Navigating Uncertainty: Best Practices in Disaster Behavioral Health Podcast

Season 1: Diversity, Equity, Inclusion, and Accessibility (DEIA) in Disaster Behavioral Health

Episode 1: Introduction and Background—Transcript

Narrator: Welcome to *Navigating Uncertainty: Best Practices in Disaster Behavioral Health* from the Substance Abuse and Mental Health Services Administration Disaster Technical Assistance Center, also known as SAMHSA DTAC. This podcast covers disaster behavioral health, or mental health and substance use-related issues and where they intersect with disaster preparedness, response, and recovery. In our first season we'll explore diversity, equity, inclusion, and accessibility in disaster behavioral health.

Please note that the views, information, and opinions expressed in this podcast are those of the speakers and do not necessarily reflect or represent the views and opinions of SAMHSA. We've worked in this podcast to bring together a range of expert voices. We will cover many complex topics that always benefit from more and different voices. We invite you to share your questions and feedback with our team so we can keep making this podcast better and continue promoting nationwide disaster resilience and information sharing.

Xani Podolny: Welcome to *Navigating Uncertainty: Best Practices in Disaster Behavioral Health*. I'm your host, Xani Podolny, Deputy Director of SAMHSA's Disaster Technical Assistance Center. Thank you for joining our new podcast where we'll be exploring the intersection of disaster behavioral health and diversity, equity, inclusion, and accessibility, known as DEIA. I'm excited to be joined by a variety of experts in the field to discuss how DEIA impacts disaster recovery and response efforts.

In this podcast, we will be examining topics such as how DEIA can influence access to mental health services during and after disasters; the role of cultural competence in disaster response; and the importance of considering diverse perspectives when developing disaster policies and procedures. So whether you're a disaster response professional, mental health provider, or simply interested in learning more about the intersection of DEIA and disaster behavioral health, this podcast is for you.

Today I'm thrilled to be joined by Dr. Carla S. Perkins. Dr. Perkins is the Founder and CEO of Abounding Joy Counseling and Wellness Services, LLC, in Indianapolis, Indiana. She holds a bachelor of arts degree in sociology from the University at Albany, a master of science in social work from Columbia University School of Social Work, and a doctor of education in organizational leadership from the University of the Potomac. Dr. Perkins is a licensed clinical social worker with 23 years of social work experience and a strong belief in continuing the legacy of cultural competence in social work practice and mental health care.

Dr. Perkins, thank you so much for joining us to kick off this podcast series. To get us started, I wanted to spend some time talking about some basics. DEIA is a term being used a lot, something of a buzzword even in certain industries. But the actual meanings of the words in the acronyms are possibly getting lost or are not fully understood by the people using them. So as a reminder and a refresher, could you walk us through some DEIA concepts and definitions and maybe get us started with the DEI and A?

Carla S. Perkins: Thank you so much, Xani, for having me today. I am happy to kick off this conversation about DEIA and disaster behavioral health and would like to start with just those basic definitions, with the D, of course, being diversity, which is the practice or quality of creating a community comprising of people of different ages, cultural backgrounds, geographies, physical abilities, disabilities, religion, sexes, gender identity, sexual orientations, etc.

So diversity really focuses us in on creating a community that includes everyone, regardless of who they may see themselves as, who they may present as. And it's a really important foundational concept because it helps us to allow everyone to have a space at the table, and it's grounded in the reality that any community comprises some diversity.

Equity is the E and suggests that resources are distributed based on the tailored needs of a specific audience. And equity is one of my favorite things to discuss as a mental health professional and someone who's worked for several years in school settings where we are frequently discussing accommodations for students who have a continuum of special needs. And that includes students who may need additional supports to learn. That includes students who may be gifted and talented. That includes students who may be dealing with physical, cognitive, or emotional difficulties or disabilities.

And equity helps us to understand that each individual person, or even a community, may need more or different resources as compared to someone else. Whereas equality focuses on everyone getting the same thing, we are at a place of understanding that equity allows communities and individuals to get the support that may be tailored to the specific need, as opposed to everybody just having the same thing.

Inclusion is the act or practice of behaviors and social norms that ensure people feel welcome. At the core, inclusion is the act or practice of behaviors and social norms that ensure people feel welcome. At the most basic element, inclusion should ensure that individuals are treated fairly and respectfully, and have equal access to opportunities and resources and can contribute to their community's or their organization's success. So again, inclusion helps us to bring the diversity of individuals to the same table with access to resources that they may need but also helps everyone to feel welcome, to experience respect, and to be able to contribute to whatever the situation may be.

