Mental Health Emergency Preparedness: The Need for Training and Coordination at the State Level

Suzanne R. Hawley, PhD, MPH;[1] Gary C. Hawley, PsyD;[1] Elizabeth Ablah, PhD, MPH;[1] Theresa St. Romain, MA;[1] Craig A. Molgaard, PhD, MPH;[1] Shirley A. Orr, MHS, ARNP, CNAA[2]

1. Department of Preventive Medicine and Public Health, University of Kansas School of Medicine-Wichita, Wichita, Kansas USA
2. Director of Local Health, Office of Local and Rural Health, Kansas Department of Health and Environment, Topeka, Kansas USA

Correspondence:
  Suzanne R. Hawley, PhD, MPH
  Department of Preventive Medicine and
    Public Health
  University of Kansas School of Medicine-
    Wichita
  1010 N. Kansas
  Wichita, Kansas 67214-3199 USA
  E-mail: shawley@kumc.edu

Abstract

Introduction: The coordination and integration of mental health agencies' plans into disaster responses is a critical step for ensuring effective response to all-hazard emergencies.

Problem: In order to remedy the current lack of integration of mental health into emergency preparedness training, researchers must assess mental health emergency preparedness training needs. To date, no recognized assessment exists. The current study addresses this need by qualitatively surveying public health and allied health professionals regarding mental health preparedness in Kansas.

Methods: Participants included 144 professionals from public health and allied fields, all of whom attended one of seven training presentations on mental health preparedness. Following each presentation, participants provided written responses to nine qualitative questions about preparedness and mental health preparedness needs, as well as demographic information, and a program evaluation. Survey questions addressed perceptions of bioterrorism and mental health preparedness, perceptions about resource and training needs, as well as coordination of preparedness efforts.

Results: Overall, few respondents indicated that they felt their county or community was prepared to respond to an attack. Respondents felt less prepared for mental health issues than they did for preparedness issues in general. The largest proportion of respondents reported that they would look to a community mental health center or the state health department for mental health preparedness information. Most respondents recognized the helpfulness of interagency coordination for mental health preparedness, and reported a willingness to take an active role in coordination.

Conclusions: The current study provides important data about the gaps regarding mental health preparedness in Kansas. This study demonstrates the present lack of preparedness and the need for coordination to reach an appropriate level of mental health preparedness for the state. These findings are the first step to implementing effective distribution of information and training.

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Introduction

Increasingly, researchers are attending to the psychological consequences of terrorist and bioterrorist events.[1–9] These studies indicate that a human-caused attack initiates more dramatic mental health sequelae than do disasters due to natural hazards.[10,11] Yet, while funding has increased dramatically for preparedness training to address the physical consequences of a terrorist or bioterrorist attack, comparatively little attention has been paid to mental health preparedness. Although every state in the US has developed some type of preparedness plan, to date, state-level preparedness assessments have not addressed mental health issues.[12–14]

Although a wide variety of mental health preparedness resources are available online through national organizations (e.g., Centers for Disease Control

and Prevention, American Psychological Association, Substance Abuse and Mental Health Services Administration), key preparedness stakeholders tend to overlook the unique contributions that can be made by mental health professionals.[15] Unfortunately, Hall et al found that less than half of the states in the US had mental health representatives on state emergency planning groups, and none had developed plans to address the mental health issues specific to a terrorist attack.[16]

The coordination and integration of mental health agencies into disaster responses is a critical step for ensuring effective response to the public's mental health needs.[17] Indeed, all potential first responders, not just mental health professionals, must be trained in the mental health effects of disasters in order to prepare for and buffer their impact.[18] In order to remedy the current lack of integration of mental health into training, interventions should be tailored to help first responders address the mental health needs of the public during disasters. As a necessary first step, researchers must find ways to assess mental health preparedness training needs of potential first responders, including public health and allied health professionals.

To date, no recognized instrument exists for evaluating preparedness on a local or state level.[19] Furthermore, any surveys that have been conducted have not addressed mental health topics.[13,14] The current study seeks to address the need for mental health preparedness assessment by qualitatively surveying public health and allied health professionals regarding mental health preparedness in Kansas.

Methods
Participants
Participants included 144 professionals from public health and allied fields who attended one of seven training presentations on mental health preparedness.

Instrument
The survey included demographic information (gender, age group, race/ethnicity, and occupation) and nine open-ended questions addressing general bioterrorism preparedness, mental health preparedness and training needs, and perceptions of coordination or regionalization of preparedness efforts. The term "bioterrorism" was selected for the instrument because of its wide identification in the State with programs relating to emergency preparedness. For example, at the time of the trainings, the State Health Department's preparedness organization was named the Kansas Bioterrorism Program.

