A HIDDEN EPIDEMIC: ASSESSING THE LEGAL ENVIRONMENT UNDERLYING MENTAL AND BEHAVIORAL HEALTH CONDITIONS IN EMERGENCIES[1]

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I. INTRODUCTION

Public health emergencies and disasters are often defined by their impacts on human morbidity and mortality.[2] The 2009/2010 A/H1N1 influenza pandemic has led to millions of human infections globally, and thousands of deaths among individuals, including children and young adults

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2. *See* James G. Hodge, Jr., Lainie Rutkow & Aubrey Joy Corcoran, *Mental and Behavioral Health Legal Preparedness In Major Emergencies*, 125 PUB. HEALTH REP. 759, 759 (2010).

who do not typically succumb to seasonal influenza.[3] The 2010 Haiti earthquake, one of the worst natural disasters in global history, resulted in over 230,000 deaths from the earthquake itself,[4] with thousands of additional deaths among individuals waiting to be treated for their injuries,[5] and a multitude of survivors facing disabling physical impairments.[6] Additional natural disasters like the 2010 Chilean and Chinese earthquakes, Hurricane Katrina in the U.S. in 2005, and the Asian tsunamis in 2004 not only caused or contributed to significant morbidity and mortality, but also displaced hundreds of thousands, uprooting entire populations from economic and social centers.[7] The catastrophic effects of these types of emergencies on the physical health and well-being of populations are a consistent focus of international, national, and regional emergency preparedness and response efforts.

In addition to the physical tolls on individual and population-based health in major emergencies, there are also significant impacts on individual mental and behavioral health.[8] Emergencies can threaten the mental and behavioral health of populations in many ways. Individuals' existing mental

3. *See Updated CDC Estimates of 2009 H1N1 Influenza Cases, Hospitalizations and Deaths in the United States*, FLU.GOV (Apr. 10, 2010), http://www.flu.gov/individualfamily/about/h1n1/estimates_2009_h1n1.html (last visited Aug. 14, 2010); *Comparing Deaths from Pandemic and Seasonal Influenza*, WORLD HEALTH ORG. (Dec. 22, 2009), http://www.who.int/csr/disease/swineflu/notes/briefing_20091222/en; *Pandemic (H1N1) 2009 – Update 81*, WORLD HEALTH ORG. (Dec. 30, 2009), http://www.who.int/csr/don/2009_12_30/en/index.html.

4. Hodge, Rutkow & Corcoran, *supra* note 2 (citing *Haiti: Death Toll Climbs to 230,000*, TELEGRAPH, Feb. 10, 2010, http://www.telegraph.co.uk/news/worldnews/centralamericaandthecaribbean/haiti/7200986/Haiti-death-toll-climbs-to-230000.html). *See also* EDUARDO A. CAVALLO, ANDREW POWELL & OSCAR BECERRA, ESTIMATING THE DIRECT ECONOMIC DAMAGE OF THE EARTHQUAKE IN HAITI 4 tbl.1, 11 (2010) (indicating the number of people killed in the Haiti Earthquake as a share of the country's total population).

5. *See* Tracy Kidder, *Recovering from Disaster—Partners in Health and the Haitian Earthquake*, 362 NEW ENG. J. MED. 769, 770-71 (2010).

6. Hodge, Rutkow & Corcoran, *supra* note 2, at 759 (citing Laurence J. Ronan & Lisa I. Iezzoni, Op-Ed, *The Long-Term Aftershocks of Care*, BOSTON GLOBE, Feb. 9, 2010, http://www.boston.com/bostonglobe/editorial_opinion/oped/articles/2010/02/09/the_long_0term_aftershocks_of_care).

7. *See, e.g.*, P. Gregg Greenough et al., *Burden of Disease and Health Status Among Hurricane Katrina-Displaced Persons in Shelters: A Population-Based Cluster Sample*, 51 ANNALS EMERGENCY MED. 426, 427 (2008); Abdur Rofi, Shannon Doocy & Courtland Robinson, *Tsunami Mortality and Displacement in Aceh Province, Indonesia*, 30 DISASTERS 340, 340-41 (2006); Alexei Barrionuevo & Liz Robbins, *1.5 Million Displaced After Chile Quake*, N.Y. TIMES, Feb. 27, 2010, at A1.

8. *See generally* Fran H. Norris et al., *60,000 Disaster Victims Speak: Part I. An Empirical Review of the Empirical Literature, 1981-2001*, 65 PSYCHIATRY 207, 207 (2002) [hereinafter Norris, *Part I*] (summarizing an empirical literature review of approximately 250 articles, chapters, and books analyzing the effects of disasters on mental health).

and behavioral health conditions (*e.g.*, schizophrenia, depression) can be exacerbated by emergency events.[9] Novel mental or behavioral health problems (*e.g.*, post traumatic stress disorder) may arise among persons who have not previously experienced mental health problems, but who are directly or indirectly impacted by the emergency.[10] Large-scale emergencies may directly impact the mental and behavioral health status of front-line emergency responders, public health officials, health care workers, and mental health counselors—each of whom may be challenged emotionally and drained physically by their response efforts.[11] Together, these persons may suffer a secondary, yet sometimes forgotten or hidden, wave of preventable or treatable mental and behavioral health "casualties" that occur during and after emergencies.[12]

Acknowledging and addressing the mental and behavioral health issues associated with emergencies are crucial. Mental health issues stemming from emergencies can be debilitating for individuals and society. Individuals may be temporarily or permanently stripped of their livelihoods, careers, and support systems.[13] Mental health conditions may impair the ability of emergency responders and health care workers (HCWs) to respond to (or handle the consequences of) the emergency itself.[14] National productivity and recovery from emergencies may be diminished by mental and behavioral health impairments.[15] Consequently, public health emergency planning, mitigation, and response efforts must increasingly consider the mental health impacts of natural disasters, pandemics, and other catastrophic events. One part of these comprehensive strategies is to require enhanced training of mental health professionals, counselors, and others to

9. *Id.* *See also* COMM. ON PSYCHIATRIC DIMENSIONS OF DISASTER, AM. PSYCHIATRIC ASS'N, DISASTER PSYCHIATRY HANDBOOK 13 (Richard C.W. Hall, Anthony T. Ng & Ann E. Norwood eds., 2004) [hereinafter DISASTER PSYCHIATRY HANDBOOK], *available at* http://www.psych.org/Resources/DisasterPsychiatry/APADisasterPsychiatryResources/DisasterPsychiatryHandbook.aspx.

10. *See* Norris, *Part I*, *supra* note 8.

11. *See, e.g.*, DEBORAH J. DEWOLFE, FIELD MANUAL FOR MENTAL HEALTH AND HUMAN SERVICE WORKERS IN MAJOR DISASTERS 23 (Diana Nordboe ed., 2000) [hereinafter DEWOLFE, FIELD MANUAL], *available at* http://mentalhealth.samhsa.gov/dtac/FederalResource/Response/3-Field_Manual_MH_Workers.pdf. *See also* DISASTER PSYCHIATRY HANDBOOK, *supra* note 9, at 15 (noting that twenty percent of rescue workers may experience some form of post-traumatic stress disorder by the end of the first month after a natural disaster).

12. *See* DEWOLFE, FIELD MANUAL, *supra* note 11. *See also* DISASTER PSYCHIATRY HANDBOOK, *supra* note 9, at 22 (stating "[r]escue workers or disaster response volunteers (including mental health professionals) have been called secondary or indirect victims.").

13. *See* DEWOLFE, FIELD MANUAL, *supra* note 11, at 5-6.

14. *Id.* at 23.

15. *See* Ellen T. Gerrity & Brian W. Flynn, *Mental Health Consequences of Disasters*, *in* THE PUBLIC HEALTH CONSEQUENCES OF DISASTERS 101, 115-16 (Eric K. Noji ed., 1997).

effectively screen, test, and treat individuals for mental health conditions during an emergency.[16] Yet, the larger goal is to raise national awareness of the equal need to treat individuals for mental and behavioral issues, in addition to physical ailments, during and after emergencies.

Achieving this goal raises multiple legal concerns. Emergency victims and their families, public health practitioners, HCWs, and other frontline responders face an array of complex legal issues that may impede their treatment for, or recovery from, mental and behavioral health conditions.[17] Since the terrorist attacks of September 11, 2001, and the ensuing anthrax exposures that Fall, substantial research and scholarship have examined critical issues of law and policy underlying medical and public health response efforts during government-declared emergencies.[18] Considerably less attention has been devoted to the corresponding legal issues underlying mental and behavioral health conditions and services during emergencies.[19] These issues have not been comprehensively assessed to date.[20]

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16. *Id.* at 108-11.

17. *See* 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, 283-84 (2008).

18. DIV. HEALTHCARE PREPAREDNESS, DEP'T. HEALTH & HUMAN SERVS., EMERGENCY SYSTEM FOR ADVANCED REGISTRATION OF VOLUNTEER HEALTH PROFESSIONALS (ESAR-VHP) - LEGAL AND REGULATORY ISSUES 9 (May 2006) [hereinafter ESAR-VHP].

19. The American Psychological Association (APA) produced the Disaster Response Network Member Guidelines (APA Guidelines). *Disaster Response Network Member Guidelines*, AM. PSYCHOL. ASS'N, http://www.apa.org/practice/programs/drn/guide.aspx (last visited Aug. 14, 2010) (describing APA's Disaster Response Network (DRN) as "the mechanism through which volunteer psychologists respond to local and national disasters and other traumatic events." Various legal issues are briefly discussed, including liability (limited to insurance issues), confidentiality, and licensure).

20. Most legal resources in emergency mental and behavioral health preparedness focus on the legislative framework for funding mental health services or the unique clinical challenges for mental health professionals during emergencies. *See, e.g.*, RAMYA SUNDARARAMAN, SARAH A. LISTER & ERIN D. WILLIAMS, CONG. RESEARCH SERV., RL 33738, GULF COAST HURRICANES: ADDRESSING SURVIVORS' MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT NEEDS (2006) (describing various federal programs providing mental health services during emergencies and the interplay between program funding and federal emergency and disaster declarations). A comprehensive collection of resources discussing the unique practice environment and clinical challenges for mental and behavioral health practitioners during emergencies has been compiled by the Substance Abuse and Mental Health Services Administration (SAMHSA). CTR. FOR MENTAL HEALTH SERVS., SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., MENTAL HEALTH ALL-HAZARDS DISASTER PLANNING GUIDANCE 24 (2003), *available at* http://mentalhealth.samhsa.gov/publications/allpubs/SMA03-3829/default.asp (identifying state licensure laws, informed consent, confidentiality, and liability issues that states need to assess and incorporate in state preparedness plans); CTR. FOR SUBSTANCE ABUSE PREVENTION, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., THE STATE AND TERRITORIAL GUIDE TO SUBSTANCE ABUSE PREVENTION IN DECLARED DISASTERS 25 (1997), *available at* http://mentalhealth.samhsa.gov/dtac/FederalResource/table_of_contents.htm (select article

Our objective is to assess the legal environment underlying the identification, accommodation, response, and treatment of mental illnesses and behavioral conditions within the population before, during, and after major emergencies. We begin in *Part II. Mental and Behavioral Health Preparedness: Planning, Mitigation, and Response* with an assessment of key elements in mental health emergency preparedness focused on major vulnerable populations in two categories: (1) persons whose mental health conditions exist prior to an emergency and (2) persons whose mental health conditions emerge as a result of the emergency.

During government-declared states of emergency, disaster, or public health emergency at the federal, tribal, state, or local levels, the legal landscape can change dramatically.[21] Government planning and powers to address mental and behavioral health impacts across populations include general emergency powers (*e.g.*, screening, surveillance, and reporting requirements) to detect and address mental health issues.[22] Emergency powers also authorize government to restrict individual movement (*e.g.*, quarantine, isolation, curfew) or displace populations (*e.g.*, evacuation).[23] As we note, implementation of these powers can lead to adverse mental health outcomes.[24]

Part III. Deployment and Use of Personnel to Provide Mental and Behavioral Health Services in Emergencies examines proliferate legal topics concerning the ability of trained mental health providers and other personnel to address mental and behavioral health issues among populations in emergencies. Major emergencies impact populations across state and territorial boundaries. Addressing their mental and behavioral health issues may require licensed mental health professionals to deploy and practice outside their specific jurisdictions to aid affected individuals, thus raising multiple questions. Under what circumstances may professionals with out-of-state licenses practice in declared emergencies? How may their practice change consistent with crisis standards of care during emergencies? What are the impacts of scope of practice limitations in the host jurisdiction, particularly concerning the authority to prescribe medications?

We also address the affirmative legal duties of mental and behavioral health personnel during declared emergencies. Public health laws may require these providers to report mental or behavioral health issues among their patients or their professional colleagues despite potential privacy

from listing) (discussing the problem of portability across states for licensed mental health professionals).

21. *See* Hodge & Anderson, *supra* note 17, at 250-51.
22. *Id.* at 253-54.
23. *Id.* at 270-71.
24. *See infra* Part II.C.3.

concerns.[25] We discuss a series of profound questions concerning patient informed consent. When may mental and behavioral health providers provide counseling services during or after emergencies without obtaining specific informed consent, particularly in regard to displaced or impacted children or other wards? Under what circumstances may individuals be civilly committed? Do mental and behavioral health providers have a duty to warn known third parties of individuals with mental illnesses who endanger others?

Liability concerns among providers predominate, especially when non-consensual mental or behavioral health services are provided.[26] We briefly explore potential liability risks as well as immunity and indemnification protections from liability for providers derived from emergency laws, volunteer protection acts, Good Samaritan provisions, interstate compacts, and other laws.[27] Conversely, mental and behavioral health providers may sustain personal injuries during declared emergencies. In non-emergencies, these providers may be protected from injuries at work through workers' compensation programs.[28] Yet, coverage under these laws for mental or behavioral health injuries sustained during declared emergencies is uncertain.[29]

In *Part IV. Mental and Behavioral Health Services and Treatment During Emergencies*, we specifically examine legal issues concerning the treatment of individuals for mental health conditions in emergency, triage-like environments. Special entitlements to treatment embedded in existing laws and policies may dictate how and to whom mental health services are provided.[30] Traditional counselor-patient relationships may have to be realigned to facilitate effective delivery of emergency-based mental health

25. *See* DEP'T OF HEALTH & HUMAN SERVS. OFFICE FOR CIVIL RIGHTS, HURRICANE KATRINA BULLETIN: HIPAA PRIVACY AND DISCLOSURES IN EMERGENCY SITUATIONS 1-2 (September 5, 2005), *available at* http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/emergency/katrinanhipaa.pdf (explaining how HIPAA Privacy Rule allows patient information to be shared to assist disaster relief efforts).

26. *See* 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, 18 (2008).

27. *See infra* Part III.D.

28. *See* 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).

29. *Id.* at 65; 3 ARTHUR LARSON & LEX K. LARSON, LARSON'S WORKERS' COMPENSATION LAW §§ 56.02(1), 56.03(1) (2010) [hereinafter LARSON'S WORKERS' COMPENSATION].

30. *See* Hodge & Anderson, *supra* note 17, at 267.

support services.[31] Legal authorities may be altered as well.[32] We consider, for example, whether restrictive federal laws governing access to psychotropic medications or other controlled substances can be waived temporarily in emergencies to allow greater access for persons suffering from mental or behavioral health conditions.[33]

Additional legal issues surround compulsory treatment of non-adherent individuals with mental health conditions who pose risks to themselves or others. Existing public health authorities grounded in state-based police powers[34] or *parens patriae*[35] powers may sustain alterations in traditional due process requirements or other legal norms concerning compulsory treatment in emergencies, particularly for displaced children or confined populations.[36] Similar concerns underlie the implementation of directly observed therapy (DOT) programs to address patient surges.[37] During emergencies, existing DOT programs may become suspended or inoperable due to lack of available personnel.[38] Alternatively, these programs may be

31. *See* AM. PSYCHOLOGICAL ASS'N, ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT: 2010 AMENDMENTS 6 (2010), *available at* http://www.apa.org/ethics/code/index.aspx.

32. *See* James G. Hodge, Jr., *Legal Triage During Public Health Emergencies and Disasters,* 58 ADMIN. L. REV. 627, 634-38 (2006) [hereinafter Hodge, *Legal Triage*] (describing various declarations that can be issued at the state and federal levels and how those declarations change their respective legal environments).

33. *See infra* Part IV.D.

34. Lawrence O. Gostin, *Public Health Law in a New Century: Part II: Public Health Powers and Limits*, 283 JAMA 2979, 2980 (2000) [hereinafter Gostin, *Public Health Law, Part II*] ("The Tenth Amendment reserves to the states all powers that are neither given to the federal government nor prohibited by the Constitution. These reserved powers include, most importantly, the police power to promote the general welfare of society.").

35. *See, e.g.*, *Developments in the Law – Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1208–09 (1974) [hereinafter *Developments in the Law*]. *Parens patriae*, a Latin phrase meaning "parent of his or her country," refers to "the state in its capacity as provider of protection to those unable to care for themselves." BLACK'S LAW DICTIONARY 1144 (8th ed. 2004).

36. *See Developments in the Law*, *supra* note 35 at 1207-45 (emphasizing that *parens patriae* authority and the police power are proper when civil commitment is used to promote a compelling state interest or to vindicate a societal interest).

37. DOT requires a physician or other health care worker to directly supervise the ingestion of medications by a patient for certain afflictions including mental or behavioral health problems (*e.g.*, non-compliant schizophrenia). *See e.g.*, CAL. DEP'T OF HEALTH SERVS. & CAL. TUBERCULOSIS CONTROLLERS ASS'N, DIRECTLY OBSERVED THERAPY PROGRAM PROTOCOLS IN CALIFORNIA 1 (Apr. 1997), *available at* http://www.ctca.org/guidelines/guidelines.html.

38. Gerald Friedland et al., *Utility of Tuberculosis Directly Observed Therapy Programs as Sites for Access to and Provision of Antiretroviral Therapy in Resource-Limited Countries*, 38 CLINICAL INFECTIOUS DISEASES S421, S425 (2004).

in demand during emergencies to ensure that at-risk individuals receive and take needed medications.[39]

Our assessment of the legal environment underlying the provision of mental and behavioral health services in emergencies is not static. In *Part V. Legal and Policy Reforms to Improve Mental and Behavioral Health Preparedness*, we propose potential legal and policy solutions to identified barriers related to mental health emergency preparedness. These include: (1) integrating mental and behavioral health priorities into existing emergency laws and policies; (2) improving interjurisdictional licensure coordination for mental and behavioral health providers; (3) developing mental health impact assessments; (4) establishing clear frameworks for using crisis standards of care in providing mental health services; (5) assuring access to psychotropic medications; and (6) protecting against denials of workers' compensation and health insurance claims for mental and behavioral health conditions.[40]

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

The trauma of public health emergencies and disasters can cause individuals to experience significant short- and long-term mental and behavioral health problems.[41] One study of hurricane survivors in Louisiana, Mississippi, and Alabama following Hurricanes Katrina and Rita in 2005 found that the number of individuals with serious mental illness had doubled.[42]

Most individuals will recover fully from emergency-related mental health conditions without specialized treatment or interventions.[43] Others may experience more severe conditions requiring immediate treatment in the short-term or they may develop more significant, ongoing problems that

39. *See* Ctrs. for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., *Tuberculosis Control Activities After Hurricane Katrina – New Orleans, Louisiana, 2005*, 55 MORBIDITY & MORTALITY WKLY. REP. 329, 332-33 (2006), *available at* http://www.cdc.gov/mmwr/PDF/wk/mm5512.pdf.

