



## Frequently Asked Questions about Legal Preparedness for Health Care Providers and Administrators, Public Health Officials, Emergency Planners, and Others Regarding Mental and Behavioral Health

As of August 22, 2011

**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 ASU Sandra Day O'Connor College of Law, 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 the public and private sector partners who seek enhanced understanding of the legal issues that arise during and after emergencies relative to mental and behavioral health. As per the Table of Contents below, this tool presents a series of frequently asked questions (FAQs) and answers within 3 sections. The content focuses primarily on relevant federal laws although select state or local laws may also be discussed. Where available, links to additional resources are provided in the References. While many significant ethical issues may arise relative to the questions listed below, this document is limited to legal concerns.

**Acknowledgment.** This document, prepared by **Lainie Rutkow, JD, PhD, MPH, Jon Vernick, JD, MPH, and James G. Hodge, Jr., JD, LLM**, is supported by CDC through a project entitled "Legal and Ethical Assessments Concerning Mental and Behavioral Health Preparedness" at the Johns Hopkins Bloomberg School of Public Health and ASU Sandra Day O'Connor College of Law. The authors acknowledge research assistance of **Erin C. Fuse Brown, JD, MPH, Fellow, and Lexi C. White, JD/PhD Candidate, ASU Sandra Day O'Connor College of Law.**

**Disclaimer.** While this document was prepared with support from CDC (5P01TP000288-02), its contents do not represent the official legal 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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## ***I. Government Powers in Declared Emergencies to Respond to Mental and Behavioral Health Harms***

### **1) What are the key laws that authorize the federal government to respond to mental and behavioral health needs during and immediately after emergencies and disasters?**

The federal government can address mental and behavioral health needs through a variety of emergency powers that are grounded in several key federal laws. The Robert T. Stafford Disaster Relief and Emergency Assistance Act allows the President to declare a major disaster or emergency, usually based on a request from a state's governor.<sup>1</sup> Once this federal declaration has been made, the federal government can coordinate response efforts and address mental and behavioral health needs, such as screening, diagnosis, and counseling, through the Act's Crisis Counseling Assistance and Training Program.<sup>2</sup>

In addition, under the auspices of the Public Health Service Act, the U.S. Department of Health and Human Services (DHHS) can declare a public health emergency.<sup>3</sup> Once this declaration is made, DHHS' Secretary can support and conduct investigations into the disease or event that caused the emergency, waive particular Medicare and Medicaid requirements, and mobilize medical personnel, including mental and behavioral health providers.<sup>4</sup> Pursuant to the Pandemic and All-Hazards Preparedness Act, DHHS' Assistant Secretary for Preparedness and Response coordinates medical and public health emergency response efforts, including mental health efforts.<sup>5</sup>

Federal emergency responses are guided by the National Response Framework, which includes Emergency Support Annexes that address mental and behavioral health issues. These issues include surveillance for mental health and substance abuse needs, the provision of psychological first aid, and the treatment of individuals with cognitive limitations.<sup>6</sup>

### **2) What are examples of laws that allow the state governments to respond to mental and behavioral health needs during and immediately after emergencies and disasters?**

State governments also have specific legal powers to declare and respond to emergencies and address mental and behavioral health needs. All states allow for declarations of disaster or emergency, which are initiated in most jurisdictions by a state's Governor.<sup>7</sup> More than half the states also authorize specific declarations of a "public health emergency," based in part on the Model State Emergency Health Powers Act (MSEHPA) of 2001.<sup>8</sup> State-based declarations of public health emergency consistent with MSEHPA authorize enhanced governmental powers, which may allow the state to: (1) screen individuals for mental and behavioral health needs; (2) conduct surveillance for mental and behavioral health conditions; and (3) mobilize licensed mental health providers to provide treatment within and across state lines through licensure reciprocity provisions and liability protections (in some cases).

