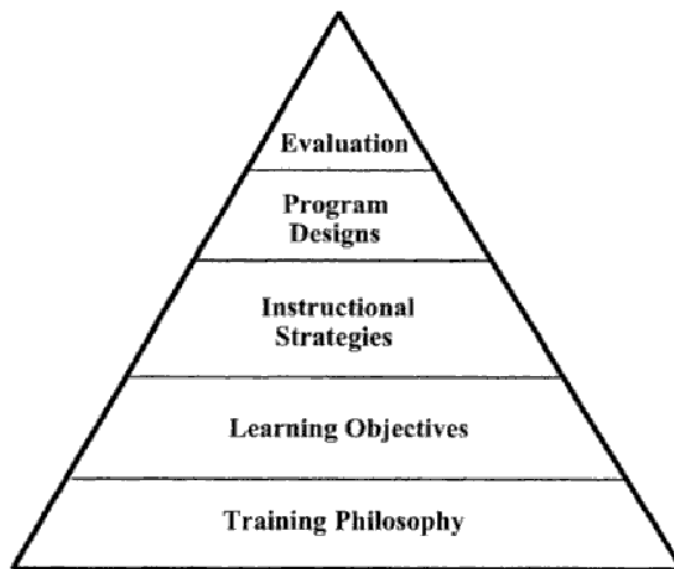


Figure 45: Multicultural Counseling Training Program Development Pyramid
Source: Ridley et al., 1994

Other models of organizing the learning content related to culture and integrating it in the mental health education curricula are summarized in Figures 46 and 47 (O’Byrne, 2007).

Model	Focus
<i>Cultural/Anthropological</i>	Re-contextualizing the notions of mental health and illness through culturally-shaped explanatory models.
<i>Clinical</i>	Practice of using interpreters, developing cultural sensitivity and awareness, communication, developing cultural sensitivity.
<i>Culture Broker</i>	Training provided by a member of specific ethnic community. Community member also serves as an intermediary between the clinician and the client.
<i>Cultural Competence</i>	Several levels of culture-based interventions at the individual, organizational, and policy levels.
<i>Ethnopsychiatry</i>	Ecological understanding of mental illness and health within the context of a specific culture
<i>Clinical/Anthropological</i>	Focus on how the culture overarches, informs, and gives meaning to psychology, biology, and social processes.
<i>Cultural Epidemiology</i>	National, cross-national, and cross-cultural patterns of mental illness and resilience in the context of migration, immigration, and refugee populations.
<i>Anti-Racism</i>	Discovering and understanding forms of racism and oppression within mental health care.
<i>Race-Culture Continuum</i>	Combining anti-racism training and knowledge about cultural groups.
<i>Development Model</i>	Stages of learning in the process of cultural awareness.

Figure 46: Models of Multicultural Training in Mental Health

Source: O'Byrne, 2007

Model	Focus
<i>Separate Course Model</i>	Offering individual courses in cross-cultural mental health.
<i>Area of Concentration</i>	A survey course with further formal course work or exposure to an ethnic group.
<i>Cluster Model</i>	Including multicultural information in multiple courses
<i>Interdisciplinary Model</i>	Encouraging students to take courses outside their discipline
<i>Integration Model</i>	Including cross-cultural content into every course

Figure 47: Integrating Culture in the Mental Health Education Curricula

Sources: O'Byrne, 2007; Mio, 2003

In general, as Collins and Arthur (2007) argue, acquiring cultural competency involves judgment and consistent diligent self-reflection. Strategies for acquiring cultural competence by individual counselors outside formal learning situations include, but are not limited to, self-reflection, research, working with a mentor, and seeking opportunities to interact with ethnic minorities (Collins & Arthur, 2007).

The number of mental health educational programs that include cultural diversity and multiculturalism has increased over the past two decades driven by the premise that culture-specific knowledge in education is “effective in producing more competent researchers, educators, therapists” and other practitioners (American Psychological Association, 2003b). Multicultural education starts with an instructor, and Frier and Ramsey (2005) contend that instructors must maintain high levels of awareness and competence. They must be aware of their own biases and their impact on instructional practices, and the limitations of their knowledge related to specific racial or ethnic groups. According to Locke and Kiselica (1999), educators should actively confront racism within themselves, and guide their students through an informal mentoring process and discussions on privilege and judgment. Instructors should also recognize

potential risks of educational activities in terms of generating anxiety and stress that students are ill-prepared to handle (Frier & Ramsey, 2005).

The need for multicultural training in mental health disaster response has been pointed out in a number of works (e.g., Cohen, 1992). It became especially apparent in the aftermath of Hurricane Katrina where many mental health disparities among affected minority population were revealed. As a part of its Katrina relief efforts, the American Psychological Association established a Task Force on Multicultural Training and Disaster Response in October 2005. The Task Force will be developing recommendations on the scope and content of multicultural training efforts in psychological interventions related to natural disasters (American Psychological Association, 2006b).

To alleviate students' anxieties and potential resistance to multiculturalism, researchers suggest activity-based learning (Mio, 2003). One of the most comprehensive models of activity-based learning is the triad training model developed by Pedersen (1994). This three-level developmental model is based on the awareness of students' cultural assumptions, knowledge of multicultural information, and the acquisition of multicultural counseling skills. The triad training involves simulated cross-cultural interviews between a counselor, an ethnic minority client, and an anti-counselor who reveals racist or culturally biased interventions of the counselor (Pedersen, 1994).

Educators are encouraged to include training on ethnic and gender issues and philosophical models related to multicultural training competence into their course syllabi, and incorporate a multicultural focus into educational programs (American Psychological Association, 2003b; King et al., 1999; Mahoney et al., 2006). Educators are also encouraged to take advantage of experiential learning activities to supplement didactic teaching, for instance games, role-playing, viewing training videos, conducting cross-cultural interviews, or studying a second language (Kim & Lyons, 2003; see also Burkholder, n.d.; Kim & Lyons, 2003; Bussema & Nemeec, 2006; Holcomb-McCoy & Myers, 1999). Games, according to Kim and Lyons (2003), can be effective in increasing cultural awareness, advancing knowledge related to specific minority groups, and enhance culturally sensitive counseling practices.

One of the recommended experiential activities is immersion as an instructional method to help "enhance awareness, facilitate participation, and encourage mutual learning opportunities" (Frier & Ramsey, 2005). Immersion has a potential of enhancing cultural competence and combating racism. Immersion requires strong support and encouragement from the instructor, as well as carefully planned assignments, for instance pre-immersion papers, immersion journals, post-immersion evaluation, comparison between pre- and post-immersion self-appraisals. Immersion helps students critically examine their prejudices and biases and their influence on people's lives (DeRicco & Sciarra, 2005).

Effective training practices also include cognitive behavioral techniques to help students develop higher levels of cognitive complexity and confront their own cognitive

distortions in order to avoid stereotyping and bias, and anxiety reduction techniques (Steward et al., 1998; Faubert & Locke, 1996).

At the same time, as pointed out in a number of works on mental health education, there is a lack of strategies to teach multicultural competencies that involve attitudes, knowledge, and skills (Kim & Lyons, 2003). There is not much empirical evidence related to “what are the key elements of cultural competence and what influence, if any, they have on clinical outcomes for racial and ethnic minorities” (DHHS, 2001). Another shortcoming of current training is that it does not encourage cognitive complexity that allows counselors avoid stereotyping and bias (Evans & Foster, 2000; Steward et al., 1998). Additionally, the majority of educational programs that educate counselors only contain one course on cultural competence and multiculturalism, and educators think it is insufficient (Arredondo & Arciniega, 2001).

Reflecting on the training methods, authors indicate that a simple description of coping behaviors or disaster reactions and interventions is insufficient in disaster mental health training (Young et al., 2006). Among suggested training approaches are a combination of lecture presentations, films, skills practice, self-awareness exploration, and group discussions. Other methods include case studies, role-playing, and disaster simulations to allow participants explore their own reactions and rehearse new skills (CMHS, 2000; Young et al., 2006, NIMH, 2002, Figure 48). The use of video can be particularly helpful during training sessions in order to illustrate the context of disaster response (NIMH, 2002). Recommended training methods in disaster mental health do not differ drastically from those suggested in multicultural mental health (Burkholder, n.d; Burnett et al., 2004; Locke & Kiselica, 1999; Kim & Lyons, 2003; Evans & Foster, 2000; Steward et al., 1998; Mio, 2003).

- Lecture presentations
- Films
- Skill practice
- Sample scripts that illustrate skills
- Role-plays
- Self-awareness exploration
- Group discussions
- Case studies
- Role playing
- (Video-based) disaster simulations

Figure 48: Recommended Training Methods in Disaster Mental Health

Sources: CMHS, 2000; Young et al., 2006; NIMH, 2002

A number of training courses related to disaster mental health have been developed by the Centers for Public Health Preparedness (CPHP) established by the Centers for Disease Control (CDC) and the Association of Schools of Public Health (ASPH) in 2000. Through this network, ASPH seeks to support the CPHP in providing life-long learning opportunities to the public health workforce so they are ready to handle the next public

health crisis (CPHP, n.d.). A report summarizing the mental health psychological preparedness online resources reveals that the majority of the twenty-nine resources (to include courses and other Web-based and CD-based products) focus on intervention, and crisis and psychological first aid (CPHP, 2005). Diverse populations are mentioned forty times within these resources with the primary focus on children and the elderly, and to a much lesser extent on ethnic/multicultural populations as shown in Figure 49.

Population	Number of references
Children	7
Elderly	5
Disabled	3
Ethnic/multicultural	3
Lower socioeconomic status	3
Mentally disabled	3
African American	1
Asian American	1
Latino	1
Native American	1
Daycare worker	1
Gay/lesbian	1
Rural	1

Figure 49: Diverse Populations in Mental Health and Psychological Preparedness Education Resources

Diverse populations as mentioned in CPHP distance learning resources, total 29 resources and 40 references to diverse populations. Source: CPHP, 2005

Training and education in the field of disaster mental health is also provided by non-government organizations. For instance, the American Red Cross requires all its disaster mental health professionals to have professional education and license/certificate in disciplines related to mental health and to go through specialized training to become familiar with Red Cross Disaster Mental Health strategies (Kaul, 2002; L. Adams, 2007; Bowenkamp, 2000).

Other examples include Disaster Psychiatry Outreach, founded in 1998, which has created an educational program that focuses on clinical areas relevant to disaster work, including all aspects of trauma, grief/bereavement, and other unique aspects of disaster response such as systems and service issues (DPO, n.d.). Another example is the Mental Health Cultural Competence Training Center created by the Mental Health Association in New Jersey and the International Institute of New Jersey. The training center is funded by the New Jersey Department of Human Services, Division of Mental Health Services. The Center works together with mental health providers in northern New Jersey to assure culturally and linguistically appropriate access to services for diverse communities and individuals (NJ DHS, n.d.).

Assessing the current level of training in disaster mental health, researchers report that training materials often make too little reference to empirical evidence examining the effects of disaster and mental health interventions. Existing training also pays little attention to problematic mental health intervention issues and does not provide sufficient guidance regarding planning for long-term follow-up services (Young at al., 2006).

Another important issue that hinders curriculum development efforts is the lack of standardized nomenclature that is widespread in the field of disaster mental health (CPHP, 2005).

F. U.S. Public Health Service Commissioned Corps

Characteristics of the Commissioned Corps

The United States Public Health Service Commissioned Corps is composed of public health officers in several professions. Basic eligibility requirements for serving in the Commissioned Corps include U.S. Citizenship, being less than 44 years of age, and having professional training with a qualifying degree in a health care field. The Commissioned Corps Emergency response teams are managed by the Office of the Surgeon General. They are trained and equipped to respond to public health crises and national emergencies, such as natural disasters, disease outbreaks, or terrorist attacks. The teams are multidisciplinary and are capable of responding to domestic and international humanitarian missions (DHHS, n.d.)

The Commissioned Corps consists of more than 6,000 officers from eleven professions, and with a wide range of specialties, including physicians, nurses, pharmacists, dentists, and scientists. During disaster response, the Corps may work independently, or with civilian teams, local and State agencies, and/or the U.S. military. For instance, following Hurricane Katrina's landfall, Commissioned Corps' officers provided direct patient care, conducted epidemiological assessments, provided mental health services in shelters, and restored public systems to working order (Carmona, 2005).

The training requirements for Commissioned Corps' officers vary widely based on professional discipline, and includes a degree from an accredited program and the corresponding licensure (i.e., nursing, medical, social work, pharmacy, etc.) from one of the States or territories, when appropriate (DHHS, 2007). In terms of demographics, Figure 50 illustrates that the majority of the Corps' officers are White (73 percent) males (62 percent) (CCB, 2000).

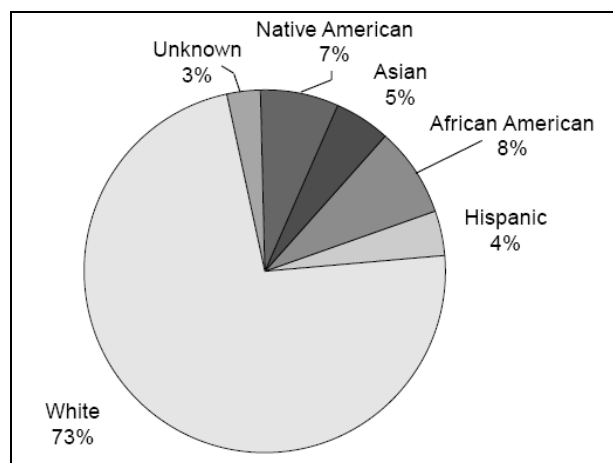


Figure 50: Commissioned Corps Active Duty Strength by Ethnicity
Source: Davidson, 2000

Professional categorical distribution of active-duty officers indicates that the largest category is Medical with the Nurse category as second largest (Davidson, 2000). More than one-third of all Public Health Service (PHS) officers are assigned to the Indian Health Service (IHS), followed by the Centers for Disease Control and Prevention (CDC), the Federal Bureau of Prisons (BOP), the National Institutes of Health (NIH), the Health Resources and Services Administration (HRSA), and the Food and Drug Administration (FDA) (Davidson, 2000; Figure 51).

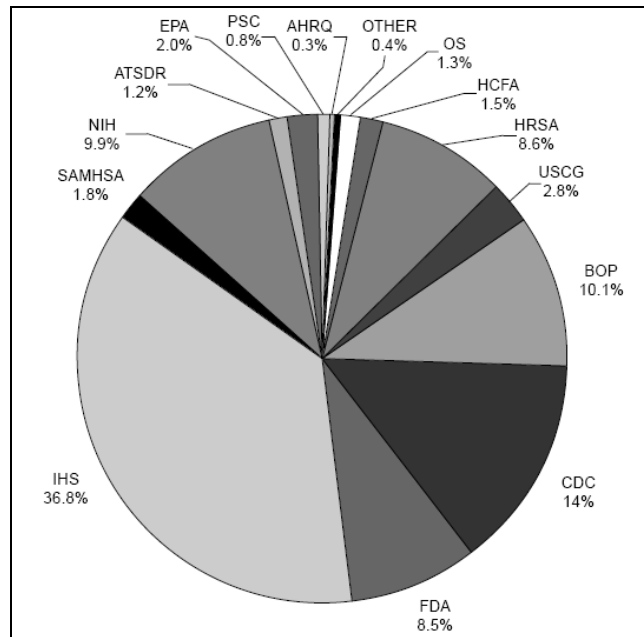


Figure 51: PHS Active Duty Strength by Agency/Operating Division/Program
Source: Davidson, 2000

The Three Areas of CLAS in Relation to Commissioned Corps

A primary purpose of the Commissioned Corps is to provide health care and related public health services to health professional shortage areas that may include specific population groups (DHHS, 2007b). The mission statement of the Commissioned Corps is to protect, promote, and advance the health and safety of the Nation through rapid and effective response to public health needs, leadership and excellence in public health practices, and the advancement of public health science (DHHS, 2007b). When deployed, the Corps' officers often interact with racial and ethnic minorities. The Corps officers are deployed both in the U.S. and overseas for relief and humanitarian missions. U.S. Public Health Service officers were sent to Indonesia in 2004 to help with tsunami relief efforts as part of Operation Unified Assistance on the Navy hospital ship the USNS Mercy, to Panama in 2006 to help deal with medicine contamination, and in 2007, on the USNS Comfort as part of a health diplomacy mission to Latin America and the Caribbean (USPHSCC, 2007; McGuinness, 2006; Rutstein, 2007).

Experts indicate that training in cultural competence can enhance disaster response and “build better rapport with communities and improve the perception of the response”

(Hunter, 2007). The delivery of culturally competent care within the Commissioned Corps is addressed through a number of required training programs. Numerous online trainings are available to all USPHS Officers and have varying degrees of focus on cultural competency and cultural awareness issues (Joskow, 2007). One course is simply called “Cultural Awareness.” Another, “Caring for People of Different Cultures: The Challenges for CCRF,” examines the challenges of providing health care to disaster victims from a multitude of different cultures (Bissell, Hsu-Trawinski, & Pratt, n.d.). Its objectives include defining culture, discussing how culture affects how humans view health and health care, citing examples of how different cultures handle personal crisis and disaster response, and providing examples of how Commissioned Corps officers can overcome cultural differences to work more effectively with persons from different racial and ethnic backgrounds (Bissell, et al., n.d.). In the last few years, these courses, which were previously only available online, have been burned onto CDs and mailed to each of the over 6000 members of the Public Health Service. Additionally, through courses such as Response Leadership Training (RLT), Disaster Mental Health Response Training (DMHRT), and Combined Humanitarian Assistance Response Training (CHART), Commissioned Corps officers receive training on cultural awareness, cultural beliefs and practices, and working with other cultures (Joskow, 2007; Center for Excellence in Disaster Management and Humanitarian Assistance, n.d.).

In terms of organizational policies, Tommy Thompson, the former Secretary of Health and Human Services, stated that the Corps was “going to develop new and innovative ways for the Corps to increase the number of professionals available to address primary care, particularly in areas that have traditionally suffered with problems of access” (Thompson, 2003). Through Commissioned Officer Advisory Committees, the Corps’ officers provide advice and consultation to the Surgeon General on issues relating to the professional practice and activities of the Corps’ officers representing diverse racial and ethnic groups (CCB, 2006).

Roles of Commissioned Corps during Disaster Preparedness and Crisis Response

The U.S. Public Health Service Commissioned Corps is made up of officers commissioned on the basis of their health-related training. To effectively respond to public health crises and national emergencies, the Commissioned Corps has emergency response teams that are managed by the Office of the Surgeon General. The teams are multidisciplinary and are capable of responding to domestic and international humanitarian missions. The Commissioned Corps’ Rapid Deployment Force (RDF) teams, report during the first 12 hours of a disaster. The mission statement of the U.S. Public Health Service Rapid Deployment Force is “to provide quality medical care, compassion and comfort to the American public, or the global community, in the event of a natural or manmade public health care crisis” (USPHS, 2007). RDF teams can be called upon by the President via the U.S. Department of Health and Human Services during times of “extraordinary need during disaster” to: provide mass medical care, work with local, state and federal authorities, supply isolation and quarantine care and support if necessary, assist residents with re-integration into their communities, and supply pre-hospital triage, treatment and medical surge support (USPHS, 2007).

The Commissioned Corps uses a tiered structure for their response to disasters. Rapid Deployment Force (RDF) teams are part of Tier 1 response, along with the Secretary's Emergency Response Teams (SERTs). Tier 2 contains Applied Public Health Teams (APHTs) and Mental Health Teams (MHTs), which report to a disaster during the first 36 hours (OFRD, n.d.). APHTs are sometimes described as a "Public Health Department in a Box," and provide public and environmental health assessments, vector control, surveillance, etc. (OFRD, n.d.). MHTs provide assessments of a disaster event from the mental health perspective, including the scope and intensity of the event or level of exposure to trauma (OFRD, n.d.).

A recent report analyzing the Commissioned Corps' response to Hurricane Katrina focused on the issues of officers' effectiveness and analyzed the response organization, officers' training and deployment (DHHS, 2007). The report shows that the officers integrated seamlessly into emergency operations centers in the early days of the response. Corps officers were instrumental in helping States identify and understand the Federal assets available for their use and understand the situation on the ground in affected areas (DHHS, 2007). At the same time, fifty-two percent of Corps officers deployed in response to the hurricanes had no previous deployment experience and 36 percent of surveyed Corps' officers indicated that their training was insufficient to prepare them for the conditions and situations they encountered (DHHS, 2007). One recommendation from the report was to increase the hands-on training Commissioned Corps' officers receive in disaster relief operations and response planning (DHHS, 2007).

Disaster Preparedness and Crisis Response Training for Commissioned Corps

The U.S. Public Health Service Commissioned Corps is made up of officers commissioned on the basis of their health-related training. Officers must have a qualifying degree or a higher degree from an accredited institution, and meet the Corps' standards of readiness that includes training (DHHS, 2007). To acquaint its members with the Corps' history and operation principles, the Corps Training Academy offers the Basic Officer Training Course (BOTC) and Independent Officer Training Course (IOTC). BOTC focuses on military bearing and courtesy, career development, promotions, leave, compensation, awards, and resource utilization (CCB, 2001). IOTC includes Uniformed Service theory, uniformed dress, protocol, organization, and personnel issues.

The core areas that are discussed in relation to the Corps' disaster response include readiness standards, disaster work experience, effective training, familiarity with response plans, and logistics of officers' deployments (DHHS, 2007b). The Office of Force Readiness and Deployment also recently added training for the Commissioned Corps Readiness Force (CCRF) on working with at risk individuals during disasters (OFRD, 2007).

Prior to deployment, Commissioned Corps officers must complete a number of online training sessions, including Basic Readiness requirements (USPHS OFRD, 2007). The

Basic Readiness requirements include information on disaster response, preventive medicine during field operations, health consequences and responses, among others. A Field Medical Readiness Badge (FMRB) is not required for all deploying officers, but may be achieved by completing additional online training modules, some of which are directly applicable to both disaster preparedness and cultural competency. These include Critical Incident Stress Management (CISM), community outreach activities, and building cultural awareness (USPHS OFRD, 2007). The Commissioned Corps receives training both online and via live courses. In addition to their Basic and Independent Officer Training Courses (BOTC and IOTC), a number of additional training opportunities exist, including Response Leadership Training (RLT), Disaster Mental Health Response Training (DMHRT), and Combined Humanitarian Assistance Response Training (CHART). Each of these trainings contains components on cultural awareness or cultural competency.

For example, one CHART course offered in Hawaii illustrates the importance of cultural awareness and cultural competence in disaster response (Center for Excellence in Disaster Management and Humanitarian Assistance, 2007). One of the course's main objectives is to "demonstrate cultural awareness for treatment protocols for persons affected by a humanitarian emergency" (Center for Excellence in Disaster Management and Humanitarian Assistance, 2007). The course defines cultural competence, and discusses the following nine principles to consider in disaster planning:

1. Recognize the importance of culture and respect diversity;
2. Understand the current cultural composition of the community;
3. Recruit disaster workers who are representative;
4. Provide ongoing cultural competence training to disaster staff;
5. Ensure that services are accessible, appropriate, and equitable;
6. Recognize the role of help-seeking behaviors, customs and traditions, and natural support networks;
7. Involve as "cultural brokers" community leaders and organizations representing diverse cultural groups;
8. Ensure that services and information are culturally and linguistically competent and appropriate; and
9. Assess and evaluate the program's level of cultural competence.

G. Military Personnel

Characteristics of Military Personnel

The primary mission of the U.S. military medical and health care system is to support combat commanders in their military missions by “conserving the fighting strength.” Much debate surrounds the role the military should play in disaster response. Currently, the U.S. military provides defense assistance to civil authorities in disasters and national emergencies, while the military health system’s first priority is maintaining a healthy and fit force.