40. *See infra* Part V.

41. *See* Gerrity & Flynn, *supra* note 15, at 101. *See also* David Vlahov et al., *Consumption of Cigarettes, Alcohol, and Marijuana Among New York City Residents Six Months After the September 11 Terrorist Attacks*, 30 AM. J. DRUG & ALCOHOL ABUSE 385, 386 (2004) (finding that early studies of the psychological effects after September 11 suggested a high prevalence of mental and behavioral health problems; follow-up studies six months after September 11 found that there was a substantial resolution of these health problems).

42. Lynne Jones et al., *Severe Mental Disorders in Complex Emergencies*, 374 LANCET 654, 655 (2009).

43. Ann M. Mitchell, Teresa J. Sakraida & Kirstyn K. Zalice, *Disaster Care: Psychological Considerations*, 40 NURSING CLINICS N. AM. 535, 542 (2005).

require formal treatment or assistance.[44] Research suggests certain populations are at an increased risk of developing mental or behavioral health conditions in early and advanced stages of an emergency.[45] Focusing on these vulnerable populations through public health planning and interjurisdictional coordination offers the potential to significantly reduce long-term mental health issues despite limited resources.

A. *Vulnerable Populations*

Mental and behavioral health preparedness in emergencies must focus on those individuals who are at an increased risk of developing mental and behavioral health issues. Vulnerable populations include persons in two broad categories: (1) those with *existing* mental or behavioral health conditions; and (2) those with *emerging* mental and behavioral health conditions.[46]

1. Persons With *Existing* Mental or Behavioral Health Conditions.

During and after an emergency, individuals with existing mental or behavioral health conditions are at an increased risk of developing new or renewed problems.[47] For some, the additional stress brought on by the emergency can cause their conditions to deteriorate.[48] Those individuals whose conditions are not fully treated before the emergency are particularly vulnerable, as are those who have suffered prior traumatic events (which can be exacerbated by the present emergency).[49] Although many of these individuals can continue to function if essential mental health services remain in place,[50] mental health systems may be severely compromised

44. *Id.* at 538.

45. *See* Fran H. Norris et al., *60,000 Disaster Victims Speak: Part II. Summary and Implications of the Disaster Mental Health Research*, 65 PSYCHIATRY 240, 241 (2002) [hereinafter Norris, *Part II*].

46. *See* Daya J. Somasundaram & Willem A.C.M. van de Put, *Management of Trauma in Special Populations After a Disaster*, 67 J. CLINICAL PSYCHIATRY Supp. 2, 2006, at 64, 68.

47. *See id*. *See also Disaster Mental Health Primer: Key Principles, Issues and Questions*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.bt.cdc.gov/mentalhealth/primer.asp (last visited March 17, 2010).

48. *See* Deborah J. DeWolfe, *Crisis Counseling Services for Disaster Survivors with Mental Illness, in* RESPONDING TO THE NEEDS OF PEOPLE WITH SERIOUS AND PERSISTENT MENTAL ILLNESS IN TIMES OF MAJOR DISASTER 31, 32-33 (Ctr. for Mental Health Emergency Servs. & Disaster Relief Branch, U.S. Dep't of Health & Human Servs., 1996) [hereinafter DeWolfe, *Crisis Counseling*], *available at* http://mentalhealth.samhsa.gov/dtac/FederalResource/Response/1-Responding_to_Needs_Serious_Mental_Illness.pdf.

49. *See* DEWOLFE, FIELD MANUAL, *supra* note 11, at 22; DeWolfe, *Crisis Counseling*, *supra* note 48, at 42-43.

50. *See* DEWOLFE, FIELD MANUAL, *supra* note 11, at 21; DeWolfe, *Crisis Counseling*, *supra* note 48, at 32.

during an emergency.[51] As a result, some individuals with existing mental and behavioral health conditions may require specialized strategies to access services or medications needed to regain stability.[52]

2. Persons With *Emerging* Mental or Behavioral Health Conditions.

Other groups of individuals are at an increased risk of developing mental and behavioral health conditions because of an emergency.[53] They include individuals in certain age groups (*i.e.*, children and the elderly); racial and ethnic minorities (*e.g.*, immigrants, non-English speakers); individuals in group facilities (*e.g.*, hospitals, nursing homes, prisons); and emergency responders.[54]

Children, including adolescents, are more likely to be severely impacted by an emergency than adults.[55] One study of children affected by Hurricane Katrina found that, during the 2005-2006 school year, half qualified for referral to mental health services.[56] A year later, forty-one percent still qualified.[57] The children who were most likely to be referred for mental health services were those who experienced a prior trauma, loss of property, separation from their caregiver, significant personal loss, or were living in shelters.[58] Children are especially vulnerable because they have not yet developed sufficient skills to cope with an emergency.[59] They may lack the language skills necessary to ask about and understand what is happening and are generally more dependent on routine and consistency for their

51. *See* Gerrity & Flynn, *supra* note 15, at 114.

52. Tony Speier, *Introduction to Crisis Counseling Programs and Services to Persons with Serious and Persistent Mental Illness, in* RESPONDING TO THE NEEDS OF PEOPLE WITH SERIOUS AND PERSISTENT MENTAL ILLNESS IN TIMES OF MAJOR DISASTER 7, 9-10 (Ctr. for Mental Health Emergency Servs. & Disaster Relief Branch, U.S. Dep't of Health & Human Servs., 1996), *available at* http://mentalhealth.samhsa.gov/dtac/FederalResource/Response/1-Responding_to_Needs_Serious_Mental_Illness.pdf.

53. Gerrity & Flynn, *supra* note 15, at 113.

54. *Id.* at 113-17; Betty Hearn Morrow, *Identifying and Mapping Community Vulnerability*, 23 DISASTERS 1, 10 (1999); Somasundaram & van de Put, *supra* note 46, at 67; DEWOLFE, FIELD MANUAL, *supra* note 11, at 15.

55. Somasundaram & van de Put, *supra* note 46, at 66; Norris, *Part I*, *supra* note 8, at 234.

56. Howard J. Osofsky et al., *Posttraumatic Stress Symptoms in Children after Hurricane Katrina: Predicting the Need for Mental Health Services*, 79 AM. J. ORTHOPSYCHIATRY 212, 216 (2009).

57. *Id.*

58. *Id.* at 218.

59. BRUCE H. YOUNG ET AL., DEP'T OF VETERANS AFFAIRS, NAT'L CTR. FOR POST-TRAUMATIC STRESS DISORDER, DISASTER MENTAL HEALTH SERVICES: A GUIDEBOOK FOR CLINICIANS AND ADMINISTRATORS 96 (1998); Gerrity & Flynn, *supra* note 15, at 113.

sense of security than adults.[60] Consequently, children are at an increased risk of developing severe long-term mental and behavioral health impairments.[61] A nationwide study following elementary and high school students six months after the September 11, 2001 terrorist attacks on the World Trade Center found that twenty-five percent of students had either clinical anxiety or a depressive disorder.[62]

Elderly adults may also be more vulnerable to emerging mental and behavioral health conditions due to multiple pre-existing medical conditions, past traumatic experiences, and social isolation.[63] Chronic health conditions, decreased mobility, memory disorders, and sensory loss can contribute to fears related to accessing medications and leaving known surroundings.[64] Emergencies may also trigger memories of past traumas and losses.[65] Displacement may unexpectedly separate families, friends, and social networks.[66] Elderly adults may simultaneously lack a strong support system and be partially or fully dependent on others.[67] Social isolation incumbent in emergency responses can lead to a heightened sense of insecurity and hopelessness that can result in mental illness.[68] These stressors may impede elderly adults' ability to effectively cope.[69]

As a result of their dependence and limited mobility, individuals living in group facilities (*e.g.*, mental health facilities, hospitals, nursing homes, and prisons) may develop mental or behavioral health conditions related to feelings of anxiety, panic, and frustration during emergencies.[70] Heightened fear and anxiety may stem from their dependence on others for care or medical resources for survival, especially when these resources are diminished by reallocations of personnel in emergency response efforts.[71]

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60. Diane G. Fendya, *When Disaster Strikes—Care Considerations for Pediatric Patients*, 13 J. TRAUMA NURSING 161, 164 (2006); Gerrity & Flynn, *supra* note 15, at 113.

61. Somasundaram & van de Put, *supra* note 46, at 66.

62. Randal D. Beaton et al., *The Role of Public Health in Mental and Behavioral Health in Children and Families Following Disasters*, 15 J. PUB. HEALTH MGMT. & PRAC., Nov.-Dec. 2009, at E1, E2 (citing Christina W. Hoven et al., *Psychopathology Among New York City Public School Children 6 Months After September 11*, 62 ARCHIVES GEN. PSYCHIATRY 545, 550 (2005)).

63. YOUNG ET AL., *supra* note 59, at 104-07; Gerrity & Flynn, *supra* note 15, at 114; Somasundaram & van de Put, *supra* note 46, at 67.

64. *See* YOUNG ET AL., *supra* note 59, at 104–07; Somasundaram & van de Put, *supra* note 46, at 67.

65. YOUNG ET AL., *supra* note 59, at 104.

66. *Id.* at 104, 107.

67. *See id.* at 104-07; Gerrity & Flynn, *supra* note 15, at 114.

68. *See* YOUNG ET AL., *supra* note 59, at 104.

69. *See id.* at 104-07; Gerrity & Flynn, *supra* note 15, at 114.

70. DEWOLFE, FIELD MANUAL, *supra* note 11, at 22.

71. *Id.* at 22.

Racial and ethnic minorities are often at greater risk of disproportionate impacts of an emergency due to socioeconomic factors.[72] As a result of socioeconomic factors and cultural influences, minorities may be more likely to experience emerging mental and behavioral health conditions.[73] Linguistic challenges, cultural norms that suppress the acknowledgement of mental and behavioral health conditions, and a lack of appropriate treatment and care can affect mental health outcomes among these groups.[74] Stress associated with historical marginalization may worsen emergency-related conditions and hinder the seeking of available treatments or counseling.[75] A study of Asian American survivors of the 1994 Northridge earthquake in Los Angeles found that they were significantly more likely to have experienced psychiatric distress and were more than twice as likely to need clinical care than their European American counterparts.[76]

Finally, emergency responders (*e.g.*, health, human services, and relief workers) are at an increased risk for emerging mental and behavioral health conditions largely due to their emergency response efforts.[77] One study of rescue and recovery workers and volunteers at the World Trade Center following the September 11, 2001 terrorist attacks found that fifty-one percent met the threshold criteria for a clinical mental health evaluation.[78] Approximately twenty percent reported symptoms that met the threshold for post-traumatic stress disorder (PTSD).[79] This rate of PTSD is nearly four

72. DEWOLFE, FIELD MANUAL, *supra* note 11, at 21; Norris, *Part I*, *supra* note 8, at 235.

73. *See also* Morrow, *supra* note 54, at 8; Norris, *Part I*, *supra* note 8, at 235-36; Somasundaram & van de Put, *supra* note 46, at 67.

74. Gerrity & Flynn, *supra* note 15, at 114; Somasundaram & van de Put, *supra* note 46, at 67. *See also* PUBLIC HEALTH SERVICE, U.S. DEP'T OF HEALTH & HUMAN SERVS., MENTAL HEALTH: CULTURE, RACE, AND ETHNICITY – A SUPPLEMENT TO MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 25-32 (2001).

75. Norris, *Part I*, *supra* note 8, at 236.

76. Madhur Kulkarni & Nnamdi Pole, *Psychiatric Distress Among Asian and European American Survivors of the 1994 Northridge Earthquake*, 196 J. NERVOUS & MENTAL DISEASE 597, 602 (2008).

77. YOUNG ET AL., *supra* note 59, at 108; Gerrity & Flynn, *supra* note 15, at 114 (listing sources of emergency responder stress identified in Don M. Hartsough, *Stress and Mental Health Interventions in Three Major Disasters*, *in* DISASTER WORK AND MENTAL HEALTH: PREVENTION AND CONTROL OF STRESS AMONG WORKERS 1, 5, 13, 20 (Ctr. for Mental Health Studies of Emergencies, Nat'l Inst. Mental Health ed., 1985)). *See also* DEWOLFE, FIELD MANUAL, *supra* note 11, at 23.

78. R.P. Smith et al., *Mental Health Status of World Trade Center Rescue and Recovery Workers and Volunteers – New York City, July 2002-August 2004*, 53 MORBIDITY & MORTALITY WKLY. REP. 807, 812 (2004), *available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5335a2.htm.

79. *Id.* at 813.

times higher than the lifetime prevalence of PTSD for men.[80] While many emergency responders are specifically trained to work in stressful emergency environments, advance training may not approximate the actual physical and mental stressors of working daily in real-time emergency situations.[81] Lack of effective training or inexperience may contribute to these individuals' stress as they work exhaustively to meet demands.[82] Even during brief periods of exposure to emergency environments, psychological and physical demands may result in feelings of grief, despair, and helplessness.[83]

B. Planning, Training, and Interjurisdictional Coordination

Beyond mere recognition of the mental and behavioral risks to multiple vulnerable populations during emergencies, there is a need to confront and address these harms. This is a significant challenge. Emergencies like pandemics, natural disasters, and terrorist attacks are often not confined to single jurisdictions.[84] As a result, governmental planning, training, communication, and interjurisdictional coordination are critical for efficient and effective emergency mental health preparedness and response.[85] These efforts, which typically involve governmental and private sector entities, rely on legal authorities.[86] Emergency laws can alter the legal landscape through new or enhanced governmental powers, or by providing access to supplemental resources.[87] Non-emergency laws, such as those affecting access to health services, liability, and workers' compensation benefits, can

80. Corey B. Bills et al., *Stories Behind the Symptoms: A Qualitative Analysis of the Narratives of 9/11 Rescue and Recovery Workers*, 80 PSYCHIATRIC Q. 173, 175 (2009).

81. Gerrity & Flynn, *supra* note 15, at 116.

82. *See id.* at 117; YOUNG ET AL., supra note 59, at 109.

83. DEWOLFE, FIELD MANUAL, *supra* note 11, at 23. *See also* YOUNG ET AL., *supra* note 59, at 108-10.

84. *2009 H1N1 Flu: Situation Update*, CTRS. FOR DISEASE CONTROL & PREVENTION (June 18, 2010, 5:00 PM), http://www.cdc.gov/H1n1flu/update.htm (updating status of H1N1 influenza across the nation over 2009); *September 11, 2001: The Attacks*, NAT'L SEPT. 11 MEM'L & MUSEUM, http://www.national911memorial.org/site/PageServer?pagename=new_history_timeline (last visited March 17, 2010) (providing a detailed account of the effect and response efforts of the 9/11 terrorist attacks across the United States). *See also The Gulf Coast in Katrina's Wake*, WASH. POST, 2005, http://www.washingtonpost.com/wp-dyn/content/custom/2005/09/01/CU2005090101358.html.

85. *See* Hodge & Anderson, *supra* note 17, at 255 ("While state and local governments are closer to the front lines of emergency response and expected to respond in organized ways, the federal government is positioned to coordinate and supplement response efforts for regional and national emergencies.").

86. *Id.* at 251-52.

87. *See id.* at 255-63.

also play a critical role in preparedness planning and response.[88] State and local mutual aid agreements and compacts allow for the sharing of resources even if emergency laws are not in effect.[89]

Most planning and training efforts focus on meeting "surge capacity" during emergencies. Surge capacity refers to a government's ability to meet demands for increased personnel, such as physicians, nurses, psychologists, and other health care professionals, as well as supplies, such as vaccines.[90] In recent years, laws and systems to meet surge capacity during emergency situations have been designed and implemented. For example, in 2002, the federal government passed the Homeland Security Act, which established the Strategic National Stockpile (SNS).[91] SNS, which is maintained by the Centers for Disease Control and Prevention's (CDC) Coordinating Office for Terrorism Preparedness and Emergency Response, ensures that medicine and medical supplies can be delivered anywhere in the United States within hours of an emergency.[92]

To meet personnel needs, the National Disaster Medical System, operated by the U.S. Department of Health and Human Services' (DHHS) Assistant Secretary for Preparedness and Response (ASPR), provides supplemental medical care during an emergency through the federal deployment of health care professionals.[93] State-based Emergency Systems for the Advance Registration of Volunteer Health Professionals (ESAR-VHP)[94] and locally-based Medical Reserve Corps (MRC)[95] units help to provide thousands of health care volunteers, including mental and behavioral health

88. *Id*. at 254–55 ("Laws governing subjects as diverse as medical licensing, workers' compensation, the environment, privacy, discrimination, health care access, tort liability, and criminal liability can significantly promote or impede response efforts.").

89. *Mission Statement*, MID-AM. ALLIANCE, http://www.unmc.edu/apps/midamerica/index.cfm?L1_ID=1&CONREF=1 (last visited July 31, 2010).

90. James G. Hodge, Jr., Lawrence O. Gostin & Jon S. Vernick, *The Pandemic and All-Hazards Preparedness Act: Improving Public Health Emergency Response*, 297 JAMA 1708, 1709 (2007). *See also* John L. Hick et al., *Health Care Facility and Community Strategies for Patient Care Surge Capacity*, 44 ANNALS EMERGENCY MED. 253, 254 (2004).

91. 42 U.S.C. § 247d-6b(a)(1) (2006).

92. *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).

93. *National Disaster Medical System*, OFFICE OF ASST. SEC'Y FOR PREPAREDNESS & RESPONSE, http://www.phe.gov/Preparedness/responders/ndms/Pages/default.aspx (last updated June 14, 2010).

94. OFFICE OF THE CIVILIAN VOLUNTEER, MEDICAL RESERVE CORPS, INTEGRATION OF THE MEDICAL RESERVE CORPS AND THE EMERGENCY SYSTEM FOR ADVANCE REGISTRATION OF VOLUNTEER HEALTH PROFESSIONALS 1 (rev. 2d ed. 2008), *available at* http://www.medicalreservecorps.gov/File/ESAR_VHP/ESAR-VHPMRCIntegrationFactSheet.pdf ("State ESAR-VHP programs are intended to serve as the statewide mechanism for tying together the registration and credential information of all potential health professional volunteers in a State.").

