Applying Cultural Awareness to Disaster Behavioral Health

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Moderator: Hello and welcome everyone! This is Marcela Aguilar from the Substance Abuse and Mental Health Services Administration's Disaster Technical Assistance Center or SAMHSA DTAC. I will be your host for this webinar. This afternoon SAMHSA DTAC is pleased to present Applying Cultural Awareness to Disaster Behavioral Health. Let's begin with the Applying Cultural Awareness to Disaster Behavioral Health webinar. The webinar will feature Ms. Lori McGee, Training and Curriculum Manager of SAMHSA DTAC, Dr. Monica Indart of Rutgers University, Dr. Kermit Crawford of Boston University, and Ms. Almarie Ford of the Louisiana Office of Behavioral Health. I would now like to introduce Ms. Lori McGee. Ms. McGee serves as the Training and Curriculum Manager for SAMHSA DTAC. She has more than 11 years' experience working with program and curriculum developers to improve services using evaluation findings. At SAMHSA DTAC she supervises the development of training both in person and web based. She is also the lead on the Crisis Counseling Assistance and Training Program activities. Ms. McGee has worked with at-risk and delinquent youth populations, populations receiving mental health services, women and families in crisis, and minority students. She has prior experience in providing counseling and legal services to survivors of domestic violence and in developing programs to reduce and prevent violence in schools. Ms. McGee holds a bachelor's in psychology from Barnard College and a master's in criminology and criminal justice from the University of Maryland, College Park. Please welcome Ms. Lori McGee.

Ms. McGee: Hi everyone, and thank you. I just want to thank everyone for joining us today, and especially our presenters. I am really looking forward to everything they have to say. I just want to say a few words about SAMHSA DTAC. We were established to support States, Territories, and Tribes to deliver effective behavioral health in response to disasters. When we say behavioral health, we do include both mental health and substance abuse. We offer many services, primarily consultation and trainings. This can include a cadre member or one of our consultants going out into the field or providing training. We provide dedicated training and technical assistance for disaster behavioral health response for grants such as FEMA's Crisis Counseling Assistance and Training Program. We also do some work around identification and promotion of promising practices in disaster behavioral health. We have had a recent series of webinars with the disaster behavioral health planning. That would be one of the kinds of work that we do that falls into that category. In addition to those services that we provide, we also have many resources. I encourage you to call us or contact us if you have any disaster behavioral health needs, regarding resources. If you go to our website you will see disaster behavioral health preparedness and response and specific Disaster Behavioral Health Information Series. We call those our DBHIS, they have toolkits and resources geared towards specific populations or specific disasters such as a flood or a tornado. One of the pieces of materials that we have is the Developing Cultural Competence in Disaster Mental Health Programs. If you are looking for more literature related to today's webinar topic you can contact us and we can get you some copies of that as well. If you prefer e-communications, we have several e-communications that go out. We have the SAMHSA DTAC Bulletin which is a monthly

newsletter that contains various resources that come out or field events that are upcoming. You can subscribe by emailing the address you see here on your screen. We also publish The Dialogue. This is a quarterly journal; it is articles that are written by professionals in the field and you can subscribe by going to SAMHSA's website and following the instructions you see here on the slide. Finally, we have the SAMHSA DTAC Discussion Board. This is a more casual place where we go to post resources and have conversations about different topics related to disaster behavioral health. We sometimes ask questions of you and get your feedback or response and you can subscribe by going to the web address that you see here. That is my quick overview of what we do. If you find yourself in any need of technical assistance or training regarding disaster behavioral health please call us. We have a toll-free number 1-800-308-3515. You can also email us at DTAC@samhsa.hhs.gov or you can go to our website and browse around and see what else is offered. Dr. Amy Mack is our Project Director; she extends her welcome and her contact information is here as well.

Moderator: Thank you so much Ms. McGee. The goal of today's webinar is to provide information, recommendations, and tools that can be used to assess and strengthen cultural awareness practices in disaster behavioral health services. We will begin with Dr. Monica Indart who will focus on guiding principles of cultural awareness and their goal in disaster behavioral health. We will then hear from Dr. Kermit Crawford who will present the challenges of addressing cultural issues when providing disaster behavioral health services. We will end with Ms. Almarie Ford who will discuss her experiences and lessons learned from applying cultural awareness concepts and techniques in supporting the disaster behavioral health needs of survivors. Following each presentation our guest speakers will respond to questions. The learning objective of today's webinar are to provide guiding principles and recommendations for applying cultural awareness to disaster behavioral health, to provide cultural awareness best practices specific to disaster behavioral health preparedness and response, and to provide tools that can be used to assess and strengthen cultural awareness practices for disaster behavioral health services. I would now like to introduce Dr. Monica Indart. Dr. Indart is a clinical and community psychologist with nearly 30 years of experience working in crisis intervention, trauma, and disaster response. She is a visiting assistant professor at the Rutgers University Graduate School of Applied and Professional Psychology. Dr. Indart has worked with various cultural communities following disasters in New Jersey. She provided training, consultation, and technical assistance to the United Nations in ongoing development of their crisis and disaster response preparedness programs and provided psychosocial assistance to survivors of torture in Uganda and Rwanda. Please welcome Dr. Indart.