### **3) How may laws facilitate screening of health care workers and first responders regarding their preexisting or emerging mental health conditions to mitigate mental health harms during an emergency?**

In emergencies, health care workers and first responders may be at an increased risk for mental health harms depending on the nature of their response work.<sup>9</sup> Screening health care workers and first responders for mental and behavioral health conditions or risks may help to identify and treat these conditions.<sup>10</sup> Provisions of MSEHPA allow public health agents (or other qualified persons authorized by the public health authority) to offer screenings to health care workers regarding mental health conditions during emergencies.<sup>11</sup> These screenings, which are not compulsory, may focus on pre-existing and emerging mental and behavioral health conditions. Disaster preparedness guidelines, such as those developed by the federal Substance Abuse and Mental Health Services Administration (SAMSHA), also encourage disaster mental health workers to "be on the lookout" for fellow workers who may be experiencing emerging or exacerbated mental or behavioral health issues.<sup>12</sup>

**4) What legal obligations regarding accommodation for mental disabilities apply to emergency planning by government and public places?**

The federal Americans with Disabilities Act and similar state-based laws prohibit the government and public entities from discriminating against physically or mentally disabled persons through services or programs.<sup>13</sup> In February 2011, a federal district court in California held that these protections apply to emergency planning efforts by government and public places (e.g., emergency shelters).<sup>14</sup> Although this decision may be appealed, the case puts government and other emergency planners on notice that they may violate federal and state disability laws if they fail to account for the needs of individuals with mental and behavioral health conditions in their emergency preparedness programs. For example, emergency planners should consider whether individuals with disabling mental health conditions will require special accommodations to receive notice that an emergency has occurred and how to proceed in an evacuation.<sup>15</sup>

**5) What is the Strategic National Stockpile (SNS) and when can it be legally accessed?**

SNS is a repository for medications and medical supplies that can be used to protect Americans in the event of a public health emergency. SNS was established by Congress through the Homeland Security Act in 2002,<sup>16</sup> and is maintained by CDC's Office of Public Health Preparedness and Response. Through the SNS, medicines and medical supplies can be delivered anywhere in the United States within hours of an emergency.<sup>17</sup> Although the precise content of the SNS is not publicly known, it includes medicines and supplies to treat largely physical injuries.<sup>18</sup> Although the SNS may not currently contain medications frequently used to treat mental health conditions, stockpiles of psychotropic medications will likely be needed during and immediately after an emergency that causes widespread mental health harms. Policy makers should devote attention to this issue. Of note, other emergency medical resources, such as the Federal Medical Stations, may contain limited quantities of psychotropic medications.

## ***II. Deployment, Use, and Authorization of Mental Health Personnel***

**6) What is meant by “licensure portability” or “licensure reciprocity” during declared emergencies?**

These terms refer to the processes by which certain licensed practitioners, including mental health providers, can have their valid licenses to practice recognized in states other than those that currently license them during declared emergencies. This can facilitate their deployment and ability to provide care in affected states.<sup>19</sup>

**7) What laws facilitate interjurisdictional licensure portability for mental and behavioral health professionals during and immediately after emergencies and disasters?**

Once an emergency is declared, licensure reciprocity and waiver laws allow providers licensed in one state to practice within the state granting licensure reciprocity for the duration of the declared emergency.<sup>20</sup> For example, the Emergency Management Assistance Compact (EMAC), executed by all states, facilitates this type of licensure portability during declared emergencies for state agents (i.e., not private sector professionals).<sup>21</sup> A number of states have adopted a provision of MSEHPA that waives state or local licensure requirements for validly-licensed health care providers from other states during an emergency.<sup>22</sup> Some states have adopted the Uniform Emergency Volunteer Health Practitioners Act (UEVHPA), which allows for licensure portability during emergencies for registered volunteer health practitioners (VHPs), including mental and behavioral health professionals. As long as they were previously registered and do not exceed the scope of practice of their own license or that of the state that hosts them during an emergency, these VHPs qualify for licensure portability.<sup>23</sup>

**8) What liability protections may exist for mental health providers during an emergency?**

Several laws limit civil liability for health care practitioners, including mental and behavioral health providers, who practice during an emergency. Some states have adopted a provision of MSEHPA that explicitly limits civil liability for health professionals during declared emergencies.<sup>24</sup> Similarly, EMAC provides civil liability protections to health

professionals who function as “state agents” during an emergency response.<sup>25</sup> In states adopting the UEVHPA, civil liability protections are available to registered VHPs who provide services through a local host agency during an emergency.<sup>26</sup> Other protections may also apply. However, none of these laws or other volunteer protection acts protect individuals from liability due to willful or wanton acts, gross negligence, or criminal acts.<sup>27</sup>

**9) Do workers’ compensation programs cover mental health harms suffered by mental health workers on the job during emergency response?**