The major player in the Army's Emergency First Responder Program is the Army Medical Department (AMEDD) that consists of six medical Special Branches: Medical Corps, Army Nurse Corps, Army Medical Specialist Corps, Medical Service Corps, Dental Corps, and Veterinary Corps. The AMEDD has practically every health care specialty found in the civilian sector. It provides chemical, biological, radiological, and nuclear protective supplies and equipment to first responders across the country (U.S. Army, 2007).

The U.S. Navy relief efforts are coordinated by the Bureau of Medicine and Surgery. The Navy offers relief support within the U.S. and worldwide through the USNS Comfort and USNS Mercy, and each ship acts as a self-contained definitive treatment facility with twelve fully-equipped operating rooms, a 1,000-bed hospital facility, radiological services, medical laboratory, a pharmacy, a dental department, an optometry lab, a cat scan, and two oxygen producing plants (U.S. Navy, 2007). The USNS Mercy played a key role in disaster response following the tsunami which struck Indonesia, Thailand and Sri Lanka in late 2004. As part of Operation Unified Assistance, civilian volunteers and uniformed members of both the U.S. Navy and U.S. Public Health Service worked together aboard the hospital ship to provide much needed medical services following the disaster (Timboe, 2006; McGuinness, 2006; McCartney, 2006).

The U.S. Marine Corps can also be called upon by the President in times of disaster. During the aftermath of Hurricane Katrina, Marines were deployed to assist with rescue efforts. A task force comprised of a command element, an aviation element, a ground infantry element and a logistics element was created to assist FEMA and state and local authorities wherever possible (U.S. Marine Corps, 2005). Marine Corps helicopters rescued hundreds of residents who had fled to higher ground during the flooding. Marines were also deployed to Los Angeles in 1992 to assist with control of the riots that broke out after the Rodney King verdict was announced (Mendel, 1996).

The U.S. Air Force is primarily focused on search and rescue, aero medical evacuation, delivering relief supplies. It offers medical care to affected areas through the Air Force Medical Services (AFMS). AFMS maintains rapid response teams which coordinate field hospitals designed to operate thirty consecutive days without resupply. Field hospital capabilities include resuscitative surgery and hospitalization with clinically appropriate ancillary services (Walsh & Ditch, 1998).

The U.S. Coast Guard's primary mission in disaster response includes search and rescue and evacuation. In the aftermath of Hurricane Katrina, the Coast Guard deployed hundreds of air and boat crews to rescue more than 24,273 people and assisted with the evacuation of an additional 9,462 patients and medical personnel from hospitals and nursing homes (DHS, 2006a).

The National Guard has a unique dual mission that consists of both Federal and State functions. State missions are called into action by the Governor and commanded by the State Adjutant General. The Governor can call the National Guard into action during local or Statewide emergencies, such as storms, fires, earthquakes, or civil disturbances. In addition, the President of the United States can activate the National Guard for participation in Federal missions. When federalized, the Guard units are commanded by the Combatant Commander of the theatre in which they are operating (GlobalSecurity.org, 2007; U.S. Army, 2007b).

Meeting the responsibilities of national defense and defense support to civil authorities requires rigorous training. Well-trained military medical personnel can readily shift from the peacetime setting to the combat or operational environment and fulfill both missions (Department of the Army, 1990). The most reoccurring theme seen in the literature regarding military medical training is the importance of "disaster triage" and crisis management. This training incorporates clinical skills, educational information, communication ability, leadership, and decision-making. Planning, rehearsing, and exercising various scenarios encourage the flexibility, adaptability, and innovation required in disaster settings (Department of the Army, 1990).

Data on the U.S. military medical personnel is fragmentary. The Government Accountability Office (GAO) reports that all branches of the military have experienced problems accessing enough medical professionals, including physicians, medical students, dentists, and nurses. The GAO report also presents evidence that minorities, particularly African Americans and Latinos, are underrepresented among the officers (GAO, 2007; Figure 52).

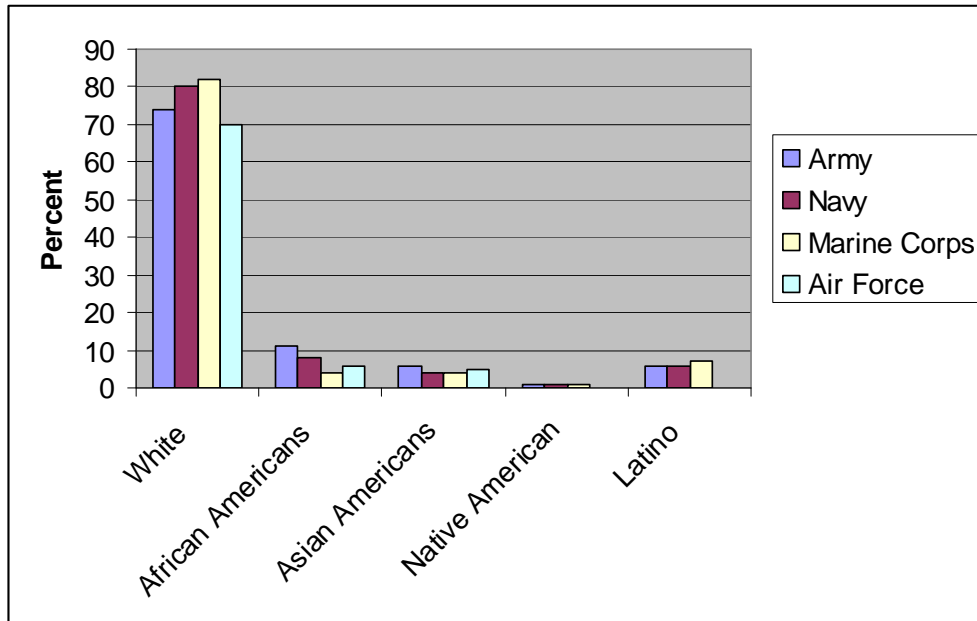


Figure 52: Racial and Ethnic Diversity of U.S. Military Officers
 Source: GAO, 2007

The Three Areas of CLAS in Relation to Military Personnel

The issues of cultural competence related to military medicine have not been sufficiently covered in the literature, though several authors discussed this concept as it relates to the U.S. military in general. The Department of Defense rated itself “inadequate” in a 2006 self-assessment in its culture and language preparation to conduct missions throughout the spectrum of operations, and, as Wunderle (2006) argues, cultural competence has not been sufficiently incorporated into military training or doctrine.

According to McFarland (2005), cultural competence includes self-awareness and understanding and appreciation of soldiers’ beliefs, behaviors, values, and norms (see also Lewis, 2006). Lewis shows that self-awareness can help fight ethnocentrism, “heighten one’s cultural influences in thinking” and “suspend judgment when encountering a cultural behavior that is different or unusual” (Lewis, 2006). Lewis suggests that the military personnel should have the knowledge of cultural variables that influence people’s behavior to include individualism-collectivism, low- and high-context communication, power distance, uncertainty avoidance, and ideas of masculinity-femininity (Lewis, 2006). In terms of culturally competent skills, authors suggest that military personnel should be bilingual, multilingual, or working toward language proficiency (McFarland 2005; Lewis 2006).

McFarland contends that at the organizational level, cultural competence implies leadership capable of bridging cultural divides and establishing cross-cultural partnerships. Lewis shows that the success of partnerships is determined by the knowledge of foundational cultural norms in that population (2006).

Roles of Military Personnel during Disaster Preparedness and Crisis Response

U.S. Armed Forces participate in disaster relief and provide support to civil authorities within the U.S. and internationally, though disaster relief is secondary to the U.S. military mission of national defense (Bowman, Kapp, & Belasco, 2005). Therefore, the approach to cultural competence is focused on conducting successful combat operations and gathering intelligence (DOD, 2005a and 2006b; Lewis, 2006; Wunderle, 2006; Ellis, 2005; Latham, 2000; Connable, B. & Speyer, A., n.d.).

There is no consistency in defining cultural competence and cultural awareness among military authors, and there are several models for incorporating cultural competence into military practices. Connable and Speyer identify cultural awareness as “understanding that cultural terrain must be considered for military operations” and propose two levels of cultural awareness: general training on the importance of culture in warfare, and specific country or area training (Connable & Speyer, n.d.).

Wunderle defines cultural competence as “the fusion of cultural understanding with cultural intelligence to allow for focused insight into planning and decision-making for current and future military operations” (Wunderle, 2006). Understanding culture, according to this author, involves understanding three main components that include cultural influences (history, religion), cultural variations (styles of behavior, values, ways of thinking), and cultural manifestations (displays of culture’s thought and behavior). McFarland’s definition of cultural competence includes organizational skills and organizational leadership necessary to manage groups and have an application-oriented understanding of culture (McFarland, 2005).

Military personnel receive culture-specific training through several sources that include the Foreign Area Officer (FAO) program, the University of Foreign Military and Culture Studies, and the Defense Language Institute Foreign Language Center (DLIFLC) at the Presidio of Monterey, California (McFarland, 2005; Ellis, 2005; Wunderle, 2006). Additionally, the U.S. Armed Forces are developing programs in order to incorporate cultural competence into professional military training and institutionalize cultural knowledge, for example, the U.S. Army Training and Doctrine Command’s (TRADOC) Culture Center integrated as part of the U.S. Army Intelligence Center at Fort Huachuca, Arizona (Hajjar, 2006).

Disaster Preparedness and Crisis Response Training for Military Personnel

U.S. Armed Forces participate in disaster relief and provide support to civil authorities within the U.S. and internationally. To help carry out relief missions, the military personnel receive humanitarian assistance training (DOD, 2004). Disaster relief is secondary to the U.S. military mission of national defense (Bowman, Kapp, & Belasco, 2005), so the training that the U.S. personnel receive, including training in cultural competence, is focused on conducting successful combat operations and gathering intelligence (DOD, 2005a and 2006b; Lewis, 2006; Wunderle, 2006; Ellis, 2005; Latham, 2000; Connable & Speyer, n.d.).

Authors argue that cultural competence training will help troops function more effectively and reduce the anxiety and stress of new environments (Lewis, 2006, Wunderle, 2006). Additionally, developing cultural self-awareness will help to reduce one's biases in communicating and understanding others (Lewis, 2006, p. 10).

According to Lewis, cross-cultural training is general or anecdotal information on the features of a specific culture, it should help soldiers learn about their internal cultural biases, understand the culture of others, and manage "culture shock", stress, and anxiety as a result of exposure to another culture (Lewis, 2006).

The effectiveness of current cultural training across the U.S. Army is mixed at best, providing Soldiers a "tourist" level of understanding which does not adequately prepare them to be culturally competent and effective.

Lewis, 2006

Current training on cultural competence is decentralized to local commanders and is limited to briefings, handouts, books, sometimes rudimentary language training. The effectiveness of current cultural training across the U.S. Army is mixed at best, providing Soldiers a "tourist" level of understanding which does not adequately prepare them to be culturally competent and effective" (Lewis, 2006).

Another way that the military personnel can get culture-specific training is the Foreign Area Officer (FAO) program that trains commissioned officers in regional expertise, language competency, and political-military awareness. FAOs serve as Attaches or Security Assistance Officers at United States embassies, to implement the United States national security strategy, often as the sole DOD representative in country (Ellis, 2005; Wunderle, 2006). Cultural education is also a part of curriculum of the University of Foreign Military and Culture Studies (McFarland, 2005).

Foreign language study is a crucial component in acquiring cultural competence skills. The Department of Defense trains its linguists at the Defense Language Institute Foreign Language Center (DLIFLC) at the Presidio of Monterey, California, through face-to-face instruction, Mobile Training Teams (MTTs), Video Tele-Training (VTT), and distance learning. DLI currently teaches 80 percent of all U.S. Government language classes that incorporate culture (Ellis, 2005; Fox, 1999; Krasner, 1999). DLI is exploring new teaching methods and leveraging technology to provide more enhance language. For instance, LingNet, a Web site supported by DLIFLC, provides access to online language courses and activities and a popular series of courses "Countries in Perspective" that educate military personnel in specific cultures (Ellis, 2005; DLIFLC, n.d.).

U.S. Armed Forces are developing programs in order to incorporate cultural competence into professional military training and institutionalize cultural knowledge. One example is a newly created U.S. Army Training and Doctrine (TRADOC) Culture Center as a part of U.S. Army Intelligence Center at Fort Huachuca, Arizona. The center develops cultural awareness training, knowledge, and products, and disseminates them across the Army, potentially throughout DOD (Hajjar, 2006).

There is no consistency in defining cultural competence and cultural awareness among military writers, and there are several models for incorporating cultural competence in military training. Connable and Speyer (n.d.) propose two levels of cultural awareness training: general training on the importance of culture in warfare, and specific country or area training. Wunderle (2006) suggests a cultural competency training continuum based on levels of cognitive hierarchy and integrating cultural awareness into the U.S. military training and operations and conducting extensive pre-deployment training with the help of DLI and FAOs.

Lewis's (2006) cultural competence continuum includes three levels: (1) initial military training with the focus on self-awareness; (2) mid-career training with the focus on the world geo-political situation; (3) senior-level courses aimed at "developing advanced understanding of the world geopolitical situation," with an emphasis on developing policies and guidelines taking into account cultural issues. He also advocates for flexibility of training methods that include briefings, role plays, books, video, and situational training (Lewis, 2006). McFarland (2005) argues that cultural competence training need to include culturally specific communication styles (factors influencing communication such as religion, tribal affiliation, and nationalism), attitudes towards conflict, approaches to completing tasks, decision-making styles, attitudes towards personal disclosure of emotions, and approaches to gaining knowledge (McFarland, 2005).

H. Citizen Corps

Characteristics of the Citizen Corps

The Citizen Corps is a coordinated movement to guide individuals in preparedness efforts. During the 2002 State of the Union address, George W. Bush “called upon every American to commit at least two years of their lives – the equivalent of 4,000 hours – to the service of others.” Service opportunities for every American were expanded upon through the USA Freedom Corps, with components such as the Citizen Corps providing motivation for volunteer citizens to aid in the strengthening of community preparedness (DHS, 2002).

The Department of Homeland Security (DHS), the Department of Justice (DOJ), and the Department of Health and Human Services (DHHS), administer the four federal Citizen Corps programs: *The Neighborhood Watch Program*, FEMA’s *Community Emergency Response Team (CERT)*, *Volunteers in Police Service (VIPS)*, and the *Medical Reserve Corps* (DHS, 2002). Local leaders, police departments, fire departments, emergency medical personnel, and citizen volunteers all contribute to crime prevention and prompt responsiveness to emergencies through these four national level programs. In addition to federally-sponsored programs, the DHS also coordinates overall efforts to help communities establish local Citizen Corps councils and programs.

The Citizen Corps consists of individuals from a variety of professions, backgrounds, and skill levels. To participate in a Citizen Corps Council, one must be dedicated to the expansion of volunteer efforts to bring about a safer community, assisting citizens to take an active role in protecting themselves and their families, teaching citizens what to do in a crisis situation, and committing to educate the public on safety. First responders and local leaders working alongside citizen volunteers allow for the inclusion of each individual’s background, training and education, to support the success of the Citizen Corps.

One goal of the Citizen Corps is to educate the public about preparedness and encourage more involvement in preparedness and public safety activities. Resources to educate and involve the public are easily accessible through the Citizen Corps website. Some of the resources available include, *The Be Ready Campaign*, *Are You Ready? A guide to Citizen Preparedness*, *The Citizens’ Preparedness Guidebook*, and Citizen Corps Affiliate Programs and Organizations, which all offer techniques and strategies to prepare individuals and families for disasters, and provide volunteer opportunities, education, and awareness (DHS, 2002).

The Three Areas of CLAS in Relation to the Citizen Corps

The major goal of the Citizen Corps is to create safer communities with citizens who are trained to respond to emergencies when outside assistance may not be available. One goal of the Citizen Corps movement is for everyone to become involved in preparedness activities by linking pre-existing volunteer, preparedness and community safety

initiatives (DHS, 2002). The inclusion of initiatives focused within minority or special needs communities is one way that the CLAS themes may be exhibited within the Citizen Corps.

Developing a Citizen Corps Council prior to a disaster is one way to make the Citizen Corps an active part of a community whose components can be utilized before, during and following a disaster (DHS, 2002). A Citizen Corps Council brings together persons who are already involved in preparedness efforts and embrace the key principles of the Citizen Corps to coordinate these efforts. The *Guide for Local Officials* suggests that, with respect to creating a Citizen Corps Council, it is important to include representatives and leadership from a variety of specific segments of the community (i.e., elected leaders, members of tribal governments, leaders from the emergency management and first responders communities, members of marginalized communities such as minorities, non-English speakers, the elderly, etc.), to ensure that all groups' voices are heard (DHS, 2002).

Roles of the Citizen Corps during Disaster Preparedness and Crisis Response

Each of the Citizen Corps' federal citizen programs encourage engagement in disaster preparedness. FEMA's Community Emergency Response Team program (CERT) includes training on providing immediate assistance to victims, organizing other volunteers, and assisting professional responders by allocating and prioritizing resources using disaster intelligence. A disaster simulation is also included, to allow participants to practice what they have learned throughout the class (DHS, 2002). The Volunteers in Police Service (VIPS) provide assistance during a disaster in tasks such as traffic control and processing paperwork, so that police officers can remain on the front lines during emergency and disaster situations. Medical Reserve Corps (MRC) volunteers are medical professionals who provide additional staffing, support and care for disaster victims who have non-serious injuries. Volunteers from an MRC can assist emergency response teams, health professionals, and physicians and nurses in a major crisis (DHS, 2002).

The Citizen Corps also encourages all citizens to engage in basic first aid training and in emergency response skills through Citizen Corps programs and affiliates. Accordingly, in 95 percent of all emergencies, the victim or bystander provides the first immediate assistance on the scene, making training of this kind even more important (DHS, 2004b).

Disaster Preparedness and Crisis Response Training for Citizen Corps

Disaster preparedness and crisis response training varies depending on which branch of Citizen Corps individuals are involved with, as well as a community's needs and likelihood to experience various disasters or crises (DHS, 2002). The federally-sponsored Community Emergency Response Team (CERT) training is a 20-hour course which takes place over a seven-week period. The CERT training includes sessions on light search and rescue, basic disaster medical services, and disaster preparedness, among other topics (DHS, 2002). Volunteers in Police Service (VIPS), a federal program funded through DOJ, offers training for volunteers to execute administrative and non-intervention

policing activities, allowing law enforcement professionals to be available for frontline duty. There are a number of programs available on the official Medical Reserve Corps website to train MRC volunteers, including a set of core competencies developed in 2006 in conjunction with the National Association of County and City Health Officials (OSG MRC, 2007; NACCHO, 2006). These core competencies were developed to provide a framework for future training activities of the MRC program and to ensure that all MRC volunteers share specific knowledge, skills and abilities (NACCHO, 2006).

There is no required training for involvement in the Citizen Corps as a whole, although all volunteers are encouraged to engage in basic first aid and emergency response training.

Appendix A. References

- American Academy of Orthopaedic Surgeons. (2005a). *Emergency care and transportation of the sick and injured* (9th ed.). (A.N. Pollak, Ed.). Boston, MA: Jones and Bartlett Publishers.
- American Academy of Orthopaedic Surgeons. (2005b). Web site companion to *Emergency care and transportation of the sick and injured* (9th ed.). Retrieved April 30, 2007, from <http://www.emtb.com/9e/interactivities.cfm>.
- Abueg, F. R., & Chun, K. M. (1996). Traumatization stress among Asians and Asian Americans. In A. J. Marsella, M. J. Friedman, E. T. Gerrity, & R. M. Scurfield (Eds.), *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications* (p. 285-299). Washington, DC: American Psychological Association.
- Adams, L. (2007). Mental health needs of disaster volunteers: A plea for awareness. *Perspectives in Psychiatric Care*, 43(1), p. 52-54.
- Agee-Aldridge, J. (2007). *Trainings teach Red Cross to partner for better disaster response*. Retrieved July 29, 2007, from http://www.redcross.org/article/0,1072,0_312_6761,00.html.
- Aguirre, B. E. (1988). The lack of warnings before the Saragosa tornado. *International Journal of Mass Emergencies and Disasters*, 6(1), p. 65-74.
- The Agency for Healthcare Research and Quality. (2006). *The national healthcare disparities report*. Rockville, MD: U.S. Department of Health and Human Services. Retrieved September 25, 2007, from <http://www.ahrq.gov/qual/nhdr06/nhdr06.htm>.
- Al-Krenawi, A., & Graham, J. R. (2000). Culturally sensitive social work practice with Arab clients in mental health settings. *Health and Social Work*, 25(1), p. 9-22. Retrieved July 7, 2007, from <http://www.socialworkers.org/pressroom/events/911/alkrenawi.asp>.
- Allen, I. M. (1996). PTSD among African Americans. In A. J. Marsella, M. J. Friedman, E. T. Gerrity, & R. M. Scurfield (Eds.), *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications* (p. 209-238). Washington, DC: American Psychological Association.
- Andrulis, D. (2006, December). *Opportunity and promising practices for advancing cultural competence in health and mental health care*. Presentation at the Culturally Competent Mental Health Meeting, Montclair, NJ. Retrieved June 14, 2007, from <http://www.culturallycompetentmentalhealthnj.org/docs/2006-12-training/CCMHAndrulis12-12.ppt>
- Andrulis, D., Siddiqui, N., & Gantner, J. (2007, March). *Emergency preparedness for racially and ethnically diverse communities*. Presentation at the National Emergency

Management Summit, New Orleans, LA. Retrieved March 28, 2007, from http://www.ehcca.com/presentations/emsummit/1_03_3.pdf.

American Psychiatric Association. (2005). *Resident census: Characteristics and distribution of psychiatry residents in the U.S., 2004-2005*. Arlington, VA: American Psychiatric Association, Office of Graduate and Undergraduate Education. Retrieved n.d., from <http://www.psych.org/edu/0405census.pdf>.

American Psychiatric Association. (2007). *What is a psychiatrist*. Retrieved June 25, 2007, from <http://www.healthyminds.org/whatisapsychiatrist.cfm>.

American Psychological Association. (1994). *The diagnostic and statistical manual of mental disorders*. Washington, DC: American Psychological Association.

American Psychological Association. (2003b). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist*, 58(5), p. 377-402.

American Psychological Association. (2006a). APA's response to international and national disasters and crises: Addressing diverse needs, 2005 annual report of the APA policy and planning board. *American Psychologist*, 61(5), p. 513-521.

American Psychological Association. (2006b). *Psychological perspective. Hurricane Katrina: A multicultural disaster. Special section*. American Psychological Association, Ethnic Minority Affairs Office. Retrieved June 26, 2007, from http://www.apa.org/pi/oema/special_section_on_katrina_march%202006.pdf.

American Red Cross. (2002). To learn click here. *InstructorFlash*, 1(2), p. 3. Retrieved June 24, 2007, from http://www.redcrossnca.org/admin/content/Publications/pdf/HS_InstructNws_Fall02.pdf

American Red Cross (2003). Total diversity: People, programs, and services. *Diversity Works*, 3(4). Retrieved July 29, 2007, from http://www.redcross.org/static/file_cont1324_lang0_586.pdf.

American Red Cross. (2004). Diversity is happening. *Diversity Works*, 5(1). Retrieved July 29, 2007, from http://www.redcross.org/images/pdfs/DW_V5N1.pdf.

American Red Cross. (2005). *Press release: American Red Cross launches new Spanish-language web site*. Retrieved July 15, 2007, from http://www.redcross.org/pressrelease/0,1077,0_489_4456,00.html.

American Red Cross. (2006b). *Press release: American Red Cross, NAACP and faith-based groups partner to provide disaster training nationwide*. Retrieved July 15, 2007, from http://www.redcross.org/pressrelease/0,1077,0_314_5355,00.html.