95. *Id*.

personnel.[96] These registries typically contain current information about volunteer health professionals' qualifications to facilitate their deployment and use during emergencies.[97]

To help meet surge capacity for mental and behavioral health needs, ASPR established the At Risk, Behavioral Health, and Human Services Coordination (ABC) program.[98] This program is designed to ensure that during a disaster "the behavioral health needs of impacted individuals, families, communities, and responders are addressed as part of the public health and medical emergency response."[99] In collaboration with the federal Administration on Aging, Administration for Children and Families, and Substance Abuse and Mental Health Services Administration (SAMHSA), the ABC program provides limited technical assistance on behavioral health issues in emergencies.[100]

C. *Government Powers to Respond in Declared Emergencies*

National, tribal, state, and local governments are bestowed with a variety of emergency powers arising from statutorily-authorized emergency declarations, executive emergency orders, or other real-time measures.[101] These emergency powers may help address mental and behavioral health issues. Federal emergency powers are grounded in the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act).[102] This 1988 law is intended "to provide an orderly and continuing means of assistance by the Federal Government to State and local governments in carrying out their responsibilities to alleviate the suffering and damage which result from . . . disasters."[103] Powers granted by the Stafford Act go into effect once the President declares the existence of a major disaster or an emergency,[104] typically based on requests made by the governor of a state

96. *Id. See also About the Medical Reserve Corps*, MED. RESERVE CORPS, http://medicalreservecorps.gov/About (last updated June 30, 2010).

97. Hodge, Gable & Cálves, *supra* note 28, at 21–22.

98. *See* OFFICE OF THE ASSISTANT SEC'Y FOR PREPAREDNESS & RESPONSE, U.S. DEP'T OF HEALTH & HUMAN SERVS., OFFICE FOR AT-RISK INDIVIDUALS, BEHAVIORAL HEALTH, & HUMAN SERVS. COORDINATION 1 (March 26, 2009), *available at* http://www.phe.gov/Preparedness/planning/abc/Documents/ABC.pdf.

99. *Id*.

100. *Id.*; *Disaster Behavioral Health: Current Assets and Capabilities*, U.S. DEP'T OF HEALTH & HUMAN SERVS., http://statedisasterbehavioralhealthconsortium.web.officelive.com/Documents/ABC_factsheet_assets_capabilities.pdf (last visited Jan. 17, 2011).

101. Hodge & Anderson, *supra* note 17, at 253. *See also* David Zocchetti et al., *Public Health Emergency Law*, 33 J.L. MED & ETHICS 66, 67 (2005).

102. *Robert T. Stafford Disaster Relief and Emergency Assistance Act*, 42 U.S.C. §§ 5121-5207 (2006).

103. *Id.* § 5121(b).

104. *Id.* § 5170.

that faces a disaster or emergency.[105] Once a declaration has been made, the federal government is empowered to coordinate response efforts and provide assistance "to save lives, prevent human suffering, or mitigate severe damage."[106] The Federal Emergency Management Agency (FEMA), part of the Department of Homeland Security (DHS), serves as the federal government's coordinating agency for disaster response.[107]

The Stafford Act contains specific provisions on mental health issues that may arise during and after a disaster.[108] During a declared emergency, the President can authorize "financial assistance to State or local agencies or private mental health organizations" to train disaster workers to provide crisis counseling services to persons affected by disasters who may have "mental health problems caused or aggravated by [the] disaster or its aftermath."[109] These services, which fall under the Stafford Act's Crisis Counseling Assistance and Training Program, cover screening, diagnosis, and counseling, and can last for up to nine months after the declared disaster.[110]

DHHS can additionally declare a public health emergency pursuant to the Public Health Services Act.[111] Once declared, DHHS' Secretary can respond in multiple ways, such as initiating, conducting, or providing financial support for investigations into the disease or other event that has caused the emergency,[112] waiving specific Medicare or Medicaid reimbursements, suspending patient screening requirements pursuant to the Emergency Medical Treatment and Active Labor Act (EMTALA), and mobilizing medical personnel (including mental and behavioral health providers).[113] These efforts are meant to supplement other response activities occurring at the federal, state, and local levels.[114]

To centralize the federal government's preparedness planning and response operations, Congress passed the aforementioned Homeland

105. *Id.*

106. *Id.* § 5170(a)(5).

107. *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 (last visited Jan. 17, 2011).

108. 42 U.S.C. § 5183 (2006).

109. *Id*.

110. FEMA, DISASTER DECLARATION, *supra* note 107, at 3.

111. 42 U.S.C. § 247d(a)(1)-(2) (2006) (This determination is made by DHHS' Secretary if "a disease or disorder presents a public health emergency; or . . . a public health emergency, including significant outbreaks of infectious diseases or bioterrorist attacks . . . exists.").

112. *Id.* § 247d(a).

113. *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 (last visited Aug. 22, 2010).

114. 42 U.S.C. § 247d(c) (2006).

Security Act in 2002,[115] authorizing DHS to administer the National Response Plan (NRP).[116] The NRP was intended to "integrate Federal Government domestic prevention, preparedness, response, and recovery plans into one all-discipline, all-hazards plan."[117] In early 2008, the NRP was replaced by the National Response Framework (NRF), which serves as a guide for "communities, States, the Federal Government and private-sector and nongovernmental partners [to implement] . . . a coordinated, effective national response" to a disaster.[118] The NRF includes twenty-three Emergency Support Function (ESF) Annexes.[119] These Annexes address important mental and behavioral health issues, such as surveillance for mental health and substance abuse needs, the provision of psychological first aid, and the treatment of individuals with cognitive limitations or other special needs.[120] Pursuant to the Pandemic and All-Hazards Preparedness Act (PAHPA) of 2006,[121] ASPR centrally coordinates medical and public health-related preparedness and response efforts, including mental health responses.[122]

State governments also have specific legal powers to declare and respond to emergencies. Many state laws mirror the federal government's preparedness structure. A state's highest official, its governor, must declare a disaster or emergency to activate the state government's emergency-based powers.[123] All states allow for declarations of disasters or emergencies.[124] Some states also authorize distinct declarations of a public health

115. *See* 6 U.S.C. §§ 101-557 (2006).

116. 6 U.S.C. § 314a(13) (2006).

117. *Homeland Security Presidential Directive 5: Management of Domestic Incidents*, U.S. DEP'T OF HOMELAND SEC. (Feb. 28, 2003), http://www.dhs.gov/xabout/laws/gc_1214592333605.shtm.

118. *National Response Framework (NRF) – Fact Sheet*, U.S. DEP'T OF HOMELAND SEC., http://www.fema.gov/pdf/emergency/nrf/NRFOnePageFactSheet.pdf (last visited Jan. 17, 2011).

119. *See infra* Part II.C.2-4 for a discussion of the Annexes that provide guidance for the care of individuals with mental and behavioral health needs during and after emergencies.

120. FED. EMERGENCY MGMT. AGENCY, U.S. DEP'T OF HOMELAND SEC., EMERGENCY SUPPORT FUNCTION ANNEXES ESF #8-7 (Jan. 2008) [hereinafter FEMA, ANNEXES], *available at* http://www.fema.gov/pdf/emergency/nrf/nrf-annexes-all.pdf.

121. 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.).

122. 42 U.S.C. § 300hh-10 (2006). *See also* Hodge, Gostin & Vernick, *supra* note 90, at 1708; 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.

123. Hodge & Anderson, *supra* note 17, at 263-67.

124. *Id.* at 263-65. *See also* VIVIAN S. CHU, CONG. RESEARCH SERV., R 40176, EMERGENCY RESPONSE: CIVIL LIABILITY OF VOLUNTEER HEALTH PROFESSIONALS 4 (2009).

emergency.[125] Since 2001, at least thirty-eight states have used the Model State Emergency Health Powers Act (MSEHPA) to classify public health emergencies and establish parameters for appropriate responses.[126] Declarations of a public health emergency under MSEHPA authorize enhanced governmental powers.[127] States, for example, may close certain facilities affected by the public health emergency, garner needed supplies, deploy essential personnel, and voluntarily examine, test, vaccinate, treat, quarantine, and isolate individuals "to prevent or limit the transmission of a contagious disease."[128] As discussed below, additional public health powers to screen HCWs, conduct surveillance for mental and behavioral health conditions, restrict individual movement, and displace populations may directly impact the ability of the public and private sectors to address mental and behavioral health issues among vulnerable populations.

1. Screening Health Care Workers for Symptoms and Risk Factors of Mental and Behavioral Health Conditions

As noted above, in emergencies, HCWs are at increased risk of mental health harms because they may have daily encounters with individuals who have experienced major physical or psychological trauma.[129] This type of work can take a serious psychological toll on HCWs and compromise their mental health.[130] Screening HCWs for mental and behavioral health susceptibilities can help to identify and effectively treat conditions.[131] The United States military's experience with the development and implementation of mental health screening tools offers useful lessons for HCWs and others in emergency situations. The military has a standardized mental health screening process, which includes pre-screening recruits for mental health issues, performing mental health assessments and providing treatment with psychiatric medications in-theater, conducting anonymous

125. Hodge & Anderson, *supra* note 17, at 265-66.

126. CTR. FOR LAW & PUBLIC'S HEALTH AT GEORGETOWN & JOHNS HOPKINS U., THE MODEL STATE EMERGENCY HEALTH POWERS ACT 1 (2001) [hereinafter MSEHPA], *available at* http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf.

127. *See* James G. HODGE, JR. & LAWRENCE O. GOSTIN, THE MODEL STATE EMERGENCY HEALTH POWERS ACT – A BRIEF COMMENTARY 17-18 (2002), *available at* http://www.publichealthlaw.net/MSEHPA/Center%20MSEHPA%20Commentary.pdf.

128. Lawrence O. Gostin et al., *The Model State Emergency Health Powers Act: Planning for and Response to Bioterrorism and Naturally Occurring Infectious Diseases*, 288 JAMA 622, 626 (2002).

129. *See supra* Part I.

130. 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) [hereinafter DEWOLFE, TRAINING MANUAL], *available at* http://mentalhealth.samhsa.gov/publications/allpubs/SMA96-0538/tmsection3.asp.

131. *See id.* at 28-29.

surveys upon return from deployment, and providing post-deployment health assessments.[132] With appropriate modifications to respect the autonomous interests of civilian HCWs, these stages of mental health screening could be adapted for non-military HCWs and others during an emergency.[133] However, systematic mental health screening of non-military HCWs is not routinely practiced in major emergencies.[134]

Provisions of MSEHPA, adopted by several states, authorize screening of HCWs regarding their mental health conditions during emergencies.[135] Screenings may focus on pre-existing mental or behavioral health conditions and symptoms that the individual is currently experiencing,[136] allowing individuals to voice concerns they may have about their mental and behavioral health issues. Individuals who report pre-existing mental or behavioral health conditions or HCWs who are preparing to engage in intensive response efforts may be screened more extensively.[137] With proper training, resources, and personnel, these types of screening programs can

132. Jan Shubert et al., *A Missing Element in Disaster Mental Health: Behavioral Health Surveillance for First Responders*, 9 INT'L J. EMERGENCY MENTAL HEALTH 201, 207-08 (2007); Mark Thompson, *America's Medicated Army,* TIME, June 16, 2008, at 38, 41-42.

133. While the military has a built-in network of trained mental health professionals who can screen and evaluate the mental health needs of all new recruits, first responders generally derive from many different organizations, each with varying capabilities for implementing a mental health screening assessment. Some scholars have argued for the development and implementation of a brief mental status screening tool which could easily be administered by HCWs with varying levels of experience, prior to deployment. In addition, field managers and supervisors could be trained to recognize the symptoms of mental distress in emergency responders during deployment. Shubert et al., *supra* note 132, at 209. *But cf.* Roberto J. Rona, Kenneth C. Hyams & Simon Wessely, *Screening for Psychological Illness in Military Personnel*, 293 JAMA 1257, 1259 (2005) ("Written questionnaires to detect psychological illness have not been proven to be effective in civilian populations . . . . This is not an argument against all psychological screening but rather an argument to thoroughly assess the efficacy of any screening program before final acceptance, with rigorous research studies such as randomized controlled trials.").

134. Shubert et al., *supra* note 132, at 202.

135. MSEHPA §§ 602 (a)-602(c) ("Medical examinations or tests may be performed by any qualified person authorized to do so by the public health authority" as long as these examinations are not "reasonably likely to lead to serious harm to the affected individual.").

136. *See Storm, Flood, and Hurricane Response: Guidance for Pre-exposure Medical Screening of Workers Deployed for Hurricane Disaster Work*, CTRS. FOR DISEASE CONTROL & PREVENTION (June 18, 2010), http://www.cdc.gov/niosh/topics/emres/preexposure.html.

137. NIOSH recommends the following additional considerations for mental and behavioral health screenings: "Simple and concise screening instrument(s);" "Designated custodian for the information collected;" "Policies in place to assure confidentiality and security of information collected;" "Appointed program administrator;" "Clear identification of those with access to data results;" "Data collection locations convenient to workers . . . ;" "Private area for conducting screening to maintain privacy;" "Secure space to maintain records containing confidential information." *Id.*

identify mental and behavioral health issues among HCWs and support personnel during and after an emergency.

2. Surveillance and Reporting Requirements for Mental and Behavioral Health Providers

In non-emergency situations, mental and behavioral health statuses are routinely measured through national surveillance activities. For example, SAMHSA conducts the National Survey on Drug Use and Health.[138] CDC maintains the Behavioral Risk Factor Surveillance System.[139] Epidemiologic surveys such as the Collaborative Psychiatric Epidemiology Survey provide information about "the distributions, social and cultural correlates, and risk factors of mental disorders among the general population and in minority groups."[140] This information can be critical to emergency preparedness activities to the extent that it provides insight about vulnerable populations and possible points of intervention.[141]

In addition to on-going surveillance for mental and behavioral health issues, in non-emergency situations, HCWs, including mental and behavioral health personnel, are required by law to report certain mental health issues to state or local public health authorities.[142] For example, every state legislatively requires HCWs to report suspected cases of child abuse.[143] Similarly, most states require health care professionals to report suspected cases of elder abuse, which can include neglect by caregivers and

138. *National Survey on Drug Use & Health*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (Dec. 30, 2008), http://www.oas.samhsa.gov/nhsda.htm. *See also* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T OF HEALTH AND HUMAN SERVS., SAMHSA STRATEGIC PLAN FY 2006 - FY 2011 6, *available at* http://www.samhsa.gov/About/SAMHSAStrategicPlan.pdf.

139. *See Behavioral Risk Factor Surveillance System*, CTRS. FOR DISEASE CONTROL & PREVENTION (June 11, 2010), http://www.cdc.gov/brfss/.

140. Elsie J. Freeman et al., *Public Health Surveillance for Mental Health,* 7 PREVENTING CHRONIC DISEASE 1, 2 (2010), *available at* http://www.cdc.gov/pcd/issues/2010/jan/pdf/09_0126.pdf.; Nat'l Inst. of Mental Health, *Collaborative Psychiatric Epidemiology Surveys*, INTER-U. CORSORTIUM FOR POLITICAL & SOC. RES., http://www.icpsr.umich.edu/CPES/ (last visited March 17, 2010).

141. *See* Freeman et al., *supra* note 140.

142. Leonard Edwards, *Child Protection Mediation: A 25-Year Perspective*, 47 FAM. CT. REV. 69, 73 (2009) ("Child protection cases often involve substance abuse, domestic violence, mental health, child abuse, and similar issues."); Paul B. Herbert, *A Duty to Warn: A Reconsideration and Critique*, 30 J. AM. ACAD. PSYCHIATRY & LAW 417, 417 (2002).

143. Ellen Marrus, *Please Keep My Secret: Child Abuse Reporting Statutes, Confidentiality, and Juvenile Delinquency,* 11 GEO. J. LEGAL ETHICS 509, 514-15 (1998) ("Mandatory reporting statutes first were expanded to include other [health] professionals who had frequent or daily contact with children, including health professionals, teachers, mental health professionals, police officers, and child care workers.").

self-neglect.[144] In an emergency situation, mental and behavioral health providers may find it difficult to comply with these reporting requirements because they lack the time and contextual information to assess whether abuse is occurring.[145]

Disaster preparedness guidelines, such as those developed by SAMHSA, encourage "[d]isaster mental health workers [to] be on the lookout for workers whose coping resources have eroded due to their personal vulnerabilities and seemingly unrelenting workload."[146] Several of the federal ESF Annexes, discussed above,[147] provide guidance about the type of surveillance and reporting that HCWs should engage in during and after an emergency. ESF Annex #8 explains that, during an emergency, DHHS, working with other agencies, can "[enhance] existing surveillance systems to monitor the health of the general and medical needs population."[148] Under this framework, mental and behavioral health providers play key roles in conducting mental health assessments and reporting information via centralized surveillance programs.

3. Restrictions on Individual Movement

During declared emergencies, mental and behavioral health providers may be asked to assist in the administration of public health interventions like quarantine and isolation that restrict individuals' movements.[149] ESF Annex #8 explains that in an emergency situation, HCWs may "assist with isolation and quarantine measures."[150] States that have codified MSEHPA's language are empowered to require individuals infected with or exposed to an infectious disease to be isolated or quarantined, respectively.[151] In these instances, mental and behavioral health care professionals may be called upon to help these individuals cope with the anxiety, panic, or depression that can accompany government-mandated restrictions on movement.[152]

144. Jennifer Beth Glick, *Protecting and Respecting Our Elders: Revising Mandatory Elder Abuse Reporting Statutes to Increase Efficacy and Preserve Autonomy*, 12 VA. J. SOC. POL'Y & L. 714, 721–22 (2005).

145. *See* MSEHPA § 301.

146. DEWOLFE, TRAINING MANUAL, *supra* note 130, at 29.

147. *See supra* Part II.C.

148. FEMA, ANNEXES, *supra* note 120, at ESF #8-4. This may include activities such as "assessing mental health and substance abuse needs, including emotional, psychological, psychological first aid, behavioral, or cognitive limitations requiring assistance or supervision; providing disaster mental health training materials for workers; [and] providing liaison with assessment, training, and program development activities undertaken by Federal, State, tribal, or local mental health and substance abuse officials." *Id*. at ESF #8-7.

149. *See id*. at ESF #8-6.

150. *Id*.

151. MSEHPA § 604(a).

152. *See* HODGE & GOSTIN, *supra* note 127, at 20-21.

Under MSEHPA, a state's public health authority can allow mental and behavioral health care professionals to access isolated or quarantined persons.[153] For individuals dependent on psychotropic medications and mental health therapies, the ability to access a mental health provider during periods of isolation or quarantine can be critical.[154]

4. Displacement of Populations

Destructive disasters may naturally displace hundreds of thousands of individuals. For example, in the days immediately following Hurricane Katrina in 2005, over one million residents of the Gulf Coast region were displaced;[155] at least 400,000 individuals remained displaced several weeks after the hurricane.[156] ESF Annex #6 authorizes DHS and FEMA to use a registration intake system to ensure that people who have been evacuated or displaced have access to federal disaster assistance, including food, shelter, and emergency first aid.[157] ESF Annex #14 notes that individuals with special needs will particularly require services following their displacement.[158] Mental and behavioral health providers can assist by diagnosing emerging mental health issues, working with individuals who have existing mental health issues, and helping displaced persons cope with the stresses that accompany their emergency evacuation.[159]

153. MSEHPA § 604(d)(1).

154. *See id*. *See also* Mark van Ommeren, Shekhar Saxena & Benedetto Saraceno, *Mental and Social Health During and After Acute Emergencies: Emerging Consensus?*, 83 BULL. WORLD HEALTH ORG. 71, 73 (2005) (noting the importance of access to psychotropic medications for those who rely on them after an acute emergency).