Workers’ compensation is a no-fault insurance program provided by employers and administered by federal or state government, giving individuals or their families limited benefits for work-related injuries and deaths.<sup>28</sup> Typically, these programs only cover employees, not volunteers, who were injured while acting in the scope of their employment.<sup>29</sup> During declared emergencies, some states have legislatively extended their workers’ compensation programs to cover certain emergency response volunteers.<sup>30</sup> States vary in the extent to which their workers’ compensation programs provide coverage for mental and behavioral health harms. All states provide coverage for: 1) physical harms caused by a mental stimulus, and 2) physical trauma that leads to a mental injury.<sup>31</sup> Some states provide no coverage when a mental stimulus causes a mental injury.<sup>32</sup> Among states that do provide compensation for this type of “mental-mental” injury, some will only compensate individuals if the mental stimulus is “sudden or unusual,”<sup>33</sup> which may include public health emergencies.

### ***III. Provision of Services and Treatment***

**10) How might the mental health care provider/patient relationship be impacted during declared emergencies?**

During an emergency, the scope and expectations associated with the provider/patient relationship may change. For example, mental health care providers may not have time to take a detailed personal history, as they would in non-emergency circumstances.<sup>34</sup> Mental health providers may also have to deliver services that are associated with those usually offered by primary care physicians, such as giving advice about general medical concerns or providing referrals to service organizations.<sup>35</sup> Mental health providers may be involved with some form of psychiatric triage, meaning that they help identify and classify individuals into priority groups, based on their need for mental health services.<sup>36</sup> Providers’ legal obligations to their patients, such as obtaining informed consent or protecting patient confidentiality, may remain in place during an emergency, but they may be affected by temporary changes in the standard of care or scope of practice.<sup>37</sup> As noted below, mental and behavioral health providers can work with other emergency responders to ensure that, to the greatest extent possible, these legal obligations are met.

**11) How are legal obligations relating to informed consent for mental health care different during an emergency than under non-emergency circumstances?**

Interactions between a patient and a mental health professional generally hinge upon provision of informed consent.<sup>38</sup> While standards vary across states, the basic tenets of informed consent require a health care provider to provide a patient with information about 1) diagnosis, 2) treatment, 3) consequences or risks, 4) alternatives, and 5) prognosis and then seek their authorization for treatment.<sup>39</sup> Informed consent is required in all medical contexts unless a person cannot provide consent (e.g., due to lack of consciousness), an individual elects to waive informed consent, or in the rare circumstance where a provider can genuinely and reasonably conclude that it would be worse to obtain consent than not.<sup>40</sup> Generally, an individual may legally consent to treatment if he or she is 18 years or older (or is an emancipated minor) and has the mental capacity to understand the consent. Individuals younger than 18 years of age and incapacitated adults often rely upon a guardian or proxy decision-maker to provide consent.<sup>41</sup> There is some variation among the states regarding the age at which a minor can consent to certain forms of care, including mental health care. During a public health emergency, these legal standards remain in place, although they may be slightly altered (e.g., oral assertions may replace written consent processes). Individuals who believe that they may need mental health treatment during an emergency and are concerned that they will lack competence to provide consent at

that time may choose to execute a psychiatric advance directive (PAD).<sup>42</sup> PADs are used to document an individual's preferences for consenting or refusing certain mental health-related treatment. Twenty-five states have authorized the use of PADs.<sup>43</sup>

## **12) Do different legal standards of care apply during emergencies?**

A medical standard of care refers to the type and level of care that is appropriate for different professions.<sup>44</sup> The legal standard of care is based on what a reasonable provider of the same specialty would do in like circumstances.<sup>45</sup> In an emergency, providers' actions are judged by assessing whether the provider acted consistently with how a reasonable provider in a similar situation would have acted. As noted below, this provides little guidance or assurance of what the standard is or should be during emergencies. Furthermore, some suggest that during an emergency the legal standard of care should shift to enable providers to act in ways that protect community as well as individual health.<sup>46</sup>

## **13) How might a crisis standard of care be applied during a declared emergency relative to mental and behavioral health care?**

During emergencies, public health departments, health care systems, and health care providers may face resource shortages while they experience a demand for mental health and other services. Recently, the Institute of Medicine issued a report explaining that the level of patient care—including mental and behavioral health care—during emergencies may fall along a continuum (conventional to contingency to crisis).<sup>47</sup> When traditional levels of care cannot be maintained during an emergency, moving to a crisis standard of care may become necessary, shifting priority to those individuals with greatest needs to receive care first. These types of triage decisions would aim to protect individual as well as population-level health.<sup>48</sup>