American Red Cross. (2007a). *Press release: American Red Cross training institute prepares local chapter representatives to respond to disasters*. Retrieved July 29, 2007, from http://www.redcross.org/pressrelease/0,1077,0_314_6806,00.html.

American Red Cross. (2007b). *Corporate diversity: Programs and projects*. Retrieved July 29, 2007, from http://www.redcross.org/services/diversity/0,1082,0_349_,00.html#stm.

American Red Cross. (2007c). *Disaster services*. Retrieved July 31, 2007, from http://www.redcross.org/services/disaster/0,1082,0_319_,00.html.

American Red Cross. (2007d). *About us*. Retrieved July 29, 2007, from <http://www.redcross.org/aboutus/>

American Red Cross of Northwest Florida. (2007). *Red Cross courses*. Retrieved May 15, 2007, from: http://northwestflorida.redcross.org/index.php?pr=Disaster_Course.

American Red Cross Mid-Michigan Chapter. (2003). *Diversity plan*. Retrieved August 1, 2007, from <http://www.midmichiganredcross.org/general.asp?SN=1355&OP=1359&IDCapitulo=4406UBS63G>.

American Red Cross Oregon Trail Chapter. (2003). *Disaster services classes*. Retrieved May 15, 2007, from http://www.redcross-oregontrail.org/services/Disaster_services_classes.htm#DisasterMentalHealthI

American Red Cross Southern California Region. (2003). *Red Cross celebrates diversity*. Retrieved July 14, 2007, from <http://chapters.redcross.org/ca/socal/whatsnew/newsoon.html>

Arnold, B. R., & Matus, Y. E. (2000). Test translation and cultural equivalence methodologies for use with diverse populations. In I. Cuéllar & F. A. Paniagua (Eds.), *Handbook of multicultural mental health: Assessment and treatment of diverse populations* (p. 121-136). San Diego, CA: Academic Press.

Arredondo, P. (1996). *Successful diversity management initiatives: A blueprint for planning and implementation*. Thousand Oaks, CA: Sage.

Arredondo, P., Toporek, R., Brown, S. P., Jones, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling and Development*, 24, p. 42-78.

Arredondo, P., & Arciniega, G. M. (2001). Strategies and techniques for counselor training based on the multicultural counseling competencies. *Journal of Multicultural Counseling and Development*, 29, p. 263-273.

Arredondo, P., & Toporek, R. (2004). Multicultural counseling competencies = Ethical practice. *Journal of Mental Health Counseling*, 26(1), p. 44-55.

American Translators Association. (2006). *ATA and American Red Cross recruit volunteer interpreters*. Alexandria, VA: American Translators Association. Retrieved June 24, 2007, from http://www.atanet.org/red_cross/.

Atkinson, D. R., Morten, G., & Sue, D. W. (1998). *Counseling American minorities* (5th ed.) New York, NY: McGraw-Hill.

Auf der Heide, E. (1989). *Disaster response principles of preparation and coordination*. St. Louis, MO: C.V. Mosby.

Auf der Heide, E. (1996). Disaster planning part II: Disaster problems, issues, and challenges identified in the Research literature. *Emergency Medical Clinics of North America*, 14, p. 453-480.

Batalova, J. (2005). Spotlight on foreign born in areas affected by Hurricanes Katrina and Rita. *Migration Information Source*. Retrieved June 27, 2007, from <http://www.migrationinformation.org/USfocus/display.cfm?id=343>

Baldwin, D. M. (2003). Disparities in health and health care: Focusing efforts to eliminate unequal burdens. *Online Journal of Issues in Nursing*, 8(1). Retrieved July 15, 2007, from http://www.nursingworld.org/ojin/topic20/tpc20_1.htm.

Barkun, M. (1974). *Disaster and the millennium*. New Haven, CT: Yale University Press.

Barton, A. (1970). *Communities in disaster*. New York, NY: Anchor Books.

Beaton, R. (2006). Disaster behavioral health: Tools and resources for Washington state health professionals. Seattle, WA: Northwest Center for Public Health Practice. Retrieved n.d., from <http://www.nwcphp.org/training/courses-exercises/courses/disaster-behavioral-health>

Benight, C., McFarlane, A. C., & Norris, F. (2006). Formulating questions about post-disaster mental health. In F. Norris, S. Galea, M. Friedman, & P. Watson (Eds.), *Methods for disaster mental health research* (p. 62-77). New York – London: The Guilford Press.

Bernal G., Trimble, J., Burlew, A. K., & Leong, F. T. L. (2003). Introduction: The psychological study of racial and ethnic minority psychology. In G. Bernal, J. Trimble, A. K. Burlew, & F. T. L. Leong (Eds.), *Handbook of Racial and Ethnic Minority Psychology* (p. 1-12). Thousand Oaks, CA: Sage Publications.

Bissell, R., Hsu-Trawinski, B., & Pratt, M. (n.d.). Caring for people of different cultures: The challenges for CCRF. Accessed via personal communication with R. Joskow, November 21, 2007.

Bisson, J. I. (2003). Single-session early psychological interventions following traumatic events. *Clinical Psychology Review*, 23(3), p. 481-499.

Blanchard-Boehm, D. (1997). *Risk communication in Southern California: Ethnic and gender response to 1995 revised, upgraded earthquake probabilities*. Boulder, CO: Natural Hazards Research and Applications Information Center.

Bolin, R., & Stanford, L. (1998). The Northridge Earthquake: Community-based approaches to unmet recovery needs. *Disasters*, 22(1), 21-38.

Bolin, R. (1986). Disaster characteristics and psychosocial impacts. In B. Sowder & M. Lystad (Eds.), *Disasters and mental health: Selected contemporary perspectives* (pp. 3-28). Rockville, MD: National Institute of Mental Health.

Bolton, P. A., Liebow, E. B., & Olson, J. L. (1993). Community context and uncertainty following a damaging earthquake: Low-income Latinos in Los Angeles, California. *The Environmental Professional*, 15, p. 240-247.

Bolton, P. A., & Weiss, W. M. (2001). Communicating across cultures: Improving translation to improve complex emergency program effectiveness. *Prehospital and Disaster Medicine*, 16(4), p. 252-256.

Bonham, V. L., Sellers, S. L., & Neighbors, H. W. (2004). John Henryism and self-reported physical health among high-socioeconomic status African American men. *American Journal of Public Health*, 94(5), p. 737-738.

Bowencamp, C. D. (2000). Coordination of mental health and community agencies in disaster response. *Journal of Emergency Mental Health*, 2(3), 159-165.

Bowman, S., Kapp, L., & Belasco, A. (2005). *Hurricane Katrina: DOD disaster response*. Washington, DC: The Library of Congress. Retrieved June 25, 2007, from <http://www.fas.org/sgp/crs/natsec/RL33095.pdf>.

Boyle, D., & Springer, A. (2001). Toward a cultural competence measure for social work with specific populations. *Journal of Ethnic & Cultural Diversity in Social Work*, 9(3-4), 53-71.

Brewer, M. B., & Brown, R. J. (1998). Intergroup relations. In D. T. Gilbert. & S. T. Fiske, *The handbook of social psychology* (4th ed.), (p. 554-594). New York, NY: McGraw-Hill.

Brodie, M., Weltzien, E., Altman, D., Blendon, R. J., & Benson, J. M. (2006). Experiences of Hurricane Katrina evacuees in Houston shelters: Implications for future planning. *American Journal of Public Health*, 96(5), p. 1402-1408.

- Bronheim, S. (2003). *Infusing cultural and linguistic competence into the multiple systems encountered by families following the sudden, unexpected death of an infant*. Washington, DC: Georgetown University Center for Child and Human Development.
- Brown, E. R., Ojeda, V. D., Wyn, R., & Levan, R. (2000). *Racial and ethnic disparities in access to health insurance and health care*. Los Angeles, CA: UCLA Center for Health Policy Research and The Henry J. Kaiser Family Foundation. Retrieved July 3, 2007, from <http://www.kff.org/uninsured/1525-index.cfm/>.
- Bryant, R. A., & Litz, B. T. (2006). Intermediate interventions. In E. C. Ritchie, P. Watson, & M. Friedman (Eds.), *Interventions following mass violence and disasters: Strategies for mental health practice* (p. 155-173). New York – London: The Guilford Press.
- Buckwalter, K., Smith, M., Zevenbergen, P., & Russell, D. (1999). Mental health services of the rural elderly outreach program. *Gerontologist*, 31, p. 408-412.
- Burkholder, J. R. (n.d.). *Multicultural training in the counseling profession: Current state and future directions*. Ohio Counseling Association. Retrieved June 13, 2007, from <http://www.ohiocounseling.org/docs/jreno.pdf>
- Burnett, J., Hamel, D., & Long, L. (2004). Service learning in graduate counselor education: Developing multicultural counseling competency. *Journal of Multicultural Counseling and Development*, 32(3), p. 180-191.
- Bussema, E., & Nemece, P. (2006). Training to increase cultural competence. *Psychiatric Rehabilitation Journal*, 30(1), p. 71-73.
- Council for Accreditation of Counseling and Related Educational Programs. (2001). *CACREP Accreditation Standards and Procedures Manual*. Alexandria, VA: Council for Accreditation of Counseling and Related Educational Programs.
- Carmona, R. (2005). *PHS roles evolve with disasters: Response to the hurricanes of 2005*. Washington, DC: U.S. Medicine. Retrieved July 6, 2007, from <http://www.usmedicine.com/column.cfm?columnID=216&issueID=33>
- Carter, R. T. (2007). *Disaster response to communities of color: Cultural responsive intervention*. Connecticut Department of Mental Health and Addiction. Retrieved July 7, 2007, from <http://www.ct.gov/dmhas/lib/dmhas/publications/dbhculturalresponse.doc>.
- Carter-Pokras, O., Zambrana, R. E., Mora, S. E., & Aaby, K. A. (2007). Emergency preparedness: Knowledge and perceptions of Latin American immigrants. *Journal of Health Care for the Poor and Underserved*, 18(2), p. 465-481.
- Centers for Disease Control and Prevention (CDC). (2006a). *Public health emergency response guide for state, local, and tribal public health directors*. Rockville, MD: U.S.

Department of Health and Human Services. Retrieved June 18, 2007, from <http://www.bt.cdc.gov/planning/pdf/cdcreponseguide.pdf>.

Centers for Disease Control and Prevention. (2006b). *Health, United States, 2006. With chartbook on trends in the health of Americans*. Hyattsville, MD: U.S. Department of Health and Human Services. Retrieved July 31, 2007, from <http://www.cdc.gov/nchs/data/hus/hus06.pdf>.

Centers for Disease Control and Prevention. (2007). *Public health workbook to define, locate and reach special, vulnerable, and at-risk populations in an emergency (Draft)*. Rockville, MD: U.S. Department of Health and Human Services. Retrieved June 26, 2007, from http://www.bt.cdc.gov/workbook/pdf/ph_workbook_draft.pdf

Center for Excellence in Disaster Management and Humanitarian Assistance. (n.d.). Combined Humanitarian Assistance Response Training (CHART). Retrieved January 2008, from http://coe-dmha.org/course_chart.htm.

Center for Excellence in Disaster Management and Humanitarian Assistance. (2007, March). Powerpoint presentation given during Hawaii CHART course, Tripler Army Medical Center, Hawaii, March 19-22, 2007.

CDLHN (California Distance Learning Health Network). (1995). *California distance learning health network*. Retrieved June 10, 2007, from <http://cdlhn.com/clickhere.cfm?type=m&id=107&title=Search%20by%20Date>

Chan, T. C., Killeen, J., Griswold, W., & Lenert, L. (2004). Information technology and emergency medical care during disasters. *Academic Emergency Medicine*, 11(11), p. 1229-1236.

Chandler, B., & Gamboa, G. (2005). *Written testimony: Hurricane Katrina response and immigrants*. Retrieved June 27, 2007, from http://www.oxfamamerica.org/newsandpublications/publications/research_reports/research_paper.2005-12-06.4237647120/OA_MIRA_testimony_12.6.05.doc.

Chau, K. L. (1990). A model for teaching cross-cultural practice in social work. *Journal of Social Work Education*, 26(2), p. 124-33.

Chen, H., Chung, H., Chen, T., Fang, L., & Chen, J. (2003). The emotional distress in a community after the terrorist attack on the World Trade Center. *Community Mental Health Journal*, 39(2), p. 157-165.

Chin, J. L. (2007). Assessment of cultural competence in mental health systems of care for Asian Americans. In K. Kurasaki, S. Okazaki, & S. Sue (Eds.), *Asian American mental health: Assessment methods and theories* (p. 1-15). New York, NY: Kluwer Academic Publishers. Retrieved July 7, 2007, from http://www.culturalcompetence2.com/articles/Kurasaki_Chpt_20-J_Chin1.doc.

Chow J., Jaffee, K., & Choi, D. (1999). Use of public mental health services by Russian refugees. *Psychiatric Services*, 50, p. 936-940.

Clawson, J. J. (1989). Position paper: Emergency medical dispatching. *Prehospital and Disaster Medicine*, 4(2). Retrieved July 29, 2007, from <http://www.emergencydispatch.org/articles/positionpaper1.htm>.

CMHS (Center for Mental Health Services). (2001). *An overview of the crisis Counseling assistance and training programs*. Rockville, MD: Department of Health and Human Services. Retrieved June 14, 2007, from http://mentalhealth.samhsa.gov/cmhs/EmergencyServices/ccp_pg01.asp.

CMHS. (2001a). *Mental health: Culture, race, and ethnicity – A supplement to mental health: A report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. Retrieved May 28, 2007, from <http://www.ce4alliance.com/articles/100174/CultureRaceEthnicity100174.pdf>.

CNN.com. (2000). *At least 160 bodies recovered from avalanche of garbage dump in Philippines*. Retrieved June 25, 2007, from <http://www.cnn.com/2000/ASIANOW/southeast/07/15/philippines.landslide.01/>.

Cohen, R. E. (1992). Training mental health professionals to work with families in diverse cultural contexts. In L. S. Austin (Ed.), *Responding to Disaster: A Guide for Mental Health Professionals*, (p. 69-80). Washington, DC – London: American Psychiatric Press.

Cokley, K., Cooke, B. G., & Nobles, W. (2005). *Guidelines for providing culturally appropriate services for people of African ancestry exposed to the trauma of Hurricane Katrina*. Washington, DC: Association of Black Psychologists. Retrieved July 8, 2007, from http://www.abpsi.org/special/abpsi_article1.pdf.

Collins, S., & Arthur, N. (2007). A framework for enhancing multicultural counseling competence. *Canadian Journal of Counselling*, 41(1), p. 31-49.

Colvin-Burque, A., Zugazage, C. B., & Davis-Maye, D. (2007). Can cultural competence be taught? Evaluating the impact of the SOAP model. *Journal of Social Work Education*, 43(2).

Combs, D. C. (2007). Mental health interventions by telephone with Katrina survivors. *Journal of Health Care for the Poor and Underserved*, 18(2), p. 271-276.

Compton, M., Cibulas, B., Gard, B., Kaslow, N., Kotwicki, R., Reissman, D., Schor, L., & Wetterhall, S. (2005). Incorporating community mental health response planning into

local bioterrorism response planning: Experiences from the DeKalb county board of health. *Community Mental Health Journal*, 41(6), p. 647-63.

Congress, E. (1994). The use of culturagrams to assess and empower culturally diverse families. *Families in Society*, 75, p. 531-540.

Congress, E. (2004). Cultural and ethical issues in working with culturally diverse patients and their families: The use of the *culturagram* to promote cultural competent practice in health care settings. *Social Work in Health Care*, 39(3/4), p. 249-262.

Congress, E., & Lyons, B. (1992). Ethnic differences in health beliefs: Implications for social workers in health care settings. *Social Work in Health Care*, 17(3), p. 81-96.

Connable, B., & Speyer, A. (n.d.). *Cultural awareness for military operations*. Concepts and proposals: USMC cultural awareness working group. Retrieved June 1, 2007, from [#299, 1, Slide 1](http://www.tecom.usmc.mil/caocl/Operational_Culture/National_Security_Community_Dialog_on_Culture/CulturalAwarenessWorkingGroupBriefDRAFT.ppt)

Cordasco, K. M., Eisenman, D. P., Glik, D. C., Golden, J. F., & Asch, S. M. (2007). "They blew the levee:" Distrust of authorities among Hurricane Katrina evacuees. *Journal of Health Care for the Poor and Underserved*, 18(2), p. 277-282.

Cook, L. (2001). The World Trade Center attack. The paramedic response: An insider's view. *Critical Care*, 5, p. 301-303. Retrieved June 26, 2007, from <http://ccforum.com/content/pdf/cc1054.pdf>

Cooper, F., & Laughy, L. (1994). *Managing hazards in a changing multinational world*. Unpublished Paper.

Council of National Psychological Associations for the Advancement of Ethnic Minority Interests. (2003). *Psychological Treatment of Ethnic Minority Populations*. Washington, DC: Association of Black Psychologists. Retrieved May 20, 2007, from http://www.apa.org/pi/oema/programs/empa_ptemp.pdf

Cox, T. H., Jr. (1993). *Cultural diversity in organizations*. San Francisco, CA: Berrett-Koehler.

CPHP (Centers for Public Health Preparedness). (2005). *Mental Health and Psychosocial Preparedness Education: A Compilation from the Centers for Public Health Preparedness. Report*. Retrieved April 20, 2007, from <http://www.asph.org/cphp/documents/MentalHealth.pdf>.

CPHP. (n.d.) *Resource Center*. Retrieved May 9, 2007, from: http://www.asph.org/cphp/CPHP_ResourceCenter.cfm

CPHP Ohio (Center for Public Health Preparedness, Ohio State University). (n.d.) *Preparedness and Response: Understanding the Needs of Special Populations*. Retrieved June 11, 2007, from <http://www.comm.ohio-state.edu/pdavid/preparedness/>.

Cross, T. L., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care. Vol. I: A monograph of effective services for children who are severely emotionally disturbed*. Washington, DC: Georgetown University Child Development Center.

Cutter, S. L. (2006). The geography of social vulnerability: Race, class, and catastrophe. In *Understanding Katrina: Perspectives from the social sciences*. New York, NY: Social Science Research Council. Retrieved June 30, 2007, from <http://understandingkatrina.ssrc.org/Cutter/>.

Cutter, S. L., Emrich, C. T., Mitchell, J. T., Boruff, B. J., Gall, M., Schmidlein, M. C., et al. (2006). Long road home: Race, class, and recovery from Hurricane Katrina. *Environment*, 48(2), p. 10-20.

Cwiak, K., Cline, K., & Karlgaard, T. (2004). *Emergency management attitudes: What can we learn from a comparative analysis of IAEM respondents and rural emergency managers?* FEMA Emergency Management Institute. Retrieved July 29, 2007, from <http://www.training.fema.gov/EMIWeb/edu/surveys.asp>.

Darlington, J. D. (2000). *The profession of emergency management: Educational opportunities and gaps*. Retrieved June 11, 2007, from http://training.fema.gov/EMIWeb/edu/prof_em.pdf.

Davidson, M. (2000). The state of the Commissioned Corps. *Commissioned Corps Bulletin*, XV(8). U.S. Department of Health and Human Services. Retrieved July 29, 2007, from <http://dcp.psc.gov/ccbulletin/MAY00CCB.PDF>.

Dees, L. (2006). *Brady Spanish reference for EMS providers*. Upper Saddle River, NJ: Pearson, Prentice Hall.

De Girolamo, G., & McFarlane, A. C. (1996). In A. J. Marsella, M. J. Friedman, E. T. Gerrity, & R. M. Scurfield (Eds.), *Ethnocultural aspects of Posttraumatic Stress Disorder: Issues, research, and clinical applications*, (p. 33-85). Washington, DC: American Psychological Association.

De La Cancela, V., Chin, J. L., & Jenkins, Y. M. (1998). *Community health psychology: Empowerment for diverse communities*. New York, NY: Routledge.

Democracy Now. (2005). *Indian tribes and Hurricane Katrina: Overlooked by the federal government, relief organizations and the corporate media*. Retrieved June 27, 2007, from <http://www.democracynow.org/article.pl?sid=05/10/10/1335220>.

Denboba, D., Bragdon, J., Epstein, L., Garthright, K., & Goldman, T. (1998). Reducing health disparities through cultural competence. *Journal of Health Education*, 29 (5 Suppl.), p. 47-53.

Department of the Army. (1990). *Field manual 25-101: Battle-focused training*. Washington, DC: Department of the Army.

DeRicco, J. N., & Sciarra, D. (2005). The immersion experience in multicultural counselor training: Confronting covert racism. *Journal of Multicultural Counseling and Development*, 33(1), p. 2-16.

DeVries, M. (1996). Trauma in cultural perspective. In B. Van der Kolk, A.D. McFarlane, & L. Weisaeth (Eds.), *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society*. New York, NY: Guilford Press.

Devore, W., & Schlesinger, E. G. (1998). *Ethnic-sensitive social work practice* (5th ed.). Boston, MA: Allyn & Bacon.

DeWolfe, D. (2000). *Training manual for mental health and human service workers in major disasters*. (2nd ed.) (Pub. No. ADM 90-538). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services. Retrieved June 14, 2007, from <http://mentalhealth.samhsa.gov/publications/allpubs/ADM90-538/Default.asp>.

DHHS (U.S. Department of Health and Human Services) (n.d.). *About the Commissioned Corps: Emergency response*. Retrieved from <http://www.usphs.gov/AboutUs/emergencyResponse.aspx>.

DHHS. (2000). *Oral health in America: A report of the Surgeon General*. Rockville, MD: Department of Health and Human Services.

DHHS. (2001a). Basic Officer Training Course—5-day version. *Commissioned Corps Bulletin*, XIV(5). Retrieved July 29, 2007, from http://dcp.psc.gov/ccbulletin/PDF_docs/Aug01ccb.pdf.

DHHS. (2005). *HHS Awards Grants to Support Minority Health*. DHHS Press-Release, September 30. Retrieved July 23, 2007, from <http://www.hhs.gov/news/press/2005pres/20050930a.html>

DHHS. (2006b). American Indian/Alaska Native commissioned officer advisory committee listserv. *Commissioned Corps Bulletin*, II(3). Retrieved July 29, 2007, from http://dcp.psc.gov/ccbulletin/articles/CCBulletin_022706.htm.

DHHS. (2007a). *America's health responders: U.S. Public Health Service Commissioned Corps*. Retrieved July 12, 2007, from <http://commcorps.shs.net/profession/>

DHHS. (2007b). *The Commissioned Corps' response to Hurricanes Katrina and Rita*. Rockville, MD: Department of Health and Human Services, Office of Inspector General. Retrieved June 22, 2007, from <http://oig.hhs.gov/oei/reports/oei-09-06-00030.pdf>.

DHHS. (2007c). *National Disaster Medical System (NDMS)*. Retrieved October 16, 2007 from <http://www.hhs.gov/aspr/opeo/ndms/index.html>.

DHHS. (2007d). *What is a disaster medical assistance team (DMAT)?* Retrieved October 16, 2007 from <http://www.hhs.gov/aspr/opeo/ndms/teams/dmat.html>

Department of Homeland Security (DHS). (2002). *Citizen Corps: A guide for local officials*. Washington, DC: Federal Emergency Management Agency, Department of Homeland Security. Retrieved from <http://www.citizencorps.gov/pdf/council.pdf>

DHS. (2004a). *National Response Plan*. Washington, DC: Department of Homeland Security. Retrieved June 12, 2007, from http://www.dhs.gov/xlibrary/assets/NRP_FullText.pdf

DHS. (2004b). *Citizen Corps tri-fold brochure*. Retrieved from <http://www.citizencorps.gov/pdf/brochure/CitizenCorpsTrifold.pdf>

DHS. (2006). *Quick reference guide for the National Response Plan*. Washington, DC: Department of Homeland Security.