And last but not least, we cannot leave out accessibility, which really is appropriate to discuss after equity and inclusion because accessibility is really giving equitable access to everyone

along the continuum of human ability and making space for the characteristics of each person, regardless of what a perception might be about an individual's or a community's ability to do something.

Podolny: Thank you so much for going over those terms. And I especially appreciate how you showed me and our listeners how interrelated the concepts are. They really don't even stand on their own unless you consider them as a whole, so that was extremely helpful. And I was wondering if you could maybe touch on a couple of terms that I know are an important part of this DEI concept—DEIA concept. I noticed cultural competency is mentioned often, as well as intersectionality. Do you think you could give us a little background on those terms and concepts and how they relate to DEIA?

Perkins: Sure. Cultural competency is the integration and transformation of knowledge about individuals and groups of people into specific standards, policy, practices, and attitudes used in appropriate cultural settings to increase the quality of services. So as a social work practitioner and mental health professional, cultural competence looks like having an understanding of the different cultural identities that individuals, families, clients, communities bring with them to the experience of either pursuing mental health treatment, in the case of disaster behavioral health, those individuals who are part of a community that has experienced disaster and will partake of the disaster behavior response, as well as contribute to how the community is supported through the disaster.

Intersectionality is the complex and cumulative intertwining of social identities which results in unique experiences, opportunities, and barriers. So people may use intersectionality to refer to many facets of their identity and also how those facets intersect. So for example, I understand that in certain situations gender may be a part of someone's identity, as well as race/ethnicity, and there are times when each of those identities stand on their own. But intersectionality focuses us in on the reality that those identities are often layered and people do not always have the choice to decide which identity is primary because it's an interplay of each of us bringing our identities and the other individuals who may interact with our identities.

Podolny: That was extremely helpful, and I appreciate you going into those additional concepts that it really sounds like are foundational parts of the DEIA concepts, even if they're not included in the acronym we're using most commonly. But the words have meaning, and the phrase I really love is "language matters," that the words we use have power. And when we use these words and concepts that you've reviewed, it's important that we know what they mean and that we're using them correctly and have a correct understanding of how the concepts work. So that's extremely helpful baseline information, whether folks who are listening are new to this work and might be learning or learning some nuances of these terms for the first time. Or even for those who have a lot of experience, I think it's a great reminder and you've offered some great perspectives.

So turning to the disaster behavioral health field specifically, when we're addressing the mental health and substance use needs of people affected by disaster, what's the connection to and the importance of DEIA in disaster behavioral health?

Perkins: Thank you so much for that question, Xani. DEIA is important in disaster behavioral health because these concepts speak to centering the experiences of the persons who are participating in and receiving the disaster behavioral response. So without an understanding of the cultural community where the disaster has occurred, it is very difficult to engage survivors in the mental health supports that exists.

Disasters are often widespread and often highlight the vulnerability of the community that has experienced the disaster. So cultural competence becomes very important as survivors want to see individuals who they perceive as similar to themselves in some way; individuals that may even look like them; individuals who they believe can relate to their experience in the disaster response.

One of the things that is of great interest to me in disaster behavioral health is really just engaging how the devastation of a disaster can also bring out the strengths that are present within a community. So by going with the mindset of centering the experience of the disaster survivors, and even the language around "surviving" a disaster versus being a "victim" of disaster, helps us to focus on the competence of the individuals within the community and the strengths that they bring to the situation, which really can help engage people in mental health and substance abuse response, because all of these concepts can be very difficult.

And once a disaster has occurred, there is a certain amount of vulnerability that is present. And communities often are rising to the occasion; they are often resilient; and they often want to be part of what's happening, not just being given something.

Podolny: You've made some really excellent points in showing why cultural competence is so important. And I'm wondering if you could give some examples of how cultural competence could or should be integrated into disaster behavioral health?

Perkins: Thanks so much for that, Xani. Cultural competence can be implemented in disaster behavioral response across the continuum of the response. So oftentimes we are talking about what happens after the disaster has already occurred. But if we go back briefly to the discussion that we had on the definition of cultural competence, it helps us to understand that the understanding and information that we have about individuals and group of people should exist within standards, policies, and practices.

