
Protecting the Mental Health of First Responders: Legal and Ethical Considerations

Lainie Rutkow, Lance Gable, and Jonathan M. Links

Introduction

The public safety, human services, health, and relief workers who comprise the first wave of a response to natural or man-made disasters play a critical role in emergency preparedness. These first responders provide care and services in the immediate aftermath of emergencies and may remain in affected communities for weeks or months. They often work long hours under stressful conditions, witnessing the human harms, physical destruction, and psychological devastation that can accompany disasters.¹

Not surprisingly, first responders may experience physical injuries or psychological harms due to their work. In recent years, emergency preparedness researchers have focused on environmental exposures and other risk factors,² such as structural instabilities within the built environment, which may impact first responders' physical health. Harms to first responders' mental health, however, are equally important to consider. Although mental health conditions may be overlooked because they can be difficult to visibly identify and diagnose, their presence may significantly affect first responders' ability to function.³

Studies have demonstrated that, after participating in disaster responses, first responders experience elevated rates of depression, stress disorders, and posttraumatic stress disorder (PTSD) for months and sometimes years.⁴ Those without disaster response training face a greater risk of receiving a PTSD diagnosis after the response concludes.⁵ Trained respond-

ers may not be prepared for a disaster response's psychological challenges, because training cannot truly replicate a disaster environment. Furthermore, most trainings do not explicitly include sufficient content regarding psychological self-aid.

Given these findings, measures must be taken to protect first responders' mental health. The development of laws and policies at the federal, state, tribal, and local levels provides numerous opportunities to implement standardized mental health protections for first responders. In some instances, these legal opportunities may benefit from guidance afforded by a consideration of relevant ethical concerns. This article discusses the legal and ethical issues raised in three key areas that are fundamental to protecting and promoting first responders' mental health: (1) mental health screening for first responders; (2) licensure portability of mental health care providers; and (3) workers' compensation for mental health claims.

Mental Health Screening for First Responders

Like other members of the general population, first responders may have pre-existing mental health conditions that are exacerbated by emergencies or they may develop new mental health conditions as a result of emergencies. Yet, the emergence or aggravation of mental health conditions may occur at higher rates for first responders when compared to the general population, because of the stresses associated with first-response duties.⁶ If first responders have access to mental health screenings during a disaster response, they may be more likely to receive timely diagnoses and treatment. Therefore, mental health screening for first responders should, ideally, be offered before, during, and after emergencies.

Lainie Rutkow, J.D., Ph.D., M.P.H., is an Assistant Professor at Johns Hopkins Bloomberg School of Public Health.

Lance Gable, J.D., M.P.H., is an Assistant Professor of Law at Wayne State University Law School. **Jonathan M. Links, Ph.D.**, is a Professor at Johns Hopkins Bloomberg School of Public Health.

While compulsory mental health screening for first responders may not be feasible or desirable, laws currently provide several options to facilitate some degree of mental health screening. For example, section 602 of the Model State Emergency Health Powers Act (MSEHPA), which has been adopted by at least 14 states,⁷ permits a state's public health authority to sanction examinations to diagnose and treat individuals during declared emergencies.⁸ This broad language allows states to establish mental health screening programs for first responders once an emergency occurs. The National Institute for Occupational Safety and Health (NIOSH) has developed guidance for pre-deployment screening of disaster relief workers, which may be useful to states that elect to use emergency powers to offer mental health screening to first responders.⁹ NIOSH suggests that screening could include questions about pre-existing mental health conditions and general mental health concerns. Based on an initial screening, additional mental health assessments might be recommended for some responders.

States may also want to consider the U.S. military's mental health screening model, which is used in three stages: (1) before recruits are deployed; (2) while they are in the field; and (3) when they return (in analogy to before, during, and after an emergency).¹⁰ Because the military can require comprehensive mental health screening among recruits whereas routine mental health screening is not compulsory for first responders,¹¹ individual components (e.g., pre-deployment screening tools, post-deployment mental health assessment surveys, etc.) rather than the entirety of the military's mental health screening model may be most useful to interested states.