DHS. (2006). *Hurricane Katrina: What government is doing*. Retrieved July 19, 2007, from http://www.dhs.gov/xprepresp/programs/gc_1157649340100.shtm.

DHS. (2007). *FirstResponderTraining.gov*. Department of Homeland Security, Office of State and Local Government Coordination & Preparedness. Retrieved June 14, 2007, from <https://www.firstrespondertraining.gov/home.do>

DHS-HSNPTF (Homeland Security National Preparedness Task Force). (2006). *Civil defense and homeland security: A short history of national preparedness efforts*. Washington, DC: Department of Homeland Security. Retrieved June 10, 2007, from <http://training.fema.gov/EMIWeb/edu/docs/DHS%20Civil%20Defense-HS%20-%20Short%20History.pdf>

Dillard, D. A., & Manson, S. M. (2000). Assessing and Treating American Indians and Alaska Natives. In I. Cuéllar, & F. A. Paniagua (Eds.), *Handbook of Multicultural Mental Health: Assessment and Treatment of Diverse Populations* (p. 225-248), San Diego: Academic Press.

Doherty, G. W. (1999). Cross-cultural counseling in disaster settings. *The Australasian Journal of Disaster and Trauma Studies*, 2, p. 1–20. Retrieved June 4, 2007, from <http://www.massey.ac.nz/~trauma/issues/1999-2/doherty.htm>.

DOD (Department of Defense). (2005a). *Defense support of civil authorities*. Fort Leavenworth, KS: U.S. Army Training and Doctrine Command. Retrieved June 12, 2007, from <http://www.au.af.mil/au/awc/awcgate/army/guidterr/sup4.pdf>.

DOD (Department of Defense). (2005b). *How the Army runs. A senior leader reference handbook* (25th ed.). Carlisle, PA: United States Army War College. Retrieved June 12, 2007, from <http://www.globalsecurity.org/military/library/report/2005/htar.htm>

DOD. (2004). *U.S. military support to Tsunami relief efforts*. DefenseLink, No. 1325-04 December 28, 2004. Retrieved June 25, 2007, from <http://www.defenselink.mil/releases/release.aspx?releaseid=8090>.

DOJ (U.S. Department of Justice). (2002). *Guidance to federal financial assistance recipients regarding Title VI prohibition against national origin discrimination affecting limited English proficient persons*. Retrieved July 23, 2007, from <http://www.hhs.gov/ocr/lep/revisedlep.html>.

DOL (U.S. Department of Labor). (2004). *Occupational employment and wages: 29-1066 psychiatrists*. Washington, DC: Bureau of Labor Statistics. Retrieved July 29, 2007, from <http://www.bls.gov/oes/2004/may/oes291066.htm>.

DOL. (2006). *Occupational outlook handbook: Emergency Medical Technicians and Paramedics*. Washington, DC: Bureau of Labor Statistics. Retrieved July 29, 2007, from <http://www.bls.gov/oco/ocos101.htm>.

DOL. (2007a). *Occupational employment and wages: 13-1061 Emergency management specialists*. Washington, DC: Bureau of Labor Statistics. Retrieved July 29, 2007, from <http://www.bls.gov/oes/current/oes131061.htm>.

DOL. (2007b). *Occupational outlook handbook: psychologists*. Washington, DC: Bureau of Labor Statistics. Retrieved July 29, 2007, from <http://www.bls.gov/oco/ocos056.htm>.

DOL. (2007c). *Occupational outlook handbook: Social workers*. Washington, DC: Bureau of Labor Statistics. Retrieved July 31, 2007, from <http://www.bls.gov/oco/ocos060.htm>.

DOT (Department of Transportation). (2001). *DOT guidance to recipients on special language services to limited English proficient (LEP) beneficiaries*. Washington, DC: Department of Transportation. Retrieved April 30, 2007, from <http://www.usdoj.gov/crt/cor/lep/dotlep.htm>.

DPO (Disaster Psychiatry Outreach) (n.d.). *Education and training*. Retrieved June 14, 2007, from <http://www.disasterpsych.org/Default.aspx?PageID=6>.

DLIFLC (Defense Language Institute Foreign Language Center). (n.d.). *The global language network*. Retrieved June 8, 2007, from <http://www.lingnet.org/>.

Drabek, T. (2007, April). *Emergency management and homeland security curricula: Contexts, cultures, and constraints*. Paper presentation at the Western Social Science Association annual meeting. Calgary, Alberta, Canada. Retrieved June 11, 2007, from <http://training.fema.gov/EMIWeb/edu/docs/Drabek%20-%20EM%20and%20HS%20Curricula-Contexts,%20Cultures,%20and%20Constra.doc>

Draguns, J. G. (1996). Ethnocultural considerations in the treatment of PTSD: Therapy and service delivery. In A. J. Marsella, M. J. Friedman, E. T. Gerrity, & R. M. Scurfield (Eds.), *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications* (p.459-482). Washington, DC: American Psychological Association.

Eggler, B. (2005). RTA back on track slowly, surely. *The Times-Picayune*, October 2005, p. B1.

Ehrenreich, J. (2001). *Coping with disasters. A guidebook to psychological intervention*. New York, NY: Mental Health Workers Without Borders. Retrieved April 20, 2007, from <http://www.mhwwb.org/CopingWithDisaster.pdf>.

Ellis, D. (2005). *Integrating language and culture*. Fort Leavenworth, KS: Army Command and General Staff College, School of Advanced Military Studies. Retrieved June 8, 2007, from <http://handle.dtic.mil/100.2/ADA437562>.

EMAP (Emergency Management Accreditation Program). (2004). *EMAP standard 2004*. Lexington, KY: Emergency Management Accreditation Program.

EMI (Emergency Management Institute). (2007). *EMI Independent Study Distance Learning Site*. Emmitsburg, MD: Emergency Management Institute, Federal Emergency Management Agency, Department of Homeland Security. Retrieved May 9, 2007, from <http://emilms.fema.gov/>.

Enarson, E., & Morrow, B. H. (1997). A gendered perspective: The voices of women. In W.G. Peacock, B.H. Morrow, & H. Gladwin (Eds.) *Hurricane Andrew: Ethnicity, gender, and the sociology of disasters*. New York, NY: Routledge.

Evans, K., & Foster, V. (2000). Relationships among multicultural training, moral development, and racial identity development of white counseling students. *Counseling and Values*, 45(1), p. 39-48.

Everly, G. (2006). *Disaster mental health intervention*. [Distance Learning Module]. John Hopkins Center for Public Health Preparedness. Retrieved May 4, 2007, from http://www.jhsph.edu/preparedness/training/online/mentalhealth_trainings.

Everly, G. (n.d.) *Disaster mental health planning*. [Distance Learning Module]. Johns Hopkins Center for Public Health Preparedness. Retrieved May 25, 2007, from http://www.jhsph.edu/preparedness/training/online/mtl_hlth_planning.html.

- Ewalt, P., Freeman, E. M., Fortune, A. E., Poole, D. L., & Witkin, S. L. (Eds.). (1996). *Multicultural issues in social work*. Washington, DC: National Association of Social Work Press.
- Faubert, M., & Locke, D. C. (1996). Applying a cognitive-behavioral approach to the training of culturally competent mental health counselors. *Journal of Mental Health Counseling*, 18, p. 200-215.
- Faupel, C. E., Kelley, S. P., & Petee, T. (1992). The impact of disaster education on household preparedness for Hurricane Hugo. *International Journal of Mass Emergencies and Disasters*, 10(1): 5-24.
- Federal Emergency Management Agency (FEMA) (n.d.). *NIMS Training*. Washington, DC: National Incident Management System, Federal Emergency Management Agency, Department of Homeland Security. Retrieved May 10, 2007, from http://www.fema.gov/emergency/nims/nims_training.shtm#1
- FEMA (2003). *FEMA emergency management higher education project*. Emmitsburg, MD: Emergency Management Institute, Federal Emergency Management Agency, Department of Homeland Security. Retrieved June 11, 2007, from <http://training.fema.gov/EMIWeb/downloads/completebroch.ppt>.
- FEMA. (2005). *Resource management and mutual aid*. Washington, DC: Federal Emergency Management Agency, Department of Homeland Security.
- Felton, C. (2002). Project Liberty: A public health response to New Yorkers' mental health needs arising from the World Trade Center terrorist attacks. *Journal of Urban Health*, 79, p. 429-433.
- Fischer, H. (2003). Distance learning via the internet: The tale of two programs. The pedagogy of current internet-based distance learning in emergency management. *Contemporary Disaster Review*, 1(2), p. 46-52.
- Flaskerud, J. H. (2000). Ethnicity, culture, and neuropsychiatry. *Issues in Mental Health Nursing*, 21(1), p. 5-29.
- Flaskerud J. H., & Liu, P. Y. (1991). Effects of an Asian client-therapist language, ethnicity, and gender match on client outcomes. *Community Mental Health Journal*, 17, p. 31-42.
- Flores, M. T., & Carey, G. (2000). *Family therapy with Hispanics: Toward appreciating diversity*. Needham Heights, MA: Allyn & Bacon.
- Flower, S. (2007). Personal communication via response to the Office of Minority Health expert survey.

- Fothergill, A., Maestas, E., & Darlington, J. (1999). Race, ethnicity and disasters in the United States: A review of literature. *Disasters*, 23(2), p. 156-173.
- Fowler, R. D. (2002). Running commentary: APA's directory tells us who we are. *Monitor on Psychology*, 33(2). Retrieved July 29, 2007, from <http://www.apa.org/monitor/feb02/rc.html>.
- Fox, L. (1999). Reflections on culture. *Dialog in Language Instruction*, 13 (1&2), 89-98.
- Fradd, S. H., & Wilen, D. K. (1990). Using interpreters and translators to meet the needs of handicapped language minority students and their families. *NCBE Program Information Guide Series*, Number 4. Retrieved July 14, 2007, from <http://www.ncela.gwu.edu/pubs/pigs/pig4.htm>
- Freeman, C. (2002). *Many Voices, One Direction: Building a Common Agenda for Cultural Competence in Mental Health - A Report to the Community*. Proceedings from the California Mental Health Directors Association Conference. Sacramento, CA. Retrieved July 11, 2007, from <http://www.cimh.org/downloads/SBProceed.pdf>.
- Friedman, M. J., Ritchie, E. C., & Watson, P. (2006). *Overview*. In E.C. Ritchie, P. Watson, & M. Friedman (Eds.), *Interventions Following Mass Violence and Disasters: Strategies for Mental Health Practice* (p.3-15). New York – London: The Guilford Press.
- Frier, E. B., & Ramsey, M. (2005). Ethical challenges in the teaching of multicultural course work. *Journal of Multicultural Counseling and Development*, 33(2), p. 94-107,
- Fritz, C. E. (1961). Disasters. In R. Merton, & R. Nisbet (Eds.), *Contemporary Social Problems*. New York: Harcourt, Brace and World.
- Futty, J. (2007). County's 911 Lines to Offer Quick Access to Translators. *The Columbus Dispatch*, May 21. Retrieved May 24, 2007, from <http://www.php.dispatch.com/news-story.php?story=dispatch/2007/05/21/20070521-A1-03.html>
- GAINS Center. (2006). *After the crisis: Healing from trauma after disasters*. Discussion Paper Presented at the After the Crisis: Healing from Trauma after Disasters Expert Panel Meeting. Retrieved April 20, 2007, from http://www.gainscenter.samhsa.gov/atc/pdfs/atc_concept_paper.pdf.
- Galea, S., Ahern, J., Resnick, H., Kilpatrick, D., Bucuvalas, M., Gold, J., et al. (2002). Psychological sequelae of the September 11 terrorist attacks in New York City. *New England Journal of Medicine*, 13, p. 982-987.
- GAO (General Accounting Office). (2003). *Hospital emergency departments: Crowded conditions vary among hospitals and communities*. Washington, DC: General Accounting Office. Retrieved June 26, 2007, from <http://www.gao.gov/new.items/d03460.pdf>.

GAO. (2007). *Military personnel: Strategic plan needed to address Army's emerging officer accession and retention challenges. Report to the Committee on Armed Services, House of Representatives*. Washington, DC: General Accounting Office. Retrieved July 29, 2007, from <http://www.gao.gov/new.items/d07224.pdf>.

Gard, B., & Ruzek, J. I. (2006). Community mental health response to crisis. *Journal of Clinical Psychology: In Session*, 62(8), p. 1029-1041.

Geiger, H. J. (2003). Racial and ethnic disparities in diagnosis and treatment: A Review of the evidence and a consideration of causes. In B. Smedley, A. Stith, & A. Nelson (Eds.). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (p. 417-454). Washington, DC: The National Academies Press.

Gheytanchi, A., Joseph, L., Gierlach, E., Kimpara, S., Housley, J., Zeno, F., & Beutler, L. (2007). The dirty dozen: Twelve failures of the Hurricane Katrina response and how psychology can help. *American Psychologist*, 62(2), p. 118-130.

Ghosh, T. S., Patnaik, J. L., & Voigt, R. L. (2007). Rapid needs assessment among Hurricane Katrina evacuees in metro-Denver. *Journal of Health Care for the Poor and Underserved*, 18(2), p. 362-368.

Gibson, L., Hamblem, J. L., Zvolensky, M. J., & Vujanovic, A. A. (2006). Evidence-based treatments for traumatic stress: An overview of the research with an emphasis on disaster settings. In F. Norris, S. Galea, M. Friedman, & P. Watson (Eds.), *Methods for disaster mental health research* (p. 208-225). New York – London: The Guilford Press.

Gillespie, C. (1978). *EMT code of ethics*. Clinton, MS: National Association of Emergency Medical Technicians. Retrieved August 1, 2007, from <http://www.naemt.org/aboutNAEMT/EMTCodeOfEthics.htm>.

Gladwin, H., & Peacock, W. G. (1997). Warning and evacuation: A night for hard houses. In W.G. Peacock, B.H. Morrow, & H. Gladwin (Eds.), *Hurricane Andrew: Ethnicity, gender, and the sociology of disasters*. New York, NY: Routledge.

Goldberg, M. (2000). Conflicting principles in multicultural social work. *Families in Society*, 81(1), p. 12-33.

Gordon, M. (1964). *Assimilation in American life: Race, religion, and national origins*. New York, NY: Oxford University Press.

Green, B. L. (1996). Cross-national and ethnocultural issues in disaster research. In A. J. Marsella, M. J. Friedman, E. T. Gerrity, & R. M. Scurfield (Eds.), *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications* (p. 341-361). Washington, DC: American Psychological Association.

- Green, B. L., & Soloman, S. D. (1995). The mental health impact of natural and technological disasters. In J. R. Freedy, & S.E. Hobfoll (Eds.), *Traumatic stress: From theory to practice*. New York, NY: Plenum.
- Green, J. W. (1995). *Cultural awareness in the human services: A multi-ethnic approach* (2nd ed.). Boston, MA: Allyn & Bacon.
- Green, W. (2004). *Teaching emergency management with blackboard: A personal case study*. Retrieved June 14, 2007, from <http://www.training.fema.gov/emiweb/edu/wgreen.pdf>.
- Grieger, T. A., Kolkow, T. T., Spira, J. L., & Morse, J. S. (2007). Post-traumatic stress disorder and depression in health care providers returning from deployment to Iraq and Afghanistan. *Military Medicine*, 172(5), p. 451-455.
- Griswold, K, Zayas, L. E., Kernan, J. B., & Wagner, C. M. (2006). Cultural awareness through medical student and refugee patient encounters. *Journal of Immigrant Health*, 9, p. 55-60.
- Gusman, F. D., Stewart, J., Young, B. H., Riney, S. J., Abueg, F. R., & Blake, D. D. (1996). A multicultural developmental approach for treating trauma. In A. J. Marsella, M. J. Friedman, E. T. Gerrity, & R. M. Scurfield (Eds.), *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications* (p. 439-457). Washington, DC: American Psychological Association.
- Gutiérrez, L. M., & Lewis, E. A. (1999). *Empowering women of color*. New York, NY: Columbia University Press.
- Hajjar, R. (2006). The Army's new TRADOC culture center. *Military Review*, November-December 2006. Retrieved June 5, 2007, from http://findarticles.com/p/articles/mi_m0PBZ/is_6_86/ai_n17093423.
- Hall, E. T. (1981). *Beyond culture*. New York, NY: Anchor Books.
- Hartsough, D. M., & Myers, D. G. (1985). *Disaster work and mental health: Prevention and control of stress among workers*. Rockville, MD: National Institute of Mental Health.
- Hill, L. (2007, July 23). Personal communication via telephone interview.
- Hite, M. (2003). *The emergency manager of the future: Summary of a workshop, June 13, 2003*. Washington, DC: The National Academies Press. Retrieved June 12, 2007, from <http://training.fema.gov/EMIWeb/downloads/HiteMoniquesummary%20.pdf>
- Ho, M. K., Rasheed, J. M., & Rasheed, M. N. (2003). *Family therapy with ethnic minorities* (2nd ed.). Thousand Oaks, CA: Sage.

- Hough, R. L., Canin, G. J., Abueg, F. R., & Gusman, F. D. (1996). PTSD and related stress disorders among Hispanics. In A. J. Marsella, M. J. Friedman, E. T. Gerrity, & R. M. Scurfield (Eds.), *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications* (p. 301-338). Washington, DC: American Psychological Association.
- Holcomb-McCoy, C. (2005). Investigating school counselors' perceived multicultural competence. *Professional School Counseling*, 8(5), p. 414-423.
- Holcomb-McCoy, C. & Myers, J. (1999). Multicultural competence and counselor training: A national survey. *Journal of Counseling & Development*, 77(3), p. 294-302.
- Hong, G. K., Garcia, M., & Soriano, M. (2000). Responding to the challenge: Preparing mental health professionals for the new millenium. In I. Cuéllar, & F.A. Paniagua (Eds.), *Handbook of multicultural mental health: Assessment and treatment of diverse populations*. San Diego: Academic Press, p. 455-476.
- Hong, G. K., & Ham, M. D. C. (2000). *Psychotherapy and counseling with Asian American clients*. Thousand Oaks, CA: Sage.
- Housley, J., Liu, W, Charvat, M., & Beutler, L. (2006). Navigating the maze of disaster mental health: The journey of the Palo Alto Medical Reserve Corps. *Journal of Homeland Security and Emergency Management*, 3(3), Article 4. Retrieved July 24, 2007, from http://www.bepress.com/cgi/viewcontent.cgi?context=jhsem&article=1201&date=&mt=MTE3NTYxNDA2Mg==&access_ok_form=Continue.
- Hunter, H. (2007). Personal communication via response to the Office of Minority Health expert survey.
- IAEM (International Association of Emergency Managers). (2006). *Certified emergency manager FAQ*. Retrieved July 26, 2007, from <http://www.iaem.com/certification/generalinfo/cem.htm>.
- IOM (Institute of Medicine of the National Academies) (2007). *Future of emergency care: Emergency Medical Services at the crossroads*. Washington, DC: The National Academies Press.
- IOM (2003). *Preparing for the psychological consequences of terrorism: A public health strategy*.
- Iwamasa, G. Y., & Pai, S. M. (2003). Anxiety disorders among ethnic minority groups. In G. Bernal, J. Trimble, A. K. Burlew, & F. T. L. Leong (Eds.), *Handbook of racial and ethnic minority psychology* (p. 429-447). Thousand Oaks, CA: Sage Publications.

- Jakobsons, L., & Buckner, J. (2007). The assessment, diagnosis, and treatment of psychiatric disorders in Hispanic/Latino clients. In J. Buckner, Y. Castro, J. M. Holm-Denoma, & T. E. Joiner (Eds.), *Mental health care for people of diverse backgrounds* (p. 9-24). Oxford: Radcliffe Publishing.
- James, S. A., Hartnett, S. A., & Kalsbeek, W. D. (1983). John Henryism and blood pressure differences among black men. *Journal of Behavioral Medicine*, 6(3), p. 259-278.
- Jenkins, R. C. (n.d.) *Cross cultural issues: African-Americans and treatment impact for PTSD*. [Distance Learning Module]. National Center for PTSD. Retrieved July 12, 2007, from http://www.ncptsd.va.gov/ptsd101/modules/jenkins_cultural.html.
- Johnston, J. (2006). View from the trenches. *NAEMT News*, Winter 2006, p. 1, 3. Retrieved August 1, 2007, from <http://www.naemt.org/NR/rdonlyres/A84597F3-5EB4-4B98-81D9-0366EA3687B6/0/NAEMTNewsWinter06.pdf>
- Johnstone, M. (2007). Disaster response and group self-care. *Perspectives in Psychiatric Care*, 43(1), p. 38-40.
- Jones, Â-M. (2005). *Empowered partnerships: Supporting special needs preparedness*. [Distance Learning Course]. Berkeley, CA: Center for Infectious Disease Preparedness, UC Berkeley School of Public Health. Retrieved May 9, 2007, from <http://www.idready.org/webcast/archive.php?id=2>.
- Jones, R. T., Hadder, J., Carvajal, F., Chapman, S., & Alexander, A. (2006). Conducting research in diverse, minority, and marginalized communities. In F. Norris, S. Galea, M. Friedman, & P. Watson (Eds.), *Methods for disaster mental health research* (p. 265-277). New York – London: The Guilford Press.
- Joskow, R. (2007). Personal communication in response to request for feedback on the Environmental Scan.
- Katayama, T. (1992). *Aftermath of the Loma Prieta earthquake: How radio responded to the disaster*. INCEDE Report No. 2.
- Katz, B., Fellowes, M., & Holmes, N. (2005). The state of New Orleans. *The New York Times*, December 7, 2005.
- Kaul, R. (2002). A social worker's account of 31 days responding to the Pentagon disaster: Crisis intervention training and self-care practices. *Brief Treatment and Crisis Intervention*, 2(1), p. 33-37.
- Keane, T. M., Kaloupek, D. G., & Weathers, F. W. (1996). Ethnocultural considerations in the assessment of PTSD. In A. J. Marsella, M. J. Friedman, E. T. Gerrity, & R. M. Scurfield (Eds.), *Ethnocultural aspects of posttraumatic stress disorder: Issues, research,*

and clinical applications (p. 183-205). Washington, DC: American Psychological Association.

Kelly, N. (2007). Personal communication via response to the Office of Minority Health expert survey.

Kelly, N., Willett, K., & Bancroft, M. (2006). Bridging the cultural divide: Cultural competence in public safety. *Emergency Number Professional Magazine*, May 2006, p. 64-70.

Kim, B. S., & Lyons, H. Z. (2003). Experiential activities and multicultural counseling competence training. *Journal of Counseling and Development*, 81, p. 400-408.

King, R., Koopman, C., & Millis, D. (1999). Training on ethnic and gender issues in psychiatry residency programs. *Academic Psychiatry*, 23, p. 20-29. Retrieved July 29, 2007, from <http://www.ap.psychiatryonline.org/cgi/content/full/23/1/20>.

Kinston, W., & Rosser, R. (1974). Disaster: Effects on mental and physical state. *Journal of Psychosomatic Research*, 18, p. 437-456.

Kinzie, D. J. (2001). Cross-cultural treatment of PTSD. In J. P. Wilson, M. J. Friedman, & J. Lindy (Eds.), *Treating psychological trauma and PTSD* (p. 255-277). New York – London: The Guilford Press.

Kirkpatrick, D. V., & Bryan, M. (2007). Hurricane emergency planning by home health providers serving the poor. *Journal of Health Care for the Poor and Underserved*, 18(2), p. 299-314.

Kirmayer, L. J. (1996). Confusion of the senses: Implications of ethnocultural variations in somatoform and dissociative disorders for PTSD. In Marsella, A. J., Friedman, M, Gerrity, & Scurfield, R. (Eds.), *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications* (p. 131-163). Washington, DC: American Psychological Association.

Kramer, R. M. (1999). Trust and distrust in organizations: Emerging perspectives, enduring questions. *Annual Review of Psychology*, 50, p. 569-598.

