Navigating Uncertainty: Best Practices in Disaster Behavioral Health Podcast

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

Episode 4: Recovery—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 [the Substance Abuse and Mental Health Services Administration's] Disaster Technical Assistance Center [DTAC]. In our final episode of this season we'll continue to explore diversity, equity, inclusion, and accessibility [DEIA] in disaster behavioral health. Today we'll be discussing DEIA in the recovery phase of disaster response, as well as looking ahead at some emerging trends and practices in the field.

We'll explore these important topics with our guests. I'm thrilled to be joined by Dr. Curt Drennen and Aimee Voth Siebert, both joining us from the State of Colorado. Dr. Curt Drennen is a licensed clinical psychologist working for the Colorado Department of Public Health and Environment Office of Emergency Preparedness and Response as the state's Disaster Behavioral Health and Community Recovery Branch Chief. In this role, he supports the Disaster Behavioral Health and Community Inclusion program and the Healthcare Worker Resilience and Retention Initiative.

Curt has led the Colorado behavioral health response to over 13 events of significance, including natural disasters, public health crises, and major community violence. Dr. Drennen received his master's and doctorate from the University of Denver in clinical psychology; his bachelor's of science in nursing from the University of Kansas; and his bachelor's of science in psychology, chemical science, and pre-medicine from Kansas State University. Dr. Drennen is also a certified emergency manager.

Aimee Voth Siebert is the Disaster Behavioral Health and Inclusion Program Manager from Colorado's Office of Emergency Preparedness and Response. Aimee holds a master's in international disaster psychology from the University of Denver and a bachelor's in psychology, communications, and a neuroscience certificate from Bethel College. In her 11 years with the office, Aimee has grown multidisciplinary emergency knowledge and experience responding to Colorado, national, and international incidents, including public health emergencies, natural disasters, and major community violence.

She is certified as a state crisis counseling program trainer and grant writer, a CDC [Centers for Disease Control and Prevention] crisis and emergency risk communication trainer, a strategies for trauma awareness and resilience practitioner, and an advanced public information officer. Aimee also serves as an Executive Advisory Committee member and trainer with Colorado's Access and Functional Needs Program.

Thank you both so much for joining me today.

Curt Drennen: Xani, I want to thank you and DTAC for inviting Aimee and I to participate in this opportunity to share our experiences and what we've been doing in Colorado. So thank so much for this opportunity.

Aimee Voth Siebert: Yes, we're thrilled to be able to have conversations with more of our colleagues around the country and to just learn alongside everyone because there is so much to continue to learn about how we do disasters better.

Podolny: Thrilled that you're both joining us today to continue this conversation that we've been having throughout this season of *Navigating Uncertainty*. The integration of DEIA into DBH [disaster behavioral health], or the failure to do so, has a huge impact on the effectiveness of a disaster response, especially for historically marginalized populations. We've heard many stories of how better DEIA approaches can improve results, so as a person working in DBH, how can you make the case within your organization for a more diverse, equitable, inclusive, and accessible approach to disaster behavioral health?

Drennen: Thank you, Xani. I believe that this is a really important area to make the case for, and ultimately is relatively easy to make this case. You know the State of Colorado has made inclusion, diversity, equity, and accessibility, I'll call IDEA or I-D-E-A throughout this, as a foundational element to all that we do. The Colorado Department of Public Health and Environment is the home to the Office of Health Equity, which works to mobilize community power and really transform systems to advance health equity and environmental justice.

Our department, CDPHE, also created the Health Equity Branch within our division, the Division of Disease Control and Public Health Response, and expanded the Champions for Vaccine Equity Initiative, a pre-COVID program. So this focus on IDEA is also included across our efforts surrounding emergency preparedness and response, and specifically disaster behavioral health. Since disaster behavioral health's primary goal is to serve and support all people impacted by a

disaster, that in and of itself sets the foundation to really promote and encourage our systems to be more inclusive, diverse, equity-focused, and accessible to all people within the state.

Disaster behavioral health's guiding question is: What will support people's ability to adapt and function, even when facing the disruptions and feelings of being overwhelmed that are caused by disasters? This is considered both at the individual and at the whole community level.