Dr. Indart: Thank you for the introduction and good afternoon everyone. I want to thank SAMHSA DTAC and my co-presenters in participating in this webinar which I think is critically important to disaster behavioral health and all of the continuum of services that we provide. My goal is to provide an introduction to the topic and then segue into my esteemed colleague, Dr. Crawford, who will be talking more about challenges and complexities in this. I am going to be providing a framework and a macro perspective for us to discuss some of these issues. The first issue that comes up is terminology. Cultural competence has been the term that we used for a long time and we are rethinking this in some ways, not to throw the baby out with the bathwater but rather than cultural competence, we are thinking of it in terms of culture and competence. As our society becomes more diverse, as we become more sophisticated in understanding what is helpful in terms of interventions, it can be beneficial to reframe our understanding to include a broader understanding that looks at difference and diversity and a continuum of competencies and skills and abilities in providing culturally good care, or culturally responsive care. Some of these terms can mean cultural responsiveness, cultural sensitivity, and certainly the term cultural competence that we have all become familiar with. It may be that we come to see cultural competence as an ideal that

we strive towards. We are introducing a term of cultural awareness as an emerging preferred term that reflects two aspects. One is this universally helpful idea of compassionate curiosity. Regardless of who you are working with and in what part of the world you are working with, people respond to this feeling that they get from us as responders of compassionate curiosity. The other part of cultural awareness is that it implies the dual aspects of culturally responsive care, which is being aware of ourselves and our own cultures, our own biases, our own limitations as well as the cultural values, beliefs, and needs of the people in communities that we are working with. The next two slides are graphic representations of what it means to integrate aspects of cultural awareness into disaster behavioral health. It is a bit of a simplification but we have two possible scenarios that emerge; both of them reflect an emergent and transitory disaster culture so that every disaster has its own unique fingerprint, is how I like to think about it, and its own culture. One scenario is that we have two distinct or fairly distinct cultures, one is the culture of survivors and the other is a culture of responders. We have responders who is not necessarily a part of the culture of the community or the geographic region come in to provide assistance and in interacting, influencing, and being influenced by the culture of survivors they form an emergent disaster culture that is transient and transitory. An example of this may be some of what we experienced here in the New York metropolitan region after 9/11, when we had people not just from all over the country but in some ways all over the world come to assist us. Many of those folks were familiar with the cultural diversity of this part of the country but many were not. We had in some ways a distinct culture of responders and a distinct culture of survivors. The second possible scenario——again, keep in mind these are general points, is where we have the culture of survivors and the culture of responders really a mixed culture that is endemic to the geographic region, to the area where the disaster occurs. The responders come from the culture of survivors and together this complicated mix again creates an emergent, transient, temporary disaster culture. An example of this may be Hurricane Katrina and what was experienced in the Gulf States, for example in New Orleans, where many of the people who were affected who come from, as this slide describes, the culture of survivors also became responders. They had the dual experience of being a survivor in that particular culture and that disaster as well as joining the culture of responders in providing assistance. Keep in mind these are encounters in disasters and that again, the situation that is created is a temporary, transient, emerging disaster culture and that is one of the foundation principles that we want to have people keep in mind. I am going to be describing culture as both a bridge and a foundation. Again, Dr. Crawford is going to elaborate on these ideas much more eloquently but keep in mind as a starting point that culture provides a bridge; it provides a way of understanding human experience. Here human experience can be simplified to include these two pillars of influence. One is biological, what we are born into the world with, our race, our culture, or ethnicity, our temperament, and those kinds of aspects. Then, what is learned, what we acquire through the socioeconomics background that we come into the world with or that we achieve, sociopolitical influences. Culture provides a bridge between these two pillars of experience and it helps us define how we understand the world. It is a lens of how we understand the world that is that fundamental. It also provides a foundation for us. Here I like to tie culture to crisis responsiveness because culture provides the responsiveness in the term crisis response. Culture is how we embody a feeling of responsiveness for the people that we work with. It is at the core of crisis and disaster response. It implies awareness of difference and diversity, as I mentioned earlier, what is experienced as well as what is expressed. I will talk a bit about that next. Awareness of individual needs and the competencies that we require to meet these needs of the people in the communities that we serve. It allows us to better understand what is expressed and listen for what is experienced so that we can provide what is needed. An example of how some of this gets played out——if I can just say from recent experience, I just returned from Rwanda where I have been doing some work for the past several years and there 17 years after the genocide in 1994 we have now a second generation of communities coming into being and trying to cope with the long-term effects of genocide and the horrors that occurred from that. What is expressed is oftentimes quite different than what is experienced. It takes a long time to win

