

Nebraska Hospital Preparedness for Psychological Consequences of Public Health Emergencies

Survey Results Summary

The University of Nebraska Public Policy Center surveyed hospitals across Nebraska in 2011 to evaluate behavioral health readiness in the event of a disaster, act of terrorism (including bioterrorism) or other mass-casualty incident. The survey also asked about hospitals' ability to effectively coordinate with other emergency service providers, such as law enforcement, in the event of a critical incident.

Behavioral health readiness refers to a hospital's capacity to effectively manage and respond to the psychological needs of patients, staff, and their families resulting from a large scale event or emergency. In many hospitals in Nebraska this capacity is not maintained internally and there is an informal reliance on local mental health resources to handle any psychological surge. The challenge associated with this mechanism is the lack of professional mental health resources in many areas of the State. The U.S. Department of Health and Human Services' Health Resources and Services Administration has designated 88 of Nebraska's 93 counties as Mental Health Professional Shortage Areas.^{1,2} This means that nearly 95% of Nebraska counties are without sufficient mental health services.

Survey Results

Invitations were sent to Emergency or Safety Coordinators of the 90 hospital members Nebraska Medical Response System (MRS) committees in April 2011 to participate in a web based survey designed to assess the resources hospitals have available to manage the psychological consequences of terrorism or other public health emergency. Respondents included 80 of those members (89%). This response rate is improved over the 51% response rate in 2004, the last time this survey was conducted.

Hospital staff must be able to identify psychological casualties following an act of bioterrorism or other public health emergency for psychological surge capacity to be activated. Many hospitals (35%) report being as "somewhat prepared" to identify psychological casualties following an act of bioterrorism or mass casualty event, while 49% report being "not very prepared" or "not at all prepared." This represents very little change since 2004, when the numbers were 40% and 48%, respectively. This raises questions regarding some hospitals' current ability to successfully triage medical versus psychological casualties.

The survey indicates that 55% of the hospitals contacted *do not* have mental health services immediately available after an act of bioterrorism or other public health

¹ Retrieved 8/31/2011 from: <http://bhpr.hrsa.gov/shortage/>

² Fraser, R.F., Hesford, B., Rauncer, T. Health Professional Shortage Areas Nebraska - 2003. Nebraska Health Data Reporter, 5 (1), December 2003.

emergency. This is an improvement from 2004 when 65% of hospitals reported not having mental health services available immediately. Respondents in 2011 report that either lack of mental health resources in their area (29%) or limited funding for mental health services (25%) pose significant barriers to their efforts to integrate mental health resources into their disaster response capabilities. Respondents also raise additional issues: mental health staff are already utilized to capacity; and lack of administrative interest in or knowledge of local mental health response resources.

Many hospitals (78%) report that they have lists of local-area mental health professionals they could contact to assist with crisis-response activities, which is a decrease from 86% in 2004. While there is a shortage of mental-health professionals, there is a perception that there is adequate access to professionals who may be called on an “as needed” basis.

The professionals that hospitals rely on to provide surge capacity to manage psychological casualties in the emergency room are varied. The vast majority of hospitals (83%, vs. 84% in 2004) report they would use area clergy and faith leaders as part of the response. In addition, 70% of respondents indicate they rely on existing hospital staff to provide the service. Social workers (69%) are the most commonly cited professional mental health resource relied upon by hospitals, followed by counselors (60%), psychologists (30%), psychiatrists (19%), psychiatric nurses (19%), and substance abuse counselors (16%). The order of the professions relied upon is unchanged from 2004, although fewer hospitals now plan to rely on social workers (80% in 2004) and more plan to rely on counselors (49% in 2004). These results are not surprising as social workers are commonly integrated and available within hospital settings, but results may indicate an increasing reliance on behavioral health resources outside of hospitals.

The trend to rely on existing staff to manage psychological casualties indicates a need for hospital staff to have competencies in psychological crisis intervention and triage. Respondents were asked about the type of training hospital staff had received in the last year. Among existing hospitals, 57% have offered no specialized crisis mental health training (vs. 59% in 2004). A sizeable minority, 43%, have trained staff in Critical Incident Stress Management (CISM), Psychological First Aid, and/or Psychological Crisis Intervention (each type of training accounting for approximately one-third of the trainings offered). This is unchanged from 2004, when 41% of hospitals offered trainings in CISM and/or Psychological Crisis Intervention. Training in Psychological First Aid was not widely available in 2004, but now accounts for one-third of the trainings offered.

A majority of hospitals, 52%, do have a written plan to address the behavioral health needs of patients following a public health emergency. This has increased since 2004 when only 32% of hospitals had a written plan to address the behavioral health needs of patients. However, the majority of the hospitals (from 54%-73%) still *do not* have a written plan designated to meet the mental health needs of: medical staff, volunteers,

family members of staff, administrative staff, and family members of patients. Respondents report that they expect to rely on their Employee Assistance Programs (74%), Critical Incident Stress Management mechanisms (52%), formal in-house peer support (40%), referral to private mental health providers (30%), and publicly-funded mental health services (26%). Other sources of mental health resources mentioned by hospitals are their local Medical Response System, and the Veterans Administration.

Hospitals generally have plans in place to coordinate with other emergency providers, such as law enforcement. Seventy percent of hospitals report having a written plan for coordinating with law enforcement after an act of bioterrorism or other public-health emergency, compared to 79% in 2004. Of those who have a written plan, 82% report that their plan addresses the topic of enhanced physical security at hospitals; 71% report covering the coordination and access to patient information for investigators; and 67% endorse reviewing Civil Commitment issues. Finally, 84% address the coordination of risk communication (i.e. dissemination of relevant risk-related information to public) with law enforcement.

Recommendations

Physicians and nurses are concerned with the psychological well being of those they care for in hospitals every day. They may rely on others within the hospital setting and from the surrounding community to augment their capacity to manage psychological consequences of large events that tax the medical resources of the facility. The results of the survey, including comments made on open ended questions, lead to three recommendations:

1. Hospital response plans for large emergencies should include a section that specifically addresses the management of psychological consequences. Any reported reliance on resources outside the hospital should be enumerated and verified regularly to ensure that they can be accessed and coordinated when needed. Consider how these community resources can be more formally linked to the hospitals. Hospitals that rely on telehealth for emergency response should consider augmenting that capacity with on-site personnel (natural helpers from the community or mental health professionals). Reported reliance on internal resources should be accompanied with specific activation and delineation of psychological helping roles that personnel will assume in the emergency. This may include roles for hospital volunteers or support workers. Additionally, plans should address the psychological needs of staff and their families that may result from their role in the response.
2. Exercise the behavioral health portion of the plan along with medical response protocols to emergencies.
3. It is recommended that education in psychological first aid or crisis intervention continue to be made available to all personnel working or

expected to work in emergency care settings during the response to a large event. This includes registrars, volunteers, and support personnel who may be expected to come in contact with the public during the course of a response. Additional professional education for medical personnel in effective triage of psychological casualties in bioterrorism or mass casualty events should also be made available on a more regular basis.

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