Voth Siebert: I agree entirely, and as we continue to answer that question, it really starts with understanding what works for communities on a regular basis and what community practices and connections people have under normal circumstances that we can try to help reconnect people with? Inclusion, diversity, equity, and accessibility efforts actively support building connections and can strengthen a social fabric, especially among people who are disproportionately impacted, historically and systematically underserved, and underrepresented.

Because when we connect, we can better understand the strengths of our communities and identify resilience that people can build upon. We also work with communities to identify gaps where increasing diversity, equity, inclusion, and accessibility practices would help us address both immediate and long-term needs after the disaster hazard has ended. Because disasters, if you think about it, are inherently disruptions to people's lives. It's less important to respond to hurricanes when they happen over open ocean and we don't tend to restore power to empty towns. A hazard really becomes a disaster when it affects people and the systems of support that we all rely on.

And so one of the strongest cases for diversity, equity, inclusion, and accessibility practices in disaster behavioral health is that with greater connections, especially ones that are familiar, ones that are part of the efficacy of the community on a regular basis, things feel less like a disaster. And when we can include those things in our services, we have better services, we have better outcomes, and the communities become more self-efficacious, which we know from the literature is just sort of the big part of what we're trying to do during disaster behavioral health. So all of these are great reasons to advocate for this in programming related to disaster behavioral health.

Podolny: Thank you both for that great overview and just sort of a summary of some of the issues involved and how we can be better advocates within our organizations for more robust DEIA efforts and how critically important that is. I was wondering if you had any real-life examples of something along those lines that our listeners might be able to identify with a little bit.

Voth Siebert: Xani, you know a story that comes to mind is from very early in my career with this team here in Colorado. When I was first hired, my position title was Disaster Behavioral Health and Vulnerable Populations Coordinator. We sit within always-changing language, and it was a lesson from a community partner, from somebody who was thinking in this realm of inclusion, diversity, equity, and accessibility, that really made me stop and think, okay, if our

work is about building closer connections and strengthening social fabric with community successes, with community organizations that do this on a regular basis, I also have to think about how I come into the conversation and present my intention for building that social fabric for the sake of emergency preparedness and response.

And early in my career, as I was learning about the different ways that we talk about this, something you'll hear us talk more about later is access in functional needs, and how that's a disaster framework we're really coming to as a way to promote more inclusive resources, more inclusive partnerships in disasters.

So I was attending a class called "Integrating Access and Functional Needs Into Emergency Planning." One of the facilitators of that training was Dave Schaad, and he served as our Region 8 FEMA [Federal Emergency Management Agency] Disability Integration Specialist and was just a wonderful person to have conversations about practical approaches but also philosophical approaches to emergency management. He was the first person that told me that people with disabilities are like emergency managers every day because they are coming up with multiple flexible solutions for their needs.

And when I told him that my position was, that I was to be Disaster Behavioral Health and Vulnerable Populations Coordinator, he gave me one of those looks that was like, "Oh, so wait, are you coordinating vulnerable populations?" I said, "Well, no, but we want to be fostering more inclusion of voices of people to understand better what works for them when a disaster happens and what resources are important to them like we've been talking about in terms of access and functional needs." And he was like, "So you're not a vulnerable populations coordinator, you're a community inclusion coordinator." I was like, "Ding, ding, ding. Yes, that's it! That's it!"

And so going back to our team and our larger office leadership, it was a really great conversation to sort of make the case that we will present ourselves better. We will have more clear conversations about what our intention is if we can make this shift in terms of not only my job title, but kind of the way that we frame some of the work that we were doing on our team. And it's been working very, very well ever since.

Drennen: You know several past experiences are really coming to mind right now about the importance of IDEA in disaster behavioral health. One of them really stands out after we experienced floods in 2013 that hit a significant swath of northern Colorado. And as most people know, housing that is in flood plains tends to be owned and utilized by people of lower socio-economic status. In Colorado, that's often our Latinx community. And we have had to really emphasize the importance of making sure that our response teams are inclusive of individuals who are bilingual and bicultural because this really come down to trust.

You know when you engage people through disaster behavioral health, it really is only possible if they have some semblance of trust with people that are responding to their needs. Otherwise, they're going to find and connect with their normal social support system or do

without. And so having individuals that can really promote that trust is absolutely critical. And we've seen that repeatedly, but it really stands out for me in those experiences following the floods of 2013.