the trust of people who are different from us and who experience us as different so that we can understand that what people experience is not always what they express and we have to understand both in order to be able to meet what they need. To have that kind of subtle understanding and appreciation is another part of culture as a foundation. Perhaps in some ways the best way of understanding the critical importance of cultural awareness is to take a look at the negative aspect, which is cultural non-awareness and how that can lead to what we think of as non-competent care. Here we see that it is more than just a principle of care, it really defines good care. What happens when we are not culturally aware, culturally responsive, and competent to meet the needs of the communities that we serve is that it results in a sense of disconnection for both ourselves and survivors. Survivors start to feel disconnected from sources of hope and healing, they start to feel a sense of disillusionment that life and circumstances can improve, that there is caring and compassion in the world. They start to feel and experience an increasing of distress, so that as hope fades despair and distress emerge again. Lastly, this can lead to dysfunction and as we know from studying long-term traumatic experiences that dysfunction can extend across generations. Lastly, these negative experiences are not just survivors but also what we as responders can feel when we start to feel disconnected from the people that we serve and that, in extreme cases, can lead to things like burnout. There are some substantial costs to non-competent care. I just want to segue quickly into evidence-based practice and talk about what in the world that has to do with culturally competent or culturally aware care, and it has a lot. Here is a very quick definition you see on your screen from the American Psychological Association that looks at a very commonsense and pragmatic definition of evidence-based practice that focuses on client characteristic, culture, and preferences and focuses on outcomes. What I really want to emphasize is that at the heart and soul of evidence-based practice is looking at two things: who are the people we serve——and that very much includes the person's cultural background——and secondly the focus on outcomes. What is most helpful to a particular client or community or group? Under what circumstances? We are looking at how culture influences positive outcomes of adaptation, recovery, and healing. I am going to leave questions for the end. The next slide that you see is a graphic representation of this. Again, clinical expertise, that includes the clinician, our own cultural awareness, the research evidence, the focus on outcomes, what is helpful for who and cultures at the center at the center of that as well as client values and preferences. Obviously, we have culture at the center of that experience as well. How much cultural awareness is tied to evidence-based practice is what we want to emphasize here. On your screen you see a photo I took number of years ago. I was in Uganda, these are the Agape Peace Dancers, they are former child soldiers, and they go from village to village dancing and singing their messages of peace, hope, unity, and reconciliation. We included the slide to remind us that healing comes in many forms and that these forms are rooted in rich cultural traditions and here is a photo example of one of those traditions and of healing and recovery in action in a particular culture. In 2003 SAMHSA published a handbook, Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations. It was developed by Dr. Jean Athey and Dr. Jean Moody-Williams with the assistance of many experts in the field. The last part of this introduction is going to review the nine principles that were included in that guide. It is still extremely useful and very pragmatic and I encourage all of us to use that. I am going to take each of these nine principles and move them a little bit forward so that 8 years down the road from when this guide was developed, emphasizing how we can operationalize these principles in today's evolving, complex matrix of culture and disaster response and what we can do that is going to promote cultural awareness. The first three really introduce the idea of culture and diversity and highlight the importance of recruiting disaster workers who are representative of the community or service area, which we all know. If we move these principles a bit forward, again this is our adaptation of an operationalization of these concepts, we find that culture is not just a buzzword, cultural awareness is not just the popular term or concept of the day, it is really how we define good care and what that means is that we have to get out and know people. We have to get out of our offices, managers and clinicians alike, and get into the street so to speak. How I operationalize this is we have to meet the people

we treat in the street. We have to develop meaningful relationships with people that are engaged and sustained for long periods of time. Clinicians and managers must do this in order to be able to have the kind of collaborative relationships that define culturally aware care. The next three principles from the 2003 guide emphasize the critical role of training and again, we used to talk about this as cultural competence training and that term may be redefined and expanded a bit, as we discussed. Ensuring that the services are accessible, they are equitable, and recognizing the role of help-seeking behaviors, natural support networks. Clearly what we have understood over the last decade of disasters is how important it is to use natural support networks but first we have to understand them before we can really use them and leverage them. To emphasize, moving forward how we want to focus attention on building and sustaining awareness and that this includes a multicultural exchange. A big part that I think we have not given sufficient attention to is the role of fairness and justice as critical principles that affect recovery, particularly in communities, large communities of refugees and immigrants. Many refugees and immigrants have had varied experiences of unfairness and injustice and those experiences have colored not just their perception of the world and the particular disaster or trauma they may experience but what they can expect from us as providers and responders. We need to integrate principles of social justice into all of our interventions. We need to be open to hearing about their experiences of unfairness of injustice and we need to provide interventions and relationships that are built upon these principles of social justice. Fairness and justice is recognizing the reciprocal nature of aid and learning, we learn from one another and we help one another. For many immigrant and refugee populations what is critical is for them to feel that this is a mutual process. They don't want to take, but also give in the process, that's the reciprocal nature. The last three principles, the importance of cultural brokers, identifying community leaders and working with those leaders, linguistic and culturally appropriate services, and using cultural brokers and leaders in evaluating the program's effectiveness. Moving that forward, a bit of a tweaking of those three principles, how important it is to have real relationships. It is not just enough to have these principles on paper. Having a cultural awareness program is a necessary but not sufficient condition for agencies that is the term we like to use in science. Cultural leaders have to be brought into every aspect, every nook and cranny of the programs that serve the communities that we provide interventions for. From planning and delivering services to evaluating and revising them. It sounds a little corny but one of the things that I like to think of is the allegory of the children's book The Velveteen Rabbit and here to recognize that these defining principles involve essentially making compassion real. The best way to make it real and keep it real is to have a true collaboration and genuine partnership with these cultures and cultural brokers in our communities. Not just occasional meetings, not just these quarterly trainings but regular events, all kinds of activities and opportunities where you come and you eat together, you sit together, you talk together, you laugh together, you argue together, you celebrate your successes together. Then, just as in The Velveteen Rabbit, when you cry together that is when you have a sense that you have made something real and sustainable and that will live on past all of us in the community. Just in closing I want to leave this quote by Azar Nafisi, the esteemed Iranian author who wrote Reading Lolita in Tehran, "In a place of knowledge, we are all citizens of the world," and I think that is a good segue to what I know will be a very informative and viable presentation by Dr. Crawford. I want to thank everyone and see if I should be taking questions now.

