



## Frequently Asked Questions on Ethical Issues Related to Mental Health Care in Emergencies

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**Introduction.** While national or regional emergencies or disasters are well-known for causing an array of harms to physical health, they can also have a significant impact on individuals' mental and behavioral health. Existing mental health conditions, such as schizophrenia and depression, may be exacerbated by an emergency. New conditions, such as post-traumatic stress disorder, may emerge in some persons as a result of the emergency. Large-scale emergencies may affect the mental and behavioral health of first responders, public health officials, health care workers, and others involved in response efforts. The mental health of certain vulnerable populations, including children, the elderly, individuals in group facilities, and persons from socially or economically disadvantaged groups, may also be impacted. Depending on the particular mental and behavioral health issues that arise, individuals may need to access mental health services during and/or after a declared emergency.

In September 2008, the Centers for Disease Control and Prevention (CDC) established a Preparedness and Emergency Response Research Center (PERRC) at the Johns Hopkins Bloomberg School of Public Health. One of the Center's goals is to identify, research, and analyze the legal and ethical issues that arise during emergencies relative to mental and behavioral health. As part of this effort, scholars and researchers at the Johns Hopkins PERRC, in collaboration with the Sandra Day O'Connor College of Law at Arizona State University, have created a series of translational tools on relevant legal and ethical issues.

**Purpose.** This tool is intended as a resource for health care providers and administrators, public health officials, emergency planners, clergy, and their public and private sector partners who seek an enhanced understanding of the ethical issues that may arise during and after emergencies relative to mental and behavioral health. Information about additional resources is provided at the end of the document.

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**Disclaimer.** While this document was prepared with support from CDC (5P01TP000288), its contents do not represent the official position of CDC or other project partners. *This document does not provide specific legal advice.* Practitioners should consult with their legal counsel for a more detailed understanding of federal laws and to understand the implications of relevant state laws.

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### ***1) What ethical principles guide a response when considering preparedness for individuals with serious mental disorders during emergencies?***

**a. Minimizing of harm:** Many individuals with serious mental disorders live on the margin. Their lives are marked by high rates of unemployment, precarious financial status, and social isolation. Further, mental health remains stigmatized in our society, leading individuals living with mental disorders often to be shunned by others or treated with less compassion than those living with equally serious physical disorders. Individuals with mental disorders may be particularly vulnerable to disruptions in normal routines inherent in an emergency and less likely than others to prepare or shelter themselves from significant harms. Anticipating their needs and developing strategies to minimize the harms that persons with mental health disorders may face in an emergency is an ethical requirement.

**b. Equity:** Although the U.S. mental health care system has experienced significant reforms, treatment of mental disorders remains, in many contexts, subject to a lesser, or inequitable, standard of care when compared to physical impairments. Expenditures for mental health care lag behind those for care of physical disorders. Individuals with mental disorders are sometimes viewed as being less worthy of care. Mental health treatments may be perceived as “less scientific” or less essential than treatments for physical disorders. Emergency planners and responders must sustain commitments to equity by (1) ensuring that the needs of those with mental health disorders are given their fair attention during emergencies and (2) engaging in effective planning and training exercises to prepare for the mental health challenges that individuals with pre-existing and emerging mental health conditions will face.

**c. Effectiveness:** A core value of public health ethics is implementing policies, actions, interventions, and strategies only when there is evidence, or high suspicion, that they are effective. Even in an emergency, when the standard of care shifts and changes arise related to who will provide care, where it is delivered, and what treatments may be available, commitments to effective treatment must be sustained to the greatest degree possible. Those with mental health conditions may be particularly at risk of exposure to ineffective interventions or constraints during an emergency. Maintaining commitments, even in times of crisis, to foundational principles of effectiveness and necessity in a response is critical—particularly for those who have been stigmatized and, importantly, may not always understand the purpose of particular actions.

**d. Respecting of choice:** Emergency mental health responses should respect the choices and preferences of those affected to the greatest degree possible, consistent with ensuring an effective public health response. Any constraints on choice should be *necessary* for achieving a successful public health outcome, should only constrain choices *proportionally* to what is required to achieve the outcome and no further, or for no longer than necessary, and should be applied *equally* across populations. For example, in the context of mental health, if there is evidence that an individual is not complying with a public health order, then constraints may be justified if a similar constraint is applied to all non-complying individuals and if it is based on actual evidence of lack of cooperation rather than stigma or suspicions that lack of cooperation might occur. While respecting choice, public health responses should, in addition, choose the intervention or strategy that provides the least infringement to achieve the desired effect. In the context of mental health, this is a particularly important commitment to sustain.

**e. Right to privacy:** Rights to informational privacy often may be compromised in the context of an emergency. Routine systems or processes for protecting information and maintaining confidentiality may have broken down. Identifiable health information regarding sensitive medical conditions may need to be shared to help those in need. In normal times, special mechanisms are in place to protect confidentiality of diagnosis and treatment, but these are subject to disruption during an emergency. Concerns about health information privacy may be heightened for those with a history of mental health disorders. Public health and emergency responders should work to protect the privacy of mental health data even during emergencies and operate consistent with a “need to know” basis (i.e., information should be shared to provide assistance or, in rare cases, protection) related to health data exchanges.

**f. Duty to provide care:** Health care providers have special duties to respond during an emergency. Professional codes of ethics reinforce the duty to continue to provide care during an emergency. This duty extends to those with mental health needs, physical needs, and the least well off. Many persons with mental health needs are also disadvantaged in other ways, including living in poverty or being unable to advocate adequately for themselves. Ethics requires attention to those who are less well off, including a duty to plan for and provide care during times of emergency.