In another lane, many years ago I was doing a round of Psychological First Aid training, and you know, I've consistently experienced Psychological First Aid and Stress First Aid as these amazing tools that really are, or at least have the capacity to be, inclusive, address diversity, and really come at needs in an equitable and accessible fashion.

So I was doing this round of training with our Asian-Pacific Development Center, a critical provider of services to the Asian-Pacific community, and we were talking about how to make sure that we could utilize Psychological First Aid equitably and in an inclusive manner. And so we were looking at each of the four components through the IDEA lens, and as we got to the second core component, safety and comfort, we started talking about what do people find comforting from that equity lens, the diversity lens, how do different people see the actions of responders as comforting or not?

And we went around the room and each individual was representative of a different ethnicity within the Asian-Pacific community, and they were talking about what do they see as primary ways to provide comfort and that they like to receive comfort. And we had a lot of fun going around the room and having that conversation/experience, but as we kind of closed that up, one of the folks said, "You know what I'm really recognizing is even in our own slice of the diversity pie, we've got a lot of diversity just in our various ethnicities."

And what's so important is the willingness to simply ask people what they find comforting. What would they find as an olive branch to build trust? What would they find as an action that they would feel safe with to connect with responders? So that importance of asking the question and, I think, training our people to be comfortable with that discomfort and ask the question of what people need, how they would find comfort, what is important with trust, what is important with safety, I think is a critical step that we don't always train toward.

Podolny: Those are fantastic examples, and I think it really brings some of the ideas home when we hear about these actual experiences that you've been through. And I think you touched on some themes that we've already addressed and that have come up multiple times during our discussions on this topic, one being that language matters, and another being that listening matters. And that those both lead into developing community trust, and that that trust opens up everything else. That gives us access to actually being able to know what the needs of communities are, and therefore, respond to them in the best way possible. So I am really. . . was glad to hear those stories and hear you touch on those important concepts.

I'd like to turn to our most recent global event that we all have spent the last few years working with, which is the COVID-19 pandemic, which certainly had many challenges and many lessons learned. So I wanted to ask you specifically regarding the response to COVID-19, how did we

access harder-to-reach communities? What did we learn and how can we carry those successes forward?

Drennen: Oh my goodness. The COVID-19 pandemic highlighted historical and long-standing inequities. That's just at a national level. You know integrated into the very nature of large-scale infectious disease events are difficult for communities and responders. Behavioral health interventions, almost by definition, require human-to-human connection, and that was impossible during the pandemic.

There are obvious limitations regarding internet bandwidth and access, especially within rural communities and within communities with higher rates of poverty and for people experiencing homelessness. Colorado is the eighth-largest geographic state of the union, but our population is relatively small. We've got areas of the state that have less than one person per square mile, so their accessibility to some of the typical resources that we have in urban and suburban areas is vastly different.

Yet the importance for connection, the importance for conversation, validation of experience during events like the pandemic can make a huge difference in people's experience of an event. So this whole process of focusing and making it a priority to access harder-to-reach communities is something that we're going to be integrating and learning from for years to come.

One thing that really stands out is the emergency management community has stated for decades that during the disaster that is the worst time to exchange business cards. Effectively, this means that we must be constantly working to build relationships with the community before the event. And it really comes down to that some communities are easier for us to build relationships with, build trust with, than others are.

And we've got to recognize and change how we do our work so that we're not just working with those communities that are easy for us, either as a system or as individuals, to reach out to. We've got to do that hard work to be building the trust, building the connections with all of our communities so that when disasters disrupt how our systems typically work, we've got to be innovative.

COVID-19 fostered a lot of creativity by teams and responders, especially within public health and public behavioral health. We saw so many just breaking down barriers and breaking down silos throughout that process. But fostering that creativity includes those of us doing disaster behavioral health, and we saw that, I think, in spades with our crisis counseling program.

Voth Siebert: I agree entirely, Curt. I think as we think about things that we learned as lessons or we're starting to learn, there were certainly lessons taught and we will implement them to make them lessons learned. But when we were thinking about reaching harder-to-reach communities, there's really a recognition that not only was this a whole-community disaster, it

would require whole-community participation in the response and the innovation that Curt was just talking about.