One example of how cultural competence is relevant in disaster behavioral health and that disaster behavioral response is highlighted through my dissertation research, where I did a qualitative study of local disaster responders and their behavioral health responses in the U.S. Virgin Islands, particularly on the island of St. Croix. And one of the issues that came up in regards to cultural competence, about 11 of the 15 responders shared that cultural

competence is relevant even in the planning and implementation of the disaster behavioral response before the disaster even happens.

The responders shared with me their thoughts and concerns around disaster planning, focusing on tabletop exercises that are attended and implemented by senior leaders or midlevel managers and not as much emphasis on the day-to-day employees, the day-to-day responders, who may actually be executing the disaster response, as well as those individuals who will be partnering with the disaster responders from outside of that local community.

So, you have a situation where the individuals within the community, because they have done it before, have a wealth of knowledge that doesn't always get translated up or down when the planning and implementation stage is actually happening. And one of the major areas of any type of disaster response is around trust.

And cultural competence becomes relevant because someone has to know, how does this community deal with their local government? How does this community deal with communication? Who are the trusted members within the community? Because oftentimes the engagement process can get bogged down if communication is challenged. Or if there is not trust occurring, people may tend to shut down and may not embrace the support that's available to them because they are not clear what the focus is or even if there may be some repercussion.

And cultural competence, if we know a community's story, if we understand what's happening, and if we go with the curiosity of what has happened as opposed to what's wrong, we get more information and cultural competence can help us to guide the response, particularly in locations where disasters have occurred frequently, or there are seasons of disaster. Because we know that hurricanes, for example, or tornadoes, or even in the situation where we're having severe winter weather across many different areas of the U.S., we can understand what it is that people need and how their need is dictated by some of the shared experiences of that local community.

Podolny: Those were really helpful examples of cultural competence and why it's so critical for the emergency preparedness process. And I think it's really interesting you've touched on so many concepts that we already know are critical: that emergencies start locally and that working before the disaster happens is the key to successful preparedness. So I really appreciate your tying together so many complex concepts in that response.

And one other thing that I think maybe you hinted at, but we didn't dive into the definition of historical trauma earlier when we were going over some basic terms and concepts. Could you tell us, what is historical trauma and what are some of the impacts of historical trauma on disaster survivors?

Perkins: That's a great question, Xani. Historical trauma is multigenerational trauma experienced by a specifical cultural, racial, or ethnic group, and generally it's related to major

events that have oppressed a particular group of people because of their status as oppressed. So, it's important to understand that historical trauma is multigenerational, it's collective based on that particular culture, racial, or ethnic group, and that particular group's status as oppressed and it's cumulative in nature.

So it does not just have an impact on those who may have witnessed the initial trauma; it has a generational impact, partly because of the particular group status as oppressed. So if we're thinking about things like the transatlantic slave trade and the slavery that resulted of that for persons of African descent, if we're thinking about the Holocaust, we're thinking about forced migration. So, if we think about Indigenous communities that have endured that, particularly in the U.S. context, and the colonization that has happened of Indigenous communities as well. So there are individuals who may experience poor overall physical and behavioral health—so we're talking about low self-esteem, depression, self-destructive behaviors—that may also show up in terms of substance misuse and/or addiction or health issues, which was highlighted most recently by the COVID-19 pandemic.

And what happens is that these individuals and groups are dealing with the impact of the historically traumatic event while dealing with whatever trauma or stress that might be still present in their present-day life, such as issues of poverty or issues that impact the community. So we went through, collectively, the pandemic, and that was traumatic to many of us. And we saw those health disparities among communities that have already experienced trauma across the U.S., and honestly, across the world.

So historical trauma is important because when we're providing responses, the responses are being provided to a wide range of individuals, including individuals who are part of groups that have experienced historical trauma, which may contribute to some grief, may contribute to distrust of majority groups or government programs because of some things that have happened.

And human service providers, such as those of us that might be participating in disaster responses, can really be more ready to engage members of these communities by understanding how current-day circumstances are related to historical trauma and really go in with a spirit of curiosity to engage individuals. And centering those individual experiences in terms of what that response is, and caring with those individuals as the experts of their own experience, as opposed to being the outside expert coming in.

Podolny: Thank you for that helpful description and background. And I think it's just a great reminder that people are so layered and bring not only their own experiences from their own lifetime to a disaster that they might be experiencing in the present moment, but also things that may have happened to their family, their community, even before they were born. So it just adds to that concept of understanding who your survivors are and what their needs are.