**g. Transparency:** Emergency response teams must communicate to the public why they are responding the way they are, how they are setting priorities, and what their strategies are. Significant opportunities for misunderstanding arise when individuals feel their needs are not being met, even when the response strategies are ethically sound and reasonable. Maintaining transparency includes identifying effective strategies for communication about how and why responses are proceeding in a

particular way. Such commitment to transparency is respectful and can minimize individual and societal anxieties and other harms.

## ***2. Why do emergencies create ethical challenges in caring for persons with serious mental disorders?***

Serious mental disorders are chronic conditions and are highly susceptible to deterioration with disruptions in care. Specialty mental health care is in short supply under normal circumstances, and access can be easily disrupted during emergencies. Knowing when to provide care—and what types of care can be provided—when specialists are not available can create challenges to principles of professional ethics, particularly if healthcare providers assist with care functions outside of their specialty. Because serious mental disorders are often highly stigmatized, they may evoke fear or avoidance even among professionals. Finally, serious mental disorders can be associated with decreased decisional capacity or the perception by caregivers that capacity is diminished (even if it is not). In normal times, special mechanisms are in place to optimize individual autonomy while reducing ill persons' risks to themselves or others. These mechanisms may not be feasible or there may be a lack of trained personnel to implement them during an emergency. Balancing commitments to individuals in need with commitments to quickly and fairly assuring the safety and wellbeing of the public can create ethical challenges; determining what it means for someone with mental health needs to receive their fair due, particularly when the responder has limited expertise in this area, also can create ethical challenges.

## ***3. Do different ethical issues arise for persons with pre-existing mental disorders compared to persons who acutely develop mental disorders during an emergency?***

Persons with pre-existing disorders are more likely to depend on a particular treatment regimen that is believed to optimally balance benefits and risks. The obligation to try to maintain this particular regimen differs from a duty to provide the safest mental health “first aid” for an individual with an acute mental disorder. Persons with pre-existing disorders may also have mental health advance directives or other plans that set out their preferences should they suffer a deterioration and a loss of capacity. Family members may also be aware of their preferences and norms. Ideally, these directives would be respected. For those with acute disorders that result in a loss of capacity, a “best interest” or substituted judgment standard may apply.

## ***4. How can the ethical duty to provide care—balancing effectiveness and risk—be respected where optimal medications, facilities, and trained staff are scarce?***

As with other considerations in emergency response, anticipating needs during preparedness phases (i.e., before an event occurs) is critically important. First, to the extent that general medical and emergency personnel receive basic training in recognition and first line management of mental disorders, harms will be minimized and respectful interactions increased. Unfortunately, even in ordinary times, this type of training is lacking in the basic curriculum of most medical professionals, despite considerable overlap in the skills required for mental health and general medical care. Planning may also involve developing ways to use available communication channels to allow front-line providers access to mental health specialists for consultation. Additionally, mental health topics (maintenance as well as emergency) should be included in emergency/disaster treatment handbooks.

Like medical preparedness, mental health preparedness requires advance stockpiling of essential medicines at the patient and population levels. For many individuals with serious mental health conditions, taking medication continuously is essential. Although most classes of mental health

medications include several medications that in theory have similar actions and potency, many patients do better with one particular medication or experience distress or deterioration when switching. Individuals may want to have extra supplies of their own medication on hand to ensure continuous access to the particular medicine that works best for them. Central stockpiles should include medications thought to be in widest use for the most serious and common mental health disorders.

Individuals with chronic mental health problems—and persons who serve as caregivers for these individuals—may want to work with their treatment team to rehearse non-pharmacologic ways of staying healthy in times of emergency. They can also identify appropriate ways to make emergency treatment information available, should it be needed by caregivers not familiar with an individual's needs or desires.

***5. How can ethical duties to respect privacy and maintain confidentiality be met during emergencies?***

Individuals with mental disorders should not be segregated from patients with other illnesses unless there are risks related to these individuals' own or others' health and safety, or unless their needs could be better met in a separate facility. Further, emergency health care facilities should make mental health surveillance and support universal components of intake and ongoing care (just as universal infection control precautions are taken to avoid singling out particular individuals and to ensure that cases are not missed). Identifiable medical records should not be “flagged” in a way that makes it externally obvious that they contain psychiatric records, and only the minimal information needed for emergency treatment should be recorded and disclosed. Whenever possible, emergency facilities should have an area to which any patient can be brought, however briefly, for private discussion.

***6. How can ethical duties to provide care in the least restrictive setting be respected during emergencies?***

Standards for compulsory evaluation, treatment, and hospitalization should be defined in emergency training manuals, including explanations of the need to provide the least restrictive care consistent with safety. Administrative personnel who facilitate emergency responses should be familiar with these standards. Security personnel should be trained to recognize individuals with mental disorders and to provide support and a safe environment in calming, non-threatening ways. These skills are likely to be of use among the many individuals caught up in an emergency, not just those with identifiable mental disorders.

*For additional information about the topics discussed in this document, see the following articles:*

Wissow LS, Rutkow L, Kass NE, Rabins PV, Vernick JS, Hodge JG. Ethical issues raised in addressing the needs of persons with serious mental disorders in complex emergencies. *Disaster Med Public Health Prep.* 2012;6:72-78, <http://www.ncbi.nlm.nih.gov/pubmed/22217528>.

Rabins PV, Kass NE, Rutkow L, Vernick JS, Hodge JG. Challenges for mental health services raised by disaster preparedness: mapping the ethical and therapeutic terrain. *Biosecur Bioterror.* 2011;9:175-179, <http://www.ncbi.nlm.nih.gov/pubmed/21476900>.