Krasner, I. (1999). The role of culture in language teaching. *Dialog in Language Instruction*, 13 (1&2), p. 79-88.

Krol, D. M., Redlener, M., Shapiro, A., & Wajnberg, A. (2007). A mobile medical care approach targeting underserved populations in post-Hurricane Katrina Mississippi. *Journal of Health Care for the Poor and Underserved*, 18(2), p. 331-340.

Lakoff, A. (2006). *From disaster to catastrophe: The limits of preparedness*. In *Understanding Katrina: Perspectives from the social sciences*. New York, NY: Social

Science Research Council. Retrieved June 30, 2007, from <http://understandingkatrina.ssrc.org/Lakoff/>.

Landau, J. & Saul, J. (2004). Family and community resilience in response to major disaster. In Walsh, F. & McGoldrick (Eds.). *Living beyond loss: Death in the family*. (2nd ed.) (p. 285-309). New York: Norton.

Larsen, L. (2004). U.S. Census Bureau current population reports, Series P20-551. *The foreign-born population in the United States: 2003*. Washington, DC: U.S. Government Printing Office. Retrieved July 31, 2007, from <http://www.census.gov/prod/2004pubs/p20-551.pdf>

Latham, G. (2000). *Cultural awareness and cross cultural communication: Combat multipliers for leaders in the next millennium*. Fort Leavenworth, KS: Army Command and General Staff College, School of Advanced Military Studies. Retrieved June 8, 2007, from <http://handle.dtic.mil/100.2/ADA389824>.

Lave, J., & Wenger, E. (1991). *Situated learning: Legitimate peripheral participation*. Cambridge: University of Cambridge Press.

Lawson, W. B. (2003). Mental health issues for African Americans. In G. Bernal, J. Trimble, A. K. Burlew, & F. T. L. Leong (Eds.), *Handbook of racial and ethnic minority psychology* (p. 561-570). Thousand Oaks, CA: Sage Publications.

Lewis, B. (2006). *Developing soldier cultural competency*. Carlisle Barracks, PA: Army War College. Retrieved June 8, 2007, from <http://handle.dtic.mil/100.2/ADA449393>.

Lewis-Fernandez, R., & Kleinman, A. (1995). Cultural psychiatry, theoretical, clinical, and research issues. *Psychiatric Clinics of North America*, 18, p. 433-448.

Lin, K. M., & Cheung, F. (1999). Mental health issues for Asian Americans. *Psychiatric Services*, 50, p. 774-780.

Lindell, M. K., & Perry, R. W. (2004). *Communicating environmental risk in multiethnic communities*. Thousand Oaks, CA: Sage Publications.

Locke, D., & Kiselica, M. (1999). Pedagogy of possibilities: Teaching about racism in multicultural counseling courses. *Journal of Counseling & Development*, 77(1), p. 80-86.

LocumTenens.com (2006). *The salary survey*. Retrieved July 29, 2007, from <http://www.locumtenens.com/psychiatry-careers/2006-LT-Psychiatrist-Salary-Survey.aspx>

Loo, C. M. (2007). *PTSD among ethnic minority veterans*. National Center for PTSD, U.S. Department of Veterans Affairs. Retrieved July 10, 2007, from

http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_ethnic_vet.html?opm=1&rr=rr42&srt=d&echorr=true.

Lum, D. (1996). *Social work practice and people of color: A process-stage approach*. Pacific Grove, CA: Brooks Cole.

Mack, D., Brantley, K. M., & Bell, K. G. (2007). Mitigating the health effects of disasters for medically underserved populations: Electronic health records, telemedicine, research, screening, and surveillance. *Journal of Health Care for the Poor and Underserved*, 18(2), p. 432-442.

Mahoney, J., Carlson, E., & Engebretson, J. (2006). A framework for cultural competence in advanced practice psychiatric and mental health education. *Perspectives in Psychiatric Care*, 42(4), p. 227-237.

Manson, S. M. (2004). *Meeting the mental health needs of American Indians and Alaska Natives*. Alexandria, VA: National Association of State Mental Health Program Directors, National Technical Assistance Center. Retrieved July 11, 2007, from http://www.nasmhpd.org/general_files/publications/ntac_pubs/reports/native%20american%20FINAL-04.pdf

Manson, S. M. (1997). Cross-cultural and multiethnic assessment of trauma. In J. P. Wilson, & T. M. Keane (Eds.), *Assessing psychological trauma and PTSD* (p. 239-290). New York – London: The Guilford Press.

Marsella, A. J., & Christopher, M. A. (2004). Ethnocultural considerations in disasters: An overview of research, issues, and directions. *Psychiatric Clinics in North America*, 27, p. 521-539.

Mason, J. L. (1995). *Cultural competence self-assessment questionnaire - A manual for users*. Portland, OR: Portland State University, Research and Training Center on Family Support and Children's Mental Health. Retrieved July 11, 2007, from <http://www.rtc.pdx.edu/PDF/pbCultCompSelfAssessQuest.pdf>.

May, B. (n.d.). *Disaster studies programs in North American higher education: Historical considerations*. Emmitsburg, MD: Emergency Management Institute, Federal Emergency Management Agency, Department of Homeland Security. Retrieved June 12, 2007, from <http://training.fema.gov/EMIWeb/downloads/DisasterStudiesinNAHistoricalConsiderations.doc>.

McArthur, A. (2006a). *Red Cross engages partners to boost future response*. Press Release. Retrieved July 15, 2007, from http://www.redcross.org/article/0,1072,0_312_5224,00.html

- McCartney, S. F. (2006). Combined support force 536: Operation Unified Assistance. *Military Medicine*, 171(10 Suppl 1), p. 24-26.
- McDonnell S., Troiano R. P., Barker N., Noji E., Hlady W. G., & Hopkins R. (1995). Evaluation of long-term community recovery from Hurricane Andrew: Sources of assistance received by population sub-group. *Disasters*, 19(4), p. 338-347.
- McEntire, D. (2004, June). *The Status of emergency management theory: Issues, barriers, and recommendations for improved scholarship*. Paper presented at the FEMA Higher Education Conference, Emmitsburg, MD. Retrieved June 8, 2007, from <http://training.fema.gov/EMIWeb/downloads/David%20McEntire%20-%20Status%20of%20Emergency%20Management%20Theory.pdf>.
- McFarland, M. (2005). Military cultural education. *U.S. Army Professional Writing Collection*, Vol. 3. Retrieved June 5, 2007, from http://www.army.mil/professionalwriting/volumes/volume3/june_2005/6_05_3.html
- McFarlane, A., & Norris, F. (2006). Definitions and concepts in disaster research. In F. Norris, S. Galea, M. Friedman, & P. Watson (Eds.), *Methods for Disaster Mental Health Research*. New York – London: The Guilford Press.
- McGuinness, K. M. (2006). The USNS Mercy and the changing landscape of humanitarian and disaster response. *Military Medicine*, 171(10 Suppl 1), p. 48-52.
- MDMH (Massachusetts Department of Mental Health). (2006). *Massachusetts behavioral health disaster responder participant reference guide*. Boston, MA: Massachusetts Department of Mental Health, Massachusetts Department of Public Health. Retrieved from <http://www.cmmh-cmtp.org/pdf/BHDRreferenceguideupdate92606.pdf>
- Mendel, W. W. (1996). *Combat in the cities: The LA riots and operation Rio*. Fort Leavenworth, KS: Foreign Military Studies Office. Retrieved from <http://www.smallwars.quantico.usmc.mil/search/LessonsLearned/LatinAm/rio.htm>.
- Messias, D. K. H., & Lacy, E. (2007). Katrina-related health concerns of Latino survivors and evacuees. *Journal of Health Care for the Poor and Underserved*, 18(2), p. 443-464.
- Mileti, D. S. (1999). *Disasters by design: A reassessment of natural hazards in the United States*. Washington, DC: Joseph Henry Press.
- Miller, K. E., Martell, Z.L., Pazdirek, L., Caruth, M., & Lopez, D. (2005). The role of interpreters in psychotherapy with refugees: An exploratory study. *American Journal of Orthopsychiatry*, 75(1), p. 27-39. Retrieved July 10, 2007, from <http://www.psychology.pomona.edu/kenmiller/Papers/The%20role%20of%20interpreters.pdf>.

Mio, J. S. (2003). On teaching multiculturalism: History, models, and content. In G. Bernal, J. Trimble, A. K. Burlew, & F. T. L. Leong (Eds.), *Handbook of racial and ethnic minority psychology* (p. 119-146). Thousand Oaks, CA: Sage Publications.

Missouri Department of Health and Senior Services (DHSS) (2006). *Planning & response strategies for culturally diverse populations*. Retrieved July 12, 2007, from <http://www.dhss.mo.gov/SpecialNeedsToolkit/EmergencyPlanning/SpecPopStrategyGrid1-24-06LC4CDtoolkit.doc>.

Mitchell, J. T. (2003). *Crisis intervention and CISM – A research survey*. Retrieved July 9, 2007, from http://www.icisf.org/articles/cism_research_summary.pdf.

Mitchell, J. T., & Everly, G. S. (2006). Critical Incident Stress Management in terrorist events and disasters. In Schein, L. A., Spitz, H. I., Burlingame, G. M., Muskin, P. R. & Vargo, S. (Eds.), *Psychological effects of catastrophic disasters: Group approaches to treatment* (p. 425-480). New York, NY: The Haworth Press.

Muñiz, B. (2006). *In the eye of the storm: How the government and private response to Hurricane Katrina failed Latinos*. Washington, DC: National Council of La Raza.

Murray, J., & Gelatt, J. (2005). *Aftermath of Katrina affects immigration enforcement*. Migration Information Source. Retrieved June 20, 2007, from <http://www.migrationinformation.org/USfocus/display.cfm?id=340>.

Myers, D. (1994a). *Disaster response and recovery: A handbook for mental health professionals*. Rockville, MD: Department of Health and Human Services. Retrieved June 14, 2007, from <http://www.empowermentzone.com/disaster.txt>.

Myers, D. (1994b). Psychological recovery from disaster: Key concepts for delivery of mental health services. *National Center for Posttraumatic Stress Disorder Clinical Quarterly* 4(2), p. 1-5.

Myers, D., & Wee, D. (2003). *Disaster mental health services: A primer for practitioners*. New York, NY: Routledge.

Myers, H. F., Lewis, T. T., & Parker-Dominguez, T. (2003). Stress, coping, and minority health: Biopsychosocial perspective on ethnic health disparities. In G. Bernal, J. Trimble, A. K. Burlew, & F. T. L. Leong (Eds.), *Handbook of racial and ethnic minority psychology* (p. 377-400). Thousand Oaks, CA: Sage Publications.

NACCHO (National Association of County and City Health Officials). (2006). *MRC core competencies*. Retrieved from http://www.medicalreservecorps.gov/File/MRC%20TRAIN/Core%20Competency%20Resources/MRC_Core_Competency_Fact_Sheet.pdf

NAAEP (The Native American Alliance for Emergency Preparedness). (n.d.). *Disaster preparedness*. Retrieved October 16, 2007 from <http://www.naaep.org/DisasterPrep.html>.

NAED (The National Academies of Emergency Dispatch). (2007). *Emergency dispatcher certification courses*. Retrieved July 29, 2007, from <http://www.emergencydispatch.org/framesetT.html>.

NAEMSP (The National Association of EMS Physicians). (1993). *Ethical challenges in emergency medical services*. Lenexa, KS: National Association of EMS Physicians. Retrieved August 1, 2007, from <http://naemsp.org/documents/EthicalChallengesinEmergencyMedicalServices.pdf>.

NAEMT (National Association of Emergency Medical Technicians). (2006a.) *EMS: Where we've been and where we're going*. Clinton, MS: National Association of Emergency Medical Technicians. Retrieved June 26, 2007, from http://www.naemt.org/aboutEMSAndCareers/history_of_ems.htm

NASW (National Association of Social Workers). (2001). *NASW standards for cultural competence in social work practice*. Washington, DC: National Association of Social Workers. Retrieved April 10, 2007, from <http://www.socialworkers.org/practice/standards/NASWCulturalStandards.pdf>.

NASW. (2003). What is NASW's practice research network? *Practice Research Network*, 2(2). Retrieved July 29, 2007, from <http://www.socialworkers.org/naswprn/surveyTwo/Datagram2.pdf>.

NASW. (2006). *Licensed social workers in health, 2004: Demographics*. Center for Health Workforce Studies, School of Public Health, University at Albany, Rensselaer, NY. Retrieved July 29, 2007, from http://workforce.socialworkers.org/studies/health/health_chap2.pdf.

NASW. (2007). *Indicators for the achievements of the NASW standards for cultural competence in social work practice*. Washington, DC: National Association of Social Workers. Retrieved June 16, 2007, from <https://www.socialworkers.org/practice/standards/NASWCulturalStandardsIndicators2006.pdf>.

Naturale, A. J. (2006). Outreach strategies: An experiential description of the outreach methodologies used in the September 11, 2001, disaster response in New York. In E. C. Ritchie, P. Watson, & M. Friedman (Eds.), *Interventions following mass violence and disasters: Strategies for mental health practice* (p. 365-383). New York – London: The Guilford Press,

NCTSN (The National Child Traumatic Stress Network) (2006). *Psychological first aid: Field operations guide*. (2nd ed.). National Child Traumatic Stress Network, National

Center for PTSD. Retrieved July 11, 2007, from http://www.ncptsd.va.gov/ncmain/ncdocs/manuals/PFA_2ndEditionwithappendices.pdf

NCTSN. (2007). Organizational, cultural, and linguistic competence. *Culture and Trauma Brief*, 2(2), p. 1-5.

Neal, D. (2004). Feedback from the field: Teaching introduction to Disaster management: A comparison of classroom and virtual environments. *International Journal of Mass Emergencies and Disasters*, 22 (1), p. 103–116. Retrieved June 11, 2007, from <http://training.fema.gov/EMIWeb/downloads/IJMEDMarch04D.Neal.pdf>.

Neighbors, H. W., Musick, M. A., & Williams, D. R. (1998). The African American minister: Bridge or barrier to mental health care? *Health Education and Behavior*, 25(6), p. 759-777.

NEMA (National Association of Emergency Managers). (2005). *NEMA policy position on the role of the military in disaster response*. Lexington, KY: National Association of Emergency Managers. Retrieved June 27, 2007, from <http://www.nemaweb.org/?1512>

Neuby, B. (2006). Bureaucratic power: Security and the National Response Plan. *Public Organization Review*, 6, p. 317-328.

New America Media. (2004, March). *Bilingual 911 dispatchers can save lives*. Retrieved December 10, 2007, from http://news.ncmonline.com/news/view_article.html?article_id=342971164108b853d098409a1b1bf08f.

NGA (National Governors Association). (2005). *NGA statement on federalizing emergencies*. Washington, DC: National Governors Association. Retrieved June 27, 2007, from <http://www.nga.org/portal/site/nga/menuitem.6c9a8a9ebc6ae07eee28aca9501010a0/?vgnextoid=ed92e01d63ae6010VgnVCM1000001a01010aRCRD>

The National Highway Traffic Safety Administration (NHTSA). (1994). *Emergency Medical Technician-Basic: National standard curriculum*. Washington, DC: Department of Transportation. Retrieved June 5, 2007, from <http://www.nhtsa.dot.gov/people/injury/ems/pub/emtbnscc.pdf>.

NHTSA. (1995). *First responder: National standard curriculum*. Washington, DC: Department of Transportation. Retrieved on March 15, 2007, from <http://www.nhtsa.dot.gov/people/injury/ems/pub/frnsc.pdf>

NHTSA. (1996). *Emergency Medical Services: Agenda for the future*. Washington, DC: Department of Transportation. Retrieved June 5, 2007, from <http://www.emsa.ca.gov/Vision/Vision1/emsmann.pdf>.

- NHTSA. (1998a). *EMS Agenda for the future: Implementation guide*. Washington, DC: Department of Transportation. Retrieved June 5, 2007, from <http://www.nhtsa.dot.gov/people/injury/ems/agenda/>.
- NHTSA. (1998b). *Emergency Medical Technician - Intermediate: National standard curriculum*. Washington, DC: Department of Transportation. Retrieved June 5, 2007, from <http://www.nhtsa.dot.gov/people/injury/ems/EMT-I/index.html>.
- NHTSA. (1998c). *Emergency Medical Technician Paramedic: National standard curriculum*. Washington, DC: Department of Transportation. Retrieved June 5, 2007, from <http://www.nhtsa.dot.gov/people/injury/ems/EMT-P/index.html>.
- NHTSA. (2000). *Emergency Medical Services education agenda for the future: A systems approach*. Washington, DC: U.S. Department of Transportation. Retrieved May 30, 2007, from <http://www.nhtsa.gov/people/injury/ems/FinalEducationAgenda.pdf>.
- NHTSA. (2005). *The national EMS scope of practice model*. Washington, DC: Department of Transportation. Retrieved June 7, 2007, from <http://www.nhtsa.gov/portal/site/nhtsa/menuitem.2a0771e91315babbbf30811060008a0c/>.
- National Highway Traffic Safety Administration (NHTSA), & Health Resources and Services Administration (HRSA). (2005). *National EMS core content*. Washington, DC: National Highway Traffic Safety Administration, Health Resources and Services Administration. Retrieved June 7, 2007, from <http://www.nhtsa.dot.gov/people/injury/ems/EMSCoreContent/>
- NICOS Chinese Health Coalition. (n.d.). *Chinatown disaster response project*. Retrieved October 16, 2007 from <http://www.nicoschc.com/cdrp.html>.
- Nigg, J. (1995). *Disaster recovery as a social process*. University of Delaware, Disaster Research Center. Preliminary Paper # 219.
- Nigg, J., & Tierney, K. J. (1993). *Disasters and social change: Consequences for community construct and affect*. Paper presented at the Annual Meeting of the American Sociological Association, Miami, Florida. Retrieved July 3, 2007, from <http://www.udel.edu/DRC/preliminary/195.pdf>.
- NIMH (National Institute of Mental Health). (2002). *Mental health and mass violence: Evidence-based early psychological intervention for victims/survivors of mass violence. A workshop to reach consensus on best practices*. Washington, DC: U.S. Government Printing Office. Retrieved July 5, 2007, from <http://www.nimh.nih.gov/publicat/massviolence.pdf>
- NJDHS (New Jersey Department of Human Services, Division of Mental Health Services). (n.d.). *Culturally competent mental health NJ*. International Institute of New

Jersey, Mental Health Association of New Jersey. Retrieved June 7, 2007, from <http://www.culturallycompetentmentalhealthnj.org/>.

Norris, F. H., & Alegría, M. (2005). Mental health care for ethnic minority individuals and communities in the aftermath of disasters and mass violence. *CNS Spectrums*, 10(2), p. 132-140.

Norris, F. H., & Alegría, M. (2006). Promoting disaster recovery in ethnic minority individuals and communities. In E. C. Ritchie, P. Watson, & M. Friedman, (Eds.), *Interventions following mass violence and disasters: Strategies for mental health practice* (p. 155-173). New York – London: The Guilford Press.

Norris, F.H., Hamblen, J.L., Watson, P.J., Ruzek, J., Gibson, L., Price, J.L., et al. (2006). Toward understanding and creating systems of postdisaster care. In E.C. Ritchie, P. Watson, & M. Friedman (Eds.), *Interventions following mass violence and disasters: Strategies for mental health practice* (p. 343-364). New York – London: The Guilford Press.

NREMT. (n.d.). *Learn about EMS*. Retrieved December 10, 2007, from http://www.nremt.org/about/ems_learn.asp.

NYSDOH (New York State Department of Health, Bureau of Emergency Medical Services). (2002). *Certified first responder (CFR) original course curriculum: Course guide*. Retrieved on May 6, 2007, from <http://www.health.state.ny.us/nysdoh/ems/cfr.htm>.

OFRD (Office of Force Readiness and Deployment). (n.d.). *Commissioned Corps response teams: A thumbnail sketch*. Retrieved n.d., from http://ccrf.hhs.gov/ccrf/response_team_description.htm.

OFRD (Office of Force Readiness and Deployment). (2007). *At risk individuals during disasters*. Powerpoint presentation updated April 20, 2007. Washington, DC: U.S. Department of Health and Human Services.

OMH (The Office of Minority Health). (2000). *National Standards on Culturally and Linguistically Appropriate Services (CLAS)*. Rockville, MD: Department of Health and Human Services. Retrieved March 28, 2007, from <http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15>.

OMH. (2001). *National Standards for Culturally and Linguistically Appropriate Services (CLAS): Final report*. Rockville, MD: Department of Health and Human Services. Retrieved March 28, 2007, from <http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf>.

OSG MRC (Office of the Surgeon General Medical Reserve Corps). (2007). *Training resources*. Retrieved from <http://www.medicalreservecorps.gov/resources.asp>

Okazaki, S. (2000). Assessing and treating Asian Americans: Recent advances. In I. Cuéllar, & F. A. Paniagua (Eds.), *Handbook of multicultural mental health: Assessment and treatment of diverse populations*. (p. 171-193). San Diego, CA: Academic Press.

Ørner, R.J., Kent, A.T., Pfefferbaum, B.J., Raphael, R., & Watson, P.J. (2006). The context for providing immediate postevent intervention. In E. C. Ritchie, P. Watson, & M. Friedman (Eds.), *Interventions following mass violence and disasters: Strategies for mental health practice* (p. 121-133). New York – London: The Guilford Press.

O'Byrne, M. (2007). *A review of training models in culture and mental health*. Montreal, Canada: McGill University, Division of Social and Transcultural Psychiatry. Retrieved April 25, 2007, from <http://www.mcgill.ca/tcpsych/publications/report/appendices/review/>.

Panel on Public Policy Implications of Earthquake Prediction. (1975). *Earthquake prediction public policy*. Washington, DC: National Academy of Sciences.

Paniagua, F. A. (2000). Culture-bound syndromes, cultural variations, and psychopathology. In I. Cuéllar, & F. A. Paniagua (Eds.), *Handbook of multicultural mental health: Assessment and treatment of diverse populations* (p. 139-169). San Diego, CA: Academic Press.

Parham, T. A., White, J., & Ajamu, A. (1999). *The psychology of Blacks: An African centered perspective*. (3rd ed.). Englewood Cliffs, NJ: Prentice Hall.

Pearce, A., Mark, P., Gray, N., & Curry, C. (2006). Responding to the Boxing Day tsunami disaster in Aceh, Indonesia: Western and South Australian contributions. *Emergency Medicine Australasia*, 18(1), p. 86-92.

Pedersen, P. (1991). Multiculturalism as a generic approach to counseling. *Journal of Counseling and Development*, 70(1), p. 6-12.

Pedersen, P. (2003). Cross-cultural counseling: Developing culture-centered interactions. In G. Bernal, J. Trimble, A. K. Burlew, & F. T. L. Leong (Eds.), *Handbook of racial and ethnic minority psychology* (p. 487-503). Thousand Oaks, CA: Sage Publications.

Pedersen, P. (1994). *A handbook for developing multicultural awareness*. (2nd ed.). Alexandria, VA: American Counseling Association.

Peguero, A. A. (2006). Latino disaster vulnerability. *Hispanic Journal of Behavioral Sciences*, 28 (1), p. 5-22.

Perez, T. E. (2003). The Civil Rights dimension of racial and ethnic disparities in health status. In B. Smedley, A. Stith, & A. Nelson (Eds.), *Unequal treatment: Confronting*

racial and ethnic disparities in health care (p. 626-663). Washington, DC: The National Academies Press.

Perilla, J. L., Norris, F. H., & Lavizzo, E. A. (2002). Ethnicity, culture, and disaster response: Identifying and explaining ethnic differences in PTSD six months after Hurricane Andrew. *Journal of Social and Clinical Psychology*, 21(1), p. 20-45.