Procedures
Seven presentations on mental health and disaster/terrorism preparedness were provided to health audiences between February and September 2005. These presentations were conducted during statewide conferences, public health preparedness regional meetings, and county health department meetings. Following each presentation, the participants were asked to provide written responses to nine qualitative questions about preparedness and mental health preparedness needs. They also were asked to provide demographic information and to evaluate the program. Some participants provided incomplete responses.

Demographic information was analyzed using descriptive techniques in SPSS 11.5 Statistical Software package (SPSS, Inc., Chicago, IL). For qualitative responses, thematic content was identified and coded by hand for each item by two individuals. Responses were assessed to better understand perceptions of preparedness, resources, training needs, and coordination. Responses that recurred in the data were indexed systematically.[20] Any questions about coding categories were discussed and resolved between the two coders. Inter-rater reliability was assessed for the nine questions. Kappa co-efficients were computed and were ≥0.90 for all items.

Results
Demographics
Of respondents, 22% were men and 78% were women; 12% were <30 years of age, 14% were 30–39 years, 34% were 40–49 years, and 40% were >50 years of age. For race/ethnicity, 93% of the respondents were white, 3% were black, and 1% each reported being Hispanic/Latino, Asian, American Indian, or other. Respondents also listed their occupation(s); many had more than one occupation (Table 1). The most commonly reported occupation was nursing (48), followed by public health professionals (39), and health administrator (27). Relatively few (8) were field workers.

Readiness
Results of tabulation of the responses to the two readiness questions are reported in Table 2. For Question 1, "Do you think your county/community is ready for a bioterrorist attack?," 40% reported that they were not ready, and 37% reported being "somewhat" ready. Only 13% reported that they were ready. In response to the question about readiness for mental health issues, 43% indicated that their county or community was not ready, while 37% reported being "somewhat" ready, and 13% reported being ready.

Mental Health Training/Information
Results of the responses to the five mental health training/information questions are reported in Table 3. When asked what information they had regarding mental health preparedness, 57% indicated that they had "none" or "very little". The most commonly listed type of information possessed by respondents was print or Web-based material (19%). When asked what preparedness information a mental health center should have, 25% of respondents indicated mental health information and plans, and an additional 23% indicated biological agents and fact sheets. In response to the question, "What information/training would you like to have regarding mental health preparedness?", the most common responses were mental health resources/more training (27%) and general mental health preparedness training (18%).

When asked where respondents would seek information needed for mental health preparedness, the largest percentage of respondents (35%) indicated they would consult their community mental health center. When asked to report on critical aspects of mental health care, 19% reported that self-care was most critical. Other common responses included the mental health of specific population groups such as children/adolescents (18%), rural populations (17%) and older, diverse, and disabled populations (each 11%).

Occupations	Frequency
Nurse	48
Public Health Professional	39
Health Administrator	27
Health Educator or Trainer	18
Bioterrorism Coordinator	17
Infection Control/Disease Investigator	16
Public Health Educator or Trainer	14
Community Outreach Field Worker	8

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Table 1—Most commonly reported occupations

	n	(%)
1. Do you think your country/community is ready for a BT attack? (n = 60)		
No	24	(40)
Somewhat	22	(37)
Yes	8	(13)
Don't Know	6	(10)
2. Do you think your country/community is ready to respond to the mental health issues related to a BT event? (n = 110)		
No	47	(43)
Somewhat	41	(37)
Yes	14	(13)
Don't Know	8	(7)

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Table 2—Readiness (BT = bioterrorism)

Coordination/Regionalization

Results of the responses to the two coordination/regionalization questions are listed in Table 4. When asked about helpful types of coordination, 52% of respondents indicated that role coordination across health agencies would be necessary through planning and meetings. When asked what role their state-designated preparedness region should play in mental health preparedness and coordination, 44% reported that their region should initiate collaboration and planning. An additional 23% noted that their region should be "very active" in any such efforts, while 15% indicated that their region could hold joint exercises and training opportunities.

Discussion

The qualitative responses gathered in this study suggest the need for collaboration, planning, and resource-sharing in order to increase mental health preparedness.