Moderator: Thank you so much for your presentation, Dr. Indart. I will now read the questions that we received for you; we have three questions. What are some of the major missteps that crisis responders or behavior assessment teams tend to make in regard to a lack of cultural awareness or sensitivity?

Dr. Indart: Whoever asked that question, I want to thank you for being open minded. By asking the question in a lot of ways you are well on your road to avoiding a misstep because you recognize that there

are missteps to be made. It reminds us that essentially the answer to that question is we have to all be learning all the time. If I had to quickly identify the top three missteps it would be thinking that we know or believing that we know how to respond to particular culture because we have had cultural awareness or cultural competence training. This is an evolving process, we are never going to know how to do things, we are going to understand the process of how to do things but believing that we know something I think can sometimes be a misstep. It is not appreciating the humility that is involved. The second one is being blind to our own biases. That is a misstep. We have to constantly be aware of our own biases, that we have them, and to be honest about them and how they may influence our behavior and actions. I have to say this from my own experience, another misstep is being afraid to take risks or being afraid to ask questions. We can't know everything and the only way we are going to learn is to ask and that involves taking a risk, it involves making ourselves vulnerable. Being hesitant to do that has a price and that is a misstep. That would be a short answer to that.

Moderator: Could you please give an example of what is expressed versus what is experienced in order to better understand this subtle, yet critical, difference?

Dr. Indart: I guess because it is fresh in my experience, having just come back from Rwanda the day before yesterday, in certain cultures there is a great deal of emotionality experienced. There is a great deal of suffering that is contained. What is shown to the outside world, not just outsiders, but even to people within the culture can be a very small part of that. The kind of suffering, the kind of internalization of racism and social injustice that one has experienced is not what is expressed. If I can say, it can be easy to miss that, it can be easy to miss the depth of suffering and the depth of injustice that someone is experiencing. It takes time and patience and that compassionate curiosity to be able to understand what is going on in the inside, not just what is shown on the outside. It is only then that you can have some idea of what the person needs. If we just go by what they are showing on the outside, in some cultures that is only a small piece of it and that is all we will ever see. I hope that helps.

Moderator: What role do our individual biases play in assessing what is expressed or what is needed?

Dr. Indart: Part of it may come from our own cultural background. I happen to come from a more Mediterranean/Latin culture and we express a lot. Not that we are expressing everything but a lot of times we are expressing most things and might miss that in a culture where it is much more contained. To be aware that our own background on either end of the continuums and everything in the middle may influence what we see because we are products of our own cultures as well and we have had our own culture to understand those two pillars of human experiences that I described earlier. To be aware of what may be our limitations and to constantly keep that in the forefront of our mind and be asking ourselves "What might I be missing here?" And "How can I compassionately assess that and find that out?"

Moderator: Thank you again for your presentation Dr. Indart. I now would like to introduce Dr. Kermit Crawford. Dr. Crawford is a licensed psychologist and designated forensic psychologist who serves as an associate professor of psychiatry and the Director of the Center for Multicultural Mental Health at the Boston University School of Medicine. He has provided response to and training for interventions across a number of disasters since 9/11. Dr. Crawford is the recipient of the Association of Psychology Postdoctoral and Internship Centers 2011 Award for Excellence in Diversity Training. Please welcome Dr. Crawford.