It was really exciting to watch how our crisis counseling teams took collaboration and even ideas and leads from many community businesses and service providers as new ways to reach their consumers. This, really across the board in our society, innovated a lot of new forms of accessibility. And out of those efforts, disaster behavioral health teams really found cool connections for bringing the psycho-education, the outreach, the resource referral to the communities that they were trying to reach themselves.

Some examples that stood out to me were back in the early days of the pandemic when everybody was asked to stay at home more. There was a lot of food and restaurant businesses that were innovating on how to do more delivery, how to make food available to people where they were. And our crisis counseling programs got in on that by saying, okay, if people are going to have, say, a pizza delivered to their house, could we work with our local pizza place and put a flyer about self-care or about an upcoming group Zoom conversation onto that so it gets delivered with the pizza? And they found that as a great secondary way to get information out about what their teams were doing.

When we got to the point that there were vaccine clinics that were being held for the pandemic, a lot of community-based organizations started to participate in delivering those clinics to communities. And then we also had these big drive-thru vaccine clinics. And what they found is that when the crisis counseling teams in their local community participated in that, there was a significant reduction in the amount of needle anxiety that people showed, and more folks were willing to follow through and get those. Not only vaccines but we also heard from our more traditional responders that they had a lot fewer needs to transport somebody for fainting or passing out or a lot less need to use their very, sort of, more acute medical resources in order to support people in that circumstance.

We also worked closely with nutrition services in older-adult programs who were converting from doing congregate meal sites to more meal-delivery solutions that they used on a regular basis and worked with them to include behavioral health messaging with their outreach to community. And I think one of my favorites, as sort of a last example, was when one of our crisis counseling teams worked with their local Best Buy. Because Best Buy was doing a lot of computer literacy programs at the time because more and more people were using devices.

And when they did that training, the crisis counseling team made it so that it was their web page, their landing page that people would surf while they took the computer literacy class. And so they were reading about the services, the stress and coping strategies, and other things as they were also learning how to navigate devices that were so critical during the pandemic. So those types of collaborations were amazing.

And even within the response system to the pandemic, we saw really, really powerful collaborations and innovations that just came from having crisis counseling teams and disaster

behavioral health trainers exchange knowledge and resources with other COVID response teams that had strong equity, diversity, inclusion, and accessibility intersections, or who were working closely with the community themselves.

Examples were we did bring Psychological First Aid to the cultural navigators and other contact tracers and case investigators who were handling distressed callers when they were notifying them about what they could do in quarantine and isolation situations. We also made sure that the crisis counseling teams across the state were connected to that Champions for Vaccine Equity group that Curt mentioned before to help increase awareness of disproportionately impacted populations and the helpful equity messaging that they were developing that then the crisis counselors could bring into their spaces.

And I think Curt and I just have to give so much credit to the crisis counseling program manager who was part of our team at that time, Reed Floria. They were an extraordinary leader that always tried to keep equity, diversity, inclusion, and accessibility considerations in mind for how to leverage what crisis counselors do well and connect them with other folks who were centering that and keeping that as a focus in their work as well.

Podolny: Thank you both for giving those excellent examples. COVID really did throw us into a very new, different, and challenging environment to do disaster behavioral health work, and I think it pushed the envelope for innovation because we were dealing with so many new circumstances. And I think the three of us have been working in and with disasters for years, decades really, and we know it's not a static field; things change very rapidly sometimes. So, you know, we've just discussed some great innovations that happened specific to COVID. What else is going on in the field? What's most new and promising emerging that you're seeing and that you'd like to talk about today?

Voth Siebert: I think what continues to strike me is that by and large the principles of disaster behavioral health have been evidence-informed and continue to be supported by the new and emerging evidence in research. A book that was significant to me during the pandemic was George Bonanno's *The End of Trauma* that came out in 2021. Has a lot of really great recent resilience research built into it, and something emphasized there is the importance of flexibility mindsets and processes as a way to say one solution might not get you to where you need to be functioning. But if you have a means by which to cycle through a growing repertoire of strategies and coping mechanisms, then it's the confidence that you can find the solution, not necessarily that the single solution is the key that becomes a very resilient factor.