Readiness

Few participants indicated that they felt their county or community was prepared to respond to an attack, highlighting the need for further preparedness trainings for the broadly interpreted community of first responders and first receivers. Respondents seemed to feel less prepared for mental health issues than they did for preparedness in general. Because respondents did not feel adequately prepared in general, the comparatively lower level of mental health preparedness indicates a great need for training that addresses mental health-specific issues. These results support the results of a 2005 report by Trust for America's Health, which found that Kansas met only five of 10 preparedness indicators.[12] Considering that 30 of 50 states in the US met ≤5 indicators, and that none of these indicators addressed mental health preparedness topics, it is clear that important gaps still must be addressed.

Mental Health Training/Information

The high percentage of respondents who indicated that they had no information regarding mental health preparedness indicates the need for widely-distributed resources. When asked about preferred types of information or training, the largest percentage of respondents recognized their lack of knowledge and wished to have more resources and training on mental health preparedness. A high percentage of respondents also noted that they were interested in aspects of training related to self-care, a vital consideration during a high-stress time such as during a response to a disaster or terrorist event, and future trainings should incorporate self-care topics. In fact, the literature supports the impact of disaster mental health training with specific populations such as diverse cultural groups,[21] rural populations,[22] children,[23] and first responders who require self-care.[24]

Respondents reported that the organizations within their community should have mental health preparedness resources. The highly specific answers provided by these community insiders provide population-tailored indications of the types of mental health information needed. By far the largest proportion of respondents (and presumably their county or community's constituent population) would look to a mental health center for mental health preparedness information, and the greatest percentage of respondents reported that mental health information and plans, and biological agents and fact sheets, should be provided by mental health centers. Efforts to increase basic mental health preparedness should include the provision of information to community mental health centers, and future trainings should include emergency contact information for these organizations.

Coordination/Regionalization

Reflecting important topics in the recent literature,[25-27] the largest percentage of respondents identified the need for interagency coordination for mental health preparedness and were willing to take an active role in the provision of coordination. In fact, the largest group suggested that state-designated preparedness regions should initiate preparedness and coordination activities, indicating a great willingness to combine efforts to improve mental health preparedness. Understanding organizational roles and agen-

	n	%*
1. What mental health information do you have regarding mental health preparedness? (n = 73)		
None	25	35
Very little	16	22
Print or Web mental health resources/trainings	14	19
Location/contact information for mental health center	8	11
Mental health plans, trainings, Websites	3	4
Basic plans	3	4
Personal experience	2	3
Don't know	2	3
2. What BT information do you think mental health centers should have? (n = 80)		
Mental health information and plans	20	25
Biological agents and fact sheets	18	23
Coordinated BT and mental health information	15	18
BT plans and resources	11	14
Information about coordination/relationships	7	9
Don't know	7	9
Mental health role in a BT event	2	3
3. What information/training would you like to have regarding mental health preparedness? (n = 74)		
Mental health resources/more training	20	27
General mental health preparedness training	13	18
State and local plans and available therapists	11	15
Planning and coordination/relationship building with mental health	10	14
Psychological first aid training	9	12
All (training, mental health plans, resources)	6	8
None	3	4
Other	2	3
4. Where would you go to get information needed for mental health and BT/all-hazards? (n = 86)		
Community mental health center	31	35
Internet and various public health agencies	11	12
State health department	9	10
County health department and BT plans	8	9
Don't know	6	8
Regional representatives	4	5
Boss or colleague	4	5
Speakers at current training	4	5
Federal agencies	4	5
SRS	3	4
Red Cross	1	1
Hospital	1	1
5. What aspects of mental health are most critical for you? (n = 270; more than one response possible)		
Self-care for health professionals and responders	53	19
Children and adolescents	48	18
Rural populations	47	17
Older adults	31	11
Ethnically diverse populations	29	11
Disabled populations	29	11
Agencies for mental health/mental health preparedness	26	10
Mass care and public health messages not to panic	5	2
Stigma of mental health issues	2	1

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Table 3—Mental Health Training/Information (BT = bioterrorism; n = number)
*Responses for some questions exceed 100% due to rounding

	n	%
1. What type of coordination do you think would help for BT and mental health preparedness? (n = 71)		
Clarifying roles, meetings, planning across agencies	37	52
Training and exercises that include mental health	12	11
Current state, plus training	8	11
Don't know	6	9
Increase recognition of the importance of mental health	5	7
The current training	3	4
2. What role should your bioterrorism preparedness region play in mental health preparedness and coordination? (n = 39)		
Initiate collaboration/planning	17	44
Should have a very active role	9	23
Have joint exercises/trainings	6	15
Don't know	4	10
Develop materials together for the public	2	5
None	1	3

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Table 4—Coordination/regionalization (n = number)

cies' willingness to partner are nascent processes in the mental health preparedness field. These responses provide encouragement for the potential involvement of public health professionals in mental health preparedness on the state and local level.