Dr. Crawford: Thank you, and I want to thank, as Dr. Indart did, DTAC. And I also want to say what an honor it is to be able to present with my colleague Dr. Monica Indart and my colleague Ms. Almarie Ford, whom I worked with for months after Hurricanes Katrina, Wilma, and Rita. She was awesome. I am going to talk about something a little different. I know in these types of presentations people look for breakthroughs, they look for magic bullets, at least I know I do. In this particular environment I think that there are a lot of challenges. In fact, I think that there are a lot more questions than there are answers when it comes down to issues related to culture, cross culture, cultural awareness, and cultural competence. I want to focus a little on cultural competence first. For the record, I think that cultural competence is worthy. I think it is essential. And at the same time I think that it is a myth. I know this sounds contradictory, and it is, but for me so too is the nature of cultural competence. As I think about this particular slide when in deep stuff, look straight ahead and keep your mouth shut and say nothing. I think maybe too many times too many of us have, around concepts in general that are right, that are correct but someone at some point has to tell the emperor that he has no clothes. I think that——again, in my opinion, as a pursuit, as a principle, and as an aspiration, cultural competence is top notch. As a concept, a social construct I think cultural competence has merit. But as a theory and as a measure of practice I think cultural competence is limited and is challenged and has restricted utility. I believe that by acknowledging its limitations and contradictions that we can more effectively seek the overdue, unmet promise of this concept and that unmet promise is considerable. I think this can also take undue pressure on responders and appropriately increase the urgency across cultural awareness, knowledge, and skills development when not in response. I see cultural competence as popularly viewed as having at least four flaws, either of which could be a fatal flaw for practice. The first I would say would be the totality problem. These are questions I have not yet been able to sufficiently answer. There is a definition of competence, there is a definition of culture and those separate I don't think are problematic but when you put them both together I think that to say that someone to be adequately or well qualified in the totality of socially transmitted behavior patterns, all other products of human work and thought, I feel that it is a bridge too far. I feel that it is almost an impossible task even before the caprice of working on disaster sites and in disaster response, the totality problem. Next, I would say there is a numbers problem. When I think of culture I think of the big eight, race/ethnicity, culture, gender——you can see them there on the screen. If we begin to combine these and think about the types of people that we see, again thinking of the totality of providing disaster behavioral health services to these individuals. Combining them we are talking about over 40,000 ways that the big eight alone can be combined. These are what people present with and this does not take into account the quantitative differences in self-identity or in multiple identities held by some people. Cultural competence's very definition requires to be well qualified to work across all of these types of differences. The third problem, the idealization problem. According to each prevailing model of cultural competence——I am talking about Cross and Purnell and Campinha-Bacote and others that I have read. Practices should always approach cultural competence as a standard but never achieve cultural competence. If you look at the slide, the red line would be the standard of cultural competence and the blue line on the Y axis would be behavioral health response practices. These practices always are said to approach cultural competence but never achieve cultural competence. In quantitative methods this is called an asymptotic function, always approaching but never achieving and this goes out to infinity. The way I see this is that if you always approach something, do things to work towards something and can never achieve that thing then that thing is unattainable. The final problem is that there is a significant lapse of quantitative validation and also a reliable qualitative replication related to outcomes with mental health and disaster behavioral health services. There is very little research and I can talk about that later if there is a question related to that. If I add the totality problem, the numbers problem, the idealization problem, the lack of quantitative validation and reliable qualitative replication, again this makes cultural competence almost unattainable. I don't want to give up on this concept because to me cultural competence still yields a great unmet promise. This type of honest and open discussion about the

challenges of the concepts to me seems to take us a little bit closer towards the awareness that we need and to me the awareness is our lack of cross-cultural competence. It is a starting point to talk about what needs to be done rather than an ending point. I offer this slide because Mike Tyson, former heavyweight boxing champ, was reportedly to have said that every boxer has a strategy for each fight, until the first time they get punched in the face. This relates to me in terms of how we go about our behavioral health response. We go into action, we have our plan, our plan is backed up by skills and experience, we are going to do our best and then something new, something different, something totally unexpected, life happens. Even in these situations of life happening most people most of the time get better. In these times when we go into disaster response we have our plan but I see our plan as classical music and that is the formal way that we are taught to do disaster behavioral health response and how we have been taught and how we are prepared to do it. The reality is that when we go into a disaster response a lot of these things we take with us only when they are ingrained within us. Instead of playing classical music we are really dealing with chord structures, rhythm patterns, and melody. Instead of playing classical music I think we have to learn how to play jazz. In order to play this we will start with an evidence base. I want to say that this is different from Dr. Indart's standard of an evidence-based practice and the APA standard. For me, I am including content knowledge and experience. Experience can also include observations. I think Dr. Indart did mention clinical experience with one of her diagrams. The evidence informs us that when we work with folks in the immediate aftermath of disaster the response typically and most effectively should be focused at safety, security, and comfort. If we look at it in terms of Maslow's hierarchy we are not going to get very high initially. A lot of that is going to be left for work later, primarily by the individual who is going through and who has made it through the disaster. Another consideration, the content of working in the aftermath of disaster with disaster victims, is the phases of recovery from disaster. This diagram was taken from a number of studies, a net analysis of looking to see how in studies people recover from disaster. There are a couple of important parts here. In the initial phases being present by the responder is important. In the continuing phases of disaster, practical support is helpful. Later, information and encouragement are helpful. All of these while understanding that at the end of the recovery process there will be a new normal for the individual who is going through the recovery. There are two methods primarily used in responding to disaster behavioral health in response. One is, Psychological First Aid and Psychological First Aid is manualized evidence-informed, modular approach to help those affected by disaster and it is intended to reduce initial distress to foster adaptive functioning and to enhance coping. After safety and security and emotional stability, a lot of this is reconnecting to the natural helping systems. The second method of response is——and more recently developed is the Skills in Psychological Recovery, SPR. SPR is aimed at problem solving, planning for more positive and meaningful activities, managing stress, building and rebuilding healthy social relationships. Both PFA, Psychological First Aid, and SPR, Skills in Psychological Recovery, incorporate the benefit of human resilience aimed toward recovery. This is a combined term that we have been working with here to get us a little bit closer to this notion of cultural competence in quotation marks to get around the limitations associated with cultural competence and also to address many of the issues related to cultural awareness. Remember, content knowledge and experience are irreplaceable but at the same time and as Dr. Indart mentioned, they are necessary, content knowledge and experience but not sufficient. The bottom line for me is and has always been whether any of this stuff works anyway. To my thinking, strong content knowledge in disaster behavioral health with an imbedded commitment to the inclusion of inter- and intra-cultural perspectives is one way, maybe a very important way to go. I use the words perspective because if we use perspective we can include specific evidence-based theories and practices, we can also include social constructs, and we can include the principles that Dr. Indart mentioned. Including, justice, equity, beneficence, and this term can be more easily operationalized for practical use than the broad terms and board expectations of cultural competence. This also includes cultural awareness. We should still recognize that much of the work to support cross-cultural and content capabilities will be done before a disaster ever occurs.