## **14) Does mental health providers' authority to prescribe medications change during and immediately after declared emergencies?**

Mental and behavioral health services are generally provided through a combination of behavior-based therapies and the prescription of psychotropic and other medications.<sup>49</sup> Mental and behavioral health providers' authority to prescribe medications depends on the state where they are licensed.<sup>50</sup> Prescriptions for medications related to mental health treatment tend to be written by psychiatrists, physicians from other specialties, physician assistants (PAs), and advance practice nurses (APNs).<sup>51</sup> For PAs and APNs, prescribing authority often depends upon a supervisory or collaborative practice agreement with a validly licensed physician. To meet surge capacity during an emergency, mental health care providers with prescribing authority may need to practice in jurisdictions where they are not licensed. Numerous legal provisions facilitate this type of licensure portability, which can allow mental health providers to practice and prescribe medications temporarily in a state affected by an emergency (see question #7).<sup>52</sup> During an emergency, whether in their home state or practicing in an affected state, mental health care providers must remain in compliance with federal and state laws that regulate the prescription of medications.

## **15) How are laws regarding the prescription of psychotropic drugs affected by a declared emergency?**

Federal laws strictly regulate the prescription of certain medications that are frequently used to treat mental and behavioral health conditions,<sup>53</sup> such as benzodiazepines for anxiety and amphetamines for ADHD. These drugs are classified into five schedules by the federal Controlled Substances Act (CSA).<sup>54</sup> This classification system determines the ease with which individuals can access medications used to treat mental and behavioral health issues. For example, drugs in Schedules II, III, and IV should be dispensed directly to the person for whom they are prescribed.<sup>55</sup> Schedule II drugs (e.g., methadone) may be dispensed pursuant to a written prescription that cannot contain refills.<sup>56</sup> Federal law defines certain "emergency" conditions when Schedule II drugs can be dispensed with an oral prescription (i.e., the drug needs to be immediately administered; no other treatment is available; and a written prescription is an impossibility).<sup>57</sup> Less restrictive laws govern the prescribing of drugs on Schedules III, IV, and V.<sup>58</sup> These laws remain in place during an emergency unless they are temporarily waived or altered by a federal or state emergency declaration.

## **16) How can certain specific legal powers facilitate treatment for some mental and behavioral health conditions during emergencies?**

During emergencies, laws may allow for the temporary use of certain treatments to help providers meet patient surge capacity. There are, however, important limitations to the utility of these treatments. In general, courts have determined that compulsory treatment may be employed only if there is “a compelling public health interest; a ‘well-targeted’ intervention; and . . . there exists no ‘less restrictive alternative.’”<sup>59</sup> The use of any form of compulsory treatment—in non-emergency and emergency situations—must be carefully balanced against the need to respect individuals’ constitutionally-protected liberty interests. Important protections of individuals’ due process rights, such as hearings for those who contest their treatment, cannot be ignored simply because an emergency has been declared.<sup>60</sup> However, alternative means of meeting these requirements may be developed, consistent with provisions of MSEHPA, noted above.

States are allowed to act to protect the interests of minors and vulnerable persons. For example, states can engage in involuntary commitment of the mentally ill for protection from harm.<sup>61</sup> During emergencies, states can act to protect minors, persons who lack legal competence, and others who may not be able to protect themselves.<sup>62</sup> For example, the state can appoint temporary caregivers for young children who have been separated from their parents.

Directly observed therapy (DOT) is a type of treatment in which a provider observes a patient to ensure that medication is taken correctly.<sup>63</sup> Variations of DOT have been used in mental and behavioral health contexts (e.g., assisting those recovering from addiction).<sup>64</sup> These types of assisted treatment therapies are legally authorized in most jurisdictions and may be used during emergencies to manage care for certain populations, such as displaced individuals who live in institutional settings.<sup>65</sup>

## **17) How do legal restrictions on individual movement such as isolation and quarantine measures affect the ability to receive treatment for emerging or pre-existing mental health conditions?**

While governmental restrictions on individuals’ movement during declared emergencies may protect the population’s physical health, they may also be associated with adverse mental health outcomes. Individuals who are isolated or quarantined due to an infectious disease outbreak may experience mental health issues, such as anxiety or depression.<sup>66</sup> Some states’ emergency laws based on MSEHPA affirm that individuals should have access to mental and behavioral health care providers while confined.<sup>67</sup>

## **18) How does the legal duty to protect third parties and individuals from threats of harm by those with mental or behavioral health conditions change during an emergency?**

Mental and behavioral health professionals generally have a duty to protect third parties from individuals who present a clear and specific danger to them.<sup>68</sup> This may include the use of certain reasonable measures, such as notifying an intended victim or reporting a dangerous person to the police. During emergencies, mental and behavioral health professionals may find it challenging to meet this legal duty due to limited encounters with a potentially dangerous individual or lack of available law enforcement officials.<sup>69</sup> Even during emergencies, however, this duty must be carried out to the greatest extent possible.