155. BRUCE KATZ ET AL., BROOKINGS INST., HOUSING FAMILIES DISPLACED BY KATRINA: A REVIEW OF THE FEDERAL RESPONSE TO DATE 1 (2005), *available at* http://www.brookings.edu/~/media/Files/rc/reports/2005/11metropolitanpolicy_katz/20051114_CostofHousing.pdf.

156. *Id.;* Peter Whoriskey, *Katrina Displaced 400,000, Study Says*, WASH. POST, June 7, 2006, at page A12.

157. FEMA, ANNEXES, *supra* note 120, at ESF #6-4, 6-6.

158. *See id.* at ESF #14-3, 14-4. The NRF Glossary defines "special needs" populations as follows: "Populations whose members may have additional needs before, during, and after an incident in functional areas, including but not limited to: maintaining independence, communication, transportation, supervision, and medical care. Individuals in need of additional response assistance may include those who have disabilities; who live in institutionalized settings; who are elderly; who are children; who are from diverse cultures; who have limited English proficiency or are non-English speaking; or who are transportation disadvantaged." *National Response Framework Glossary*, FED. EMERGENCY MGMT. AGENCY http://www.fema.gov/emergency/nrf/glossary.htm#S (last visited March 17, 2010).

159. *See generally* FEMA, ANNEXES, *supra* note 120 (laying out a series of annexes describing the roles and responsibilities of federal departments and agencies as emergency support function coordinators, primary agencies, or support agencies).

III. DEPLOYMENT AND USE OF PERSONNEL TO PROVIDE MENTAL AND BEHAVIORAL HEALTH SERVICES IN EMERGENCIES

Responding to proliferate mental and behavioral health needs of vulnerable populations stemming from emergencies presupposes the availability of adequate mental and behavioral health providers and programs in emergency regions. However, multiple legal issues directly affect or limit the deployment and use of these personnel despite intense demand for their services. These issues, discussed below, include the ability of these personnel to practice outside their licensed jurisdictions, their authority to prescribe medications across jurisdictions, changes in the standard of care during crises, and potential liability risks faced by providers.

A. *Interjurisdictional Licensure Portability*

In non-emergencies, health care professionals must be licensed, certified, or registered by the state in which they work before they are permitted to practice.[160] State laws also define the scope of their practice.[161] All states feature licensing, certification, or registration laws regulating the practice of psychiatrists,[162] psychologists, and other mental and behavioral health professionals (*e.g.*, social workers, marriage and family therapists, and professional counselors).[163] These laws vary from state to state. For example, all states regulate social workers.[164] However, their licensure depends on their classification, of which there are forty-one professional social work licensure categories nationally[165] and four practice levels.[166] Some states recognize only one practice level, while others

160. Hodge, *Legal Triage*, *supra* note 32, at 642. Professional licensure is a core state function stemming from the states' police powers. Gilbert Eric DeLeon, *Telemedicine in Texas: Solving the Problems of Licensure, Privacy, and Reimbursement*, 34 ST. MARY'S L.J. 651, 668 (2003).

161. *See* ESAR-VHP, *supra* note 18, at 11.

162. *See* Hodge, Gable & Cálves, *supra* note 28, at 46, 47. "Psychiatrists are regulated by the same rules as physicians." ESAR-VHP, *supra* note 18, at 32.

163. Farifteh F. Duffy et al., Substance Abuse & Mental Health Servs. Admin., U.S. Dep't of Health & Human Servs., *Mental Health Practitioners and Trainees*, *in* MENTAL HEALTH, UNITED STATES, 2004 256, 272, 278, 280 (Ronald W. Manderscheid & Joyce T. Berry eds., 2006), *available at* http://download.ncadi.samhsa.gov/ken/pdf/SMA06-4195/CMHS_MHUS_2004.pdf.

164. *Id.* at 271.

165. *State Legislation*, SOCIAL WORK REINVESTMENT INITIATIVE, http://www.socialworkreisocialwor.org/State/ (last visited Sept. 8, 2010).

166. CTR. FOR HEALTH WORKFORCE STUDIES, UNIV. AT ALBANY FOR NAT'L ASS'N OF SOC. WORKERS, CTR. FOR WORKFORCE STUDIES, LICENSED SOCIAL WORKERS IN THE UNITED STATES, 204 2 (2004), *available at* http://workforce.socialworkers.org/studies/fullstudy0806.pdf. The four practice levels are: "a baccalaureate degree in social work (BSW); a master's degree in social

recognize two or more.[167] Forty-eight states regulate marriage and family therapists[168] under differing approaches.[169] State regulations of professional counselors also differ as to their titles and practice levels.[170] Some states also regulate additional types of professionals who provide mental and behavioral health services.[171] For example, Minnesota, New Hampshire, and Maryland license alcohol and drug counselors;[172] Delaware and Ohio license chemical dependency professionals;[173] Arizona licenses substance abuse counselors;[174] and Washington registers recreational therapists.[175]

During major emergencies, mental health professionals from other jurisdictions may be needed to meet patient surge capacity.[176] However, their availability may be impeded by limitations on their ability to practice in states in which they are not licensed, certified, or registered.[177] In declared

work (MSW); an MSW with two years of postgraduate supervised experience; and an MSW with two years of post[-]master's direct clinical social work experience." *Id*.

167. *Id.*

168. *Frequently Asked Questions on Marriage and Family Therapists*, AM. ASS'N FOR MARRIAGE & FAMILY THERAPY, http://www.aamft.org/faqs/index_nm.asp (last visited July 23, 2010).

169. *See* Duffy et al., *supra* note 163, at 282.

170. *See Licensure & Certification – State Professional Counselor Licensure Boards*, AM. COUNSELING ASS'N, http://www.counseling.org/Counselors/LicensureAndCert/TP/State Requirements/CT2.aspx (last visited July 23, 2010). Counseling is distinguished from other mental and behavioral health professions by its emphasis on developmental, preventative, and educational aspects of mental health care, not just the traditional focus on the remedial treatment of illnesses. Duffy et al., *supra* note 163, at 277.

171. *Types of Mental Health Providers*, MAYOCLINIC.COM, http://www.mayoclinic.com/health/mental-health/MH00074 (Apr. 16, 2009); *Fact Sheet: Mental Illness and the Family: Finding the Right Mental Health Care for You*, MENTAL HEALTH AMERICA, http://www.nmha.org/farcry/go/information/get-info/mi-and-the-family/finding-the-right-mental-health-care-for-you/mental-illness-and-the-family-finding-the-right-mental-health-care-for-you (last visited August 23, 2010).

172. N.H. REV. STAT. ANN. § 330-C:14(I) (2009) (New Hampshire licenses three categories of alcohol and drug use professionals: master licensed alcohol and drug counselor, licensed alcohol and drug counselor, and licensed clinical supervisor.); MD. CODE. ANN., HEALTH OCC. § 17-302(a) (West 2009); MINN. STAT. § 148C.015 (2005).

173. DEL. CODE ANN. tit. 24, § 3015 (2005); OHIO REV. CODE ANN. § 4758.24 (West 2005).

174. ARIZ. REV. STAT. § 32-3321 (2009) (Arizona licenses three categories of substance abuse counselors: substance abuse technicians, associate substance abuse counselors, and independent substance abuse counselors).

175. WASH. REV. CODE § 18.230.020 (2006).

176. Nat'l Ass'n of Public Hospitals & Health Systems, *Hospital Staffing and Surge Capacity During a Disaster Event*, RESEARCH BRIEF, at 3-4 (2007), *available at* http://www.naph.org/Main-Menu-Category/Publications/Emergency-Preparedness/hospitalstaffingandsurgecapacityduringadisasterevent.aspx.

177. *See* Hodge, *Legal Triage*, *supra* note 32, at 642.

emergencies, license reciprocity, exemption, and waiver laws can facilitate deployment of mental health professionals to affected areas, notwithstanding inconsistencies among these state-based provisions.[178]

Reciprocity and waiver laws, which are typically triggered by the declaration of an emergency, allow mental and behavioral health professionals licensed in other jurisdictions to practice within the jurisdiction granting reciprocity for the duration of the emergency.[179] Before a state will grant a reciprocal license to a practitioner, officials may have to determine that the practitioner's license was issued under similar requirements as those of the state issuing the reciprocal license.[180] This finding is complicated by varied licensing and certification requirements for mental and behavioral health professionals nationally. Some have proposed creating national reciprocity programs,[181] using provisions under the Emergency Management Assistance Compact (EMAC) to cross-license individuals, or enacting explicit statutory exemptions on licensure during emergencies.[182]

Many states have passed laws or joined compacts to facilitate interjurisdictional coordination in emergency responses. For example,

178. *Id.* at 643.

179. *See The Uniform Emergency Volunteer Health Practitioners Act (UEVHPA)*, CTRS. FOR LAW & THE PUBLIC'S HEALTH, http://www.publichealthlaw.net/ModelLaws/UEVHPA.php (last updated Jan. 27, 2010). *See also* Cindy De Vaney Olvey, Andy Hogg & Wil Counts, *Licensure Requirements: Have We Raised the Bar Too Far?*, 33 PROF. PSYCHOL: RES. & PRAC. 323, 325 (2002).

180. *See, e.g.*, ARIZ. REV. STAT. § 32-3274 (2009); MD. CODE. ANN., HEALTH OCC. §§ 17-305, 17-307 (West 2009); OHIO REV. CODE ANN. §§ 4757.18, 4758.25 (West 2004).

181. The Association of State and Provincial Psychology Boards (ASPPB) has established a licensure mobility program to assist psychologists with interjurisdictional licensure portability. *ASPPB Agreement of Reciprocity (AOR) Overview*, ASS'N OF STATE & PROVINCIAL PSYCHOL. BOARDS, http://www.asppb.net/i4a/pages/index.cfm?pageid=3280 (last visited July 30, 2010) [hereinafter ASPPB, *AOR Overview*]. The licensure mobility program consists of an Agreement of Reciprocity (AOR) and two practice certificates. *Id.* Under the AOR, any licensed psychologist holding a license in one member jurisdiction may obtain licensure in all other member jurisdictions. Olvey, Hogg & Counts, *supra* note 179; *ASPPB Mobility Programs*, ASS'N OF STATE & PROVINCIAL PSYCHOL. BOARDS, http://www.asppb.net/i4a/pages/index.cfm?pageid=3280 (last visited July 30, 2010) [hereinafter ASPPB, *Mobility Programs*]. The Certificate of Professional Qualification in Psychology (CPQ) documents that the certified psychologist has met the specific requirements necessary for licensure. Olvey, Hogg & Counts, *supra* note 179, at 325; ASPPB, *Mobility Programs*, *supra*. The Interjurisdictional Practice Certificate (IPC) is a certification program that provides member licensing boards with a mechanism to more easily allow psychologists to temporarily practice in the jurisdiction accepting the IPC without obtaining full licensure. *ASPPB Interjurisdictional Practice Certificate (IPC) Overview*, ASS'N OF STATE & PROVINCIAL PSYCHOL. BOARDS, http://www.asppb.net/i4a/pages/index.cfm?pageid=3459 (last visited July 30, 2010).

182. BRUCE R. LINDSAY, CONG. RESEARCH SERV., RL 34585, THE EMERGENCY MANAGEMENT ASSISTANCE COMPACT (EMAC): AN OVERVIEW CRS-1 (2008).

during a declared emergency in Minnesota, mental health care professionals who are licensed in other states or Canada may practice in-state at the Governor's request for the duration of the emergency.[183] Minnesota law is also reflected in EMAC,[184] which was authorized by Congress in 1996 and has since been approved via legislation in all states.[185] During preparedness training exercises or declared emergencies, EMAC authorizes licensed health care professionals from member states to practice in affected states as if they were licensed in that state.[186] While EMAC applies only to official state agents (and not private sector professionals), its provisions help states and localities to garner sufficient personnel to meet surge capacity related to mental and behavioral health issues and other needs during an emergency.[187]

Statutory waivers of professional licensure requirements during declared emergencies typically apply interjurisdictional licensure portability to mental and behavioral health professionals.[188] MSEHPA contains a provision that waives local licensure requirements for validly licensed health care providers,[189] allowing them to practice outside their jurisdiction during a declared emergency.[190] This provision has been adopted by at least thirteen states and localities.[191] Drafted in 2007, the Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) allows for licensure portability for volunteer health practitioners (VHPs),[192] including mental health

183. MINN. STAT. § 12.42 (2009).

184. MINN. STAT. § 192.89 (2009); *Model EMAC Legislation*, EMACWEB.ORG, http://www.emacweb.org/?13 (last visited July 30, 2010).

185. *What Is EMAC?*, EMACWEB.ORG, http://www.emacweb.org/?9 (last visited September 10, 2010).

186. *EMAC Articles of Agreement Art. V*, EMACWEB.ORG (1996), http://www.emacweb.org/?1838.

187. H.R.J. RES. 193, 104th CONG. (1996) (enacted). *See also What is EMAC?*, *supra* note 185.

188. *See* Hodge, Gable & Cálves, *supra* note 28, at 48.

189. MSEHPA § 608(b)(2). MSEHPA defines "health care provider" as "any person or entity who provides health care services including, but not limited to, hospitals, medical clinics and offices, special care facilities, medical laboratories, physicians, pharmacists, dentists, physician assistants, nurse practitioners, registered and other nurses, paramedics, emergency medical or laboratory technicians, and ambulance and emergency medical workers." MSEHPA § 104(e).

190. *See id.* § 608(b)(1).

191. *See* CTR. FOR LAW & THE PUBLIC'S HEALTH, THE MODEL STATE EMERGENCY HEALTH POWERS ACT (MSEHPA): STATE LEGISLATIVE ACTIVITY (2006), *available at* http://www.publichealthlaw.net/MSEHPA/MSEHPA%20Leg%20Activity.pdf.

192. NAT'L CONFERENCE OF COMM'RS ON UNIF. STATE LAWS, UNIFORM EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT (UEVHPA) § 2(15) (2006) [hereinafter UEVHPA], *available at* http://www.uevhpa.org/Uploads/uevhpafinal.pdf (a volunteer health practitioner is a health practitioner who provides health or veterinary services which excludes practitioners

professionals.[193] Under the UEVHPA, a VHP's license will be recognized in the state where he is volunteering during a declared emergency so long as he has registered with a VHP registration system and is in good standing in all jurisdictions where he is licensed.[194] The VHP must not exceed the scope of practice of his license or that of a similar practitioner licensed by the state in which he is volunteering.[195]

Finally, upon authorization from the President pursuant to section 1135 of the Social Security Act, DHHS's Secretary may temporarily waive or modify certain requirements of the Medicare, Medicaid, and State Children's Health Insurance programs.[196] This includes waiving licensing requirements for health care professionals so long as they have equivalent licenses in another state and are not barred from practicing in the state where the emergency is occurring.[197]

B. *Prescribing Authority of Mental and Behavioral Health Personnel*

Mental and behavioral health services are offered through a combination of non-medical interventions, such as behavior-based therapy, and medical interventions, such as the prescription of psychotropic medications.[198] For most mental and behavioral health providers, prescribing authority depends on the state in which they are licensed.[199] Every state grants psychiatrists, who are physicians that specialize in the diagnosis and treatment of mental disorders, the ability to prescribe

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who are compensated pursuant to a preexisting employment relationship, unless they are out-of-state residents working for a disaster relief organization).

193. *Id.* § 2(12) (defining the scope of practice as that which is authorized by licensure in the state where the principal part of the practitioner's services are rendered).

194. *Id.* § 6(a).

195. *Id.* § 8(a-c) ("[A] volunteer health practitioner shall adhere to the scope of practice for a similarly licensed practitioner established by the licensing provisions, practice acts, or other laws of this state.").

196. 42 U.S.C. § 1320b-5(b) (2006).

197. § 1320b-5(b)(2).

198. *See* 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 (the report highlights the use of both psychosocial and pharmacological treatments).

199. *See* 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) (noting that a physician's legal ability to prescribe drugs that are controlled substances requires controlled substances registration in some states); *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 (last visited July 30, 2010) [hereinafter *Prescribing Privileges*] (listing the twelve states that have rejected legislation to grant psychologists prescription privileges since 1990).

medications to address mental and behavioral health issues.[200] Yet, the specialized training that psychiatrists receive is not required among physicians to prescribe medications for patients with mental health issues.[201] Research has consistently demonstrated that most prescriptions for psychotropic medications are written by physicians who have received minimal training in psychiatry.[202] This may be due, in part, to the fact that psychiatric services and licensed psychiatrists are not evenly distributed throughout the country, leaving some areas with a dearth of psychiatrically-trained physicians.[203]

Although psychologists must complete clinical training as part of their degree requirements, they are not medically-trained physicians.[204] Accordingly, only two states—Louisiana and New Mexico—grant them prescribing authority.[205] Psychologists' prescribing authority remains a contentious issue.[206] Proponents argue that psychologists can provide prescribing expertise and improve the quality of mental health care in areas where there are few psychiatrists.[207] In the 1990s, the U.S. Department of Defense conducted its Psychopharmacology Demonstration Project, which trained ten military psychologists to prescribe psychotropic medications.[208] Evaluations of this program were favorable.[209] Opponents argue that

200. BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, OCCUPATIONAL OUTLOOK HANDBOOK (2010) [hereinafter OCCUPATIONAL OUTLOOK HANDBOOK], *available at* http://www.bls.gov/oco/pdf/ocos074.pdf.

201. Mark Muse & Robert E. McGrath, *Training Comparison Among Three Professions Prescribing Psychoactive Medications: Psychiatric Nurse Practitioners, Physicians, and Pharmacologically Trained Psychologists*, 66 J. CLINICAL PSYCHOL. 96, 100 (2010).

202. Deanna F. Yates, *Patient Safety Forum: Should Psychologists Have Prescribing Authority?: A Psychologist's Perspective*, 55 PSYCHIATRIC SERVICES 1420, 1420 (2004) (stating that "more than 70 percent of all psychotropic medications are prescribed by nonpsychiatric physicians, typically after six weeks' training in psychiatry"). *See also* Muse & McGrath, *supra* note 201.

203. *See* Yates, *supra* note 202. *See also* James H. Scully, Jr., *Patient Safety Forum: Should Psychologists Have Prescribing Authority?: A Great Leap Backwards*, 55 PSYCHIATRIC SERVICES 1424, 1424 (2004).

204. *See* Yates, *supra* note 202, at 1420-21.

205. C. Munsey, *Prescriptive Authority in the States*, 39 MONITOR ON PSYCHOL. 60, 60 (2008), *available at* http://www.apa.org/monitor/feb08/prescriptive.aspx (psychologists must undergo additional training and collaborate with an individual's primary care physician); Yates, *supra* note 202, at 1421.