Perry, H. S., & Mushkatel, A. H. (1986). *Minority citizens in disasters*. Athens, GA: University of Georgia Press.

Perry, R.W., & Lindell, M.K. (1991). The effects of ethnicity on evacuation decision-making. *International Journal of Mass Emergencies and Disasters*, 9 (1), p. 47-68.

Perry, R. W., Lindell, M. L., & Greene, M. R. (1982). Crisis communications: Ethnic differentials in interpreting and acting on disaster warnings. *Social Behavior and Personality*, 10 (1), p. 97-104.

Perry, R. W., & Nelson, L. (1991). Ethnicity and hazard information dissemination. *Environmental Management*, 15(4), p. 581-587.

PHF (Public Health Foundation, State of Texas). (n.d.) *TRAINTexas.org*. Retrieved April 30, 2007, from <https://tx.train.org/DesktopShell.aspx?tabid=62>.

Phillips, B. (2003, October). *Disasters by discipline: Necessary dialogue for emergency management education*. Presentation at the workshop, Creating Educational Opportunities for the Hazards Manager of the 21st Century, Denver, CO. Retrieved June 11, 2007, from <http://training.fema.gov/EMIWeb/downloads/DenverFinal.doc>

Phillips, B. D. (1993). Cultural diversity in disasters: Sheltering, housing, and long-term recovery. *International Journal of Mass Emergencies and Disasters*, 11(1), p. 99-110.

Phillips, B. D., & Ephraim, M. (1992). Living in the aftermath: Blaming processes in the Loma Prieta Earthquake. Working Paper No. 80. IBS, Natural Hazards Research and Applications Information Center, University of Colorado, Boulder.

Pole, N., Best, S., Metzler, T., & Marmar, C. R. (2005). Why are Hispanics at greater risk for PTSD? *Cultural Diversity and Ethnic Minority Psychology* 11(2), 144-161.

The President's New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America. Final Report*. Rockville, MD: President's New Freedom Commission on Mental Health. Retrieved May 22, 2007, from <http://www.mentalhealthcommission.gov/reports/FinalReport/downloads/FinalReport.pdf>

Puckett, D. (2004.) NAF disaster teams prepare for the worst. *Navy Newsstand*. Naval Air Facility Atsugi, Japan. Retrieved July 14, 2007, from http://www.news.navy.mil/search/displaybbs.asp?bbs_id=828.

Puig, M., & Glynn, J. (2003). Disaster responders: A cross-cultural approach to recovery and relief work. *Journal of Social Service Research*, 30(2), p. 55-66.

Quarantelli, E. L. (1981). *Evacuation behavior and problems: Findings and implications from the research literature*. Miscellaneous Report No. 27. Newark, DE: Disaster Research Center, University of Delaware.

Quarantelli, E. L. (1986). What is disaster? The need for clarification in definition and conceptualization in research. In B. Sowder, & M. Lystad (Eds.), *Disasters and mental health: Selected contemporary perspectives* (p. 41-73). Rockville, MD: National Institute of Mental Health.

Rabkin, N. (2005). *Hurricane Katrina: Providing oversight of the nation's preparedness*. Washington, DC: Government Accounting Office. Retrieved June 26, 2007, from <http://www.gao.gov/new.items/d051053t.pdf>.

Ridenour, M. J., Cummings, K. J., Sinclair, J. R., & Bixler, D. (2007). Displacement of the underserved: Medical needs of Hurricane Katrina evacuees in West Virginia. *Journal of Health Care for the Poor and Underserved*, 18(2), p. 369-381.

Ridley, C. R., Mendoza, D. & Kanitz, B. (1994). Multicultural training: Reexamination, operationalization, and integration. *The Counseling Psychologist*, 22(2), p. 227-289.

Robb, M. (2004). Mastering disaster: Continuing education in crisis response. *Social Work Today*, 4(5), p. 34.

Robert Wood Johnson Foundation (RWJF). (n.d.) Interpreter training programs. Claremont, CA: Hablamos Juntos (We Speak Together).

Robin, E. W., Chester, B., & Goldman, D. (1996). Cumulative trauma and PTSD in American Indian communities. In A. J. Marsella, M. J. Friedman, E. T. Gerrity, & R. M. Scurfield (Eds.), *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications* (p. 239-253). Washington, DC: American Psychological Association.

Rodríguez, H., & Aguirre, B. (2006). *Hurricane Katrina and the healthcare infrastructure: A focus on disaster preparedness, response, and resiliency*. *Frontiers of Health Services Management*, 23(1), p. 13-24.

Rodríguez, H., Diaz, W., & Santos, J. (2006). Communicating Risk and Uncertainty: Science, Technology, and Disasters at the Crossroads. In H. Rodriguez, E. L. Quarantelli, & R. Dynes (Eds.), *Handbook of disaster research*. New York, NY: Springer.

Rodriguez, S. R., Tocco, J. S., Mallonee, S., Smithee, L., Cathey, T., & Bradley, K. (2006). Rapid needs assessment of Hurricane Katrina evacuees—Oklahoma, September 2005. *Prehospital and Disaster Medicine*, 21(6), p. 391-395.

- Rogers, J. R. (2007). Disaster response and the mental health counselor. *Journal of Mental Health Counseling*, 29(1), p. 1-3.
- Romero, A. J. (2000). Assessing and treating Latinos: Overview of research. In I. Cuéllar, & F. A. Paniagua (Eds.), *Handbook of multicultural mental health: Assessment and treatment of diverse populations* (p. 209-223). San Diego, CA: Academic Press.
- Ronnau, J. P. (1994). Teaching cultural competence: Practical ideas for social work educators. In P. Keys (Ed.), *School social workers in multicultural environment: New roles, responsibilities, and educational enrichment* (p. 29-42). New York-London: The Haworth Press, Inc.
- Rounds, K. A., Weil, M., & Bishop, K. (1994). Practice with culturally diverse families of young children with disabilities. *Families in Society*, 75(1), p. 3-15.
- Rubin, C. (2004). *Emergency management in the 21st century: Dealing with Al Qaeda, Tom Ridge, and Julie Gerberding*. Working Paper #108. Boulder, CO: University of Colorado, the Natural Hazards Center.
- Rutstein, D. (2007). USNS Comfort humanitarian assistance training deployment of USPHS Team One. *Commissioned Corps E-Bulletin*, 3(9). Retrieved from http://dcp.psc.gov/ccbulletin/ccbul_main.aspx.
- Ruzek, J. I. (2006). Models of early intervention following mass violence and other trauma. In E. C. Ritchie, P. Watson, & M. Friedman (Eds.), *Interventions following mass violence and disasters: Strategies for mental health practice* (p. 16-34). New York – London: The Guilford Press.
- Sáez-Santiago, E., & Bernal, G. (2003). Depression in ethnic minorities: Latinos and Latinas, African Americans, Asian Americans, and Native Americans. In G. Bernal, J. Trimble, A. K. Burlew, & F. T. L. Leong (Eds.), *Handbook of racial and ethnic minority psychology* (p. 401-428). Thousand Oaks, CA: Sage Publications.
- Sahni, R. (2007). Personal communication via response to the Office of Minority Health expert survey.
- Saldaña, D. (1995). Acculturative stress: Minority status and distress. In A. M. Padilla (Ed.), *Hispanic psychology* (p. 43-56). Thousand Oaks, CA; Sage.
- Saldaña, D. (2001). *Cultural competency: A practical guide for mental health service providers*. Austin, TX: Hogg Foundation for Mental Health, The University of Texas at Austin. Retrieved April 23, 2007, from <http://www.hogg.utexas.edu/PDF/Saldana.pdf>.
- Salmon, J. L. (2005). Red Cross bolstering minority outreach: Recruitment a priority after storms expose sensitivity gaps. *Washington Post*, December 5. Retrieved July 15, 2007,

from <http://www.washingtonpost.com/wp-dyn/content/article/2005/12/04/AR2005120400886.html>.

SAMHSA (Substance Abuse and Mental Health Services Administration). (1998). *Cultural competence standards in managed care mental health services: Four undeserved/underrepresented ethnic/racial groups*. Rockville, MD: U.S. Department of Health and Human Services. Retrieved June 13, 2007, from <http://mentalhealth.samhsa.gov/publications/allpubs/SMA00-3457/default.asp>.

SAMHSA. (2003). *Developing cultural competence in disaster mental health programs: Guiding principles and recommendations*. DHHS Pub. No. SMA 3828. Rockville, MD: U.S. Department of Health and Human Services.

Sanchez, F., & Gaw, A. (2007). Mental health care of Filipino Americans. *Psychiatric Services*, 58 (6), p. 810-815.

Sarewitz, D., & Pielke, R. A., Jr. (2001). Extreme events: A research and policy framework for disasters in context. *International Geology Review*, 43, p. 406-418.

Sarhill A., LeGrand, S., Islambouli, R., Davis, M., & Walsh, D. (2001). The terminally ill Muslim: Death and dying from the Muslim perspective. *American Journal of Hospice and Palliative Care*, 18(4), p. 251-255.

Saunders, J. (2007). Vulnerable populations in an American Red Cross shelter after Hurricane Katrina. *Perspectives in Psychiatric Care*, 43(1), p. 30-37.

Schneider, R. O. (n.d.) *A strategic overview of the "new" emergency management*. Emmitsburg, MD: Emergency Management Institute, Federal Emergency Management Agency, Department of Homeland Security. Retrieved August 1, 2007, from <http://training.fema.gov/EMIWeb/downloads/SchneiderStrategicOverview.doc>.

Schuster, M. A., Stein, B., Jaycox, L., Collins, R., Marshall, G. N., Elliott, M. N., et al. (2001). A national survey of stress reactions after the September 11, 2001, terrorist attacks. *The New England Journal of Medicine*, Volume 345 (20), p. 1507-1512.

Seidenberg, J. (2006). *Cultural competence in disaster recovery: Lessons learned from the Hurricane Katrina experience for better serving marginalized communities*. Berkeley, CA: University of California at Berkeley Law School. Retrieved July 24, 2007, from <http://www.law.berkeley.edu/library/disasters/Seidenberg.pdf>

Shalev, A. Y. (2006). Interventions for traumatic stress. In E. C. Ritchie, P. Watson, & M. Friedman (Eds.), *Interventions following mass violence and disasters: Strategies for mental health practice* (p. 103-120). New York – London: The Guilford Press.

Shin, H. (2003). *Language use and English-speaking ability: 2000*. Census 2000 Brief. U.S. Department of Commerce, Economics and Statistics Administration. Retrieved July 31, 2007, from <http://www.census.gov/prod/2003pubs/c2kbr-29.pdf>.

Shover, H. (2007). Understanding the chain of communication during a disaster. *Perspectives in Psychiatric Care*, 43(1), p. 4-14.

Siegel, C., Haugland, G., & Chambers, E. D. (2003). Performance measures and their benchmarks for assessing organizational cultural competency in behavioral health care service delivery. *Administration and Policy in Mental Health*. 31: 141-170.

Simon, B. (1994). *The empowerment tradition in American social work*. New York, NY: Columbia University Press.

Smedley, B. D., Stith, A. Y., & Nelson, A. R. (Eds.) (2003). *Unequal treatment: Confronting racial and ethnic health disparities in health care*. Institute of Medicine Report. Washington, DC: The National Academies Press.

Smith, R. P., Katz, C. L., Holmes, A., Herbert, R., Levin, S., Moline, J., et al. (2004). Mental health status of World Trade Center rescue and recovery workers and volunteers – New York City, July 2002 – August 2004. *Morbidity and Mortality Weekly Report*, 53(35), p. 812-815..Retrieved July 18, 2007, from <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5335a2.htm>.

Solomon, S. (2003). Introduction. In B. Green, M. J. Friedman, J. T. V. M. Jong, S. D. Solomon, T. M. Keane, J. A. Fairbank, B. Donelan, & E. Frey-Wouters (Eds.), *Trauma interventions in war and peace: Prevention, practice, and policy* (p. 3-16). New York, NY: Kluwer/Plenum Academic Publishers.

Speier, A. H. (2006). Immediate needs assessment following catastrophic disaster incidents. In E. C. Ritchie, P. Watson, & M. Friedman (Eds.), *Interventions following mass violence and disasters: Strategies for mental health practice* (p. 80-99). New York – London: The Guilford Press.

Spence, P. R., Lachlan, K., Burke, M., & Seeger, M. W. (2007). Media use and information needs of the disabled during a natural disaster. *Journal of Health Care for the Poor and Underserved*, 18(2), p. 394-404.

Stamm, B. H., & Friedman, M. (2000). Cultural diversity in the appraisal and expression of trauma. In A. Y. Shalev, R. Yehuda, & A. C. McFarlane (Eds.), *International handbook of human response to trauma* (p. 69-85). New York, NY: Kluwer Academic/Plenum Publishers.

State of Alaska. (2004). *Emergency response plan*. Anchorage, AK: Department of Military and Veterans Affairs, Division of Homeland Security and Emergency

Management. Retrieved June 25, 2007, from http://www.ak-prepared.com/plans/acrobat_docs/Alaska_Emergency_Response_Plan.pdf

State of Alaska. (2005). *Behavioral health emergency response plan*. Anchorage, AK: Department of Health and Social Services. Retrieved from http://hss.state.ak.us/dbh/resources/initiatives/dp/emergency_response_plan.pdf

State of California. (2005). *Emergency plan*. Sacramento, CA: Governor's Office of Emergency Services, Planning Section. Retrieved June 25, 2007, from [http://www.oes.ca.gov/Operational/OESHome.nsf/PDF/California%20Emergency%20Plan/\\$file/CEP-05.pdf](http://www.oes.ca.gov/Operational/OESHome.nsf/PDF/California%20Emergency%20Plan/$file/CEP-05.pdf).

Steward, R. J., Boatwright, K. J., Sauer, E., Baden, A., & Jackson, J. D. (1998). The relationships among counselor-trainees' gender, cognitive development, and white racial identity: Implications for counselor training. *Journal of Multicultural Counseling and Development, 26*, p. 254-272.

Straker, H., & Finister, S. (2007). Not business as usual. *Journal of Health Care for the Poor and Underserved, 18*(2), p. 241-246.

Stengel, R. (2000). *Meeting the needs of vulnerable people in times of disaster: A guide for emergency managers*. Oakland, CA: California Office of Emergency Services. Retrieved March 20, 2007, from [http://www.oes.ca.gov/Operational/OESHome.nsf/PDF/Vulnerable%20Populations/\\$file/Vulnerable%20Populations.PDF](http://www.oes.ca.gov/Operational/OESHome.nsf/PDF/Vulnerable%20Populations/$file/Vulnerable%20Populations.PDF)

Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist, 53*, p. 440-448.

Sue, W. D., Arredondo, P., & McDavis, R. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development, 70*, p. 477-486.

Sue, W. D., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice* (4th ed.). New York, NY: John Wiley and Sons, Inc.

Tedeschi, R., Park, C. L., & Calhoun, L. G. (1998). *Post-traumatic growth: Positive changes in the aftermath of crisis*. Mahway, NJ: Lawrence Erlbaum Associates.

Thiel de Bocanegra, H., & Brickman, E. (2004). Mental health impact of the world trade center attacks on displaced Chinese workers. *Journal of Traumatic Stress, 17*(1), p. 55-62.

Thomas, D., & Milet, D. (2003, October). *Designing educational opportunities for the hazards manager of the 21st Century*. Workshop Report, October 22-24, 2003, Denver,

CO. Retrieved June 12, 2007, from <http://training.fema.gov/EMIWeb/downloads/Thomas%20and%20Milleti.pdf>

Thompson, T. (2003). *Transformation of the Commissioned Corps of the Public Health Service*. Remarks from the Reserve Officers Association, Washington, DC. Retrieved August 2, 2007, from <http://www.hhs.gov/news/speech/2003/030703.html>.

Tierney, K. J. (1993). *Socio-economic aspects of hazard mitigation*. Preliminary Paper No. 190. Newark, DE: University of Delaware, Disaster Research Center.

Tierney, K. J., Lindell, M. K., & Perry, R. (2001). *Facing the unexpected: Disaster preparedness and response in the United States*. Washington, DC: Joseph Henry Press.

Timboe, H. L. (2006). Project HOPE volunteers and the Navy hospital ship Mercy. *Military Medicine*, 171(10 Suppl 1), p. 34-36.

Ton, H. (2004). Cultural and ethnic considerations in disaster psychiatry. In R. C. W. Hall, A. T. Ng, & A. E. Norwood (Eds.), *Disaster psychiatry handbook* (p. 28-33). Washington, DC: American Psychiatric Association, Committee on Psychiatric Dimensions of Disaster. Retrieved March 15, 2007, from <http://www.psych.org/disasterpsych/pdfs/apadisasterhandbk.pdf>

Torres, L., & Rollock, D. (2007). Acculturation and depression among Hispanics: The moderating effect of intercultural competence. *Cultural Diversity and Ethnic Minority Psychology*, 13(1), p. 10-17.

Trainer, P., & Hutton, J. (1972). *An approach to the differential distribution of deaths and disaster*. Paper presented at the meeting of the Midwest Council on Social Research in Aging, Kansas City, MO.

USFA (U.S. Fire Administration). (2007). *Emergency medical services curriculum*. Retrieved June 10, 2007, from <http://www.usfa.dhs.gov/nfa/resident/2week/index.shtm>.

U.S. Army. (2007a). *Army health care*. Retrieved July 31, 2007, from <http://www.goarmy.com/amedd/>.

U.S. Army. (2007b). *Army National Guard*. Retrieved July 31, 2007, from <http://www.globalsecurity.org/military/agency/army/arng.htm>.

U.S. Census Bureau (2001). *United States Census 2000: Redistricting data (Public Law 94-171)*. Washington, DC: Economics and Statistics Administration, U.S. Department of Commerce. Retrieved July 31, 2007, from <http://www.census.gov/clo/http://www/redistricting.html>.

U.S. House of Representatives. (2006). *A failure of initiative: Final report of the select bipartisan committee to investigate the preparation for and response to Hurricane*

Katrina. Washington, DC: Government Printing Office. Retrieved June 28, 2007, from <http://a257.g.akamaitech.net/7/257/2422/15feb20061230/http://www.gpoaccess.gov/katrina/report/mainreport.pdf>

U.S. Marine Corps. (2005). Press release: Marines arrive in Louisiana to aid hurricane relief efforts. Retrieved January 23, 2008, from <http://www.marines.mil/marinelink/mcn2000.nsf/releaseview/19E060CD00E6C3328525707200057A91>

U.S. Navy. (2007.) United States Navy fact file: Hospital ships – T-AH. Retrieved July 14, 2007, from http://www.navy.mil/navydata/fact_display.asp?cid=4400&tid=400&ct=4.

U.S. Public Health Service (USPHS). (2007). *Mission statement*. Retrieved January 23, 2008, from <http://www.ihs.gov/NonMedicalPrograms/PHS/RDF/index.asp?module=rdf>

U.S. Public Health Services Office of Force Readiness and Deployment (USPHS OFRD). (2007). Retrieved January 23, 2008, from <http://ccrf.hhs.gov/ccrf/>

Valero-Garcés, C. (2005). Emotional and psychological effects on interpreters in public services: A critical factor to bear in mind. *Translation Journal*, 9(3). Retrieved from <http://accurapid.com/journal/33ips.htm>.

Van der Veer, G. (1995). Psychotherapeutic work with refugees. In R. J. Kleber, C. R. Figley, & B. P. R. Gersons (Eds.), *Beyond trauma: Cultural and societal dynamics* (p. 151-169). New York, NY: Springer.

Vasquez, M. T. J. (2006). *Why cross-cultural competence must inform trauma treatment of children and families*. Paper presented as part of Symposium, Treating Traumatized Children and Families at the 114th Annual convention of the American Psychological Association. Retrieved July 10, 2007, from http://www.apatraumadivision.org/program/melba_paper.pdf.

Vega, V., & Alegría, M. (2001). Latino mental health treatment in the United States. In M. Aguirre-Molina, C. W. Molina, & R. E. Zambrana (Eds.), *Health issues in the Latino community* (p. 179-208). San Francisco, CA: Jossey-Bass.

Vera, M., Vila, D., & Alegria, M. (2003). Cognitive behavioral therapy: Concepts, issues, and strategies for practice with racial/ethnic minorities. In G. Bernal, J. Trimble, A. K. Burlew, & F. T. L. Leong (Eds.), *Handbook of racial and ethnic minority psychology* (p. 521-538). Thousand Oaks, CA: Sage Publications.

Virginia Department of Emergency Management. (2004). *Emergency operations plan: Basic plan*. Richmond, VA: Virginia Department of Emergency Management. Retrieved June 28, 2007, from http://www.vaemergency.com/library/plans/coveop/eopvol1/eopvol1_a.pdf

- Wagner, V. L., Radigan, M. S., Roohan, P. J., Anarella, J. P., & Gesten, F. C. (2005). Asthma in Medicaid managed care enrollees residing in New York City: Results from a post-World Trade Center disaster survey. *Journal of Urban Health*, 82(1), p. 76-89.
- Walker, B., Jr., & Warren, R. (2007). Katrina perspectives. *Journal of Health Care for the Poor and Underserved*, 18(2), p. 233-240.
- Walsh, F. (2007). Traumatic loss and major disasters: Strengthening family and community resilience. *Family Process*, 46(2), p. 207-227.
- Walsh, P. T., & Ditch, R. L. (1998.) *Air Force medical service concept of operations for Air Force theater hospitalization*. Washington, DC: U.S. Air Force.
- Wasem, R. E. (2005). *Hurricane Katrina-related immigration issues and legislation*. Washington, DC: Congressional Research Service, The Library of Congress. Retrieved June 28, 2007, from <http://fpc.state.gov/documents/organization/53687.pdf>.
- The Washington Post, Kaiser Family Foundation, & Harvard University. (2005). *Survey of Hurricane Katrina evacuees*. Retrieved July 20, 2007, from <http://www.kff.org/newsmedia/7401.cfm>
- Watson, P. J. (2006). Improving Resilience Trajectories Following Mass Violence and Disaster. In E. C. Ritchie, P. Watson, & M. Friedman (Eds.), *Interventions following mass violence and disasters: Strategies for mental health practice* (p. 37-53). New York – London: The Guilford Press.
- Weaver, M. (1995). *Disaster mental health interventions*. Sarasota, FL: Professional Resource Press.
- Weeks, S. M. (1999). Disaster mental health services: A Personal Perspective. *Journal of Psychological Nursing*, 37(2), p. 14-18.
- Wells, M. (2006). Psychotherapy for families in the aftermath of a disaster. *Journal of Clinical Psychology: In Session*, 62(8), p. 1017-1027.
- The White House. (2007, October 18). Homeland Security Presidential Directive/HSPD-21. Retrieved January 29, 2007, from <http://www.fas.org/irp/offdocs/nspd/hspd-21.htm>
- Wisner, B. (1993). Disaster vulnerability: Scale, power, and daily life. *GeoJournal* 30(2), p. 127-40.
- Wisner, B. (2004). *At risk: Natural hazards, people's vulnerability, and disasters*. (2nd ed.). London: Routledge.