## References

- <sup>1</sup> Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§ 5121-5207 (2010).
- <sup>2</sup> 42 U.S.C. § 5183 (2010); *A Guide to the Disaster Declaration Process and Federal Disaster Assistance*, FED. EMERGENCY MGMT. AGENCY, U.S. DEP'T OF HOMELAND SEC., [http://www.fema.gov/pdf/rrr/dec\\_proc.pdf](http://www.fema.gov/pdf/rrr/dec_proc.pdf).
- <sup>3</sup> 42 U.S.C. § 247d(a)(1)-(2) (2010).
- <sup>4</sup> *Legal Authority of the Secretary*, OFFICE OF THE ASSISTANT SEC'Y FOR PREPAREDNESS & RESPONSE, <http://www.phe.gov/Preparedness/support/secauthority/Pages/default.aspx#without>.
- <sup>5</sup> Pandemic and All-Hazards Preparedness Act, Pub. L. No. 109-417, 120 Stat. 2831(codified as amended in scattered sections of 42 U.S.C.).
- <sup>6</sup> *National Response Framework (NRF) – Fact Sheet*, U.S. DEP'T OF HOMELAND SEC., <http://www.fema.gov/pdf/emergency/nrf/NRFOnePageFactSheet.pdf>; OFFICE OF ASSISTANT SEC'Y FOR PREPAREDNESS & RESPONSE, FY 2010 ONLINE PERFORMANCE APPENDIX 1, 5 (2010), available at <http://dhhs.gov/asfr/ob/docbudget/2010aspropa.pdf>.
- <sup>7</sup> James G. Hodge, Jr. & Evan D. Anderson, *Principles and Practice of Legal Triage During Public Health Emergencies*, 64 N.Y.U. ANN. SURV. AM. L. 249, 263-67 (2008).
- <sup>8</sup> CTR. FOR LAW & PUBLIC'S HEALTH AT GEORGETOWN & JOHNS HOPKINS U., MODEL STATE EMERGENCY HEALTH POWERS ACT (MSEHPA) 1 (2001), available at <http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf>.
- <sup>9</sup> DEBORAH J. DEWOLFE, U.S. DEP'T OF HEALTH & HUMAN SERVS., TRAINING MANUAL FOR MENTAL HEALTH AND HUMAN SERVICES WORKERS IN MAJOR DISASTERS 28 (2000), available at <http://mentalhealth.samhsa.gov/publications/allpubs/SMA96-0538/tmsection3.asp>.
- <sup>10</sup> DEBORAH J. DEWOLFE, U.S. DEP'T OF HEALTH & HUMAN SERVS., TRAINING MANUAL FOR MENTAL HEALTH AND HUMAN SERVICES WORKERS IN MAJOR DISASTERS 28-29 (2000), available at <http://mentalhealth.samhsa.gov/publications/allpubs/SMA96-0538/tmsection3.asp>.
- <sup>11</sup> MSEHPA §§ 602 (a)-602(c).
- <sup>12</sup> DEBORAH J. DEWOLFE, U.S. DEP'T OF HEALTH & HUMAN SERVS., TRAINING MANUAL FOR MENTAL HEALTH AND HUMAN SERVICES WORKERS IN MAJOR DISASTERS 29 (2000), available at <http://mentalhealth.samhsa.gov/publications/allpubs/SMA96-0538/tmsection3.asp>.
- <sup>13</sup> Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327 (codified as amended at 42 U.S.C. §§ 12101-12213 (2006)).
- <sup>14</sup> CALIF v. City of Los Angeles (CV 09-0287 CBM (RZx) U.S. Dist. Ct., Central Dist. CA 2011).
- <sup>15</sup> *The Potential Implications of CALIF v. City of Los Angeles for Mental and Behavioral Health Preparedness*, CDC PERRC Project # 4: Legal and Ethical Assessments Concerning Mental and Behavioral Health Preparedness (March 18, 2011).
- <sup>16</sup> 42 U.S.C. § 247d-6b(a)(1) (2010).
- <sup>17</sup> *Strategic National Stockpile: What it Means to You*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.bt.cdc.gov/stockpile/#means> (last updated May 21, 2010).
- <sup>18</sup> *Strategic National Stockpile: What It Means to You* (2009), CTRS. FOR DISEASE CONTROL & PREVENTION, [www.bt.cdc.gov/stockpile](http://www.bt.cdc.gov/stockpile).
- <sup>19</sup> James G. Hodge, Jr., *Legal Triage During Public Health Emergencies and Disasters*, 58 ADMIN. L. REV. 627, 643(2006).
- <sup>20</sup> *Uniform Emergency Volunteer Health Practitioners Act (UEVHPA)*, CTRS. FOR LAW & THE PUBLIC'S HEALTH, <http://www.publichealthlaw.net/ModelLaws/UEVHPA.php>.
- <sup>21</sup> *What Is EMAC?*, EMACWEB.ORG, <http://www.emacweb.org/?9>.
- <sup>22</sup> MSEHPA § 608(b)(2).
- <sup>23</sup> NAT'L CONFERENCE OF COMM'RS ON UNIF. STATE LAWS, UNIFORM EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT (UEVHPA) § 2(15) (2006), available at <http://www.uevhpa.org/Uploads/uevhpafinal.pdf>.
- <sup>24</sup> MSEHPA § 608(b)(3).
- <sup>25</sup> *EMAC Articles of Agreement Art. V*, EMACWEB.ORG (1996), <http://www.emacweb.org/?1838>.
- <sup>26</sup> Michealle Carpenter, James G. Hodge, Jr. & Raymond P. Pepe, *Deploying and Using Volunteer Health Practitioners in Response to Emergencies: Proposed Uniform State Legislation Provides Liability Protections and Workers' Compensation Coverage*, 3 AM. J. DISASTER MED. 17, 19 (2008).
- <sup>27</sup> James G. Hodge, Jr., *Legal Triage During Public Health Emergencies and Disasters*, 58 ADMIN. L. REV. 627, 641(2006).
- <sup>28</sup> James G. Hodge, Jr., Lance A. Gable & Stephanie H. Cálves, *The Legal Framework for Meeting Surge Capacity Through the Use of Volunteer Health Professionals During Public Health Emergencies and Other Disasters*, 22 J. CONTEMP. HEALTH L. & POL'Y 5, 50 (2005).