206. John Caccavale, *Opposition to Prescriptive Authority: Is This a Case of the Tail Wagging the Dog?*, 58 J. CLINICAL PSYCHOL. 623, 623-24 (2002).

207. Bridget Murray, *A Brief History of RxP*, 34 MONITOR ON PSYCHOL. 66, 66 (2003), *available at* http://www.apa.org/monitor/oct03/rxp.aspx.

208. *Prescribing Privileges*, *supra* note 199.

209. Yates, *supra* note 202 (citing AM. C. OF NEUROPSYCHOPHARMACOLOGY, DOD PRESCRIBING PSYCHOLOGISTS: EXTERNAL ANALYSIS, MONITORING, AND EVALUATION OF THE

psychologists are trained primarily to deliver psychotherapy, which focuses on a behavioral approach rather than a medical model.[210] Because psychotropic medications can be associated with significant risks, such as metabolic side-effects,[211] dependency,[212] and even death,[213] opponents have argued that psychologists are not appropriately trained to prescribe psychotropic medications.[214]

Other health care professionals, such as Advance Practice Nursing Professionals (APNs), have some form of prescribing authority in every state.[215] APNs undergo traditional nursing education and participate in additional training before acquiring prescribing authority.[216] Their authority, however, must derive generally from collaborative agreements with physicians.[217] Some states restrict the types of medications that APNs can prescribe, meaning that they can prescribe antibiotics and pain-relieving medications, but not controlled substances.[218] Physician assistants, whose training allows them to practice limited medicine under a physician's supervision, have prescribing authority in every state, subject to restrictions like those placed on APNs.[219]

While state licensure is generally required for mental and behavioral health personnel to prescribe medications, physicians licensed in any jurisdiction who are employed by the federal government (*e.g.*, U.S. Department of Defense, Veterans Affairs Administration, Indian Health

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PROGRAM AND ITS PARTICIPANTS 2-3 (1998), *available at* http://www.dod.mil/pubs/foi/PrescribePsychologists.pdf).

210. Ron Honberg & Joel Miller, *Prescribing Privileges Task Force Report and Recommendations to the NAMI Board of Directors*, NAT'L ALLIANCE ON MENTAL HEALTH, http://www.nami.org/Template.cfm?Section=Issue_Spotlights&template=/ContentManagement/ContentDisplay.cfm&ContentID=47075 (last visited Oct. 8, 2010).

211. Christoph U. Correll & Harold E. Carlson, *Endocrine and Metabolic Adverse Effects of Psychotropic Medications in Children and Adolescents*, 45 J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 771, 771 (2006).

212. *See* Carl Salzman, Editorial, *The APA Task Force Report on Benzodiazepine Dependence, Toxicity, and Abuse*, 148 AM. J. PSYCHIATRY 151, 151 (1991).

213. *Psychotropic Drugs Linked to Risk for Sudden Death During an Acute Coronary Event*, CARDIOLOGY TODAY (May 18, 2009), http://www.cardiologytoday.com/view.aspx?rID=39926.

214. Yates, *supra* note 202. *See also Prescribing Privileges*, *supra* note 199.

215. *See* Susan J. Phillips, *22nd Annual Legislative Update: Regulatory and Legislative Successes for APNs*, NURSE PRACTITIONER, Jan. 2010, at 24, 25-26.

216. *See* Muse & McGrath, *supra* note 201, at 97-98.

217. Scott Burris et al., *Stopping an Invisible Epidemic: Legal Issues in the Provision of Naloxone to Prevent Opioid Overdose*, 1 DREXEL L. REV. 273, 295 (2009).

218. Honberg & Miller, *supra* note 210.

219. *See PA Prescribing Authority by State*, AM. ACAD. PHYSICIAN ASSISTANTS, http://www.aapa.org/images/stories/Advocacy-state-summaries/Rx_Chart.pdf (last visited July 30, 2010); Burris et al., *supra* note 217, at 293.

Service) may practice in any state where federal facilities are located without obtaining local licensure.[220] For example, in the military, physicians and other health care professionals with a current professional license can practice in any Department of Defense health care facility nationally.[221]

C. *Crisis Standard of Care*

During emergencies, public health departments and health care systems often face shortages of resources (*e.g.*, equipment, supplies, pharmaceuticals, personnel) while simultaneously encountering an increased demand for services.[222] As recently conceptualized by an Institute of Medicine (IOM) committee, the level of patient care in emergencies is likely to fall along a continuum from "conventional" to "contingency" to "crisis."[223] Conventional care is the usual level of care provided in a non-emergency setting.[224] Contingency care attempts to remain functionally equivalent to conventional care while adapting to stressors placed on the health care system.[225] Although contingency care may place patients at a slightly increased risk of harm, the delivery of care is nearly consistent with usual community standards.[226] When normal safeguards cannot be maintained during an emergency, a crisis standard of care becomes necessary.[227] Under a crisis standard of care, persons with the greatest needs receive available care first until everyone desiring services can be

220. Alison M. Sulentic, *Crossing Borders: The Licensure of Interstate Telemedicine Practitioners*, 25 J. LEGIS. 1, 36 (1999).

221. 10 U.S.C. § 1094(d)(1) (2009) (authorizing the military to lift geographic limitations of a health care professional's local license, including any prescribing authority, for the exclusive purpose of providing care in a military context). *See also* Sulentic, *supra* note 220, at 36.

222. COMM. ON GUIDANCE FOR ESTABLISHING CRISIS STANDARDS OF CARE FOR USE IN DISASTER SITUATIONS, INST. OF MED. OF THE NAT'L ACADS., GUIDANCE FOR ESTABLISHING CRISIS STANDARDS OF CARE FOR USE IN DISASTER SITUATIONS: A LETTER REPORT 14 (Bruce M. Altevogt et al., eds., 2009) [hereinafter IOM, GUIDANCE].

223. *Id.* (citing John L. Hick, Joseph A. Barbera & Gabor D. Kelen, *Refining Surge Capacity: Conventional, Contingency, and Crisis Capacity*, 3 DISASTER MED. & PUB. HEALTH PREPAREDNESS S59, S66 (2009)). *See also* Lawrence O. Gostin & Dan Hanfling, *National Preparedness for a Catastrophic Emergency: Crisis Standards of Care*, 302 JAMA 2365, 2365 (2009).

224. *See* IOM, GUIDANCE, *supra* note 222.

225. *Id.*

226. *Id.* at 14-15.

227. *Id.* ("[I]n an important ethical sense, entering a crisis standard of care mode is not optional – it is a forced choice, based on the emerging situation. Under such circumstances, failing to make substantive adjustments to care operations – i.e., not to adopt crisis standards of care – is very likely to result in greater death, injury or illness.").

assessed and treated.[228] Implementing a crisis standard of care may require choices and actions that are legally suspect, such as providing preferential treatment to those most likely to benefit.[229] Since a legal standard of care is not synonymous with a medical standard of care, uncertainty regarding the outcomes of potential legal disputes may arise, which may affect providers' actions and community interests.[230]

D. Professional Liability and Immunity

Of all the legal issues faced by mental and behavioral health providers during emergencies, their potential liability related to the provision of services is the most concerning. Risk of exposure to liability can greatly deter practitioners from volunteering their services during an emergency.[231] Liability issues that are already complex in non-emergencies become even more complicated during an emergency. Mental and behavioral health providers have unique responsibilities[232] and differing philosophies with which to contend.[233] Controlled research studies have not addressed the efficacy of many mental and behavioral health interventions during emergency and disaster responses.[234] Consequently, to the extent mental health interventions lack an evidence base, there is no definitive guide of proven best practices for mental and behavioral health providers to follow.[235]

Without a definitive standard of care, it may be unclear whether certain acts or omissions constitute negligence. For example, some disaster mental health workers believe that hiding their roles as mental health workers from prospective patients or at-risk individuals "will minimize stigma and create

228. *Id.* at 57 (citing Merritt Schreiber, *Learning from 9/11: Toward a National Model for Children and Families in Mass Casualty Terrorism*, *in* ON THE GROUND AFTER SEPTEMBER 11: MENTAL HEALTH RESPONSES AND PRACTICAL KNOWLEDGE GAINED 605, 607 (Yael Daniele & Robert L. Dingman, eds. 2005)).

229. Eleanor D. Kinney et al., *Altered Standards of Care for Health Care Providers in the Pandemic Influenza*, 6 IND. HEALTH L. REV. 1, 10-11 (2009). *See also* IOM, GUIDANCE, *supra* note 222, at 44; Donna Levin et al., *Altered Standards of Care During an Influenza Pandemic: Identifying Ethical, Legal, and Practical Principles to Guide Decision Making*, 3 DISASTER MED. & PUB. HEALTH PREPAREDNESS S132, S137 (2009).

230. IOM, GUIDANCE, *supra* note 222, at 45. *See also* Kinney et al., *supra* note 229, at 2.

231. Carpenter, Hodge & Pepe, *supra* note 26, at 18.

232. Tarik Abdel-Monem & Denise Bulling, *Liability of Professional and Volunteer Mental Health Practitioners in the Wake of Disasters: A Framework for Further Considerations*, 23 BEHAV. SCI. & L. 573, 579 (2005).

233. Lawrence P. Hampton, Note, *Malpractice in Psychotherapy: Is There a Relevant Standard of Care?*, 35 CASE W. RES. L. REV. 251, 253, 269–72 (1984).

234. Abdel-Monem & Bulling, *supra* note 232, at 575.

235. *Id.*

an environment that encourages sharing of experiences."[236] Thus, some recommendations encourage mental and behavioral health workers to develop a normalizing atmosphere by identifying themselves only as emergency volunteers when conducting mental health screenings and assessments.[237] Failing to identify oneself as a health professional when delivering mental health services can be deceiving for those subject to or receiving screening, assessment, or treatment, implicating issues of liability relating to informed consent.[238] As a result, some suggest that emergency mental and behavioral health providers should always self-identify to promote transparency and facilitate access to services.[239]

While there are multiple avenues to potential liability for mental and behavioral health providers, there are a number of legal protections limiting civil liability for health professionals who practice during a declared emergency.[240] These include emergency laws (*e.g.*, MSEHPA,[241] Model Intrastate Mutual Aid Legislation (MIMAL),[242] UEVHPA[243]), interstate compacts (*e.g.*, EMAC[244]), sovereign immunity provisions,[245] volunteer protection acts,[246] and Good Samaritan protections.[247] While these

236. *Id.* at 580.
237. *Id.*
238. *See id.*
239. *See* Abdel-Monem & Bulling, *supra* note 232, at 580.
240. Hodge, *Legal Triage*, *supra* note 32, at 640–42.
241. MSEHPA § 608(b)(3) ("[a]ny out-of-state emergency health care provider appointed pursuant to this Section shall not be held liable for any civil damages as a result of medical care or treatment related to the response to the public health emergency unless such damages result from providing, or failing to provide, medical care or treatment under circumstances demonstrating a reckless disregard for the consequences so as to affect the life or health of the patient.").
242. NAT'L EMERGENCY MGMT. ASS'N & NAT'L PUB. SAFETY ORGS., MODEL INTRASTATE MUTUAL AID LEGISLATION (2004), *available at* http://www.emacweb.org/?76. MIMAL grants broad immunity for in-state government employees responding to a declared emergency. *Id.* art. X ("All activities performed under this agreement are deemed hereby to be governmental functions. For the purposes of liability, all persons responding under the operational control of the requesting political subdivision are deemed to be employees of the requesting participating political subdivision. Neither the participating political subdivisions nor their employees, except in cases of willful misconduct, gross negligence or bad faith shall be liable for the death of or injury to persons, or for damage to property when complying or attempting to comply with the statewide mutual aid system.").
243. UEVHPA, *supra* note 192, § 11.
244. *EMAC Articles of Agreement*, *supra* note 186, art. VI. EMAC offers civil liability protections to state agents who are sent by one state to respond to a disaster or emergency in another. Carpenter, Hodge & Pepe, *supra* note 34, at 19; Hodge, *Legal Triage*, *supra* note 32, at 641–42.
245. Hodge, *Legal Triage*, *supra* note 32, at 640.
246. *Id.*
247. *Id.*

protections offer immunity or indemnification, they do not safeguard all actions or individuals delivering mental and behavioral health care in emergencies.[248] None of these liability provisions, for example, protect individuals from liability for willful or wanton acts, acts that constitute gross negligence, or criminal actions.[249]

UEVHPA provides two options for civil liability protections for registered emergency health volunteers who provide services through a local host agency and conform to certain limitations.[250] Under the first option, a VHP who provides services pursuant to the Act will not be liable for any damages resulting from the provision of those services.[251] Moreover, no person will be held vicariously liable for damages if the VHP is not liable.[252] The second option offers liability protections only to those VHPs who receive no more than nominal compensation (consistent with the approach taken in the federal Volunteer Protection Act of 1997[253]). Under option two, vicarious liability of various entities is not addressed, thus deferring to existing state law.[254]

State and federal employees may also be protected from tort liability via sovereign immunity.[255] In some states, sovereign immunity has been statutorily extended to protect emergency volunteers, but most states only protect government employees.[256] Every state also has "Good Samaritan" laws, which provide immunity from civil liability for individuals who render aid at the scene of an emergency, generally in the absence of an emergency declaration.[257] These statutes typically cover individual rescuers who do not

248. *Id.* at 641.

249. *Id.*

250. Carpenter, Hodge & Pepe, *supra* note 26, at 19.

251. UEVHPA, *supra* note 192, § 11(a).

252. *Id.* § 11(b).

253. 42 U.S.C. § 14503 (2006). Under the federal Volunteer Protection Act, volunteers for non-profit organizations or governmental entities may receive liability protection if they (1) acted within the scope of their responsibilities; (2) were properly licensed, certified, or authorized; (3) did not engage in willful, criminal, or reckless misconduct, grossly negligent conduct, or conduct demonstrating a conscious, flagrant indifference to the rights or safety of the individual harmed; and (4) did not cause the harm by operating a vehicle for which an operator's license or insurance is required. *Id.*

254. Carpenter, Hodge & Pepe, *supra* note 26, at 21.

255. Sharona Hoffman, *Responders' Responsibility: Liability and Immunity in Public Health Emergencies*, 96 GEO. L.J. 1913, 1937 (2008); Hodge, Gable & Cálves, *supra* note 28, at 219. Sovereign immunity prohibits individuals from bringing tort lawsuits against governmental entities. *See* DAN B. DOBBS & PAUL T. HAYDEN, TORTS AND COMPENSATION: PERSONAL ACCOUNTABILITY AND SOCIAL RESPONSIBILITY FOR INJURY 393 (4th ed. 2001) (explaining that the concept of sovereign immunity is a carryover from the English common law, which established that "[t]he King can do no wrong").

256. Hodge, Gable & Cálves, *supra* note 28, at 35-37.

257. Carpenter, Hodge & Pepe, *supra* note 26, at 19; Hoffman, *supra* note 255, at 1943.

have a pre-existing duty to provide aid.[258] Consequently, volunteers who provide care in a health care setting or during declared emergencies are usually not protected through these laws.[259] Some states explicitly exclude health professionals from Good Samaritan liability protections.[260]

E. Workers' Compensation

Not only do mental health providers face liability risks, they may also be susceptible to developing their own employment-related mental and behavioral health harms during emergencies.[261] The extent to which providers are covered for resulting mental health injuries is governed by workers' compensation laws.[262] Workers' compensation is a no-fault insurance program provided by all employers and administered by the government through which individuals (or their families) receive limited benefits for work-related injuries and deaths.[263] While every state has enacted workers' compensation statutes, there is considerable variation in coverage.[264] Generally, employers are responsible for employees' injuries that arise out of, or occur in the course of, employment.[265]

Workers' compensation programs typically cover only employees,[266] thus excluding persons serving as volunteers.[267] During declared emergencies, states like Wisconsin, Minnesota, Ohio, Illinois, and Alabama extend workers' compensation coverage to select emergency response volunteers.[268] Under UEVHPA, volunteers who otherwise lack workers' compensation coverage are deemed state employees and thus eligible for benefits.[269] As a result, registered volunteers responding to the emergency through organized efforts receive basic workers' compensation protections.[270]

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258. Hoffman, *supra* note 255.
259. Hodge, Gable & Cálves, *supra* note 28, at 30-32.
260. *See* ESAR-VHP, *supra* note 18.
261. Hodge, Gable & Cálves, *supra* note 28, at 50.
262. *Id.* at 51.
263. *Id.* at 50.
264. *Id.* at 52.
265. *Id.* at 50-51.
266. Hodge, Gable & Cálves, *supra* note 28, at 51. An employee is ordinarily defined as "someone who the employer hires and compensates to provide services in the workplace." *Id.* at 52.
267. *Id.* at 51.
268. 20 ILL. COMP. STAT. 3305/10-k (2010); MINN. STAT. § 12.22 (2009); OHIO REV. CODE ANN. § 4123.025 (West 2007); ALA. CODE § 13-9-16 (1998); *Michels Pipeline Constr., Inc. v. Labor & Indus. Review Comm'n,* 541 N.W.2d 241, 242-43 (1995).
269. Carpenter, Hodge & Pepe, *supra* note 26, at 21.
270. *Id.*

The extent to which mental and behavioral health harms are covered by workers' compensation programs varies. Three types of work-related mental health harms are typically recognized via workers' compensation programs: (1) mental stimulus resulting in physical injury (mental-physical), (2) physical trauma resulting in mental injury (physical-mental), and (3) mental stimulus resulting in mental injury (mental-mental).[271] Mental-physical and physical-mental injury claims are uniformly compensable.[272] Mental-mental claims, however, are regulated differently across the states.[273] Approximately fifteen states' programs do not compensate for these types of injuries.[274] Other states offer compensation only if the stimulus is sudden or unusual.[275] Approximately eight states compensate regardless of the nature of the stimulus.[276]

When the emergency environment is claimed as the mental stimulus that caused the injury, it may affect the likelihood of recovery via workers' compensation. Because the emergency would most likely be considered a sudden or unusual mental stimulus, mental-mental injuries stemming from the emergency could be compensable in nearly every state. Conversely, the emergency may preclude coverage because it may be difficult to prove that the mental stimulus associated with the emergency was directly attributable to the provider's employment rather than the occurrence of the emergency itself.

IV. MENTAL AND BEHAVIORAL HEALTH SERVICES AND TREATMENT DURING EMERGENCIES

As discussed in the sections below, significant legal issues surround the provision of mental and behavioral health services and treatment during emergencies.[277] Changing legal norms during declared emergencies may dictate how and to whom services are delivered. For example, legal standards associated with the duty of informed consent, the duty to protect third parties, and providers' legal obligations to patients may be altered in

271. 82 AM. JUR. 2D *Workers' Compensation* § 320 (2009). Mental-physical injuries would include injuries such as a sudden fright that resulted in a physical consequence such as a heart attack. LARSON'S WORKERS' COMPENSATION, *supra* note 29, § 56.02. An example of a physical-mental injury would be depression following amputation from a work related injury. *Conner Mfg. v. Indus. Comm'n*, 836 P.2d 464, 465 (Ariz. Ct. App. 1992). An example of a mental-mental injury would be paranoia resulting from a life threatening incident at work. *See* LARSON'S WORKERS' COMPENSATION, *supra* note 29, § 56.02.