- Woodbury, A. (2005). Critical curriculum for emergency management leaders: Three essential themes. *Journal of Emergency Management*, 3(2), 72-92. Retrieved June 11, 2007, from <http://training.fema.gov/EMIWeb/edu/docs/Glen%20Woodbury%20-%20Critical%20Curriculum%20for%20EM%20Leaders.pdf>.
- Wunderle, W. (2006). *Through the lens of cultural awareness: A primer for U.S. armed forces deploying to Arab and Middle Eastern countries*. Fort Leavenworth, KS: Combat Studies Institute Press.
- Yali, A. M., & Revenson, T.A. (2004). How changes in population demographics will impact health psychology: Incorporating a broader notion of cultural competence into the field. *Health Psychology*, 23 (2), p. 147–155.
- Yang, J. S., & Kagawa-Singer, M. (2007). Increasing access to care for cultural and linguistic minorities: Ethnicity-specific health care organizations and infrastructure. *Journal of Health Care for the Poor and Underserved*, 18(2), p. 532-549.
- Yelvington, K. A. (1997). Coping in a temporary way: The tent cities. In W.G. Peacock, B.H. Morrow, & H. Gladwin (Eds.) *Hurricane Andrew: Ethnicity, gender, and the sociology of disasters*. New York, NY: Routledge.
- Young, B. (2006). The immediate response to disaster: Guidelines for adult psychological first aid. In E. C. Ritchie, P. Watson, & M. Friedman (Eds.), *Interventions following mass violence and disasters: Strategies for mental health practice* (p. 134-154). New York – London: The Guilford Press.
- Young, B., Ford, J. D., Ruzek, J. I., Friedman, M. J., & Gusman, F. D. (1998). *Disaster mental health services: A guidebook for clinicians and administrators*. Washington, DC: Department of Veterans Affairs. Retrieved April 15, 2007, from <http://www.wramc.army.mil/departments/socialwork/provider/DMHS.htm>.
- Young, B., Ruzek, J., Wong, M., Salzer, M. S., & Naturale, A. J. (2006). Disaster mental health training: Guidelines, considerations, and recommendations. In E. C. Ritchie, P. Watson & M. Friedman (Eds.), *Interventions following mass violence and disasters: Strategies for mental health practice* (p. 54-79). New York – London: The Guilford Press.
- Zinner, E. S., & Williams, M. B. (Eds.). (1999). *When a community weeps: Case studies in group survivorship*. New York, NY: Taylor & Francis, Inc.
- Zoellner, L. A., Feeny, N. C., Fitzgibbons, L. A., & Foa, E. B. (1999). Response of African American and Caucasian women to behavioral therapy for PTSD. *Behavior Therapy*, 30 (4), p. 581-595.

Appendix B. Search Terms

We searched for combinations of the following terms in PubMed, EBSCO, ProQuest, and PILOTS databases. We limited articles to those written in English about the disaster response in the U.S. When searches yielded many results, we limited the search to review articles.

- American Red Cross
- Call centers
- Crisis counseling
- Cultural awareness
- Cultural competence in disaster response
- Commissioned Corps
- Community outreach
- Community partnerships
- Community recovery
- Defense support of civil authorities
- Disaster mental health
- Disaster outreach
- Disaster preparedness
- Disaster recovery in minority communities
- Disaster response
- Disaster social work
- Dispatcher
- Dispatcher education
- Dispatcher job function
- Dispatcher training
- Disparities in mental health
- Distance learning courses for disaster responders
- Emergency care
- Emergency management
- Emergency management training
- Emergency preparedness
- Emergency response
- EMS
- EMS workforce diversity
- EMT
- EMT education
- EMT protocols
- EMT training
- Evacuation orders
- First responders
- Hurricane Katrina
- Hurricane Rita
- Intercultural communication
- Interpretation
- Interpreters in psychotherapy
- Medical first responders
- Mental health first responders
- Mental health response planning
- Military in disaster response
- Multicultural counseling
- Multicultural training
- National Response Plan
- National Incident Management System
- Organizational cultural competence
- Paramedic
- Populations with special needs
- Posttraumatic Stress Disorder
- Psychiatrists
- Psychiatrist education
- Psychiatrist job function
- Psychological first aid
- Psychological interventions in disasters
- Psychologist
- Psychologist education
- Psychologist job function
- Psychologist training
- Public communication
- Public disaster relief
- Racial disparities in mental health
- Social work first responders
- Social vulnerabilities
- Social work first responders
- Social work education
- Social work job function
- Social work training
- Standards for cultural competence
- Training curricula for emergency responders
- Vulnerable populations
- U.S. Marine Corps
- U.S. Military
- U.S. Air Force
- U.S. Army
- U.S. Coast Guard
- U.S. National Guard
- U.S. Navy

Appendix C. Disaster Response Expert Survey Results

The process for the development of the Office of Minority Health (OMH) cultural competency curriculum for disaster response began in December 2006 with a three-pronged needs assessment comprised of: an Environmental Scan presented herein; needs assessment focus groups conducted with disaster response practitioners; and responses from a survey distributed to a group of experts in the field of cultural competency education and disaster response. A summary of results from the expert survey is presented in this Appendix. Results from the needs assessment focus groups will be released in a separate document which will be posted on the <http://www.thinkculturalhealth.org> Web site.

Information from the needs assessment process will be presented to the National Project Advisory Committee (NPAC) and a Consensus-Building Panel in Fall 2007. Results from this needs assessment, together with input from the NPAC and Consensus-Building Panel, and findings from three commissioned concept papers will serve as the foundation for determining key objectives and content for the curriculum.

Through a review of the literature and relevant resources, sixteen experts were identified for participation in the survey. The project team developed open-ended survey items using research objectives as the foundation for item development. Sixteen surveys were distributed between June 27, 2007, and August 2, 2007. Six completed surveys were returned for a response rate of 37.5 percent.

Respondents offered a wide range of expertise relevant to cultural competency training for disaster responders, including: instructional design for emergency medicine, training for language access services and cultural competence for 911 dispatchers and telephone interpreters; health policy and administration, community-based health education, mental health, emergency medicine, air medical transport and ground-based ambulance services, organization of community-wide response, and culturally-specific disaster response research. All respondents have either participated in or delivered some type of training about cultural competency.

A summary of responses are provided below for each survey item:

What are the “hot topics” or most pressing issues in the field of disaster and emergency response?

Survey respondents offered a number of “hot topics” in the field of disaster response. The most common issues cited were: community outreach to vulnerable populations, preparedness at the community and local level, and addressing the unique disaster response needs of the elderly and individuals with disabilities (i.e., special evacuation needs and supports).

Other pressing issues noted by our experts include:

- Ensuring appropriate language support from qualified interpreters
- Training and resources for volunteer interpreters
- Lack of stress debriefing, particularly for volunteer multilingual workers
- Cultural competency
- Timeliness of response
- Ethical dilemmas in disaster response
- Identification of high-risk individuals
- Treatment of acute trauma response
- Community education for prevention of PTSD
- Support and education of parents dealing with distressed children
- Preparation for daily or more common disasters that can be expanded for “surge” events

What is the most common format of professional training in your field (i.e., classroom instruction, hands-on training and simulations, computer-based training (CBT), or distance learning)?

The majority of respondents indicated that classroom instruction and lecture are the most common formats of professional training in the disaster response field. The next most common response was hands-on training, followed by CBT/distance learning. One expert commented that: “CBT programs are often the most effective way to reach large numbers of people consistently.”

One respondent, who is an expert in community response, noted that simulations and video are common formats for professional training in disaster response.

Have you ever had difficulty treating a patient due to language barriers? Have you ever had difficulty treating a patient due to cultural beliefs (i.e., they refused your treatment)? Can you describe your experiences and how you overcame these obstacles?

Respondents stated that they have encountered cultural and/or language barriers in providing treatment to patients. Several respondents emphasized the importance of using appropriate language access services and engaging family and community as a means to overcome cultural or language barriers to care.

Key examples from respondents are provided below:

- *“To give a poignant example, I was interpreting for a speech therapist once who was conducting a speech therapy session for a patient recovering from a stroke. The therapist asked various questions, such as “who drives the bus?” The appropriate response was, “the bus driver,” and the patient got most of these correct. However, some questions were more challenging. When asked, “who do you borrow a cup of sugar from?” the anticipated answer was, “a neighbor,” but of course, in many countries, you would never borrow a cup of sugar from anyone for any purpose, as this is simply not part of the diet. Also, in many countries, you would rely first on your family for such needs, and it would be unusual, or even*

disrespectful, to ask a neighbor for this type of thing. So, the patient was unable to answer this question, simply because it did not make sense given her cultural background. At the time, as a trained medical interpreter, I did alert the provider that the question would not be fitting with the patient's cultural background, and would probably not generate the desired response, but the provider simply did not seem to understand or believe me, so she asked the question anyway. My sense was that the patient became very frustrated due to not being able to provide the "correct" answer, no matter how the provider rephrased it, and I believe this affected the patient's level of confidence for the remainder of the exam, an unfortunate and avoidable consequence."

- *"I have used phone based interpretation resources to communicate with patients whose primary language is not English or Spanish. I have also often encountered patients with cultural beliefs that needed to be understood and appreciated in order for our work to be productive. I work in a medical setting and the way we overcame the issue is to take the lead from the patient and family – explaining our goals and inviting them to tell us how they felt it would be important to communicate with the patient and family. We needed to really be open to understanding our own cultural assumptions as they influence our daily approach to medical care and be willing to do things differently, though the end result might be the same – we had to be comfortable taking "alternate routes" and willing to negotiate with the patient/family with respect for their traditions."*
- *"In Emergency Medicine, I see Spanish speaking populations every day (I do not speak Spanish). We heavily depend on interpreters in our department. Sometimes a patient will try to work through without an interpreter or utilize a family member. These are very high risk situations and I always strongly prefer that at least part of the session be with a "neutral" interpreter. We often have older Asian patients who speak their native dialect. They are often accompanied by adult children or grandchildren who were raised in the United States. I do rely on those family members to help "bridge" any cultural gaps or misunderstandings we may have."*

In what ways do you think first responders could benefit from cultural competency training?

Survey respondents articulated that cultural competency training could provide the following benefits to first responders: create more tolerance, remove artificial biases, improve rapport with communities, and make responders more accepting of other cultures.

Additional comments to this question are provided below:

- *"I think that it would help first responders understand why patients that are in very stressful situations may have a different set of priorities than would be expected in their personal cultural belief systems. It is impossible to "expect"*

what people will believe or think, but it should create more tolerance and less surprise when confronted with cultural differences.”

- *“In addition to cultural competency, it’s also important to understand the role that socioeconomic status plays in cultural identification. I think this area of training is hugely lacking and needs attention as every disaster in recent years has touched people of diverse cultures and world regions, not the mainstream, middle-class.”*
- *“I believe that one of the most important benefits for first responders is simply an awareness of the role that culture plays in their everyday work life and encounters with members of their communities. In terms of concrete benefits, I believe that cultural competence training may help first responders to view their diverse communities as a valuable resource, as opposed to viewing these populations in a negative way. I believe that in the process of community engagement, important bonds could be built and relationships could be developed that will provide opportunities for mini “cultural immersion” experiences of their own type. By having closer ties to these communities and working collaboratively, first responders will likely develop greater cultural competence as part of the process.”*
- *“Emergencies or disaster situations are times when communication and effective care are critical. Cultural competency is even more important in these situations to calm fears, worries, frustrations, and ultimately to provide the best possible care. First responders would build better rapport with communities and even the perception of the response would most likely improve with cultural competency training.”*

In your opinion, what are the biggest barriers to effective emergency and disaster response services for diverse communities?

Respondents cited a number of barriers to effective response for minority populations, including:

- Language barriers
- Health beliefs, particularly those with respect to mental health issues
- Building trust with communities
- Perceptions of past response efforts
- General lack of knowledge and understanding
- Representation
- Leadership
- Involvement from the diverse communities we hope to serve
- Community wide preparation

One expert provided the following comment which emphasizes the importance of communication in ensuring culturally and linguistically appropriate response:

The biggest barriers, in my opinion, all fall within the area of communication. Most importantly, the necessary communication paths need to be built to ensure that communications can be delivered clearly to all people affected in times of emergency. For that to happen, stronger relationships need to be built between first responders and the affected populations by means of community engagement and outreach. Second, the necessary linguistic resources and strategies need to be clearly identified in advance of any disaster. First responders need to receive cultural competence training to work effectively and efficiently with their interpreters and community members. Also, those who will act as interpreters need to receive at least some basic volunteer interpreter tools to help them do an effective job. Finally, the importance of stress debriefing should not be overlooked, to ensure that the first responders and language workers who support them can protect their own health and wellbeing.

Appendix D. Distance Learning Resources for Disaster Responders

Resources for Disaster Response and Emergency Management

Course Title and Author	Format	Topics covered	Learning Activities	Cultural Competency
Basic Emergency Preparedness for Public Health Workers (National Center for Disaster Preparedness, Columbia University, Mailman School of Public) http://www.ncdp.mailman.columbia.edu/training.htm	Distance learning course	<ul style="list-style-type: none"> • Emergency response as a public health activity • Core system capacities for public health emergency response • Disaster communications • Disaster response plans • Chain of command in disaster management • Disaster communication 	<ul style="list-style-type: none"> • Audio narration synchronized with PowerPoint slides • Pre-test and post-test 	<ul style="list-style-type: none"> • No
Building Cross-Cultural Partnerships in Public Health (Alabama Department of Public Health) http://www.adph.org/ALPHTN/Default.asp?DeptId=143&TemplateId=3780&TemplateNbr=3	Webcast	<ul style="list-style-type: none"> • Overview of partnerships and diversity • High-low context cultures • Group/individual-oriented values in partnerships • Cultural transformation • Interpersonal cross-cultural dynamics • Polychronic communication • Process for achieving culturally competent partnerships 	<ul style="list-style-type: none"> • Webcast • Downloadable slides • Personal transformation exercises (reflection and introspection) • Downloadable cultural competence self-assessment worksheet 	<ul style="list-style-type: none"> • Cultural competence • Cultural knowledge • Cross-cultural skills
Building Partnerships with Tribal Governments (Emergency Management Institute, FEMA)	Distance learning course	<ul style="list-style-type: none"> • Challenges of partnerships • Historical and legal perspectives of working with tribes (history of 	<ul style="list-style-type: none"> • Interactive content presentation • Knowledge review activities • Knowledge 	<ul style="list-style-type: none"> • History of Native Americans and their relations with Whites • Overview of

Course Title and Author	Format	Topics covered	Learning Activities	Cultural Competency
http://emilms.fema.gov/is650_Tribal/index.htm		<ul style="list-style-type: none"> • FEMA tribal policy • Overview of tribal cultures (values, attitudes, behaviors, languages) • Tribal decision-making • Disaster management in tribal communities 	<ul style="list-style-type: none"> • Video-enhanced case study unfolds through all lessons of the course • Additional resources 	<ul style="list-style-type: none"> • Information sharing behaviors among Native Americans • Recommendations on interacting with tribal representatives
<p>Community Engagement (Prepare Iowa Learning Management System, Iowa Department of Public Health)</p> <p>http://www.prepareiowa.com/Public/Catalog/</p>	Distance learning course	<ul style="list-style-type: none"> • Principles of community engagement • Barriers to community participation in practice • Strategies for community involvement • Communication skills and strategies for engaging key stakeholders 	<ul style="list-style-type: none"> • Text with course materials • Interactive online activities online 	<ul style="list-style-type: none"> • Covered marginally
<p>Community-based Preparedness Strategies for Special Populations (Center for Infectious Disease Preparedness UC Berkeley School of Public Health)</p> <p>http://www.idready.org/webcast/archive.php?id=2</p>	Half-semester course delivered through 7 Webcasts	<ul style="list-style-type: none"> • Special populations and their needs • Disasters and traditional response organizations • Limits of government organizations in disaster response • Traditional vs. community-based disaster response • Tips for public health • Effective communication strategies with local communities 	<ul style="list-style-type: none"> • Streaming video • Video lectures synchronized with slides 	<ul style="list-style-type: none"> • Generic discussion of ethnic communities. • Recommendations related to grounding disaster response in the communities • Recommendations partnering with CBOs
<p>Diversity and Cultural Competency in Public Health</p>	Distance learning course	<ul style="list-style-type: none"> • Health and illness and their significance • Diversity (with 	<ul style="list-style-type: none"> • Video lecture synchronized with slides • Knowledge 	<ul style="list-style-type: none"> • Models of cultural competence • Community-

Course Title and Author	Format	Topics covered	Learning Activities	Cultural Competency
Settings – Basic Level (South Central Public Health Partnership) http://www.soph.uab.edu/scphp/default.aspx?ID=591		focus on Latinos) <ul style="list-style-type: none"> • Screening • Racial and ethnic differences in morbidity and mortality • Cultural competence • Public health triads – diagnostic and intervention • Community-based participative partnership model 	review activities <ul style="list-style-type: none"> • Case study • Assessment at the end of the course 	based participative partnership model <ul style="list-style-type: none"> • CLAS Standards
Emergency Risk Communication for Public Health Professionals (Northwest Center for Public Health Practice, Department of Health Services, School of Public Health and Community Medicine, University of Washington) http://www.nwcphp.org/riskcomm/overview	Distance learning course	<ul style="list-style-type: none"> • Planning • Media relations • Community relations (to include preparing presentations, Q&A sessions, tips for dealing with hostility) • Toolkit for community planning 	<ul style="list-style-type: none"> • Interactive content presentation • Video-based case studies with follow-up transfer questions with feedback • Simulation knowledge transfer activity 	<ul style="list-style-type: none"> • No
First Responder Training (American Academy of Orthopaedic Surgeons, 2005b) http://www.emtb.com/9e/interactivities.cfm	Web-based collection of interactive activities	<ul style="list-style-type: none"> • 41 topics related to most common health emergencies and medical, legal, and ethical issues 	<ul style="list-style-type: none"> • Interactive review and practice activities • Scenario-based activities • Interactive simulations • Interactive animated presentations 	<ul style="list-style-type: none"> • No
Introduction to Disaster Services (American Red Cross)	Distance learning course	<ul style="list-style-type: none"> • Overview of disaster services provided by the American Red 	<ul style="list-style-type: none"> • Interactive content presentation enhanced by 	<ul style="list-style-type: none"> • No

Course Title and Author	Format	Topics covered	Learning Activities	Cultural Competency
http://www2.redcross.org/flash/course01_v01/		<ul style="list-style-type: none"> Cross Disaster preparedness Volunteer opportunities within the American Red Cross 	<ul style="list-style-type: none"> audio narration Case studies Knowledge review activities 	
<p>Learning from Katrina: Tough Lessons in Preparedness and Emergency Response (Public Health Grand Rounds. North Carolina Institute for Public Health)</p> <p>http://www.publichealthgrandrounds.unc.edu/katrina306/webcast.htm</p>	Webcast	<ul style="list-style-type: none"> Analysis of Hurricanes Katrina and Floyd response Community disaster preparedness Community infrastructure Pre-event emergency planning Event emergency planning, allocating resources Triage Bioterrorism Disaster communication Post-disaster recovery Counting on the public and the key asset 	<ul style="list-style-type: none"> Webcast Downloadable handouts 	<ul style="list-style-type: none"> No
<p>Planning and Execution of Disaster Response (Alabama Department of Public Health, South Central Center for Public Health Preparedness)</p> <p>http://www.adph.org/alphn</p>	Webcast	<ul style="list-style-type: none"> Response to a terrorist WMD attack Local disaster response agencies Operational disaster response plans 	<ul style="list-style-type: none"> Webcast Downloadable handouts 	<ul style="list-style-type: none"> No
<p>Planning for and Engaging Special Populations in Emergency Preparedness (University of</p>	Webcast	<ul style="list-style-type: none"> Special populations Function-based approach for people with special needs 	<ul style="list-style-type: none"> Webcast Downloadable PDF files with slides Pre-test and post-test, 	<ul style="list-style-type: none"> Covered marginally General recommendations related to special

Course Title and Author	Format	Topics covered	Learning Activities	Cultural Competency
Minnesota, Emergency Readiness Rounds) http://cpheo.sph.umn.edu/cpheo/meret/rounds/rounds_110806.html		<ul style="list-style-type: none"> • Non-profit and community-based organizations in emergency response (to include language services) • Mistakes in understanding the needs of special populations • Planning • Needs of special populations • Examples of local community outreach initiatives 	evaluation	populations can be applied to minority populations
Special Needs Planning Considerations for Service and Support Providers (FEMA, Emergency Management Institute) http://emilms.fema.gov/IS197SP/index.htm	Distance learning course	<ul style="list-style-type: none"> • Hazard analysis • Emergency planning • Emergency communications • Public/private partnerships • Personal support network • Registries of people with special needs • Evacuation concerns • Sheltering considerations 	<ul style="list-style-type: none"> • Interactive content presentation • Video-based activities • Knowledge review activities • Supplementary Web resources 	<ul style="list-style-type: none"> • No
Special Populations (Center for Public Health Preparedness, University of Minnesota) https://cpheo1.sph.umn.edu/PHET/special/index.asp	Distance learning module	<ul style="list-style-type: none"> • Definition of special population • Special considerations for special needs populations • Factors that make special populations vulnerable • Planning for special populations • Procedures 	<ul style="list-style-type: none"> • Pre-test • Slides enhanced with images and audio • Knowledge review activities • Post-test • Supplementary text with action planning worksheets and reflective discussion 	<ul style="list-style-type: none"> • Covered marginally • LEP patients are an example of special needs • Special considerations for minority populations • Communication barriers • Planning for cultural and ethnic groups

Course Title and Author	Format	Topics covered	Learning Activities	Cultural Competency
			questions	
Vulnerable Populations and Emergency Management (Alabama Department of Public Health South Center for Public Health Preparedness) http://www.adph.org/ALPHTN/default.asp?TemplateNbr=3&DeptID=143&TemplateId=4635	Webcast	<ul style="list-style-type: none"> Disabilities Experience of populations with special needs during Katrina and Rita Addressing the needs of vulnerable populations during Katrina and Rita relief efforts 	<ul style="list-style-type: none"> Webcast Downloadable handouts and evaluation forms 	<ul style="list-style-type: none"> Covered marginally

Resources for Public Health and Mental Health Providers

Course Title	Format	Topics covered	Learning Activities	Cultural Competency
Addressing Disaster and Emergency Stress Beyond First Responders (Satellite Conference, Alabama Public Health Training Network) http://www.adph.org/ALPHTN/default.asp?TemplateNbr=3&DeptID=143&TemplateId=4065	Webcast of a satellite conference	<ul style="list-style-type: none"> Disaster response Disaster workers who are deployed to the disaster site Nature of disaster stressors Signs of disaster stress Disaster-related stress in families Strategies for coping with stress (for individuals, families, and the workplace) 	<ul style="list-style-type: none"> Webcast 	<ul style="list-style-type: none"> Covered marginally Culture is mentioned among special considerations, since it shapes the way people experience disasters
Assuring Cultural Competence in Disaster Response (University of South Florida Center for Public Health Preparedness)	Distance learning course	<ul style="list-style-type: none"> Cultural competency Rationale for cultural competency in disaster response Approaches and principles for providing culturally 	<ul style="list-style-type: none"> Streaming video supported by downloadable text Pre-test and post-test 	<ul style="list-style-type: none"> Yes

Course Title	Format	Topics covered	Learning Activities	Cultural Competency
http://www.fcphp.usf.edu/courses/course/course.asp?c=ACC		competent disaster response <ul style="list-style-type: none"> • Strategies for developing cultural competence • Cultural barriers to offering disaster intervention services • Information about ethnic groups in the U.S. 		
Cultural Competence: Current Multicultural Issues in Research and Therapy (Association for Advanced Training in the Behavioral Sciences) http://www.aatbs.com/main/Ce_Desc.asp?inv=593775&ct=1&pg=1&ID=78&eid=1&page=2	Distance learning course	<ul style="list-style-type: none"> • Culture, race, and ethnicity • Treatment recommendations for specific minority groups • Other minority populations (sexual orientation, gender, elderly, disabled, patients with HIV) 	<ul style="list-style-type: none"> • Course content presentation through downloadable text • Online assessment 	<ul style="list-style-type: none"> • Treatment recommendations for specific minority groups • Research findings on racial and cultural identity development • Guidelines for counseling culturally diverse groups
Cultural Competence in Disaster Mental Health (Psychceu.org) http://www.psychceu.com/cultural_competence/disasterindexpdf.asp	Online course based on (SAMHSA, 2003)	<ul style="list-style-type: none"> • Culture and disaster • Diversity within racial and ethnic minority groups • Cultural competence in disaster mental health services • Key concepts of disaster mental health • Staff KSAs essential to the development of cultural competence • Suggestions for working with refugees and guidelines for using interpreters. 	<ul style="list-style-type: none"> • Text with course materials • Interactive online activities 	<ul style="list-style-type: none"> • Cultural competence continuum • Nine guiding principles for culturally competent disaster mental health services • Cultural competence self-assessment for disaster crisis counseling programs