And I feel like that really reinforces the value of things like Curt's already mentioned, Psychological First Aid, Stress First Aid, the Skills for Psychological Recovery, that have as foundations engaging people with practical assistance and helping people to build those skills in helpful thinking, problem solving, promoting positive activities, even when there are some significant disruptions going on in our lives.

So what's promising in the field is really finding new places and teams, as we were mentioning before, where we can embed disaster behavioral health training and interventions and just a little bit of that knowledge to empower and support more communities.

Our state program and local partners are constantly learning about those new connections and places where disaster behavioral health training and support can be helpful. And I think it even sort of points us sometimes to what we might consider a disaster behavioral health mission moving forward. So for example, early in the fire seasons that I was a part of this team for, some of our local teams started to work side by side with non-mental health responders like the damage assessment teams that go in after a disaster and figure out, okay, what has the fire destroyed?

But that can be the first time that somebody in the community has seen somebody they can talk to about what they experienced, and so they found it really helpful to have a disaster behavioral health team member go in with the damage assessment teams so they could do the work that they needed to do to assess the situation but the community member still had somebody to talk to. That was a very similar principle in terms of embedding some of those teams at our vaccine clinics, as was mentioned.

And on the other side, sometimes it’s just helpful to consult with or train others before they go to do work that is community facing and they may encounter people who are distressed or in stress, like the cultural navigators and contact tracers during COVID-19 or Mpox. We’ve also had opportunities to work with community-based initiatives and organizations like Safe Heaven, which here in Denver responds to neighborhood gang violence.

And we’re also right now making more connections with our state incident management teams to better understand the impact that the work has when you’re in that responder role and you’re continuously responding to different kinds of disasters. Increasing their knowledge to empower team care, self-care, protect their teams, has become a really great avenue by which to spread the disaster behavioral health knowledge more widely.

The other framework that I think is really valuable to bring up here again is access and functional needs. In disaster work, access and functional needs is an emerging shared language, an emerging memory tool that helps to promote inclusive preparedness and response and those diversity, equity, and inclusion, accessibility practices in disasters. The framework was developed by disability advocates June Kailes and Alexandra Enders back in the early 2000s and has really been promoted extensively not only on sort of a national level more recently, but especially in Colorado state disaster work, including by our state disaster behavioral health team.

So one of the memory tools that they use in access and functional needs is called CMIST. That's spelled C-M-I-S-T, and it stands for the five big functional areas that help to promote people’s ability to function and adapt during disasters but also represents an incredible diversity across our communities about how people meet those needs on a regular basis.

So planners and responders, including disaster behavioral health response teams, can improve planning assumptions and better deliver our disaster services by integrating the diverse ways in how people promote and use resources in these five areas. C - Communication; M - Maintaining health; I - Independence; S – Safety, supports, and services; and T - Transportation.

So as a move away from saying, “Who is vulnerable?” and recognizing instead that vulnerability is a gap between what the systems are ready for and what the community does to meet needs on a regular basis, and when we can bring those planning assumptions and characteristics of our community more into the conversation around emergencies, people are less likely to experience vulnerability because we are including the ways that they communicate, the ways that they maintain their health, the ways that they understand the safety, supports, and services that are critical to their functioning across community.

And so all of this, both access and functional needs and disaster behavioral health, I think, are in a good state to recenter human functioning during disruptions. What is it that's going to help people adapt to the difficult, unhappy, disruptive circumstances that we face during hazards? So holding on to that and putting people back in the center of disaster seems to me to be the good momentum, the good practices that we’re seeing coming forward again.

Drennen: Recently it’s really come to mind that what is new is old. We continue to be in spaces in disaster behavioral health where our responders are licensed clinicians that are well trained and immersed in the modalities of mental health/behavioral health that are very Eurocentric. And for us to be able to do disaster behavioral health, we’ve got to recognize our biases and be able to constantly challenge our own point of view, to be able to be connecting with individuals that don’t have our same perspectives, experiences, belief systems, and resources.