At least one long-term mental health screening program for first responders has been established among the federal and state governments. In 2002, NIOSH began funding the World Trade Center Medical Monitoring and Treatment Program with clinics in New York and New Jersey. Through this program, first responders from the terrorist attacks on September 11, 2001, can receive free yearly screenings and treatment for physical and mental health issues. The program covers treatment for several emerging or pre-existing mental health conditions related to first responders' 9/11 work, including PTSD, depression, and substance abuse.¹² This enduring screening program recognizes that some mental health conditions will affect first responders long after a disaster is resolved.

Any mental health screening program for first responders raises certain ethical issues. Individuals with mental health conditions are often wary of the stigma associated with diagnosis and treatment.¹³ First responders may be especially concerned about

how managers and colleagues will perceive their fitness to perform within a stressful environment, for fear of discrimination. Therefore, first responders may be reluctant to pursue mental health screening and care at distinct mental health sites. Instead, care should be offered consistently in general health care settings. Similarly, first responders may benefit from explanations of the steps being taken through the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, emergency legal protections, or state mental health privacy laws to ensure that their identifiable mental health records will be securely stored and shared only with providers directly involved in their care.

Licensure Portability of Mental Health Care Providers

During emergencies, licensed health care providers may be deployed across state lines to meet patient surge capacity. A variety of emergency laws and policies allow individuals to provide care in states where they are not licensed during declared emergencies.¹⁴ These include waiver and reciprocity agreements, such as the Emergency Management Assistance Compact, which allows licensed health care providers who work for local or state governments to provide care in affected states.¹⁵ Also, some states have their own licensure portability laws, which allow out-of-state health care providers to practice as if they were licensed in the state during and immediately after disasters.¹⁶

In non-emergency contexts, mental health care providers are often in short supply,¹⁷ making it difficult to access their services. While emergency licensure portability provisions can help states meet surge capacity, non-emergency shortages of mental health care providers are likely to be amplified during response efforts.¹⁸ Although general health care providers may have the additional training or work experience to offer emergency mental health care, many individuals will need dedicated mental health care providers. The likely shortage of emergency mental health care providers is particularly troubling given the needs of many first responders for mental health services.¹⁹ First responders' elevated susceptibility to mental health conditions suggests that they should have consistent access to mental health care providers during and after emergencies.

Federal, state, tribal, and local governments can begin to address this through concerted efforts to make mental health care providers aware of opportunities to participate in response activities through emergency licensure portability systems. For example, they can work with mental health care providers' professional associations to educate members about first respond-

ers' unique mental health challenges and highlight the need for members' expertise during disaster responses. First responders should be encouraged to play integral roles in these educational efforts.

Even if these efforts are successful, they are unlikely to fully address the shortage of emergency mental health care providers. This raises the following ethical challenge: Given their duties, should first responders receive priority over other individuals for mental health care during and after emergencies? How should access to trained and credentialed emergency mental health care providers — scarce resources in emergencies — be allocated? Priority access for first responders can be justified under notions of reciprocity (i.e., rewarding responders for their sacrifices) or efficiency (i.e., helping responders allows them to continue to serve others). These ethical considerations must be balanced, however, against the need to treat others who might have equally compelling claims to mental health services.

Workers' Compensation for Mental Health Claims

Employees who develop work-related physical or mental health conditions are usually eligible for employer-sponsored workers' compensation benefits. Workers' compensation is a type of no-fault insurance, which means that employees only need to demonstrate that a health condition is work-related to be eligible for monetary benefits. In general, workers' compensation programs offer coverage to paid employees, which may not include first responders who volunteer their services or provide services outside their typical workplace. Some states have addressed this gap legislatively by extending workers' compensation coverage to certain volunteer first responders who serve during government-declared emergencies.²⁰ This coverage is extremely important, as some first responders will inevitably develop response-related physical or mental health conditions.