Sometimes it is important when you go into a disaster site to do nothing because the folks who are there who you are working with don't need that; human resilience is real. Sometimes cultures dictate or indicate to us—at least in our observation of the cultural expressions—that people don't need any direct intervention but just be there in case they do reach out to you but don't force anything. Intercultural to intra-cultural perspective require us to do work inside out and outside in, from looking at our own biases and resistances to working in the context of others and with the dynamics of difference that others have. This is where we talk about awareness and knowledge and other factors that the literature is important, experience is important, lived experience is important, and cross-cultural engagement really pays off. In addition, there are a number of skills that might be considered common factors. Common factors is a term that was used back in the 1930s, where they talked about the ability to establish an alliance with an individual and the ability to engage an individual emotionally. Much of this would be a building block, a foundation even, of common factors. I think that ultimately we are going to find that a lot of cultural competence, if we ever get there, to this unattainable term is going to be at its root, competence. Then there are the principles that Dr. Indart talked about, which would include justice, equity and beneficence, humility, and respect. We have the principles, social justice, equity, beneficence, the social constructs, cultural, history, politics, income levels and we have theories, dynamics of difference, identity development, power, privilege, micro aggressions, we have many of the building blocks of this new thing that we will call cultural awareness or we will call inter- or intra-cultural perspective and this can also provide a greater measure of practical benefit and interventions as they be more easily operationalized and measured more so than cultural competence. I ask finally that you please not say that Kermit Crawford killed cultural competence—that is not my intention. That couldn't be further from the truth. I think as with many other things cultural competence is very worthy and essential but it is challenged but so was a rosebush before a rosebush is cut back. I know because I did that to the rosebush in my yard that my wife planted and it is amazing this year after cutting back some of the dead parts how much of the rosebush actually comes back and how much a new rosebush comes through. I also have faith that we will have a breakthrough if we can talk about these things and how things are—by slightly shifting the words I think even this whole notion of cultural competence one day—I will use the words of my man Isaac Hayes who would say and this is by slightly shifting the words, let's not think of cultural competence as running out of gas, let's think of cultural competence as saving its best for last.

Moderator: Thank you so much for you presentation Dr. Crawford. We have two questions for you. How do you implement cultural competency in the midst of a crisis?

Dr. Crawford: I think that cultural competence is really worked out before you get to the crisis. Sensitivity, we have human resilience going, everyone has a history and has lived experience. I think we bring all of those into a crisis but true engagement, understanding, finding ways to understand more about culture, understanding the questions that we don't know that we don't know and pursing those questions and those answers. I think that would be the way to do it. We can plan to go into disaster setting and provide a response as pretty as we want to be with everything that we need to address the challenge. As I said earlier, things are so different once you get there. I had the privilege and awesome responsibility of being director of the Family Assistance Center in 9/11 and as you know the planes flew out of Logan International Airport here in Boston so I was there and we were there when many other clinicians and many other organizations providing services. We had rehearsed this several years for such a disaster, God forbid, but we had rehearsed it. We had gone through it with many different professions there and even going into that with all of the work that we had done, the drills and everything else, it was so different there would almost be parts of it unrecognizable. We were glad that we had done the work but a lot of that

certainly was contextual and situational that we had to play jazz as we were there with what we already knew.

Moderator: How do you suggest agencies address the cultural issues to develop outcome? How do we know that our approaches are reaching diverse populations?

