Law and the Public's Health

This installment of *Law and the Public's Health* examines how the law shapes and influences prevention, care, and management of mental and behavioral health conditions before, during, and after major emergencies that affect the population's health. The authors bring an important focus to issues affecting not only residents exposed to emergency conditions, but also emergency responders and health workers.

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MENTAL AND BEHAVIORAL HEALTH LEGAL PREPAREDNESS IN MAJOR EMERGENCIES

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In this installment of *Law and the Public's Health*, we assess the U.S. legal environment underlying the identification, accommodation, response, and treatment of mental illnesses and behavioral conditions before, during, and after major emergencies. Following a background and overview, we discuss implications for public health policy and practice.

BACKGROUND

Public health emergencies and disasters are often defined by their impact on human health. The 2010 Haiti earthquake, one of the worst natural disasters in global history, had a staggering impact on human morbidity and mortality. More than 230,000 individuals perished from the earthquake itself,[1] thousands more died waiting to be treated for their injuries, and a multitude of survivors face disabling physical impairments.[2] In a country of abject poverty and dysfunctional health services, the physical plight of Haitians constitutes a health emergency necessitating international response efforts. Other natural disasters such as the 2004 Asian tsunamis and the 2005 Hurricane Katrina in the U.S. displaced hundreds of thousands of people and caused billions of dollars in damage. Entire economic and social centers were destroyed.[3] Although the 2009/2010 H1N1 influenza pandemic did not damage the built environment, it did affect millions globally, causing or contributing to thousands of deaths among children, young adults, and others who do not typically succumb to seasonal influenza.[4]

The physical effects of large-scale emergencies are a consistent and deserved focus of emergency preparedness and response efforts. However, a hidden epidemic of mental and behavioral health threats will linger among affected populations for years, exacerbated by the extreme loss of life, environmental destruction, and diminutions in socioeconomic status.[5] Invisible, unspoken, and unacknowledged in many cultures,[6] mental and behavioral health conditions are pervasive during and after major emergencies. These conditions arise among those previously unaffected (e.g., posttraumatic stress disorder) as well as among individuals with existing, clinically diagnosed mental illnesses. Frontline responders, health-care workers (HCWs), and mental health counselors may also be challenged emotionally by their response efforts.[7,8]

Addressing mental and behavioral health needs associated with emergencies is a crucial element of individual, community, and societal health and productivity. Public health emergency planning, mitigation, and response efforts must increasingly consider the mental health effects of natural disasters, pandemics, and other catastrophic events.

MENTAL AND BEHAVIORAL HEALTH PREPAREDNESS: PLANNING, MITIGATION, AND RESPONSE

Numerous laws and policies are relevant to the detection and treatment of mental and behavioral health conditions among emergency survivors and their families, public health practitioners, HCWs, and others. Our assessment of mental health legal preparedness focuses on vulnerable populations, namely (*1*) people with

preexisting mental and behavioral health conditions and (*2*) otherwise healthy people whose mental health conditions emerge as a result of an emergency.

Individuals with existing mental and behavioral health conditions are at an increased risk of developing new or renewed problems during and after an emergency.[9,10] Particularly susceptible are those whose conditions are misdiagnosed or undertreated or who have experienced prior traumatic events.[7] Because mental health services and support systems may be severely compromised during an emergency, specialized strategies (e.g., temporary mental health support services or readily available medications) may be needed to help these individuals regain stability.[11] Other individuals are at an increased risk of developing mental and behavioral health conditions due to an emergency, including individuals in certain age groups (e.g., children and the elderly), racial/ethnic minorities (e.g., immigrants), individuals in group facilities (e.g., hospitals, nursing homes, and prisons), and emergency responders.[10,12]

Detecting mental health needs and providing mental health services during and after an emergency can be challenging because of changes to the legal environment. During government-declared states of emergency, disaster, or public health emergency, the legal landscape changes dramatically.[13] Some of these changes can facilitate mental health preparedness efforts. Emergency powers that authorize screening, surveillance, and reporting of mental health conditions can enable public and private actors to address mental and behavioral health conditions within the affected population. For example, emergency mental health surveillance laws may require health personnel to report mental or behavioral health issues among their patients or professional colleagues to public health authorities despite potential privacy concerns.

At the same time, emergency laws may contribute to negative mental health outcomes. Government may be empowered in major emergencies to restrict individuals' movement through quarantine, isolation, or curfew requirements, or to displace populations through legal orders of evacuation.[13] Though these emergency powers are designed to protect the public's health, implementing them can lead to adverse mental health outcomes because of stress arising from the restriction or displacement of individuals, families, and social networks.

Deployment and use of personnel to provide mental and behavioral health services in emergencies

The availability and authorization of trained mental HCWs and other personnel to address mental and behavioral health needs among populations are key to mental health emergency preparedness and response. Deployment of licensed mental health personnel may be hampered in major emergencies through prohibitions of the practice of mental health care by providers outside of their licensing jurisdictions.[13] Even where emergency laws or other state licensure provisions recognize licensure reciprocity during declared emergencies, reciprocity lasts only for the duration of the emergency, which is often tied solely to addressing physical health threats to the public. States of emergency do not typically extend to address mental health impacts for months or years beyond the initial emergency event.