- <sup>29</sup> James G. Hodge, Jr., Lance A. Gable & Stephanie H. Cálves, *The Legal Framework for Meeting Surge Capacity Through the Use of Volunteer Health Professionals During Public Health Emergencies and Other Disasters*, 22 J. CONTEMP. HEALTH L. & POL'Y 5, 50-51 (2005).
- <sup>30</sup> James G. Hodge, Jr., Lainie Rutkow & Aubrey Joy Corcoran, *A Hidden Epidemic: Assessing the Legal Environment Underlying Mental and Behavioral Health Conditions in Emergencies*, 4 ST. LOUIS U. J. HEALTH L. & POL'Y 33, 67 (2010).
- <sup>31</sup> ARTHUR LARSON & LEX K. LARSON, LARSON'S WORKERS' COMPENSATION LAW §§ 56.02-.03, 56.06 (2010).
- <sup>32</sup> ARTHUR LARSON & LEX K. LARSON, LARSON'S WORKERS' COMPENSATION LAW § 56.06[4].
- <sup>33</sup> ARTHUR LARSON & LEX K. LARSON, LARSON'S WORKERS' COMPENSATION LAW § 56.06[2].
- <sup>34</sup> Erin Smith & Rhona Macdonald, *Managing Health Information During Disasters*, 35 HEALTH INFO. MGMT. J. 8, 8, 11, 13 (2006).
- <sup>35</sup> COMM. ON PSYCHIATRIC DIMENSIONS OF DISASTER, AM. PSYCHIATRIC ASS'N, DISASTER PSYCHIATRY HANDBOOK 22 (Richard C.W. Hall, Anthony T. Ng & Ann E. Norwood eds., 2004), available at <http://www.psych.org/Resources/DisasterPsychiatry/APADisasterPsychiatryResources/DisasterPsychiatryHandbook.aspx>.
- <sup>36</sup> Frederick M. Burkle, Jr., *Acute-Phase Mental Health Consequences of Disasters: Implications for Triage and Emergency Medical Services*, 28 ANNALS EMERGENCY MED. 119, 123 (1996).
- <sup>37</sup> James G. Hodge, Jr., Lainie Rutkow & Aubrey Joy Corcoran, *A Hidden Epidemic: Assessing the Legal Environment Underlying Mental and Behavioral Health Conditions in Emergencies*, 4 ST. LOUIS U. J. HEALTH L. & POL'Y 33, 70 (2010).
- <sup>38</sup> *Canterbury v. Spence*, 464 F.2d 772, 780-81 (D.C. Cir. 1972).
- <sup>39</sup> 2 Robert I. Simon, *Ethics and Forensic Psychiatry*, in COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 3972 (Benjamin J. Sadock & Virginia A. Sadock eds., 8th ed. 2005).
- <sup>40</sup> *Schloendorff v. Soc'y N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914); Erin Talati, *When A Spoonful of Sugar Doesn't Help the Medicine Go Down: Informed Consent, Mental Illness, and Moral Agency*, 6 IND. HEALTH L. REV. 171, 175-76 (2009).
- <sup>41</sup> Andrew Newman, *Adolescent Consent to Routine Medical and Surgical Treatment: A Proposal to Simplify the Law of Teenage Medical Decision-Making*, 22 J. LEGAL MED. 501, 502 (2001); C.W. Van Staden & C. Krüger, *Incapacity to Give Informed Consent Owing to Mental Disorder*, 29 J. MED. ETHICS 41, 41 (2003).
- <sup>42</sup> Nat'l Res. Ctr. on Psychiatric Advance Directives, *What Is a Psychiatric Advance Directive (PAD)?*, at <http://www.nrc-pad.org/content/view/19/25/> (last visited May 20, 2011).