Dr. Crawford: That question I would answer in a different way. It is very difficult when we talk about cultural anything related to outcomes. There have been a number of studies that have looked at cultural responsivity or linguistic resource support such as brochures in the language of the individuals that are serviced or people who spoke the language or speak the language and also who share the culture of the individual. There has even been assessment of cultural competence in many different agency settings. Until today there has not been a single—to my knowledge—outcome study that talks to the effectiveness of outcome of cultural-focused practices. In my heart I think it is there and morally I know it is there but as far as the science we don't have that yet. The term cultural competence has been around since 1982 and we are talking almost 30 years and we still don't have that. The thing that I ask myself is that in all the time that I have been working have I ever met anybody who was culturally competent. I can't say I have. I am certainly not there and wouldn't be there. With all of these considerations I would think that an agency would have a long way to go. There are things that an agency can do to put in place to show that diversity is welcome, to show that there is an understanding of different cultures, to show that there are people there who represent the culture—many of the things that Dr. Indart talked about. As far as outcomes, the bottom line for me still is are you making a positive difference in the lives of the people who are coming in as in disaster behavioral health, are we making a positive difference in the outcomes.

Moderator: Thank you for your presentation Dr. Crawford. I want to let everyone know that we are extending our webinar today by about 15 minutes, we hope you can stay a little longer but if not the webinar recording will be available online so you can hear all of it. I would now like to introduce Ms. Almarie Ford. Ms. Ford has over 30 years of experience in direct services, human services administration, program development, and evaluation. She has worked in the area of cultural and linguistic competence for over 20 years, currently serving as the Cultural Competence Officer for the Louisiana Office of Behavioral Health through Hurricane Katrina and Rita. Ms. Ford also supervises the SAMHSA system of care grant, Louisiana Youth Enhanced Services. She has also served as the Director of the City of New Orleans Mayor's Office of Human Resources Policy and Planning, overseeing the women's office, human rights office, citizen action center, volunteers in government of responsibility and the neighborhood planning office. Please welcome Ms. Ford.

Ms. Ford: I would like to thank DTAC for the opportunity to talk a little about field experiences and lessons learned from one of the largest disasters in our country. I am also privileged to be on this webinar with Dr. Indart and Dr. Crawford and I have to publicly acknowledge that Dr. Crawford was of great assistance to us in Louisiana as were so many other national experts in the field. Thanks again Dr. Crawford for all of your help. I would like to look at disaster workers' use of cultural awareness values and principles and efforts within survivor communities. Disaster workers collaborate and network with survivor communities to engage them in self-determination, help to develop community capacity by assisting and reestablishing rituals, culturally appropriate anniversaries, and commemorations. Setting specific meetings for disaster survivors to provide information is important because many times information is slow in getting to survivors. Reporting transitional living community's success stories give hope to other communities to help them strive for their goals. You must match the disaster workforce to the cultural makeup of the environment which helps to achieve local support and engage survivors. This

was a huge success in Louisiana with a large number of survivor workers throughout the State. Assertive outreach to community centers will help to address early needs of survivors to help them accept their transition community and be accepted. This includes safe communities in all education and human and social service agencies' involvement regarding ongoing needs. You should inform transition communities of the cultures of survivors residing in them and of their needs so that they can try to appropriately assist them. Development and implementation of specific culturally aware projects and events to benefit survivors. Specific support groups should be developed for survivors. In Louisiana we used a number of different types of names for stress management groups, two that were named were Coffee Break for adults and Juice Group for children. Just to mention another one or two, there was the Quilting Queens group and there was a Coping Bingo for the elderly group. You need various types of groups for crisis counseling and public education groups can be especially beneficial because they may be the best way to get correct information to survivors in a timely manner. Community events that can be utilized to reach some survivors include community fairs, festivals, and other types of community celebrations which Louisiana is famous for but I think in other communities those things can also be used. Interventions that boost and protect naturally occurring social supports and build social skills and neutral support are essential. In New Orleans neighborhoods generally people look out for each other and loan items to each other, watch each other's children. You want to keep folks moving in that direction to help each other even though they have all of these other problems going on. You have to enhance capacity to solve problems in the transition communities and you must reestablish people's rhythm and routines and you must assess and address vulnerabilities such as drinking and other substance use which increase during disasters. Disaster workers' engagement with individual survivors, implementation of cultural and linguistically aware individualized services, will help people cope with living arrangement with relatives, living in extremely rural areas and trailers. You can better assist survivors with the lack of public transportation in those rural areas to be able to get to grocery stores, drugstores, or local organizations to access resources. In Louisiana we had to work with survivors on the lack of food and some spices in grocery stores in transition communities that were staples in their diets in New Orleans. As you know it is important that comfort foods are available during this type of stress. The lack of support systems because they are separated from relatives and friends can cause issues such as the elderly being placed in nursing homes and/or senior apartments in the transition communities when they have been living on their own prior to the disaster because of their support systems. Many people become homeless when they are moved to transition communities due to the lack of family support. Specifically, people who are mentally ill and substance users. We also found that some first responders that were separated from their families and their usual work units to help in remote locations experienced significant stress. Youth and school and community adjustment issues, teens and other children survivors may face cultural issues such as dialect and slang used. In Louisiana many transition community children dealt with the fact that the new youth who were from other cities by referring to them by their area codes which was an insult and there were a number of fights and problems around all of that. You have to address disaster-related issues with the youth but also assist them in coping with stressors related to discrimination about the previously mentioned issues. In Louisiana we also found that lower income families were more likely to have a child at risk for behavioral disorders following the disaster and attention in this area is needed. Key lessons learned, in the communities specifically disaster workers used cultural awareness to educate and empower survivors to help emotional recovery. You must be aware of the need to shift areas of emphasis based on culture as survivors' needs change during each phase of recovery. You can initially intensify your focus on survivors willing and able to work on realistic and practical recovery plans immediately and then intensify your work with the other survivors. You must establish culturally appropriate social networks and partnerships for survivors as well as interventions and referrals in transition communities, include culturally appropriate mental health and substance abuse services as well as faith healers and the faith community. Recognition of ordinary citizens' acts of kindness with whom various survivor communities