And that as clinicians trained in disaster behavioral health, it’s probably really good for us to make sure that we are building teams that are not politically based, that we pull in a great deal of paraprofessionals and train them in disaster response, and people that are multicultural, people that have the capacity to speak multiple languages and see experience through different lenses, to see the gaps in the system, to see the challenges of our systemic disaster behavioral health’s capacity to actually reach out to all of the community, build that trust, and provide a service.

In a similar vein, I think we have to recognize the ongoing stigmas around mental health and how that impacts our capacity to deliver service. In Colorado, we’ve been very fortunate that we’ve been able to really make the case for behavioral health to really be at the table of emergency management and be integrated into the emergency management cycle and be part of the response early in the process.

But let’s face it: even though we’re at the table, many times people don’t understand what we actually do. And being able. . . You know I think it’s a new model that is old is constantly finding language that is translatable to other systems that are active in response and help them

recognize what we do and don’t do, but also how their own systems are limited in the inclusion, diversity, equity, and access arena.

And this is definitely an area where Aimee as been very active is working with our emergency management system, co-hosting a whole committee at the state level for really driving that equity across emergency management, not just within disaster behavioral health. So I think that's an important new model is making sure that we are integrating with all systems that are part of the response structure.

Podolny: Thank you, Curt and Aimee, for those great examples and for that great look forward at what's on the cutting edge of research and publishing and practices that we’re finding improve our services and improve our ability to understand what's needed by the community. One thing I don’t think either of you touched on in that explanation was the use of data. And I know there are growing sources of data; data is more available to folks working in this field. So how can we best use data to plan for next time and to set ourselves up for success?

Drennen: Throughout the COVID pandemic we learned about how data analysis can help us move closer to our equity goals. For example, early in the COVID vaccine rollout, CDPHE’s equity team created data maps that showed us where the highest population of low-income seniors of color lived in the state using census estimates from 2018. This was critical as the team focused on outreach efforts really with the focus on these highly impacted communities, with the goal of hosting equity vaccine clinics in 50 percent of the top-50 census tracts, which we met by April of 2021.

On the whole, using healthcare data to advance equity is always a big challenge that needs serious focus at many levels, which is why we were very intentional about it throughout the pandemic. It’s important to remember that not all people are represented accurately in current data-collection processes. Our terminology and our categories used by different data-collection systems often don’t match the way people really identify themselves. And research and data collection shouldn’t be done on marginalized communities, but should be done with them, utilizing their expertise and their knowledge and their connections so that the data can be analyzed from both that perspective of identifying problems but also identifying strengths.

Specifically considering mental health data and trying to use it in disasters, there are also challenges due to data-collection limitations and how mental health stigma can affect the way people respond. Community mental health surveys, for example, surveys that ask about how many poor mental health days a person experiences a month, or heavy drinking, or substances use, et cetera, are often only collected annually. This makes it much harder to see the impact of mental health or find opportunities to intervene. This type of data is also not often captured with community groups or geographic information that would really help us respond to communities at sub-county levels or within those marginalized populations that we’re constantly working to improve our connection with.

Voth Siebert: And acknowledging the challenges that come with data frequency and who has access to what data at what point, there are still opportunities to use data that we think would be really exciting to see move forward in support of disaster behavioral health. The Office of Emergency Preparedness and Response and our team had a student intern named Alexis help us research some of these following topics.

One, we were thinking about what would it look like to have a behavioral health sentinel surveillance system, much like is used in public health and hospital to track certain conditions or symptomology? Could we recognize changes from a community baseline in terms of some of those behavioral health symptoms of stress, of disaster dysfunction? We were thinking about community indicators like, as Curt was saying, you know the number of poor mental health days a month, the number of heavy drinking days, or increased internet searches for mental health symptoms that could be recognized and codified.

We also talked about data around the availability of mental health resources, including substance-use treatment services and providers that are available in your communities and where are there resource deserts? Where are there gaps in terms of if this one provider is not available, where do people go next?

Data can also help us think about adaptive coping behavior, so like indicators that help us think about help-seeking, maybe as shown in an increase in crisis call-center volume or the use of other disaster behavioral health services being able to track that. We also know that collectively things like donations and volunteer rates are indicating that people are seeking a way to give back to the community, and we think that is very adaptive.