- <sup>43</sup> Nat'l Res. Ctr. on Psychiatric Advance Directives, *Do All States Specifically Have PAD Statutes?*, at <http://www.nrc-pad.org/content/view/41/25/> (last visited May 20, 2011).
- <sup>44</sup> COMM. ON GUIDANCE FOR ESTABLISHING CRISIS STANDARDS OF CARE FOR USE IN DISASTER SITUATIONS, INST. OF MED. OF THE NAT'L ACADS., GUIDANCES FOR ESTABLISHING CRISIS STANDARDS OF CARE FOR USE IN DISASTER SITUATIONS: A LETTER REPORT (Bruce M. Altevogt et al., eds., 2009).
- <sup>45</sup> James G. Hodge, Jr. & Brooke Courtney, *Assessing the Legal Standard of Care in Public Health Emergencies*, 303 JAMA 361 (2010).
- <sup>46</sup> James G. Hodge, Jr. & Brooke Courtney, *Assessing the Legal Standard of Care in Public Health Emergencies*, 303 JAMA 361 (2010).
- <sup>47</sup> COMM. ON GUIDANCE FOR ESTABLISHING CRISIS STANDARDS OF CARE FOR USE IN DISASTER SITUATIONS, INST. OF MED. OF THE NAT'L ACADS., GUIDANCES FOR ESTABLISHING CRISIS STANDARDS OF CARE FOR USE IN DISASTER SITUATIONS: A LETTER REPORT 14 (Bruce M. Altevogt et al., eds., 2009).
- <sup>48</sup> James G. Hodge, Jr., Lainie Rutkow & Aubrey Joy Corcoran, *A Hidden Epidemic: Assessing the Legal Environment Underlying Mental and Behavioral Health Conditions in Emergencies*, 4 ST. LOUIS U. J. HEALTH L. & POL'Y 33, 89-90 (2010).
- <sup>49</sup> U.S. PUB. HEALTH SERV., U.S. DEP'T OF HEALTH & HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 64-66, 68 (1999), available at <http://download.ncadi.samhsa.gov/ken/pdf/surgeongeneralreport/C2.pdf>.
- <sup>50</sup> David E. Joranson, *Guiding Principles of International and Federal Laws Pertaining to Medical Use and Diversion of Controlled Substances*, 131 NAT'L INST. DRUG ABUSE RES. MONOGRAPH 18, 19 (1993); *Prescribing Privileges for Psychologists: An Overview*, NAT'L ALLIANCE ON MENTAL ILLNESS, [http://www.nami.org/Template.cfm?Section=Issue\\_Spotlights&template=/ContentManagement/ContentDisplay.cfm&ContentID=8375](http://www.nami.org/Template.cfm?Section=Issue_Spotlights&template=/ContentManagement/ContentDisplay.cfm&ContentID=8375).
- <sup>51</sup> James G. Hodge, Jr., Lainie Rutkow & Aubrey Joy Corcoran, *A Hidden Epidemic: Assessing the Legal Environment Underlying Mental and Behavioral Health Conditions in Emergencies*, 4 ST. LOUIS U. J. HEALTH L. & POL'Y 33, 59-60 (2010).
- <sup>52</sup> Lainie Rutkow, Jon S. Vernick, Lawrence S. Wissow, Christopher N. Kaufmann, James G. Hodge, Jr., *Prescribing Authority During Emergencies: Challenges for Mental Health Care Providers*, J. LEGAL MED. (in press).
- <sup>53</sup> 21 U.S.C. § 823 (2010).
- <sup>54</sup> 21 U.S.C. § 812(a) (2010).
- <sup>55</sup> 21 C.F.R. § 290.5 (2010).
- <sup>56</sup> 21 U.S.C. § 829(a) (2010).