Course Title	Format	Topics covered	Learning Activities	Cultural Competency
Disaster Behavioral Health: Tools and Resources for Idaho Emergency Responders (Northwest Center for Public Health Practice, University of Washington) http://www.nwcphp.org/training/courses-exercises/courses/disaster-behavioral-health	Distance learning course	<ul style="list-style-type: none"> Psychological phases of a disaster Temporal patterns of mental/behavioral response to disaster Resilience Signs and symptoms of disaster victims Principles of post-disaster psychological needs assessment Basic principles of post-disaster approaches to mental health Rural mental health 	<ul style="list-style-type: none"> Audio presentation supported by slides Interactive case study Links to additional resources 	<ul style="list-style-type: none"> Covered marginally (Native American tribes are mentioned among vulnerable populations) General recommendations on community involvement
Disaster Mental Health (Center for Public Health Preparedness, University of Minnesota) https://cpheo1.sph.umn.edu/PHET/disaster/intro.asp	Distance learning module	<ul style="list-style-type: none"> Types of disasters Types of reactions to trauma Resiliency Disaster mental health (DMH) goals Disaster psychotherapy and DMH Community partnerships 	<ul style="list-style-type: none"> Pre-test Slides enhanced with images and audio Knowledge review activities Post-test 	<ul style="list-style-type: none"> No
Disaster Mental Health (Essential Learning, approved by the American Psychological Association) http://www.volunteersolutions.org/volunteer/news/one.tc?item_id=10238452883 http://www.cequick.com/individual/	Distance learning course	Part 1: <ul style="list-style-type: none"> Comprehensive model of disaster PTSD symptoms PTSD diagnosis Factors contributing to PTSD Part 2: <ul style="list-style-type: none"> Assessing for comorbidity Depression, alcohol/drug abuse Other disorders 	<ul style="list-style-type: none"> Interactive content presentation Knowledge review activities Flash cards review activities Scenario-based knowledge transfer activities Post-test 	<ul style="list-style-type: none"> No

Course Title	Format	Topics covered	Learning Activities	Cultural Competency
		Part 3: <ul style="list-style-type: none"> • Treatment and triage • Decision tree • Medication for PTSD • 7 practical frontline skills 		
Disaster Mental Health: A ‘Lessons Learned’ Update (John Hopkins Center for Public Health Preparedness) http://www.jhsph.edu/preparedness/training/archives/mental_health_2005.html	Webcast of a conference	<ul style="list-style-type: none"> • Terrorism • Psychological contagion and its influence in disaster planning • Populations at risk for pathological reactions • Integration of disaster mental health, public health, and human services • Mental Health Community Response Coalition • Strategic mental health planning 	<ul style="list-style-type: none"> • Webcast • Downloadable PDF files with handouts 	<ul style="list-style-type: none"> • No
Disaster Mental Health Intervention (John Hopkins Center for Public Health Preparedness) http://www.jhsph.edu/preparedness/training/online/mentalhealth_trainings	Distance learning module	<ul style="list-style-type: none"> • Basic assumptions of the disaster • Basis for disaster mental health intervention • Models for disaster mental health intervention 	<ul style="list-style-type: none"> • Interactive content presentation • Audio narration synchronized with slides • Interactive knowledge assessment 	<ul style="list-style-type: none"> • No
Disaster Mental Health Services (Riverbend Behavioral Healthcare Associates) http://www.psychceu.com/cultural_competence/disasterindexpdf.asp	Distance learning course	<ul style="list-style-type: none"> • Key concepts of disaster mental health • Survivors’ needs and reactions • Disaster counseling skills • Potential risk groups (to include ethnic groups) • Disaster 	<ul style="list-style-type: none"> • Course content is presented through downloadable text • Online assessment 	<ul style="list-style-type: none"> • Covered marginally • Cultural and ethnic groups are mentioned as having potential risk factors. • Recommendation provided for

Course Title	Format	Topics covered	Learning Activities	Cultural Competency
		reactions and suggested mental health interventions <ul style="list-style-type: none"> Organizational approach to disaster mental health 		providing culturally sensitive services
Effects of Disaster on Mental Health: Technical Level (University of Iowa) https://icon.uiowa.edu/d2l/orgTools/ouHome/ouHome.asp?ou=60924	Distance learning course	<ul style="list-style-type: none"> Screening and intervention Assessing traumatic impact Tips for providing mental health help Screening patients Normal vs. pathological reactions to trauma Common mental health disorders associated with trauma Treatment options Cultural barriers to interventions Providing culturally sensitive interventions Outline for cultural formulation 	<ul style="list-style-type: none"> Text with images Interactive content presentation Interactive features allowing to submit course feedback and bookmark pages Case studies Tools to self-assess the knowledge Discussion forums 	<ul style="list-style-type: none"> Cultural barriers to interventions Providing culturally sensitive interventions Outline for cultural formulation
Introduction to Mental Health and Disaster Preparedness (John Hopkins Center for Public Health Preparedness) http://www.jhsph.edu/preparedness/training/online/mental_hlth_intro.html	Distance learning module	<ul style="list-style-type: none"> Topics of disaster mental health services Mental health surge capacity Psychiatric first aid 	<ul style="list-style-type: none"> Interactive content presentation Audio narration synchronized with slides Interactive knowledge assessment 	<ul style="list-style-type: none"> No
Mental Health: Culture, Race, and Ethnicity (CEU-	Distance learning course	<ul style="list-style-type: none"> Mental health and mental illness 	<ul style="list-style-type: none"> Course content presentation 	<ul style="list-style-type: none"> Yes

Course Title	Format	Topics covered	Learning Activities	Cultural Competency
<p>Hours.com Riverbend Behavioral Healthcare Associates)</p> <p>http://www.ceu-hours.com/tests/disasterentry2.html</p>		<ul style="list-style-type: none"> • Race, ethnicity, and culture • Diagnosis and culture • Culture-bound syndromes • Risk factors common to mental health problems and mental disorders • Protective factors against mental health problems and mental disorders • Methodological issues in studying minorities • The influence of culture and society on mental health and illness • Culturally competent services 	<p>through downloadable text</p> <ul style="list-style-type: none"> • Online assessment 	
<p>Mental Health Implications of Public Health Emergencies (Michigan Public Health Training Center, University of Michigan, School of Public Health)</p> <p>https://www.sph.umich.edu/iscr/mphtc/module.php?module=courses_one_online_course_popup&id=220</p>	Webcast	<ul style="list-style-type: none"> • Health consequences of mass trauma • Injuries co-occurring with mental illness • Disaster psychological stressors after Katrina • Planning mental health operations • Emphasis on local public health agencies 	<ul style="list-style-type: none"> • Webcast synchronized with PowerPoint slides 	<ul style="list-style-type: none"> • No
<p>Practicing Cross-Cultural Communication</p> <p>http://www.nynj-phtc.org/cc2/menu.cfm?CFID=835988&CFTOKEN=59503887#</p>	Distance learning course	<ul style="list-style-type: none"> • Tips on effective intercultural communication • Interacting with specific racial and ethnic populations • Public health campaigns and community 	<ul style="list-style-type: none"> • Case-study based presentation related to minority communities with public health problems • Knowledge 	<ul style="list-style-type: none"> • Strategies for effective cross-cultural communication • Analysis of cross-cultural communication problems • Communication

Course Title	Format	Topics covered	Learning Activities	Cultural Competency
New York New Jersey Public Health Training Center		outreach	review activities <ul style="list-style-type: none"> Knowledge transfer through selecting appropriate communication strategies 	on scenarios for minority communities
Title VI – Cultural Competency (North Carolina Center for Public Health Preparedness) http://www.sph.unc.edu/nccphp/training/cultural_comp/certificate.htm	Online tutorial	<ul style="list-style-type: none"> Implications of Title VI Cultural competence Laws related to cultural competence CLAS Standards (detailed discussion) OCR guidance Measuring cultural competence 	<ul style="list-style-type: none"> Audio lecture supplemented with slides 	<ul style="list-style-type: none"> Implications of Title VI Cultural competence Laws related to cultural competence Measuring cultural competence CLAS standards
WMD-MHI: Mental Health Interventions (Saint Joseph's University, Early Responders Distance Learning Center) http://erdlc.sju.edu/education/course-launch.php?id=19&passthru=true	Distance learning course	<ul style="list-style-type: none"> Module 1: History of psychological trauma (19th and 20th century research on causes and treatments) Module 2: Causes and effects of psychological trauma Module 3: Early interventions of psychological trauma (crisis intervention, behavioral prevention programs, traumatic memory restructuring) 	<ul style="list-style-type: none"> Interactive engaging content presentation Knowledge review activities Knowledge transfer activities (case studies, some are video-based) 	<ul style="list-style-type: none"> No

Appendix E. Web Resource Centers for Disaster Response Training

Web Site Title and Author	Format	Topics covered ⁵
<p>California Distance Learning Health Network (Graduate School of Public Health, San Diego State University)</p> <p>http://cdlhn.com/clickhere.cfm?type=m&id=107&title=Searchpercent20bypercent20Date</p>	Resource center	<ul style="list-style-type: none"> • Administration • Communication • Health and wellness • Mental health • Public health (to include community programs) • Culture (racial and ethnic disparities, minorities) • Preparedness and response
<p>Centers for Public Health Preparedness (Association of Schools of Public Health, Centers for Disease Control and Prevention)</p> <p>http://www.asph.org/cphp/CPHP_ResourceCenter.cfm</p>	Resource center	<ul style="list-style-type: none"> • Emergency management • Incident command system • Mental health/psychosocial preparedness • Cultural competence • Mass trauma • Terrorism preparedness
<p>CEU-Hours.com (Riverbend Behavioral Healthcare Associates)</p> <p>http://www.ceu-hours.com/courses.html#drugs</p>	Distance learning center	<ul style="list-style-type: none"> • Mood disorder • Substance abuse • Domestic violence • Counseling the culturally diverse • Disaster mental health services
<p>Independent Study Distance Learning Site (Emergency Management Institute, FEMA, DHS)</p> <p>http://emilms.fema.gov/</p>	Distance learning center	<ul style="list-style-type: none"> • Incident command system • Planning • Community response teams • Hazardous materials • Building partnerships with tribal governments • Resource management
<p>Michigan Public Health Training Center (University of Michigan, School of Public Health)</p> <p>https://www.sph.umich.edu/iscr/mphtc/site.php?module=courses&PHPSESSID=6a17422e26e1e1e9aaef57b34fbcfb43</p>	Training center	<ul style="list-style-type: none"> • Public health • Health disparities • Health data analysis • Legal issues for public health
<p>National Center for Disaster Preparedness (Columbia University, Mailman School of Public Health)</p> <p>http://www.ncdp.mailman.columbia.edu/training.htm</p>	Training center	<ul style="list-style-type: none"> • Resources, face-to-face workshops, and distance learning courses related to disaster preparedness • Training topics include: <ul style="list-style-type: none"> ○ Basic emergency preparedness ○ Basic crisis and emergency communication ○ Principles of disaster and public health emergency response

⁵ The lists of topics in this Appendix only include selected topics that are most relevant to the Scan.

Web Site Title and Author	Format	Topics covered ⁵
<p>New York New Jersey Public Health Training Center (Columbia University, University at Albany and the University of Medicine and Dentistry of New Jersey, state, city, county and local health departments throughout New York and New Jersey).</p> <p>http://www.nynj-phtc.org</p>	Resource and training center	<ul style="list-style-type: none"> • Cultural competence • Epidemiology • Injury/trauma • Minority health/health disparities • Policy planning • Terrorism/emergency readiness
<p>PublicHealthLearning.com (Mid-America Public Health Training Center (MAPHTC), the Illinois Public Health Preparedness Center (IPHPC))</p> <p>http://www.publichealthlearning.com/Public/Catalog/</p>	Learning management system	<ul style="list-style-type: none"> • 221 courses offered online that include the following topics: <ul style="list-style-type: none"> ○ Epidemiology ○ Community health development ○ Infectious disease preparedness ○ Public health, policy development
<p>North Carolina Center for Public Health Preparedness (University of North Carolina, School of Public Health)</p> <p>http://www2.sph.unc.edu/nccphp/</p>	Online training center	<ul style="list-style-type: none"> • Biostatistics • Bioterrorism agents • Chemical terrorism • Crisis leadership • Epidemiology • Emerging and re-emerging disease agents • Nuclear terrorism • Disaster planning and recovery
<p>South Central Public Health Partnership (University of Alabama at Birmingham, School of Public Health)</p> <p>http://www.soph.uab.edu/scphp/default.aspx?ID=591</p>	Training courses catalogue	<ul style="list-style-type: none"> • Cultural competence • Cultural diversity • Diversity leadership • Community partnerships and perspectives • WMDs, bioterrorism, chemical terrorism, agroterrorism • Epidemiology
<p>TRAINTexas (Public Health Foundation, State of Texas)</p> <p>https://tx.train.org/DesktopShell.aspx?tabid=1</p>	Training courses database	<ul style="list-style-type: none"> • Cultural competence • Emergency management • Emergency medical services • Epidemiology • Hazardous materials • Injury/trauma • Mental health • Minority health • Terrorism
<p>Understanding the Needs of Special Populations (Center for Public Health Preparedness, Ohio State University)</p> <p>http://www.comm.ohio-state.edu/pdavid/preparedness/index.htm</p>	Resource center	<ul style="list-style-type: none"> • Language barriers to hospital access • Overcoming language barriers • Documents are organized under the following categories: animals and pets, bioterrorism, children, cross-cultural, disability, language, reference, seniors, and links to online resources.

***Please note: Web sites referenced in this document may not be currently available.*

Appendix F. Tools for Cultural Competence in Disaster Response

Citation:

- Stengel, May 2000

Type:

- Guide

Highlights/Overview:

- A cooperative relationship between governments and community-based organizations (CBOs) provides the best assurance that the needs of under-served people and the needs of the community for long-term recovery will be addressed.
- CBOs provide an ongoing human service infrastructure to people in the community and they are often the best indicators of post-disaster needs.
- CBOs should be informed and involved in recovery activities since:
 - CBO services often supplement government disaster aid programs because in recovery government programs may not reach the people that CBO support.
 - Populations that are culturally isolated, non-English speaking or homebound present the greatest challenges in connecting services with needs.

Tools:

- Vulnerability profile.
- Diagram of what CBOs bring to emergency management.
- Bridging organizational differences between government and CBOs.
- Model of CBOs in the emergency operations center.
- Disaster service needs of vulnerable people.
- Finding a local CBO.
- Tips for developing a CBO emergency response plan.

Citation:

- Congress, 2004

Type:

- Paper

Highlights/Overview:

- Culturagram as a tool for assessing cultural backgrounds of families and identifying appropriate interventions (primary tool for social workers). The concept of culturagram examines 10 areas:
 - Reasons for relocation
 - Legal status
 - Time in community
 - Language spoken at home and in the community
 - Health beliefs
 - Crisis events
 - Contact with cultural and religious institutions
 - Values about education and work
 - Values about family-structure, power, myths, and rules
- Examples of how to use culturagram

Tools:

- Culturagram and examples of how it can be used.

Citation:

- CMHS, 2001

Type:

- Report

Highlights/Overview:

- “Racial and ethnic minorities bear a greater burden from unmet mental health needs and thus suffer a greater loss to their overall health and productivity.”
- Each minority group is highly heterogeneous and includes diverse mix of recent immigrants and refugees with vastly different histories, languages, etc.
- The report covers cultural interpretation of symptoms and different meaning that ethnic groups ascribe to their illnesses. Other cultural factors include causation and prevalence, family factors, coping styles, treatment seeking, mistrust, stigma, and immigration.
- The report states that cultural competence is driven by “humanistic values and intuitive sensibility rather than empirical evidence.” The report states that proposed models of cultural competence have not been empirically tested and need further research.
- The report contains chapters on mental health issues of major racial/ethnic groups (African Americans, Native Americans, Asian Americans, and Latino Americans). Each chapter describes historical context, current socio-economical status, mental health needs, availability, accessibility, and utilization of mental health services, and appropriateness and outcomes of mental health treatments.

Tools:

- Definitions of mental health, mental illness, and mental health problems.
- Definitions of race, ethnicity, and culture.
- Five aspects of cultural context of illness (cultural identity, cultural explanation of illness, cultural factors related to the psychosocial environment and levels of functioning, cultural elements in the patient-clinician relationship, overall cultural assessment for diagnosis and care.
- Definitions of idioms of distress and culture-bound syndromes.

Citation:

- SAMHSA, 2003

Type:

- Guide

Highlights/Overview:

- The guide provides guiding principles and recommendations for culturally competent disaster mental health services.
- The guide describes the “disaster phases” of emotional response that include:
 - Warning or threat
 - Impact
 - Rescue or heroic
 - Inventory
 - Disillusionment
 - Reconstruction or recovery
- The guide describes key concepts of disaster mental health.

Tools:

- List of questions to address in a disaster mental health plan.
- List of staff attributes, knowledge, and skills essential to development of cultural competence.
- Cultural competence self-assessment for disaster crisis counseling programs.
- Cultural competence checklist for disaster crisis counseling programs.

Citation:

- CDC, 2007

Type:

- Workbook

Highlights/Overview:

- The workbook offers step-by-step approach that can guide emergency managers and public health professionals in defining, locating, and reaching vulnerable minority populations.
- The workbook shows that adopting the CLAS Standards can greatly benefit organizations who strive to achieve cultural and linguistic competence.

Tools:

- The definition of vulnerable populations.
- Step for defining, locating, and reaching vulnerable minority populations.

Citation:

- Ehrenreich, 2001

Type:

- Guidebook

Highlights/Overview:

- The guidebook argues that “there is no single, universally applicable recipe for responding to disasters.”
- The guidebook shows that different cultural groups have various beliefs about mental health, and may respond in unexpected ways to outside medical and mental health professionals.
- The guidebook discusses stages of psychological response to disasters, and needs of different population groups.
- The guidebook provides principles of psychological intervention following disasters. Two major interventions include rebuilding the community affected by the disaster and intervening with individual victims.
- The guidebook offers ten principles of disaster mental health interventions:
 - Safety and material security underline emotional stability
 - Emotional responses to disaster are normal
 - Matching interventions to the disaster phase
 - Integrate psychosocial assistance with overall relief programs
 - Interventions must take people’s culture into account
 - Direct interventions have underlying logic
 - Children have special needs
 - Women have special needs
 - Residents of refugee camps have special needs
 - Rescue and relief workers have special needs
- The guidebook provides an overview of specific intervention techniques, for instance defusing, critical incident stress debriefing, and stress reduction techniques, expressive techniques.

Tools:

- Factors that influence disaster response.
- Stages of psychological response to disaster among survivors, as well as list of common disorders that follow disaster.
- Responses to disaster among different population groups (excluding minorities).
- Suggestions on assessing the disaster survivors.
- Cross-cultural issues of disaster victims’ assessment including working on interpreters.
- List of factors to take into considerations when providing cross-cultural interventions.

Citation:

- Jones et al., 2006

Type:

- Paper

Highlights/Overview:

- The paper suggests a “cultural competence model for assessing minority and marginalized communities affected by disaster.”

- The suggested model is based on cultural competence and the CLAS Standards and emphasizes that the relationship between the disaster and outcomes is mediated by resources (for instance, trust, access, and cultural/linguistic capabilities).
- The paper hypothesizes that if the resources are provided to minority communities in a culturally competent manner, the outcomes for minority communities will improve.

Tools:

- Cultural competence model for accessing minority and marginalized communities affected by disaster.
- Recommendations on conducting disaster mental health research in a culturally competent manner.

Citation:

- MDMH, 2006

Type:

- Guide

Highlights/Overview:

- The guide underlines the focus of behavioral health disaster response (BHDR) as short-term interventions that help survivors cope with the aftermath of disaster mitigate additional stressors or psychological harm, and to help developing coping strategies.
- The guide discusses goals of BHDR (promote safety and security, identify needs, problems, and solutions, assess functioning and coping, provide reassurance, normalization, and education).
- The guide discusses skills necessary for providing BHDR (establishing contact, building rapport, maintaining calm presence, active listening, responding to survivor's needs, and maintaining flexibility).
- The guide lists factors to consider when screening and assessing survivors to include culture.
- The guide includes recommendations on how to respond to minorities affected by disasters in a culturally sensitive manner. Considerations for working with diverse ethnic groups include communication, personal space, social organizations, time, etc. and practical suggestions.

Tools:

- Principles of behavioral health disaster response.
- List of common reactions to disasters.
- Suggestions on developing cultural competence.
- Quick Tip Sheets.
- Collection of resources related to treating PTSD.

Citation:

- Norris and Algeria, 2005

Type:

- Paper

Highlights/Overview:

- The paper discusses epidemiology of mental disorders among minority populations (e.g. PTSD) and argues that the research on this subject is inadequate due to research design and culturally different responses to screener items. Research and current effective treatments still need to be "translated into community settings." The gap between research and practice is worse for minorities than it is for white survivors.
- The paper reveals ethnic disparities in using mental health services and help-seeking behaviors.

Tools:

- Framework for cultural competence in mental health services.
- Recommendations for culturally competent care.

Citation:

- Saldana, 2001

Type:

- Guide

Highlights/Overview:

- The guide provides an overview and definition of cultural competence as “the integration and transformation of knowledge, information, and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques, and marketing programs that match the individual’s cultural and increase the quality and appropriateness of health care and outcomes.”
- The guide lists KSA related to cultural competent mental health service.
- The guide provides general communication tips when counseling diverse populations and notes potential areas of miscommunication.
- The guide points to common pitfalls when assessing culturally diverse groups and lists culture-related syndromes.
- The guide contains suggestions on conducting effective outreach in local communities.

Tools:

- Tips on working with translators and interpreters.
- Tips for evaluating culturally specific syndromes.
- Suggestions for addressing cultural variability.
- Suggestions for working with translators and interpreters.

Citation:

- Sue and Sue, 2003

Type:

- Book

Highlights/Overview:

- The book suggests 3-dimensional model of identity and multidimensional model of cultural competence in counseling.
- The book lists barriers to cultural therapy (culture, language, class, institutional practices).
- The book discusses minority identity development models and cultural issues related to mental health of major racial and ethnic groups (African Americans, Asian Americans, Latino, and White Americans).
- The book lists principles of organizations change related to cultural competence that include: realistic assessment of the level of multicultural development, interrelatedness of the subsystems within an organization (changing one aspect does not mean changing the whole system), and dangers of prematurely introducing change.

Tools:

- List of cultural competence attributes sorted by awareness, knowledge, and skills.
- Racial/cultural minority identity development and its cultural implications.
- Suggestions on counseling African Americans, American Indians, Asian Americans, Latino Americans.
- Model of intercultural organizational development.

Citation:

- Young et al., 1998

Type:

- Guidebook

Highlights/Overview:

- The guidebook identifies the primary objective of disaster mental health services as restoring community equilibrium. “Disaster mental health services, in particular, work toward restoring psychological and social functioning of individuals and the community,

and limiting *the occurrence and severity of adverse impacts* of disaster-related mental health problems.”

- The guidebook provides overview of stress reactions among survivors (disaster stress, peritraumatic stress reactions, PTSD).
- The guidebook offers guidelines on helping the survivors during each disaster phase.
- The guidebook provides guidelines for mental health services for disaster relief teams (helping the helpers), and organizational policies and procedures related to providing disaster mental health services.

Tools:

- Stress reactions.
- Guidelines for helping survivors.