272. LARSON'S WORKERS' COMPENSATION, *supra* note 29, §§ 56.02-.03.

273. *Id.* § 56.06

274. *Id.* § 56.06[4].

275. *Id.* § 56.06[2].

276. *Id.* § 56.06[7].

277. *See* DISASTER PSYCHIATRY HANDBOOK, *supra* note 9, at 35.

emergencies.[278] Changes to law and policies may enhance access to medications or authorize compelled treatment.[279] Other laws and policies governing entitlements to treatment may impact the delivery of services.[280]

A. *Reassessing Mental or Behavioral Counselor-Patient Relationships*

In non-emergency contexts, the scope of the clinical relationships that arise between mental and behavioral health professionals and their patients is well-established.[281] Mental health professionals employ the *Diagnostic and Statistical Manual of Mental Disorders*, which provides a standardized classification of mental disorders.[282] Clinical relationships may include the provision of psychotherapy or other behavior-based therapies and psychotropic medications in a variety of settings including in-patient care and out-patient care.[283] Once a clinical relationship exists, the law generally requires mental and behavioral health providers to maintain their patients' confidentiality, which includes protecting their personal medical information.[284]

Psychiatrists traditionally employ a combination of medication and psychotherapy to treat their patients.[285] To assist psychiatrists in their approach to treating some of the most common mental health conditions, the American Psychiatric Association has developed a series of practice guidelines containing evidence-based recommendations.[286] These

278. *See id. See also* MSEHPA § 607(b).

279. *See* Cheryl Person & Elizabeth J. Fuller, *Disaster Care for Persons With Psychiatric Disabilities: Recommendations for Policy Change*, 17 J. DISABILITY POL'Y STUD. 238, 245-46 (2007).

280. *See id.* at 244-45.

281. AM MED. ASS'N, OPINION 10.01 - FUNDAMENTAL ELEMENTS OF THE PATIENT-PHYSICIAN RELATIONSHIP (1993), *available at* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion1001.shtml.

282. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS DSM-IV-TR (4th ed. 2000). This manual provides diagnostic criteria for mental illnesses; it does not recommend treatment approaches or describe best practices. *See* discussion *supra* Part III.D (discussing a lack of evidence about mental health services in emergencies).

283. OCCUPATIONAL OUTLOOK HANDBOOK, *supra* note 200.

284. *Patient Confidentiality*, AM MED. ASS'N, http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/patient-physician-relationship-topics/patient-confidentiality.shtml (last visited March 17, 2010) ("[C]ourts generally allow a cause of action for a breach of confidentiality against a treating physician who divulges confidential medical information without proper authorization from the patient.").

285. OCCUPATIONAL OUTLOOK HANDBOOK, *supra* note 200.

286. *Practice Guidelines*, AM. PSYCHIATRIC ASS'N, http://www.psych.org/MainMenu/PsychiatricPractice/PracticeGuidelines_1.aspx (last visited March 17, 2010).

guidelines address the treatment of conditions such as bipolar disorder,[287] major depressive disorder,[288] and substance use disorders.[289]

The American Psychiatric Association has recognized, however, that in disaster situations, the psychiatrist-patient relationship may change.[290] In its *Disaster Psychiatry Handbook*, the American Psychiatric Association describes how emergencies can alter the traditional psychiatrist-patient relationship.[291] For example, psychiatrists may serve on a crisis intervention team, through which they provide psychiatric services in the hours immediately following an event.[292] In these situations, psychiatrists often will not have an opportunity to take the type of detailed personal history that they would solicit under normal circumstances.[293] Additionally, they may have to provide services that are more commonly associated with a primary care physician, such as offering advice about general medical concerns and referrals to social service organizations.[294] Psychiatrists must also be attuned to individuals' lack of access to medications, which may cause some traditionally medical diseases, such as hypertension, to present as mental health conditions.[295]

Although psychologists lack the same medical training as psychiatrists, their experiences with patients during emergencies may be similar; members of both professions may be called on to provide generalized mental health

287. ROBERT M.A. HIRSCHFELD ET AL., AM. PSYCHIATRIC ASS'N, PRACTICE GUIDELINES FOR THE TREATMENT OF PATIENTS WITH BIPOLAR DISORDER *passim* (2d ed. 2002), *available at* http://www.psychiatryonline.com/pracGuide/pracGuideChapToc_8.aspx.

288. T. BYRAM KARASU ET AL., AM. PSYCHIATRIC ASS'N, PRACTICE GUIDELINES FOR THE TREATMENT OF PATIENTS WITH MAJOR DEPRESSIVE DISORDER *passim* (2d ed. 2000), *available at* http://www.psychiatryonline.com/pracGuide/pracGuideChapToc_7.aspx.

289. HILARY SMITH CONNERY & HERBERT D. KLEBER, GUIDELINE WATCH (April 2007): PRACTICE GUIDELINE FOR THE TREATMENT OF PATIENTS WITH SUBSTANCE USE DISORDERS, 2ND EDITION, AM. PSYCHIATRIC ASS'N, PRACTICE GUIDELINES FOR THE TREATMENT OF PATIENTS WITH SUBSTANCE USE DISORDERS *passim* (2d ed. 2006), *available at* http://www.psychiatryonline.com/pracGuide/loadGuidelinePdf.aspx?file=SUD2ePG_04-28-06.

290. DISASTER PSYCHIATRY HANDBOOK, *supra* note 9, at 14; *cf.* Aaron Levin, *Psychiatrists Should Prepare for 'Swine' Flu Fallout*, 44 PSYCHIATRIC NEWS, Sept. 4, 2009, at 6 ("Flu is usually not the concern of psychiatrists . . . but some aspects of last spring's mini-pandemic have raised some concerns in the disaster mental health community. These include not only neuropsychiatric effects of the disease or the medications used to treat it, but the community mental health issues that follow any major disaster.").

291. *See generally* DISASTER PSYCHIATRY HANDBOOK, *supra* note 9 (stressing that relationships with psychiatric personnel are crucial for addressing emergencies).

292. *Id.* at 4-5.

293. Erin Smith & Rhona Macdonald, *Managing Health Information During Disasters*, 35 HEALTH INFO. MGMT J. 8, 8, 11, 13 (2006).

294. *See* DISASTER PSYCHIATRY HANDBOOK, *supra* note 9, at 22.

295. Robert J. Ursano et al., *Hurricane Katrina: Disasters Teach Us and We Must Learn*, 31 ACAD. PSYCHIATRY 180, 181 (2007).

care and subsequent follow-up care (except for prescribing medications in most states).[296] The American Psychological Association provides some resources for psychologists regarding their role during natural disasters and trauma[297] and offers anecdotal evidence about the changing psychologist-patient relationship during emergencies.[298] For example, during the California wildfires in 2007, some psychologists served as roving mental health workers in evacuation centers to identify people in need of counseling.[299] They also offered assistance in coping with the stress associated with losing one's home.[300]

Mental health professionals responding to emergencies are likely to be involved with some form of psychiatric or psychological triage.[301] In general, this requires the identification and classification of individuals into priority groups, ranging from those most in need of immediate mental health services to those who may need no services at all.[302] Once individuals have been triaged, a mental health professional "must address the risks these patients face with them and their family members and establish comprehensive lists and follow-up plans for the future assessment and treatment."[303]

Providers' legal obligations to their patients may be particularly difficult to fulfill in emergencies. For example, patient confidentiality can be compromised in temporary facilities that do not offer discrete areas for

296. *See supra* Part III.B.

297. *Resources Helpful to Psychologists*, AM. PSYCHOL. ASS'N, http://www.apa.org/international/resources/networks/emergency-psych.aspx (last visited July 31, 2010); *Trauma*, AM. PSYCHOL. ASS'N, http://www.apa.org/topics/topictrauma.html (last visited July 31, 2010).

298. AM. PSYCHOL. ASS'N, ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT § 2.02 (2002), *available at* http://www.fapse.ulg.ac.be/documents/code2002.pdf. APA acknowledges that the nature of services for psychologists can change dramatically in an emergency situation. Its Code of Ethics notes that: "[i]n emergencies, when psychologists provide services to individuals for whom other mental health services are not available and for which psychologists have not obtained the necessary training, psychologists may provide such services in order to ensure that services are not denied." *Id.*

299. Christopher Munsey, *Volunteer Psychologists Helped Californians Cope with Wildfires*, 39 MONITOR ON PSYCHOL. 12 (2008).

300. *Id.*

301. 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) ("Triage is a critical event in disaster management . . . . Without early recognition of psychologic risks, those severely injured often obtain psychologic support only weeks or months into physical recovery and only after behavioral signs and symptoms have become clearly established.").

302. *Id.*

303. DISASTER PSYCHIATRY HANDBOOK, *supra* note 9, at 14.

assessing patients' mental health.[304] Similarly, mental and behavioral health providers may have to work in conjunction with other emergency responders who are less familiar with clinicians' legal obligations to their patients.[305] In these situations, health providers may need to ensure that other responders understand the importance of taking precautions to maintain individuals' privacy rights.

B. *Legal Duties of Mental and Behavioral Health Personnel*

As with all health care professionals, mental and behavioral health personnel must adhere to certain legal duties in providing treatment and other health services. Because most regulations of mental and behavioral health personnel occur at the state level, corresponding legal duties vary although they share some core legal characteristics. In emergencies, adherence to these legal duties, discussed below, may be significantly compromised.

1. Duty to Obtain Informed Consent

Interactions between a mental health professional and a patient hinge on the attainment of informed consent.[306] The concepts behind informed consent were developed "to promote autonomy of the individual in medical decision making."[307] While informed consent standards vary across states, the basic tenets require a mental health care professional to provide a patient with information about (1) diagnosis, (2) treatment, (3) consequences, (4) alternatives, and (5) prognosis.[308] Informed consent also includes an individual's right to refuse treatment.[309] Once informed consent is achieved, medical treatments or interventions can proceed until such point as the patient or her guardian withdraws consent.[310]

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304. *See generally* Joshua Miller, *Reflections on 9/11: Vulnerability and Strength in the "New World Order,"* 73 SMITH C. STUD. IN SOC. WORK 73, 78 (2002) (mentioning the difficulty in preserving patient confidentiality at ground zero); John C. Moskop et al., *From Hippocrates to HIPAA: Privacy and Confidentiality in Emergency Medicine – Part I: Conceptual, Moral, and Legal Foundations*, 45 ANNALS EMERGENCY MED. 53, 53, 60 (2005) (commenting on the lack of patient privacy and confidentiality in large treatment areas).

305. *See* Miller, *supra* note 304, at 78. *See also* Moskop et al., *supra* note 304, at 53, 54.

306. *See* Canterbury v. Spence, 464 F.2d 772, 780-81 (D.C. Cir. 1972).

307. Alan Meisel & Mark Kuczewski, *Legal and Ethical Myths About Informed Consent*, 156 ARCHIVES INTERNAL MED. 2521, 2521 (1996).

308. 2 Robert I. Simon, *Ethics and Forensic Psychiatry*, *in* COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 3972 (Benjamin J. Sadock & Virginia A. Sadock eds., 8th ed. 2005).

309. Dale H. Cowan, *United States Laws and the Rights of the Terminally Ill*, 28 MED. & L. 519, 519 (2009).

310. *See, e.g.*, Schreiber v. Physicians Ins. Co. of Wis., 588 N.W.2d 26, 31 (Wis. 1999).

Informed consent is required in all medical contexts, with three exceptions. First, informed consent does not need to be obtained when an individual cannot provide consent (*e.g.*, due to lack of consciousness or emergency condition) and a health care professional believes that failure to act would result in significant harm to the patient.[311] Second, an individual may elect to waive informed consent.[312] Finally, a health care professional can elect to invoke the "therapeutic privilege" and withhold information that he believes would result in a serious deterioration of the patient's medical condition.[313] Therapeutic privilege is extremely controversial and largely disfavored because it lessens individuals' (or their guardians') ability to make informed decisions about their medical care.[314]

To provide informed consent, an individual must have the capacity to do so.[315] Most persons who are at least 18 years old are presumed to be competent to give informed consent.[316] Some adults, however, due to mental disabilities or other severe health conditions, are incapable of providing informed consent because they cannot understand the consequences of accepting or refusing treatment.[317] In these situations, another adult is appointed to serve as the guardian, surrogate, or proxy decision-maker. When this occurs, the proxy decision-maker must "act in accordance with the patient's own wishes or, if their wishes are not known, in the patient's best interest."[318]

For individuals who may need mental health treatment at a future date and are concerned that they will lack competence to make decisions and

311. 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).

312. *See* Nicolas P. Terry & Leslie P. Francis, *Ensuring the Privacy and Confidentiality of Electronic Health Records*, 2007 U. ILL. L. REV. 681, 725 (2007) ("Legal mechanisms such as informed consent and privacy-confidentiality that operationalize patient interaction with medical services typically provide that patients may waive autonomy-derived 'rights.'").

313. Joan Vogel & Richard Delgado, *To Tell the Truth: Physicians' Duty to Disclose Medical Mistakes*, 28 UCLA L. REV. 52, 82 (1980).

314. *See* Richard W. Bourne, *Medical Malpractice: Should Courts Force Doctors to Confess Their Own Negligence to Their Patients?,* 61 ARK. L. REV. 621, 643 n.74 (2009); Jessica J. Flinn, Comment, *Personalizing Informed Consent: The Challenge of Health Literacy,* 2 ST. LOUIS U. J. HEALTH L. & POL'Y 379, 387–88 (2009).

315. Canterbury v. Spence, 464 F.2d 772, 780 (D.C. Cir. 1972).

316. 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).

317. C.W. Van Staden & C. Krüger, *Incapacity to Give Informed Consent Owing to Mental Disorder*, 29 J. MED. ETHICS 41, 41 (2003).

318. *See* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 273, 280 (1990).

provide consent, a psychiatric advance directive (PAD) may be employed.[319] PADs allow individuals "to plan for, consent to, or refuse future treatment, such as: hospital admission, administration of medication, [and] electroconvulsive treatment."[320] To date, twenty-five states have legislatively authorized the use of PADs.[321] A paucity of litigation on the legitimacy of PADs makes it difficult to predict whether mental health care professionals are legally bound to adhere to them.[322]

Some populations, such as young children, are presumed to be incapable of providing informed consent for their medical care.[323] Their parents typically serve as their proxies.[324] As children age, however, they can take a more active role in the informed consent process.[325] For adolescents, mental health professionals are encouraged to solicit "assent of the patient as well as the participation of the parents."[326] The assent process involves the provision of the same type of information included in the informed consent process, but it is adjusted to account for the child's ability to comprehend the information.[327] Some young people have been legally authorized to provide their own informed consent without parental involvement.[328] These "emancipated minors" fall into several categories that vary by state, often including young people who are married, pregnant or parenting, or in the military.[329]

During an emergency, the legal requirements associated with informed consent typically remain subject to alteration through crisis standards of

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319. *What Is a Psychiatric Advance Directive (PAD)?*, NAT'L RES. CTR. ON PSYCHIATRIC ADVANCE DIRECTIVES, http://www.nrc-pad.org/content/view/19/25/ (last visited July 31, 2010).

320. *What Does a PAD Allow Me to Do?*, NAT'L RES. CTR. ON PSYCHIATRIC ADVANCE DIRECTIVES, http://www.nrc-pad.org/content/view/11/25/ (last visited July 31, 2010).

321. *See Do All States Specifically Have PAD Statutes?*, NAT'L RES. CTR. ON PSYCHIATRIC ADVANCE DIRECTIVES, http://www.nrc-pad.org/content/view/41/25/ (last visited July 31, 2010).

322. *See* Hargrave v. Vermont, 340 F.3d 27, 31-33 (2d Cir. 2003); Marvin S. Swartz, Jeffrey W. Swanson & Eric B. Elbogen, *Psychiatric Advance Directives: Practical, Legal, and Ethical Issues*, 4 J. FORENSIC PSYCHOL. PRAC., no. 4, 2004 at 97, 98-99.

323. Ruth E. Greenfield, *The Recent Amendments to the Texas Natural Death Act: Implications for Health Care Providers*, 17 ST. MARY'S L.J. 1003, 1016 (1986).

324. *Id.*; Comm. on Bioethics, Am. Acad. of Pediatrics, *Informed Consent, Parental Permission, and Assent in Pediatric Practice*, 95 PEDIATRICS 314, 315 (1995); *cf.* Richard E. Redding, *Children's Competence to Provide Informed Consent for Mental Health Treatment*, 50 WASH. & LEE L. REV. 695, 704 (1993) ("Children traditionally have been . . . viewed by our society and in our courts as incapable of mature decision-making.").

325. Comm. on Bioethics, Am. Acad. of Pediatrics, *supra* note 324, at 316, 317.

326. *Id.* at 315.

327. *Id.* at 314, 315.

328. *Id.* at 316-17.

329. *Id.* at 316.

care.[330] Crisis situations may necessitate changes in the practice of obtaining informed consent consistent with its core principles. For example, formal written consent that is usually required prior to the administration of mental health services may be temporarily replaced with oral assertions of consent as needed.[331] Children who are displaced from their families during an emergency may receive mental health care so long as a proxy decision-maker, typically a court-appointed guardian, approves.[332]

2. Duty to Protect Third Parties from Risks Involving Individuals with Mental or Behavioral Health Conditions

Although there are some interpretive variations among the states in statutory and case laws,[333] mental and behavioral health professionals generally have a duty to protect third parties from individuals who present a danger to them;[334] this "duty to protect" can include a duty to report dangerous individuals and a duty to warn the third party.[335] In 1976, the Supreme Court of California issued a seminal decision, *Tarasoff v. Regents of the University of California*, which held that "[w]hen a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another," the therapist is obligated to "use reasonable care to protect the intended victim against such danger."[336] Reasonable measures may include a variety of protective actions, such as notifying the intended victim or contacting the

330. *See supra* Part III.C.

331. North Dakota has developed "stages of care" plans to consider how the standard of care might change during emergency situations. During "Stage III" of the North Dakota plan, the "system operates under a 'best efforts' basis [and] the impact on care is severe." Stage III anticipates "changes in informed consent requirements." FORUM ON MED. & PUB. HEALTH PREPAREDNESS FOR CATASTROPHIC EVENTS, INST. OF MED. OF THE NAT'L ACADS., CRISIS STANDARDS OF CARE: SUMMARY OF A WORKSHOP SERIES 14, 15 (Clare Stroud et al. eds., 2010).

332. *See* Comm. on Bioethics, Am. Acad. of Pediatrics, *supra* note 324, at 315–16.