And similarly, we also look at indicators of maladaptive coping behavior, such as increases in DUIs [driving under the influence] or in calls around abuse scenarios. Because we know, unfortunately, especially anecdotally, that those things go up after disasters as well. So trying to create a system of data that could be watched for changes in frequency in that rate of behavior that could be a surveillance system. And so we could monitor the data then for the impact of a nearby disaster or disaster exposure of some kind on the symptom acuity, how strongly people were reporting these symptoms.

We could check it against the sort of long-standing phases of disaster model. Like do we see a period of really good adaptive community cohesion behavior? And can we start to notice when we're sliding into that disillusionment phase and maybe use that as a point for adding additional resources? Like using that data to inform us and really check, then, the data with when a new disaster behavioral health intervention has reached the community that was impacted, whether that has a shaping of the indicators as well. So it's a big idea. We had a basic paper and collection of ideas compiled for us, and we'd love to continue to see where that goes in the future.

Podolny: That was very helpful discussion of both the strengths and weaknesses of data, right, because it's another tool in our toolbox. And it's not, as powerful as data can be, it is not the

end-all be-all, and it has to be carefully balanced against the weak points or some of the issues that Curt pointed out, that it's not really capturing the true state of affairs. But on the other hand, I think some of these innovative ways to use it that Aimee touched on are also really promising and have a lot of potential. As we have the power to use the data and the access to the data, I think it's important to keep that balance in mind. So thank you very much for that great discussion.

I know you've already touched on some excellent real-life examples of successes that you've both experienced in your years of disaster behavioral health work, and I wanted to give an opportunity for you to share any other stories that you think our audience would benefit from, and thinking about just how can we learn during our emergency response and translate those lessons into improvements during non-emergency times, because that's most of the time, right? But can you tell me a little bit about how you approach that question in Colorado?

Drennen: Aimee mentioned our crisis counseling program previously, and that program director, Reed. And one of the things that they were so good at was building that relationship and bringing people and community partners to the table that haven't consistently been at the table, or haven't been at he table at all.

So, with the COVID CCP [Crisis Counseling Assistance and Training Program], we reached and built relationships with the Denver Indian Center, the Center for African American Health, Servicios de la Raza, and Lutheran Family Services. And we worked really closely with many other core community organizations—healthcare facilities, schools, hospitals, LGBTQI+ programs, military veteran facilities, and homeless shelters—and the list just goes on—to, really, through the CCP, illustrate the importance of the connection of the ongoing relationship development and utilizing those community partners as trusted gatekeepers, trusted partners to really make the opportunities for service available. And this really continues to help us re-learn that equity is not a single discipline or a team, but it's a collective process; it's a collective work that we all have to take responsibility for in order to truly make our resources, our systems, our knowledge accessible to all.

So we actively had our crisis counseling program providers budget for non-English language services, make sure that they were outreaching and pulling people into the team that were bilingual. We continue to emphasize things that had not been historically emphasized, such as getting our disaster behavioral health team to identify specific pediatric disaster mental health capability and materials and resources to support the medical community.

We have consistently heard and experienced from EMS [emergency medical services], and even sometimes our emergency department professionals, that they're scared of children. They're not adults. They don't know how to interact with them. So being able to provide them support in order to keep that frontal lobe up and going when you've got a little one in front of you and you need to care for them to the best of your ability, addressing that fear of our providers has been really important.

Several of our crisis counseling program providers also found really innovative ways to preserve their community outreach teams beyond the disaster grants. We have seen repeatedly that a crisis counseling program often changes the relationship between the community and the community mental health center itself. All of a sudden, people see that mental health is for everybody, and all of a sudden you have this different relationship with this mental health resource.

And so that allows the provider to demonstrate their value to the community as an organization, but also the resources that they bring to bear, and that changes the dynamic with every facet of the community and increases our capacity to really be inclusive, making sure that mental health is diverse and our capacity of disaster behavioral health is diverse, and that we're serving people equitably.

Voth Siebert: That's such a wonderful example, Curt, of the bridge that I think, Xani, you named in the question. How do we not just think about what one disaster teaches about what we need to do the next disaster, but also what one disaster uncovers about how we can think about community needs, community resources, things like mental health as a community conversation differently? And I think part of that starts with really recognizing that a key to continuous improvement is not letting relationships that get built in the crucible of a disaster and really sort of forge that sense of "we made it through," not to let that go between incidents.