Workers' compensation programs, however, do not offer universal coverage for work-related health claims. States' coverage varies significantly for workers' compensation claims related to mental health.²¹ For example, not all states extend workers' compensation coverage to employees who experience a work-related mental stimulus (e.g., witnessing human carnage) that leads to a mental health harm (e.g., PTSD).

Disparities among workers' compensation programs raise justice and equity concerns for first responders. Issues of justice are implicated because, whether first responders are salaried employees or volunteers, they are necessary for quality disaster response operations. During disasters, affected states and localities expect

first responders to become immediately available and put themselves at risk. Therefore, first responders should have assurances that if they develop health conditions related to their emergency response duties, they will be covered by workers' compensation.

Furthermore, equity is implicated because employees, including first responders, who experience work-related mental health harms should receive the same workers' compensation coverage as those who face work-related physical health conditions. Prevalent mental health conditions such as PTSD, which can be triggered by work-related mental stimuli,²² can be as debilitating as physical injuries.

Conclusion

First responders' efforts in emergencies can make them susceptible to the development or exacerbation of mental health conditions.²³ Many states and localities have enacted legal protections in areas relevant to first responders' mental health, but more could be done in light of ethical concerns about stigma, justice, equity, and allocation of scarce resources. For example, states could use emergency powers to establish priority access to mental health services for first responders within general care settings. Model emergency laws and compacts could contain similar provisions. Unfortunately, this priority access would only last for the duration of a declared emergency.

Permanent legal solutions are necessary to ensure that first responders can easily access mental health services before, during, and after emergencies. This article has discussed unresolved legal and ethical concerns that arise in relation to mental health screening policies, licensure portability, and workers' compensation programs, which are all critical to first responders' access to mental health services. States and localities that tackle these issues, with an ultimate goal of establishing permanent legal protections for first responders' access to mental health services, may better safeguard first responders' mental health, thus strengthening their own emergency preparedness systems.

Acknowledgements

This research was supported by the Centers for Disease Control and Prevention (CDC) (5P01TP000288-02) through a project entitled "Legal and Ethical Assessments Concerning Mental and Behavioral Health Preparedness," funded at the Johns Hopkins Bloomberg School of Public Health and Arizona State University's Sandra Day O'Connor College of Law. Any views or opinions expressed in this article are those of the authors and not CDC or other project partners. The authors would like to acknowledge Chris Kaufmann, M.H.S., who provided research assistance with this article.