identify is very important. In Louisiana we call them the unsung heroes. The acknowledgment of community-identified group leaders and other indigenous people for their contributions to make their communities and others proud and give hope to survivors. Key lessons learned around agencies involved. Priority outreach to provide special programming for staff who are survivors should be instituted to take care of their emotional needs. There is a need for staff with specialized training around the issues faced by priority populations, those who are mentally ill, homeless, etcetera, as well as general staff training and development regarding responsiveness to phases of recovery. Coordination and collaboration with the agencies in the transitions communities is most important to try to provide the most culturally aware services to the survivors. Reemergence and stabilization of the public and private sector infrastructure in the disaster communities with the assistance of outside experts and consultants is important so that creativity is used in rebuilding these systems. You must build ongoing preparedness in recovery planning, implementation, and evaluation so that all agencies and individuals will be constantly developing and refining their plans and have drills on what to do to be ready when future disasters occur. Working with survivors who have their own stress related to their losses must be more culturally aware of the emotional, financial, and other needs of the population receiving services. The survivors working with others must focus on the specific problems such as the lack of a job that would cause these specific circumstances. Disaster program administrative managers need cultural awareness regarding the disaster survivors who are workers because they are extremely vulnerable to emotional problems and compassion fatigue. Special ongoing stress management activities are necessary as well as sometimes changing the workers' jobs to address this issue. Key lessons learned regarding families, individuals, and those with special needs: You can help urban residents adjust to long-term placement in rural areas by addressing many of the issues already discussed and work within the transition community to try to remove any stigma related to the survivors being in that community. In Louisiana there was the hurricane evacuee stigma which caused many problems for people throughout the State. Use strategies that are culturally accepted by minority populations—that is another important thing we need to do. You need in-depth information relevant to specific survivor's cultures. I think Dr. Crawford said this as well, do not assume that everything you know about a race or culture applies to every individual or family in that group. If you ask the communities will help you with strategies that are needed. You must also help survivors close old, non-viable options by providing new ones, helping them get new ones. You can help them establish different and/or new customs or rituals and social relationships which will help them achieve a sense of normalcy. Some people cannot return to their original community because of medical issues, because the infrastructure issues are still around you don't have all of the medical institutions available, not enough doctors. Due to these kinds of problems you have to help the survivors to develop acceptable alternatives. I think Dr. Crawford also mentioned the whole thing about the new normal. The key thing is you have to work with folks and specifically the Gulf Coast, Louisiana and the New Orleans metro area specifically has the new normal and the information that I have provided for you are just a few of the important field experiences and lessons learned that we were able to present to you today but there are many more and we hope to never have disasters to get the kind of learning experiences that we have but then we do have to appreciate that we have a lot of information available to us now.

Moderator: Thank you so much for your presentation Ms. Ford. I have two questions for you. Are there any lessons learned about the cross-cultural issues in church-supported family support following relocations from shelters?

Ms. Ford: I would say there was a lot of that within the State of Louisiana where folks were moved from shelters through the help of church organizations and various churches and I believe that overall they were very positive experiences and one of the concerns was that the metro New Orleans area is primarily

Catholic and most of the rest of our State is non-Catholic. The work that was done was excellent work but the people did not have the opportunity to worship in the religion that they were most comfortable with at that time. As far as the provision of food, shelter, clothing, and other kinds of resources that were needed it was an excellent experience. No matter the race or culture of the group of the faith group that was providing services we did not find any problems with that. Cross-culturally it worked well.

Moderator: What part of the community is considered indigenous?

Ms. Ford: New Orleans—in fact I believe the data says approximately 70 percent of New Orleanians are lifelong and that is what we consider indigenous because they were born, raised, and die here.

Moderator: Thank you so much Ms. Ford and thank you to all of our presenters. Before we conclude today's webinar we wanted to give you the contact information for SAMHSA DTAC again. Please feel free to contact SAMHSA DTAC at any time. If you have any followup questions or we were not able to answer your questions during the webinar today please contact the presenters via email; their addresses are on the screen. Thank you all for participating in the SAMHSA DTAC Applying Cultural Awareness to Disaster Behavioral Health webinar.

[End of session.]