333. Alan R. Felthous, *Warning a Potential Victim of a Person's Dangerousness: Clinician's Duty or Victim's Right?*, 34 J. AM. ACAD. PSYCHIATRY & L. 338, 338 (2006) ("Whether framed as a component of the broader duty to protect or as a separate protective duty, warning a victim is itself a duty in some case law and statutory law that establish *Tarasoff*-like protective duties."); *cf.* Claudia Kachigian & Alan R. Felthous, *Court Responses to* Tarasoff *Statutes*, 32 J. AM. ACAD. PSYCHIATRY & L. 263, 273 (2004) ("[C]linicians are well advised to be familiar with the statute(s) in their states, and any case law preceding or following enactment(s).").

334. *See* Tarasoff v. Regents of the Univ. of Cal., 551 P.2d 334, 340 (Cal. 1976).

335. Felthous, *supra* note 333, at 338.

336. *See Tarasoff*, 551 P.2d. at 340. *Tarasoff* involved an individual who, while voluntarily receiving outpatient therapy, told his therapist that he intended to kill someone who was "readily identifiable as Tatiana [Tarasoff]." *Id.* at 341. The therapist did not take protective actions, such as warning Tarasoff or her relatives that she was in danger. *Id.* Tarasoff was subsequently murdered, in keeping with her killer's previously stated intentions. *Id.*

police and reporting the dangerous individual.[337] While the traditional confidentiality that accompanies a therapist-patient relationship must, in most circumstances, be adhered to,[338] confidential information can be disclosed "to avert danger to [an identifiable victim,] . . . in a fashion that would preserve the privacy of [the] patient to the fullest extent compatible with the prevention of the threatened danger."[339]

While the court in *Tarasoff* did not address whether mental and behavioral health professionals are obligated to commit dangerous persons,[340] a few courts have since considered this question. In 1980, a Nebraska district court found that in some situations there may be "a duty to attempt to detain a patient."[341] Several years later, in 1986, a North Carolina court affirmed that "a psychotherapist, perhaps the only one with knowledge of the danger posed by his patient, may have a duty to protect society by . . . seeking the involuntary commitment of a patient whom he knows is dangerous."[342] To this end, the court created a "psychotherapist judgment rule,"[343] considering factors such as "good faith, independence and thoroughness" when deciding whether to impose liability upon a therapist who had failed to commit a dangerous patient.[344] This was envisioned as a compromise between a duty to commit and the removal of any potential liability from therapists who fail to control their most dangerous patients.[345] While individual states may "list civil commitment as

337. *Id*. at 340. In determining whether to warn a third party, mental health professionals must act with a "reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of [their profession] under similar circumstances." *Id*. at 345.

338. *See* Brian Ginsberg, Tarasoff *at Thirty: Victims' Knowledge Shrinks the Psychotherapist's Duty to Warn and Protect*, 21 J. CONTEMP. HEALTH L. & POL'Y 1, 10 (2004) ("None of these statutory [therapist-client] privileges, however, are absolute. In every case, extenuating circumstances can arise where a psychotherapist can violate the privilege and not be held liable to the patient for doing so.").

339. *Tarasoff*, 551 P.2d at 347. Ultimately, the court found that the defendants (at the University of California, Berkeley) were protected by governmental immunity from any resulting claims. *Id*. at 353.

340. *Id*. at 340.

341. Lipari v. Sears, Roebuck & Co., 497 F. Supp. 185, 193 (D. Neb. 1980).

342. Currie v. United States, 644 F. Supp. 1074, 1081 (M.D.N.C. 1986).

343. *Id*. at 1083.

344. *Id*.

345. The American Psychological Association does not support the imposition of a duty to commit because, *inter alia*, "the imposition of liability on therapists for failing accurately to predict and control their patients' future dangerousness was unsound as a matter of law and public policy because (a) mental health professionals can neither reliably nor validly predict dangerousness and imposition of tort liability for their failure to do so is therefore unwarranted, and (b) a rule imposing a duty to assess dangerousness and take preventive measures will undermine the goal of public safety it is meant to serve." *Currie v. United States, 836 F.2d 209*, AM. PSYCHOL. ASS'N, http://www.apa.org/about/offices/ogc/amicus/

an option [that can be employed to protect a third party], nowhere is it a duty."[346]

Similar issues arise when a mental or behavioral health provider faces the decision to commit someone who presents a danger to himself. In these instances, civil commitment is generally considered if an individual has made threats or taken actions that indicate he intends to put himself in imminent, serious danger.[347] In recent years, a handful of states have created an additional standard, beyond imminent danger to self, which can lead to civil commitment.[348] This standard concerns an individual's inability, due to mental illness, to understand "the advantages and disadvantages of accepting medication or treatment."[349] For commitment to be an option, individuals in this category likely face a lack of services that would ultimately "result in . . . the individual's [impaired] ability to function independently in the community."[350]

During emergencies, mental health professionals may be challenged to meet the standards imposed by *Tarasoff* and its progeny. First, because of the emergency, a mental health professional may only have limited encounters with a patient to assess her likelihood of harming herself or a third party. Even if the professional is able to ascertain the patient's potential to harm herself or others, notifying affected parties may be severely hampered by government orders to evacuate emergency areas resulting in displacement of mass populations. Locating the intended victim to provide a warning may be impossible. If the intended victim cannot be reached directly, law enforcement officials may be asked to help relay information about an individual's threatening behavior. This presupposes that police officers are available to carry out this duty, which may be unlikely given competing emergency response efforts. Finally, during an emergency, mental health professionals may lack access to information about a person's medical history that could aid in assessing the likelihood that the person presents a threat to himself or others.

currie.aspx (last visited July 31, 2010); Brief for Am. Psychol. Ass'n as Amici Curiae Supporting Respondent, Currie v. United States, 644 F. Supp. 1074 (1986) (No. 86-2643).

346. Paul B. Herbert & Kathryn A. Young, *Tarasoff at Twenty-Five*, 30 J. AM. ACAD. PSYCHIATRY & L. 275, 275 (2002).

347. Samuel Jan Brakel & John M. Davis, *Overriding Mental Health Treatment Refusals: How Much Process is "Due"?*, 52 ST. LOUIS U. L.J. 501, 571-72 (2008).

348. *Id.* at 572.

349. WIS. STAT. § 51.20(1)(a)(2)(e) (2008).

350. *Id.*

C. *Entitlements to Treatment Services*

In a U.S. health care system where millions of Americans lack access to basic health care services,[351] it is easy to conclude that many who could benefit from mental health services do not receive them. Individuals are entitled to mental and behavioral health treatment services only under limited circumstances. Mental health patients and prisoners who are involuntarily confined have a Fourteenth Amendment liberty interest to be treated by appropriately trained mental health professionals.[352] As a result, any individual who is involuntary confined by government, whether in a mental health hospital, prison, or other facility, has a right to "minimally adequate" mental health treatment.[353]

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)[354] created requirements for mental and behavioral health benefits to be in parity with other health benefits.[355] Under MHPAEA and the Mental Health Parity Act of 1996,[356] group health plans with fifty or more enrollees are required to provide parity in annual and lifetime limits;[357] deductibles, co-payments, coinsurance and out-of-pocket expenses; and frequency of treatment, number of visits, days of coverage, and other similar limits on scope or duration of treatment between medical and mental health benefits.[358] State Children's Health Insurance Program (SCHIP) plans must also comply with these parity provisions.[359] However, MHPAEA does not

351. *See* Carmen DeNavas-Walt, Bernadette D. Proctor & Jessica C. Smith, U.S. Census Bureau, U.S. Dep't of Commerce, *Income, Poverty, and Health Insurance Coverage in the United States: 2007*, P60 CURRENT POP. REPS., no. 235, 2008 at 19, *available at* http://www.cdc.gov/nchs/data/hus/hus07.pdf.

352. Youngberg v. Romeo, 457 U.S. 307, 318 (1982) ("the State is under a duty to provide [involuntarily confined patients] with such training as an appropriate professional would consider reasonable to ensure . . . safety and to facilitate . . . [their] ability to function free from bodily restraints"). *Id*. at 324.

353. *Id*. at 319.

354. Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, § 511, 122 Stat. 3881 (2008) [hereinafter MHPAEA].

355. *Id*. § 512(a)(1).

356. Mental Health Parity Act of 1996, Pub. L. No. 104-204, § 701, 110 Stat. 2944 (1996).

357. *Id*. §§ 702 (amending Section 712 of the Employee Retirement Income Security Act of 1974), 703 (amending Section 2705 of the Public Health Service Act).

358. MHPAEA §§ 512(a)(1) (amending Section 712 of the Employee Retirement Income Security Act of 1974), 512(b)(1) (amending Section 2705 of the Public Health Service Act), 512(c)(1) (amending Section 9812 of the Internal Revenue Code of 1986).

359. Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, 123 Stat. 8 (to be codified at 42 U.S.C. § 1397cc). MHPAEA only applies to plans that already offer mental and behavioral health benefits and that have more than fifty enrollees. MHPAEA § 512(c)(3). Additionally, plans that experience an increase in total costs of one percent or more will be exempt for one year. *Id*. § 512 (a)(1).

require employers to provide mental health and addiction benefits if they do not already, nor are employers prohibited from dropping existing mental health benefits.[360] The recently passed national health care reform legislation, known as the Patient Protection and Affordable Care Act, includes similar mental health parity requirements for most health insurance plans.[361]

The federal Medicaid program funds mental health services for qualified individuals.[362] Persons who are enrolled in Medicaid, for example, are entitled to a multitude of mental health services, including medical or other remedial care recognized under State law; diagnostic, screening, preventive, and rehabilitative services recommended for restoring an individual to the best possible functional level; inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases; and services in an intermediate care facility for the mentally disabled (other than in an institution for mental diseases).[363] Children are entitled to additional health care and diagnostic services and other measures even if such services are not covered under state plans.[364]

D. Access to Psychotropic Medications or Other Controlled Substances or Treatments

Federal laws strictly regulate who may prescribe and receive psychotropic medications and other controlled substances.[365] These powerful drugs are essential to the treatment of conditions such as depression, anxiety, and schizophrenia.[366] Despite their possible medical utility, the potential for abuse of these medications domestically and abroad has resulted in significant federal controls.[367] Congress has a long-standing interest in regulating the use of psychotropic medications domestically.[368] The United States has ratified an international treaty, the Convention on

360. MHPAEA §§ 512(a)(1) (requiring parity only in plans that already offer mental and behavioral health benefits), 512 (a)(2) (allowing one year exemption for plans that experience an increase in total costs of one percent or more).

361. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

362. 42 U.S.C. § 1396d (2006).

363. *Id.*

364. *Id.*

365. *See, e.g.*, 21 U.S.C. § 823 (2006).

366. *See* 21 U.S.C. § 801(1) (2006). *See also Psychotropic Drugs*, WORLD HEALTH ORG., http://www.who.int/topics/psychotropic_drugs/en/index.html (last visited July 26, 2010).

367. *See* 21 U.S.C. § 801a(1) (2006).

368. *Id.*

Psychotropic Substances,[369] to signal its commitment to controlling these substances.

Psychotropic medications and other controlled substances are classified by federal law into five schedules.[370] Schedule I drugs, such as heroin and mescaline,[371] have no accepted medical use and a high potential for abuse.[372] Drugs classified under Schedule I cannot be prescribed by mental health professionals for any purpose.[373] Schedule II drugs, which include opium and methadone,[374] have no accepted medical use or a highly restricted medical use and a high potential for abuse.[375] Schedule III drugs, such as amphetamines and anabolic steroids,[376] have an accepted medical use and the potential for abuse.[377] Schedule IV drugs, which include phenobarbital and petrichloral,[378] have a medically accepted use and a low potential for abuse.[379] Schedule V drugs, such as those containing limited quantities of codeine,[380] have an accepted medical use and limited potential for abuse compared to drugs listed in Schedule IV.[381] This classification system is crucial for determining the ease with which an individual can access psychotropic or other medications to treat mental or behavioral health issues. For example, drugs that have been classified as Schedule II, III, or IV must be dispensed directly to the individual for whom they were prescribed.[382] Schedule II drugs may only be dispensed with a written prescription, which cannot be refilled.[383]

In situations that meet the federal definition of "emergency," a Schedule II drug may be dispensed based on an oral prescription.[384] However, this oral prescription exemption is limited. The prescribing practitioner must find that (1) the drug needs to be administered immediately; (2) no other

369. Convention on Psychotropic Substances, Preamble, Feb. 21, 1971, 32 U.S.T. 543, 1019 U.N.T.S. 175; 21 U.S.C. § 801a(2) (2006).
370. 21 U.S.C. § 812(a) (2006).
371. 21 U.S.C. § 812(c) (2006).
372. 21 U.S.C. § 812(b) (2006).
373. 21 C.F.R. § 290.1 (2010). Schedule I drugs are only made available for research purposes. *Commonly Abused Drugs*, NAT'L INST. ON DRUG ABUSE, http://www.drugabuse.gov/PDF/CADChart.pdf (last visited on July 26, 2010).
374. 21 U.S.C. § 812(c).
375. *Id.* § 812(b).
376. *Id.* § 812(c).
377. *Id.* § 812(b).
378. *Id.* § 812(c).
379. 21 U.S.C. § 812(b).
380. *Id.* § 812(c).
381. *Id.* § 812(b).
382. 21 C.F.R. § 290.5 (2010).
383. 21 U.S.C. § 829(a) (2006).
384. *Id.*

treatment is available; and (3) it is impossible to provide a written prescription.[385] Less restrictive practices concern the prescribing and dispensing of Schedule III, IV, and V drugs.[386] Violations by either the person dispensing or the person possessing the drug can lead to fines and prison sentences.[387]

Emergency situations challenge the strict federal regulation of psychotropic medications and other controlled substances. For example, some persons may have physical limitations that make it difficult for them to reach an alternate location to receive psychotropic medications; they may have to rely on a friend or relative to pick up their medication during an emergency.[388] Under the current regulatory scheme, however, Schedule II, III, and IV drugs must be dispensed directly to the person for whom they were prescribed.[389] Additionally, persons who require Schedule II drugs may have difficulty obtaining a written prescription, as required by law,[390] during an emergency.

E. Compulsory Treatment of Non-Adherent Individuals

Public health powers, including the police power[391] and the *parens patriae power*,[392] allow the state to act to protect and promote the public's health. The U.S. Supreme Court expressed its support generally for the use of state police powers to protect communal health in its 1905 decision, *Jacobson v. Massachusetts*.[393]

Concepts articulated in *Jacobson* are echoed in contemporary debates about the compulsory treatment of individuals who refuse to comply with medical regimens. In general, courts have recognized that state and local governments have a strong interest in the use of compulsory treatment to protect citizens from a dangerous individual who refuses to take

385. 21 C.F.R. § 290.10 (2010).

386. 21 U.S.C. §§ 829(b)-(c) (2006).

387. 21 U.S.C. § 841 (2006), *amended by* Pub. L. No, 110-425, 122 Stat. 4828 (2008).

388. *But see* 45 C.F.R. § 164.510(b)(3) (2009) (allowing family or friend to pick up prescriptions for incapacitated patients or in emergency circumstances if it can reasonably be inferred that this is in the best interest of the patient).

389. 21 C.F.R. § 290.5 (2010).

390. *See* 21 C.F.R. § 290.1 (2010).

391. Gostin, *Public Health Law, Part II*, *supra* note 34, at 2980 ("The Tenth Amendment reserves to the states all powers that are neither given to the federal government nor prohibited by the Constitution. These reserved powers include, most importantly, the police power to promote the general welfare of society.").

392. *See, e.g.*, *Developments in the Law*, *supra* note 35, at 1208–09.

393. Jacobson v. Massachusetts, 197 U.S. 11, 29-31 (1905) (approving the City of Cambridge, Massachusetts, law requiring mass vaccinations in the face of a localized smallpox outbreak).

antipsychotic medication.[394] Compulsory treatment is controversial, however.[395] Appropriate trade-offs must be considered.[396] Risks to patients and individual constitutional protections, including due process concerns, may militate against forced treatment despite some risks to others.[397] Compulsory treatment "may be held unconstitutional where the person did not pose a danger to others or the treatment was not medically appropriate."[398] As the Supreme Court has noted, "[w]hile the therapeutic benefits of antipsychotic drugs are well documented, it is also true that the drugs can have serious, even fatal, side effects."[399] Consistent with the state's *parens patriae* powers, some courts have found that the state may "treat a patient 'against his will to prevent the immediate, substantial, and irreversible deterioration of a serious mental illness,' . . . in cases in which 'even the smallest of avoidable delays would be intolerable.'"[400]

Concerning convicted prisoners, the compulsory administration of antipsychotic drugs is only allowed if there is "a finding of overriding justification and a determination of medical appropriateness."[401] Additionally, the Supreme Court has held that, in certain instances, the state may use its *parens patriae* powers to compel mentally ill prisoners who present a danger to themselves or others to take antipsychotic medications as long as procedural due process protections are observed.[402]

After decades of jurisprudence, courts have established that compulsory treatment can be implemented only if there is "a compelling public health interest; a 'well-targeted' intervention; and . . . there exists no 'less restrictive alternative.'"[403] The standards are open to interpretation as there is "little clear guidance concerning the most basic aspects of compulsory

394. *See* Lawrence O. Gostin, *Tuberculosis and the Power of the State: Toward the Development of Rational Standards for the Review of Compulsory Public Health Powers*, 2 U. CHI. L. SCH. ROUNDTABLE 219, 269 (1995) [hereinafter Gostin, *Tuberculosis*].

395. Daniel S. Reich, *Modernizing Local Responses to Public Health Emergencies: Bioterrorism, Epidemics, and the Model State Emergency Health Powers Act*, 19 J. CONTEMP. HEALTH L. & POL'Y 379, 401-03 (2003).

396. *Id.* at 401, 406.

397. *See id.* at 402-03.

398. *Id.* at 403.

399. Washington v. Harper, 494 U.S. 210, 229 (1990).

400. Rogers v. Okin, 738 F.2d 1, 6 (1st Cir. 1984) (quoting *In re Guardianship of Roe*, 421 N.E.2d 40, 55 (Mass. 1981)).

401. Riggins v. Nevada, 504 U.S. 127, 135 (1992).

402. *Harper*, 494 U.S. at 220-23 (upholding a policy that allowed mentally ill prisoners to be required to take antipsychotic drugs if, *inter alia*, they were "gravely disabled" from a mental disorder and likely to seriously harm themselves or others).

403. Lawrence O. Gostin, *Public Health Theory and Practice in the Constitutional Design*, 11 HEALTH MATRIX 265, 305–06 (2001).

intervention."[404] In emergencies, compulsory treatment may be even more difficult to justify legally because systems established to ensure individuals' due process rights, such as hearings for those who contest their treatment, may be temporarily unavailable. Psychiatric or psychological reviews of patients, which can be essential to determining whether an individual poses risks to others, may not be available due to limitations of personnel and time. Mental and behavioral health professionals may need to rapidly assess the danger that an untreated individual presents to others with little or insufficient information, running afoul of patient due process rights.