Perkins: Absolutely, Xani. Another piece of it is when we're talking about mental health response, we know that communities of color do experience a disparity between the amount

of treatment they receive for mental health concerns. It doesn't mean that the mental health concerns do not exist; it means that they are less likely to seek that mental health treatment. Partly, it does have to do sometimes with the stigma around mental health support. But historical trauma may cause those individuals to be suspect of the support that's provided through the government or perceived outsiders.

And we cannot ignore the impact of systemic oppression which has created barriers to accessing services. And even though many of us may not have been born when historical traumas have happened, our roles can trigger or initiate some of the responses that could keep people from finding out more about the services if we do not approach the situation with a certain amount of cultural humility and being able to ask good questions that help people guide you in their own experience.

Podolny: Yeah, I think you're sort of leading me to my next question, which is about racial disparities. So as we were just talking about historical trauma, I think we were sort of getting to one of the concerns for all of disaster behavioral health, which is addressing racial disparities whether they come from historical trauma or other factors. But I was hoping you could elaborate on that a little bit and talk about some of the racial disparities that exist in the field of disaster behavioral health and how those disparities impact the access and quality of services for vulnerable communities during and after the disaster.

Perkins: Thank you so much for that question. Yes, it is true that racial disparities affect disaster behavioral health because there are gaps between mental health treatment incidents and treatment for communities of color. One of the major areas where we see this, just like when we were discussing cultural competence, is prior to even the experience of the disaster, are we understanding how DBH relates in terms of providers and trainers being concerned with diversity, equity, inclusion, and accessibility in training materials and presentations?

Do the materials include individuals that represent the diversity of most communities? Do the training materials include statistics about communities of color and about other vulnerable populations that exist anywhere a disaster is going to be? Because if we start with the premise that diversity is part of the society that we live in, then we are more intentional around those training materials, those conversations, and trainers, presenters, responders can speak to it as people are being prepared to provide the disaster response. And also just kind of understanding the reality of what mental health care and treatment looks like for communities of color.

So as a mental health professional, I have lived in communities where there are many mental health professionals of color, and individuals who are seeking those individuals out are able to find somebody that they might feel more comfortable talking about their mental health needs with. However, I've also lived in communities where that presence is not as well known. And when you look at some of the statistics, you do understand that persons of color represent about 4% of mental health professionals that are diagnosing and treating

individuals for mental health disorders, which was a surprise to me, even as a clinician, when I first saw that number.

Because since I know many colleagues and I exist in spaces where I have experienced mental health professionals of color, for example, I was not as aware that when you're looking at such a small number, it does impact people's perception around who should receive mental health treatment. It does impact people's perception around whether they might find someone to talk to that they will feel comfortable with, and local community responders are a necessary component of disaster behavioral health.

I shared with you that my dissertation was on disaster behavioral health and the responses of local responders. I too was a survivor of Hurricane Maria, which was a Category 5 storm that passed over the U.S. Virgin Islands and had particular impact to St. Croix. Some of the listeners may be aware that that was actually the second storm in about a 17-day period as St. Thomas was impacted by Hurricane Irma about 10 to 12 days prior to Maria passing over St. Croix.

And what I learned in that process was that it took every last one of us that was part of the local response to partner with those individuals who came from outside to provide support to help members of the community. Because even in a small, resilient community, there were folks who would not go to the FEMA service center because the roof was still on their structure, whereas a neighbor's roof was blown off.

So you have to understand that even in the midst of the stigma and the complication of how to engage people, understanding strengths and resilience and helping people to be part of the situation goes a long way in engagement, rapport building, and helping the community to be part. And going to the places where you find people—so in the neighborhood, in the church, in the community center, on the ball fields—is where you would be able to provide resources and support, because it's not going to look like everybody visiting the local group practice.

Podolny: Thank you for giving those excellent examples, including your personal experiences in the Virgin Islands. I think that really helps folks understand what happens on the ground after a disaster like that. And you've already started talking about how important it is to pull these DEIA concepts all the way into our disaster behavioral health policies and decisions, all the way down to the training materials we create and making sure that they are culturally competent or culturally appropriate. So could you maybe just expand a little bit more about some of those places where disaster behavioral health practitioners and related professions should be incorporating DEIA into their processes?

Perkins: Absolutely. DEIA should be reflected through all DBH doctrines, guidelines, background information. And research efforts should include members of underrepresented populations to capture experiences, strengths, and concerns from their perspective. Because again, there is a wealth of knowledge that exists among the communities that have

experienced multiple disasters over time and an understanding of what those experiences have been and how best to engage the particular communities.