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- <sup>57</sup> 21 U.S.C. § 829(a) (2006).
- <sup>58</sup> 21 U.S.C. §§ 829(b)-(c) (2010).
- <sup>59</sup> Lawrence O. Gostin, *Public Health Theory and Practice in the Constitutional Design*, 11 HEALTH MATRIX 265, 305-06 (2001).
- <sup>60</sup> James G. Hodge, Jr., Lainie Rutkow & Aubrey Joy Corcoran, *A Hidden Epidemic: Assessing the Legal Environment Underlying Mental and Behavioral Health Conditions in Emergencies*, 4 ST. LOUIS U. J. HEALTH L. & POL'Y 33, 81-82 (2010).
- <sup>61</sup> *Developments in the Law – Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1208–10 (1974).
- <sup>62</sup> Lawrence O. Gostin, *Public Health Law in a New Century: Part III: Public Health Regulation: A Systematic Evaluation*, 283 JAMA 3118, 3119 (2000).
- <sup>63</sup> E.g., CAL. DEP'T OF HEALTH SERVS. & CAL. TUBERCULOSIS CONTROLLERS ASS'N, DIRECTLY OBSERVED THERAPY PROGRAM PROTOCOLS IN CALIFORNIA 1, 1 (Apr. 11, 1997), available at [www.ctca.org/guidelines/IIA5dot.pdf](http://www.ctca.org/guidelines/IIA5dot.pdf).
- <sup>64</sup> Geetanjali Chander, Seth Himelhoch & Richard D. Moore, *Substance Abuse and Psychiatric Disorders in HIV-Positive Patients: Epidemiology and Impact on Antiretroviral Therapy*, 66 DRUGS 769, 776 (2006).
- <sup>65</sup> Janet Baggett, *Letter to the Editor, Florida Disasters and Chronic Disease Conditions*, PREVENTING CHRONIC DISEASE 1, 1 (2006), available at [http://www.cdc.gov/pcd/issues/2006/apr/pdf/05\\_0230.pdf](http://www.cdc.gov/pcd/issues/2006/apr/pdf/05_0230.pdf).
- <sup>66</sup> CTRS. FOR DISEASE CONTROL & PREVENTION, U.S. DEP'T OF HEALTH & HUMAN SERVS., SEVERE ACUTE RESPIRATORY SYNDROME: SUPPLEMENT D: COMMUNITY CONTAINMENT MEASURES, INCLUDING NON-HOSPITAL ISOLATION AND QUARANTINE 3 (Jan. 8, 2004), available at <http://www.cdc.gov/ncidod/sars/guidance/d/pdf/d.pdf>.
- <sup>67</sup> MSEHPA § 604(d)(1).
- <sup>68</sup> *Tarasoff v. Regents of the Univ. of Cal.*, 551 P.2d 334, 340 (Cal. 1976).
- <sup>69</sup> James G. Hodge, Jr., Lainie Rutkow & Aubrey Joy Corcoran, *A Hidden Epidemic: Assessing the Legal Environment Underlying Mental and Behavioral Health Conditions in Emergencies*, 4 ST. LOUIS U. J. HEALTH L. & POL'Y 33, 76 (2010).