It is important to note that women, older respondents, public health professionals, and nurses made up a large proportion of the participant sample. This is not considered a limitation of the sample, as this is demographically appropriate to the Kansas public health workforce and representative of the target population. Such workers also would comprise the greatest proportion of first responders or first receivers in the case of a public health disaster; therefore, these responses are appropriate for developing a mental health preparedness needs profile. However, the participant sample contained a small percentage of minority respondents. Future studies should address this limitation in order to gather the most representative profile possible of mental health coordination and training needs.

Conclusions

This study assessed multiple aspects of mental health coordination and training needs, which can allow interventions to be developed for specific populations and occupations. The open-ended response format elicited key responses to each item, which can be integrated by future studies into a multiple choice quantitative instrument. Other states' preparedness agencies can use this methodology to identify gaps, develop training and programs, and assess progress toward fully operational preparedness plans integrating mental health and public health. Still, further research on the coordination and training needs of public health and mental health agencies is needed so that they can become a fully integrated part of state-level preparedness networks.

Acknowledgments

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Mental Health Emergency Preparedness

Carol Amaratunga, PhD

Department of Epidemiology and
Community Medicine, University of Ottawa,
Ottawa, Canada
Co-Chair, Psychosocial Task Force, World
Association for Disaster and Emergency
Medicine

Correspondence:
    E-mail: carol.amaratunga@uottawa.ca

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The coordination and integration of mental health and psychosocial considerations into disaster agency planning and response is a central theme of this pragmatic Kansas study. The authors have used a qualitative approach to identify and discern the extent to which public health and allied health professionals have adopted mental health as a central tenet of emergency preparedness training. The findings portray a worrisome picture—one that policy and decision-makers would be wise to heed.

Emergency planners in the state of Kansas were surveyed with respect to their perceptions of bioterrorism, mental health preparedness, resource and training needs, and the coordination of preparedness efforts. Although the study is somewhat delimited by its geography, the findings are likely relevant for communities across the US and the world.

The human dimension, including psychosocial and gender aspects of disaster planning, training, and management, often are a forgotten and neglected territory. Mental health preparedness and training tend to be the poor relations in the field of traditional emergency and disaster planning responses. Indeed it is ironic that decision-makers often focus resources on high technology equipment and computerized simulations, to the neglect of basic mental health.

Hawley's study is important, in so far as the research demonstrates the dichotomy between awareness and action. Although the findings pinpoint an appreciation with respect to the importance of psychosocial aspects in emergency planning, the data demonstrate a general lack of integration, investment, and tactical support for mental health training and preparedness. This conundrum demonstrates that knowledge alone is not sufficient. Adult educators have long appreciated this fact. Knowing "how" to ride a bicycle is quite different from the skill of actually riding a bicycle. In other words, knowledge without action, e.g., training, is insufficient. Taken to its conclusion, an appreciation of mental health planning without follow through action, such as collaboration, resource sharing, and practice cannot lead to change. It also may be fair to say that practice and action, sometimes referred to as "praxis" cannot take place without critical consciousness. Successful coordination and integration of mental health agencies' plans into disaster responses requires both processes!

The findings of this small, but sentinel, study should be cause for concern for decision-makers. Indeed, the caveats represent a red flag. The respondents from the Kansas survey indicated they had little or no information regarding mental health preparedness. Few respondents indicated strong self-efficacy, i.e., that they or their organizations were prepared. If Kansas is representative of the wider community, then efforts to increase investment in mental health training are long overdue. Regrettably, policy audiences often are reluctant to change the status quo in view of competing sectoral interests and perceived cost implications.

One of the inherent purposes of research is to help shape and influence public policy. In terms of disaster planning and training, this study points to the need, in fact, the social imperative, to invest in basic mental health training. However, evidence is not always enough. In preparing for future disasters it is important to learn from past lessons. Hurricane Katrina, 11 September 2001,

and the 2004 Asian Tsunami all demonstrated the need for the full and comprehensive integration of mental health coordination and training. These emergencies demonstrated the need to ensure that psychosocial and gender aspects of disaster management are mainstreamed into all levels of preparedness and recovery.

The efforts of the Psychosocial Task Force of the World Association for Disaster and Emergency Medicine (WADEM) hold promise that mental health coordination and training will continue to receive greater support and recognition. This small study in America's heartland speaks loudly and clearly. Sometimes, we need a combination of evidence, public opinion, and a touch of courage to effect change.