And the focus on DEIA enhances well-being for everyone because more people have access and are contributing to the ongoing recovery and functioning of communities post-disaster. So as I shared earlier, I lived for almost four years of my life in a Caribbean climate where every single hurricane season we prepared for the worst. And thankfully, it was not the worst every single time. But I will say that the anxiety around preparation, I will say that just the feeling of individuals as we talked about what preparation means, how to do it, was received differently among different groups of the population.

So one example would be I had a colleague whose parents were older. And they had been there, done this, several times because they had migrated to the Virgin Islands from another Eastern Caribbean island, so they experienced Hurricane Hugo, for example, there. Some of the individuals who had lived in the Virgin Islands their whole life had experienced Hurricane Hugo in the U.S. Virgin Islands. So any amount of discussion or dialogue around preparation was liable to bring up the concern of what if it's as bad as it was the last time? For some people, the trauma of it is fresh and they're numb. So they may get to the place of whatever happens, happens.

And even really just being able to explore that and being able to help individuals come to a place where the collective nature of the community could help to spur people on who may not be in a position to respond themselves right in the moment in terms of the actual preparation for the disaster. Because sometimes people take the approach that it won't be that bad.

And the challenge with disaster is you don't always know what the outcome will be, and there are many disasters that cannot be predicted in enough time for people to actually make a change. Or you do have your earthquake, for example, that no one is prepared to experience at that time. So it's really important to understand where people are, what they bring to the situation.

And even the geography is important, right? Caribbean nations are vulnerable because they're on the water. And so if you're talking about a hurricane, there's nowhere to go. The day before the storm passes over and everybody figures out because the weather forecast has changed to a Category 5, you're not getting a flight off of the island, so what are you going to do?

And I think that we had learned a lot over the years in terms of how people may travel, what migration looks like when a disaster happens, but we still have to be sensitive to who is the population? And even in the mainland U.S., who has a car that can leave? If you're in particular cities, how many exits are there? Does the evacuation order go out the day before or 5 days before?

Now, those are all complicated discussions, because the officials that make those decisions are doing the best they can under pressure. But also knowing how your community responds to that level of stress can be helpful in targeting the most vulnerable populations and the most vulnerable communities to really impress upon them the potential seriousness or the reality that you may need to leave.

So I think it is a complicated and nuanced discussion, but every time we respond, we have an opportunity to ask the individuals who not only experienced the disaster, who responded to the disaster, to fine-tune what we do the next time. But it takes every single one of us to be on the same page. Because diversity, equity, inclusion, and accessibility have to be the foundation of these responses in order to not only keep people safe, but to prepare appropriately. Because we do understand with climate change that the potential for disasters and the expanded impact of those disasters is happening, whether we are prepared or not.

Podolny: Thank you again, Dr. Perkins, for that fantastic answer that just really gave us so much context and so many great personal examples to show us the real-life consequences of these DEIA concepts and how they show up in our real-world response. And I think you really brought us to a great point, which is about uncertainty. The name of this podcast. Disasters are unpredictable.

Even the ones we can predict, often there's much that we won't know until the disaster is upon us. So part of the challenge of this entire field is navigating that and preparing for whatever may happen. So I really appreciate you diving into those concepts and for all of your great feedback today. So with that, is there anything else you'd like to touch on before we wrap up this episode?

Perkins: I do not have anything further to add because I feel that we have spent this time engaging in a robust discussion of what DEIA looks like in disaster behavioral health response. I would like to say thank you again for the opportunity, Xani. I am both honored and humbled to share my perspective about something that is so important and has become a passion of mine over the last 5 or 6 years.

And I look forward to the remainder of the series and hope that this conversation will get individuals involved and interested in what is going on in their communities. Because as I said before, we are all part of the diversity of our communities, and DEIA is foundational and works best when we are all at the table with a voice to share our successes, our concerns, and our hope and vision for the future. So thank you so much.

Podolny: And thank you for the fantastic discussion, information, and for your personal stories of survival. This was a wonderful way to begin our podcast series. We very much appreciate your time. And to the listeners, I hope you enjoyed and please join us next time on *Navigating Uncertainty: Best Practices in Disaster Behavioral Health*.

Narrator: Thank you for listening to this episode of *Navigating Uncertainty: Best Practices in Disaster Behavioral Health*. If you enjoyed this episode, please consider subscribing on Apple Podcasts, Spotify, or Google Podcasts. You might also like to explore other SAMHSA DTAC products on our website at www.samhsa.gov/dtac.

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