References

1. S. DeWolfe, *Field Manual for Mental Health and Human Service Workers*, DHHS Publication No. ADM 90-537 (2000).
2. E.g., K. Wheeler, W. McKelvey, and L. Thorpe et al., "Asthma Diagnosed after 11 September 2001 among Rescue and Recovery Workers: Findings from the World Trade Center Health Registry," *Environmental Health Perspectives* 115 (2007): 1584-1590; Centers for Disease Control and Prevention, "Injuries and Illnesses among New York City Fire Department Rescue Workers after Responding to the World Trade Center Attacks," *Morbidity and Mortality Weekly Report* 51 (Special Issue) (2002): 1-5.
3. D. M. Benedek, C. Fullerton, and R. J. Ursano, "First Responders: Mental Health Consequences of Natural and Human-Made Disasters for Public Health and Public Safety Workers," *Annual Review of Public Health* 28 (2007): 55-68.
4. E.g., J. M. Stellman, R. P. Smith, and C. L. Katz et al., "Enduring Mental Health Morbidity and Social Function Impairment in World Trade Center Rescue, Recovery, and Cleanup Workers: The Psychological Dimension of an Environmental Health Disaster," *Environmental Health Perspectives* 116 (2008): 1248-1253; C. S. Fullerton, R. J. Ursano, and L. Wang, "Acute Stress Disorder, Posttraumatic Stress Disorder, and Depression in Disaster and Rescue Workers," *American Journal of Psychiatry* 161 (2004): 1370-1376; S. Ozen and A. Sir, "Frequency of PTSD in a Group of Search and Rescue Workers Two Months After 2003 Bingol (Turkey) Earthquake," *Journal of Nervous and Mental Disease* 192 (2004): 573-575.
5. M. A. Perrin, L. DiGrande, and K. Wheeler et al., "Differences in PTSD Prevalence and Associated Risk Factors among World Trade Center Disaster Rescue and Recovery Workers," *American Journal of Psychiatry* 164 (2007): 1385-1394.
6. See DeWolfe, *supra* note 1.
7. Center for Law and the Public's Health, *Model State Emergency Health Powers Act: Legislative Surveillance Table*, July 15, 2006, available at <<http://www.publichealthlaw.net/MSEHPA/MSEHPA%20Surveillance.pdf>> (last visited December 7, 2010).
8. Center for Law and the Public's Health, *Model State Emergency Health Powers Act*, December 21, 2001, available at <<http://www.publichealthlaw.net/MSEHPA/MSEHPA.pdf>> (last visited December 7, 2010).
9. National Institute for Occupational Safety and Health, *Guidance for Pre-Exposure Medical Screening of Workers Deployed for Hurricane Disaster Work*, June 18, 2010, available at <<http://www.cdc.gov/niosh/topics/emres/preexposure.html>> (last visited December 7, 2010).
10. R. J. Rona, K. C. Hyams, and S. Wessely, "Screening for Psychological Illness in Military Personnel," *JAMA* 293 (2005): 1257-1260.
11. J. Shubert, E. C. Ritchie, and G. S. Everly, Jr. et al., "A Missing Element in Disaster Mental Health: Behavioral Health Surveillance for First Responders," *International Journal of Emergency Mental Health* 9 (2007): 201-213.
12. World Trade Center Medical Monitoring and Treatment Program, *Medical Treatment for 9/11 Responders*, August 9, 2010, available at <<http://www.wtcexams.org/index.html>> (last visited December 7, 2010).
13. Cf. Centers for Disease Control and Prevention, "Attitudes toward Mental Illness - 35 States, District of Columbia, and Puerto Rico, 2007," *Morbidity and Mortality Weekly Report* 59 (2010): 619-625.
14. J. G. Hodge, Jr., L. A. Gable, and S. P. Calves, "The Legal Framework for Meeting Surge Capacity through the Use of Volunteer Health Professionals During Public Health Emergencies and Other Disasters," *Journal of Contemporary Health Law and Policy* 22 (2005): 5-71.
15. Emergency Management Assistance Compact, *EMAC Articles of Agreement* (1996), available at <<http://www.emacweb.org/?1838>> (last visited December 7, 2010).
16. See, e.g., Center for Law and the Public's Health, *supra* note 7.
17. K. C. Thomas, A. R. Ellis, and T. R. Konrad et al., "County-Level Estimates of Mental Health Professional Shortage in the United States," *Psychiatric Services* 60 (2009): 1323-1328.
18. National Council for Community Behavioral Healthcare, *Emergency Mental Health and Addiction Treatment Needs*, available at <http://www.thenationalcouncil.org/cs/project_helping_hands> (last visited December 7, 2010).
19. See Benedek et al., *supra* note 3.
20. J. G. Hodge Jr. and E. D. Anderson, "Principles and Practice of Legal Triage During Public Health Emergencies," *NYU Annual Survey of American Law* 64 (2008): 249-291.
21. American Jurisprudence 2d, *Workers' Compensation* §§ 320-329 (2009).
22. National Institute of Mental Health, *Post-Traumatic Stress Disorder (PTSD)*, August 31, 2010, available at <<http://www.nimh.nih.gov/health/publications/post-traumatic-stress-disorder-ptsd/complete-index.shtml>> (last visited December 7, 2010).
23. See Benedek et al., *supra* note 3; Stellman et al., *supra* note 4; Fullerton et al., *supra* note 4.