Even when out-of-state mental HCWs are authorized to practice, they face other legal barriers. Liability concerns can arise, as evidenced by multiple claims of criminal and civil liability following Hurricane Katrina.[14] These claims may be furthered by the uncertainties of providing mental health care for vulnerable populations whose conditions are not always easily diagnosed or treated. To counter liability risks, legal protections derived from emergency laws, volunteer protection acts, Good Samaritan laws, interstate compacts (e.g., Emergency Management Assistance Compact), and other laws may offer immunity or indemnification for mental HCWs.[13] Like other emergency responders, mental HCWs may lack coverage for their own physical or mental injuries sustained during an emergency. Although workers' compensation programs typically protect these providers for physical injuries that occur in the work environment,[15] coverage for mental or behavioral health injuries incurred through emergency responses is uncertain.[16]

Crisis standard of care

The provision of emergency mental health services may significantly deviate from the standard of care in non-emergencies. Through what the Institute of Medicine has recently characterized as "crisis standards of care,"[17] mental HCWs must be prepared to adjust their practices to comport with emergency standards in providing mental health services as well as potential changes to their scope of practice. During major emergencies, when resources are scarce, the focus of mental and behavioral health services shifts from individualized patient care to providing essential services to those most in need among vulnerable populations.[18] Traditional counselor-patient relationships and informed consent requirements may be reassessed to enable effective delivery of emergency-based mental health services. Counseling and prescription treatments may be provided without specific informed consent,

particularly when caring for displaced or at-risk children or other wards.

Alterations of counseling and treatment services pursuant to a crisis standard of care can muddle how legal decision makers assess mental health providers' performance in emergencies.[19] Liability claims against mental HCWs lacking immunity may be judged pursuant to the prevalent legal standard of care, which characteristically examines what a "reasonable and prudent" practitioner of the same specialty nationally would do under similar circumstances.[20] This examination can be difficult to assess in crises when the standard of care may change constantly to address communal needs. In response, some have suggested that the legal standard of care for claims arising during crises should explicitly recognize how mental health practitioners act in the interest of protecting the public's health.[19]

MENTAL AND BEHAVIORAL HEALTH SERVICES AND TREATMENT DURING EMERGENCIES

Treating individuals for mental health conditions in crises raises additional legal concerns. Federal health-care programs such as Medicare, Medicaid, Indian Health Service, and veterans health benefits offer important sources of financing for mental health treatment, but eligibility restrictions limit their reach. Changes in prescription practices may facilitate the delivery of emergency mental health services through temporary emergency waivers of federal laws[21] to alter prescription requirements for psychotropic medications or other controlled substances. However, countervailing risks include the potential for prescription drug abuses and improper access.

Public health laws grounded in state-based police powers[22] or *parens patriae*[23] powers routinely authorize directly observed therapy (DOT) programs[24] and civil commitment of potentially dangerous people with mental disabilities, but only pursuant to significant due process protections (e.g., right to hearing, counsel, outside expert examination, and appeal). Alterations of normal due process requirements, privacy considerations, or other legal norms may lead to constitutional or other legal tensions. Federal and state laws banning discrimination against qualified people with disabilities (e.g., Americans with Disabilities Act[25]) or protecting patient privacy (e.g., the HIPAA Privacy Rule[26] and state mental health privacy acts[27]) may be implicated. These and other laws protecting individual liberty and privacy interests must be balanced effectively with community protections and the public's health during major emergencies.

LEGAL AND POLICY REFORMS TO IMPROVE MENTAL AND BEHAVIORAL HEALTH PREPAREDNESS

Amid legal complexities underlying mental health response efforts during and after major emergencies, potential law and policy solutions begin with prioritizing effective mental health responses. Under many existing emergency laws and policies, mental health impacts are addressed, if at all, only as an option for public health intervention. While it is natural initially to focus on physical safety, the emergency may not end simply because physical injuries have been addressed. For many, a mental health emergency has just begun, triggered in some cases by emergency response efforts themselves.

Mental and behavioral health impacts must be assessed and integrated into existing emergency laws and policies. In formulating and executing direct and indirect actions during declared emergencies, public and private actors should consider mental health impacts in advance. For example, social-distancing measures designed to separate individuals to limit exposures to communicable diseases are routinely used during disease outbreaks or epidemics. While these measures may alleviate potential physical impacts, commensurate consideration is needed of mental health impacts resulting from orders of evacuation, isolation, or displacement of populations. Emergency declarations that facilitate mental health response efforts through licensure reciprocity and liability protections could be extended to toll mental health response efforts. Defining "mental health crisis standards of care" and implementing a more extensive use of cost-effective DOT programs can focus and strengthen response efforts.

Public and private health insurers, medical malpractice carriers, and workers' compensation programs should be required to adjust their coverage and payment policies during emergencies to protect patients and providers from mental health harms. Unlike people with physical impairments, those with mental and behavioral health conditions may be shaded from common view. They are, however, equally entitled to care and coverage during and after emergencies.

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