And so something I've been very grateful and proud of Colorado's disaster behavioral health program for is that we facilitate opportunities for stakeholders to regularly come together and learn from one another. So even when a disaster doesn't take place, our disaster behavioral health network called COCERN, Colorado's Crisis Education and Response Network, comes together on a quarterly basis and talks about what we have learned from the recent experiences of our community response teams, but also what that or who that points to needing to build stronger relationships with, what that tells us about possible collaborators within both our emergency systems and our community networks.

Similarly, our disaster coordinators for each disaster behavioral health team come together on a regular basis. Continuing to build disaster behavioral health capacity among providers who offer behavioral health services to the community on a regular basis helps us not only in, what Curt just so eloquently talked about, in terms of understanding that mental health is for everyone and that this is a conversation not just about when we are challenged but how we support that on a regular basis.

It also helps us to bridge connections from an incredibly challenging experience like a wildfire, like a community shooting, to this notion of you're never going to have all of the resources pulled away from you because these are mental health partners that are there in your community on a regular basis. So thinking about that continuity of care for both individual survivors but sort of this bigger community perspective as well has been so critical to the way we've tried to build the system here in Colorado.

And so when providers can apply disaster lessons to services outside of acute responses, it means that more inclusive and equitable practices become standard operating procedures in the next disaster, but also on a regular basis, which then makes those easier to resource and maintain when we need them.

I love thinking about disasters as a crucible environment for, hopefully, innovation. Because on the one hand they can exacerbate community needs and inequities. They uncover things that are true on a regular basis. But when everybody is experiencing them at the same time, they become much more apparent and they can also be these extraordinary times of creativity and cleverness about the unexpected has disrupted all our structures; what do we do? We can think and act differently. And when we take the very strong intention to center diversity, equity, inclusion, and accessibility in the way that we approach disasters, even if sometimes it feels like it runs a little bit against the sort of urgency and timelines of disaster energy, inclusion is worth the time it takes, and disasters can teach us new ways to do community that benefit us all.

And so I guess, again, big thank you for letting us be part of this conversation and framing it almost in the disaster recovery area specifically. Because I think one of the things I would call forth moving forward is that planning for and supporting disaster recovery, not just disaster response, is critical because that's the bridging point between what we learn in disasters reentering our communities. And if we can take advantage of the really good improvement culture that exists in emergency management and after-action reports and improvement plans and all that sort of stuff, we have the opportunity to bring some really neat diversity, equity, inclusion, and accessibility experiences, practices, and lessons into our world on a regular basis.

Podolny: Aimee and Curt, I appreciate so much this entire discussion, but especially your responses to that last question. Thinking about moving forward, thinking about how we can utilize what we learn in emergencies, not just during emergencies but for overall improvement in behavioral health and keeping that ongoing growth and learning and improvement process alive in Colorado and sharing it with our listeners. So thank you so much for the conversation and sharing such great information. I really appreciate your time and your expertise.

Drennen: Xani, thank you so much not only for the opportunity to be here and talk with you, but for starting this conversation or continuing this conversation. Because this is a conversation that I think, especially in today's world, we need to have more and more. It needs to be at the forefront of what we do in not only disaster behavioral health but in the field of behavioral health as a whole. So thank you for making this a priority coming from SAMHSA DTAC, and I look forward to continuing this conversation with you.

Voth Siebert: Echoing everything Curt just said. I also want to say, Curt, thanks for doing it, because every time I listen to you, I feel like I get a new story or a new insight, and even in answering these questions I hear the voices of other members of our team who've been part of the work for many years, other folks that have been part of our networks, and certainly a lot of new connections across Colorado who are continuing to teach us. So, in the most general way, I

hope if they hear this they are hearing us say thank you to them as well for helping us learn along the way. And yes, thank you for facilitating a place where we could share these wonderful insights that they've given us, Xani. It's been a pleasure to be part of the podcast.

Podolny: I'm so glad you both could join us. Thanks again. And to our audience, thank you for listening. We hope you've enjoyed our podcast, *Navigating Uncertainty: Best Practices in Disaster Behavioral Health.*

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