F. Parens Patriae *Authority*

The doctrine of *parens patriae* empowers the state to protect the interests of minors and other vulnerable persons, and to engage in the involuntary commitment of the mentally ill for protection from harm.[405] *Parens patriae* power can be used to protect a state's "quasi-sovereign interests, such as health, comfort, and welfare of the people."[406] In emergency situations, this power grants the state the ability to protect individuals, such as minors and incompetent persons, who may not be able to care for themselves.[407]

When children are separated from their caregivers in emergency or other contexts, the state may assume parental responsibility for them using its *parens patriae* power,[408] until such point when the child is reunited with a parent or caregiver.[409] For example, to ensure that children without caregivers generally have the ability to receive medical care, including treatment for mental and behavioral health issues, the state can appoint a

404. Gostin, *Tuberculosis*, *supra* note 394, at 276. Issues to be considered include: "the need for individualized determinations; the level of risk to justify compulsion; the nature and extent of the procedural due process, and whether there must be judicial or merely clinical determinations; and when the duty to explore less intrusive alternatives is triggered, and the kinds of alternatives that are required." *Id*.

405. *See, e.g.*, *Developments in the Law*, *supra* note 35, at 1208–10.

406. Gibbs v. Titelman, 369 F. Supp. 38, 54 (E.D. Pa. 1973), *rev'd on other grounds*, 502 F.2d 1107, 1115 (3d Cir. 1974).

407. Lawrence O. Gostin, *Public Health Law in a New Century: Part III: Public Health Regulation: A Systematic Evaluation*, 283 JAMA 3118, 3119 (2000) (stating that the rationale for government making decisions for those with diminished capacity is to ensure their health or safety).

408. *See* 47 AM. JUR. 2D *Juvenile Courts and Delinquent and Dependent Children* § 19 (2009) ("The parental right is not absolute but is subject to intervention by the state under the doctrine of *parens patriae*, to protect the welfare and best interest of the child, and this includes legislating for the protection, care, and custody of children within its jurisdiction.").

409. *See id*.

guardian for them.[410] In some situations, if a child's caregiver is abusive or otherwise neglectful, placing the child's health and safety at risk, the state will intervene and remove the child from the harmful environment.[411] Under the *parens patriae* power, the state can then appoint a guardian to serve as the child's caregiver.[412] Unless a child faces an imminent danger to his or her health, an appointed guardian must provide consent for medical care, including treatment for mental and behavioral health issues.[413]

G. *Directly Observed and Assisted Therapies*

Directly observed therapy (DOT) is a form of medical treatment in which a health care professional observes a patient to ensure that medication is taken at the correct dose, at the correct time, and for the complete duration of the prescribed therapy.[414] Most commonly, DOT is employed to control the spread of highly infectious diseases that require months to treat, such as tuberculosis (TB).[415] By completing a course of DOT for TB, an infected individual can recover and lessen the likelihood of transmitting TB to others in the community.[416]

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410. Kimberly M. Mutcherson, *Whose Body Is It Anyway? An Updated Model of Healthcare Decision-Making Rights for Adolescents*, 14 CORNELL J.L. & PUB. POL'Y 251, 262-63 (2005).

411. Jessica E. Marcus, *The Neglectful* Parens Patriae*: Using Child Protective Laws to Defend the Safety Net*, 30 N.Y.U. REV. L. & SOC. CHANGE 255, 260 (2006).

412. *See id*. (stating that the state's intervention is a last resort for individuals whose health or safety is in imminent danger).

413. Allison Mantz, Note, *Do Not Resuscitate Decision-Making: Ohio's Do Not Resuscitate Law Should Be Amended to Include a Mature Minor's Right to Initiate a DNR Order*, 17 J.L. & HEALTH 359, 367 (2002-03) ("In the case of an emergency situation, if a minor's condition requires immediate attention because it poses imminent danger to the minor's health, and parental consent is not available, courts typically hold that parental consent is implied by law.").

414. *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.

415. Gostin, *Tuberculosis*, *supra* note 394, at 272. DOT has also been used during the administration of HAART treatment to persons with HIV. Grace E. Macalino et al., *A Randomized Clinical Trial of Community-Based Directly Observed Therapy as an Adherence Intervention for HAART Among Substance Users*, 21 AIDS 1473, 1474 (2007). *See also* MINN. DEP'T OF HEALTH, DIRECTLY OBSERVED THERAPY (DOT) FOR THE TREATMENT OF TUBERCULOSIS (Jan. 2006), *available at* http://www.health.state.mn.us/divs/idepc/diseases/tb/dot.pdf (stating that national TB treatment guidelines strongly recommend using a patient-centered approach, including DOT, when treating active TB).

416. CTRS. FOR LAW & THE PUBLIC'S HEALTH, CTRS. FOR DISEASE CONTROL & PREVENTION, TUBERCULOSIS CONTROL LAWS AND POLICIES: A HANDBOOK FOR PUBLIC HEALTH AND LEGAL PRACTITIONERS 18 (2009), *available at* http://tbcontrollers.org/docs/TBLawResources/TBControlLawsHandbook10012009.pdf.

Variations of DOT are used in mental and behavioral health contexts;[417] in these situations, DOT may be used for several reasons, such as assisting those who are recovering from addiction or preventing potentially violent persons from harming others.[418] For example, individuals in methadone maintenance programs to treat heroin addiction are required by federal regulations to receive their medication from a certified treatment program.[419] Often, a health care professional from the program will observe as individuals ingest their daily doses of methadone.[420]

States like New York have enacted legislation to implement a therapy related to DOT, known as assisted outpatient treatment (AOT).[421] Under AOT, individuals who are deemed "unlikely to survive safely in the community without supervision, based on a clinical determination"[422] can be required, by court order, to receive treatment for their mental illness on an outpatient basis.[423] AOT can only be mandated if an individual has met certain conditions, such as previous non-compliance with treatment for a mental illness and a history that suggests that serious harm to others is likely to result without AOT.[424]

During emergencies, DOT, AOT, or related practices may be suspended due to logistical difficulties. For example, during Hurricane Katrina in August 2005, 195 persons in heavily affected areas (*e.g.*, Louisiana, Alabama, Mississippi) were undergoing DOT for TB treatment.[425] The chaos of the hurricane's aftermath temporarily derailed treatment for these individuals.[426] Within a month, however, using coordinated responses at

417. *See* 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).

418. *See* Jason Grebely et al., *Directly Observed Therapy for the Treatment of Hepatitis C Virus Infection in Current and Former Injection Drug Users*, 22 J. GASTROENTEROLOGY & HEPATOLOGY 1519, 1523 (2007).

419. 42 C.F.R. § 8.11 (2009).

420. Karina M. Berg et al., *Rationale, Design, and Sample Characteristics of a Randomized Controlled Trial of Directly Observed Antiretroviral Therapy Delivered in Methadone Clinics*, 30 CONTEMP. CLINICAL TRIALS 481, 482, 484 (2009).

421. *An Explanation of Kendra's Law*, N.Y. STATE OFFICE OF MENTAL HEALTH (May 2006), http://www.omh.state.ny.us/omhweb/Kendra_web/Ksummary.htm.

422. N.Y. MENTAL HYGIENE LAW § 9.60(c)(3) (McKinney 2006) (amended 2010).

423. *Id.* § 9.60(c).

424. *Id.* §§ 9.60(c)(4), (c)(6).

425. Ctrs. for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., *Infectious Disease and Dermatologic Conditions in Evacuees and Rescue Workers After Hurricane Katrina – Multiple States, August-September, 2005*, 54 MORBIDITY & MORTALITY WKLY. REP. 961, 963 (2005), *available at* http://www.cdc.gov/MMWR/preview/mmwrhtml/mm5438a6.htm.

426. *See id.*

the local, state, and federal levels, over seventy percent of these patients had been located and their DOT had been resumed.[427] This highlights the need to maintain primary and secondary contact information for patients receiving DOT to locate them quickly during or after an emergency. Assisted treatment therapies may also be used during an emergency to manage the care of individuals who normally live in institutional settings.[428] If institutionalized persons are displaced, DOT could allow mental or behavioral health providers to continue to monitor drug regimen compliance.

V. LEGAL AND POLICY REFORMS TO IMPROVE MENTAL AND BEHAVIORAL HEALTH PREPAREDNESS

Our assessment of the legal environment underlying the provision of mental and behavioral health services during emergencies suggests legal barriers and gaps that may impede the delivery of essential care and services. In this section, we present a series of legal and policy reforms to address these concerns and improve mental and behavioral health preparedness. Integrating mental and behavioral health priorities into existing emergency laws and policies would allow federal and state governments to more thoroughly consider physical *and* mental health harms in allocating scarce resources. Because disasters are rarely confined to a single state or locality, states should align to ensure that their laws and compacts are conducive to interjurisdictional licensure for mental and behavioral health providers during emergencies. Development of mental health impact assessments would allow emergency planners to anticipate how the implementation of existing emergency powers will likely affect the population's mental health, with adjustments made to limit negative mental health effects in future emergencies. To better protect mental and behavioral health providers from liability for acts or omissions during emergencies, crisis standards of care must be well-established to reflect the realities of providing care in an emergency environment. Federal and state regulations for psychotropic medications should be reassessed so that essential medications will be available and accessible. Finally, workers' compensation programs and health insurance plans should be reformed to allow emergency responders to receive coverage for the treatment of mental health injuries that occurred while assisting in response efforts. These recommendations are discussed in turn below.

427. *Id.*

428. *See* 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.

A. *Integrating Mental and Behavioral Health Priorities Into Existing Emergency Laws and Policies*

Many existing emergency laws and policies do not explicitly prioritize mental and behavioral health needs, or afford them only limited attention.[429] To ensure the physical *and* mental health of populations before, during, and after emergencies,[430] current laws should be revisited to assess whether they adequately address individuals' and populations' mental and behavioral health needs.

The Stafford Act[431] offers an initial approach to the provision of mental health services during and after an emergency. Once the President declares the existence of a major disaster or emergency, the President is authorized to offer financial assistance to states or localities to provide crisis-counseling services to persons facing mental health problems due to the disaster.[432] These mental health services, which include screening, diagnosis, and counseling, can last for up to nine months after an original declaration of disaster.[433] However, because some mental health issues, such as PTSD among emergency responders, can take months to emerge or diagnose, states and localities may need federal assistance for mental health surveillance and treatments for considerably longer than nine months after a declared emergency.[434] Federal authorities should consider extending the Stafford Act's nine month cut-off of federal support for mental health crisis counseling services.

Mental health needs should also be reflected in state-based emergency laws and policies. Definitions of what constitutes an emergency or disaster in many state laws tend to focus on the physical health impacts of disasters and epidemics.[435] They may not explicitly include mental and behavioral health conditions, no matter how significantly these conditions may impact populations.[436] State public health emergency laws modeled after MSEHPA[437] may offer greater flexibility to authorize mental health responses.

429. *See* NAT'L COUNCIL ON DISABILITY, SAVING LIVES: INCLUDING PEOPLE WITH DISABILITIES IN EMERGENCY PLANNING 38 (Apr. 15, 2005), *available at* www.ncd.gov/newsroom/publications/2005/pdf/saving_lives.pdf.

430. *See supra* Part II.

431. *See supra* Part II.C

432. FEMA, DISASTER DECLARATION, *supra* note 107, at 3.

433. *Id.*

434. *See* Robert M. Brackbill et al., *Asthma and Posttraumatic Stress Symptoms 5 to 6 Years Following Exposure to the World Trade Center Terrorist Attack*, 302 JAMA 502, 508, 515 (2009).

435. *See, e.g.*, CONN. GEN. STAT. § 28-1(3) (2009); MONT. CODE ANN. § 10-3-103(7) (2009).

436. *See, e.g.*, CONN. GEN. STAT. § 28-1(3); MONT. CODE ANN. § 10-3-103(7).

437. *See supra* Part II.C.

MSEHPA's definition of "public health emergency"[438] is sufficiently broad to include harms beyond mere physical injuries, thus justifying a state's continued emergency status to address mental and behavioral health needs for weeks or months after the original declaration. Of course, emergencies cannot extend indefinitely. Extending the duration of a declared emergency, however, may be justified where mental health response efforts may be facilitated.

B. *Interjurisdictional Licensure Coordination*

Emergency compacts, like EMAC, and waiver and reciprocity statutes, such as MSEPHA and UEVHPA, greatly aid in interjurisdictional coordination. Yet potential gaps in licensure portability still exist for mental and behavioral health professionals. As trained physicians, psychiatrists are included in definitions of "health care provider" or other similar terms typically identified in these laws.[439] Less clear is whether other mental and behavioral health professionals are included among the providers entitled to reciprocity. States should ensure that licensure reciprocity laws include the full range of mental and behavioral health professionals. At a minimum, this includes psychologists, social workers, marriage and family therapists, and professional counselors.

Some states have created statutory exceptions that provide a time frame or compensation limitations for licensed mental and behavioral health professionals who plan to work in a jurisdiction where they are not licensed. In Washington, for example, counselors are exempt from licensing requirements if they do not receive compensation while practicing.[440] Statutes like these provide an automatic mechanism for interjurisdictional licensure, but they may be burdensome to administer in emergencies. It may be impractical for a mental or behavioral health professional, for example, to inform patients that she is not licensed in the state during emergencies. Additionally, without licensure oversight, such as a thorough registration system, these statutes may not adequately protect those seeking mental and behavioral health services.

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438. MSEHPA § 104(m). "Public health emergency" is expansively defined as:

> [A]n occurrence or imminent threat of an illness or health condition that: (1) is believed to be caused by . . . bioterrorism; the appearance of a novel or previously controlled or eradicated infectious agent or biological toxin;. . . and (2) poses a high probability of . . . a large number of deaths in the affected population; a large number of serious or long-term disabilities in the affected population; or widespread exposure to an infectious or toxic agent that poses a significant risk of substantial future harm to a large number of people in the affected population. *Id.*

439. *See id.* § 104(c).

440. WASH. REV. CODE § 18.19.040(3) (2009).

We recommend that all prospective mental and behavioral health practitioners seeking to serve populations in- and out-of-state during and after emergencies register with existing state ESAR-VHP systems, local MRC chapters, or other registries that vet and approve practitioners in advance of their deployment. These registries, coupled with state departments of health, boards of medicine, and other licensing authorities, may also help augment related scope of practice limitations and educate mental and behavioral health practitioners about jurisdiction-specific requirements.

C. *Mental Health Impact Assessments*

The field of emergency preparedness should increasingly include plans to address and lessen the mental and behavioral health impacts of emergencies. This involves not only prospective interventions, but also retrospective analyses of the mental health impacts that are likely to result from the use of emergency powers. By improving understanding of how the implementation of existing emergency laws and public health powers may lead to negative mental and behavioral impacts, lessons can be applied to the use of these powers in future emergencies. Potential interventions that may be effective in controlling infectious diseases, but highly damaging to the affected populations' mental health, may be reconsidered so long as other interventions with fewer mental health impacts may be efficacious.

During emergencies, government may be empowered to use certain emergency public health powers, such as restricting individuals' movement through isolation and quarantine[441] or displacing populations as part of an evacuation.[442] While these powers may safeguard populations' physical health, they may also lead to adverse mental health outcomes. For example, individuals who are isolated or quarantined during an infectious disease outbreak may face significant mental health challenges, including anxiety, panic, and depression.[443] Some state emergency laws, such as those based on MSEHPA, affirm that these individuals may access mental or behavioral health providers during their confinement.[444] States should develop regulations delineating clear processes for offering mental health care to individuals whose movements have been restricted. Similarly, individuals who are displaced during an evacuation may face mental health challenges brought on by the stress of being separated from their homes

441. FEMA, ANNEXES, *supra* note 120, at ESF #8-6.

442. *Id.* at ESF #14-3.

443. 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.

444. MSEHPA § 604(d)(1), at 28.

and possessions.[445] They are equally entitled to access to mental and behavioral health providers.

Finally, federal and state governments should alter reporting and screening requirements for emergency responders. Due to the stress associated with meeting a community's varied needs during a disaster, emergency responders are at an increased risk for emerging mental or behavioral health issues.[446] Governments should consider requiring emergency responders to report fellow responders who are experiencing mental health issues. At present, this is voluntary, if done at all.[447] In addition, state governments could amend their emergency response laws to mandate the availability of mental health screenings for emergency responders. Responders would not be compelled to participate in these screenings, but should be encouraged to utilize these services.

D. Crisis Standard of Care Concerning Mental and Behavioral Health Conditions

Mental health providers may face difficult decisions when providing services under a crisis standard of care.[448] They may also fear the specter of liability underlying their acts or omissions during emergencies, especially those lacking liability protections. These concerns can impair response efforts. During a declared emergency when a crisis standard of care goes into effect, mental health providers need to make triage decisions that aim to protect the health of individual patients as well as the public's health. However, legal standards assessing liability do not normally consider a community-level duty of care.[449] The legal standard of care arguably must shift during an emergency to match the medical standard of care in crises. Assessing liability under a crisis standard of care may include examining whether a health care provider adheres to established plans or emergency practices.[450]

445. *See* HODGE & GOSTIN, *supra* note 127, at 20-21. *See also* DEWOLFE, FIELD MANUAL, *supra* note 11, at 22 (specifically discussing displacement of people in nursing homes and group facilities).

446. DEWOLFE, FIELD MANUAL, *supra* note 11, at 23.

447. *See* DEWOLFE, TRAINING MANUAL, *supra* note 130, at 29. *See also* DEWOLFE, FIELD MANUAL, *supra* note 11, at 23.

448. James G. Hodge, Jr. & Brooke Courtney, Commentary, *Assessing the Legal Standard of Care in Public Health Emergencies,* 303 JAMA 361, 361 (2010).

449. *See id.* (noting that a national standard of care is generally used. This standard is "based on what a reasonable and prudent practitioner of the same specialty nationally would do under similar circumstances.").

450. *Id.* at 362; *cf.* George S. Everly, Jr. et al., *Mental Health Response to Disaster: Consensus Recommendations: Early Psychological Intervention Subcommittee (EPI), National Volunteer Organizations Active in Disaster (NVOAD)*, 13 AGGRESSION & VIOLENT BEHAVIOR

For mental and behavioral health services, for example, the use of compulsory treatment may be temporarily expanded under a crisis standard of care to meet patient surge. Because compulsory treatment conflicts with individual rights embedded in constitutional principles of liberty,[451] clear rules for when expanded use of compulsory treatment is authorized and the duration of such treatment should be established in advance of an emergency situation. Additionally, protections should ensure that mental and behavioral health issues are part of the triage assessment. Considerations may include the increased difficulty in accessing services for those already requiring specialized strategies to obtain needed care, the likelihood that an individual will turn to substance abuse to compensate for lack of access or outright denials of treatment, and the possible deterioration of an individual's mental and behavioral health functioning if treatment is unavailable. Denial of services must also be examined to ensure that those with mental and behavioral health conditions are not being prejudicially excluded from services in violation of equal protection principles and disability anti-discrimination laws.

E. Access to Psychotropic Medications

Psychotropic medications are an important component of treatment for a variety of mental and behavioral health conditions.[452] Because of their powerful effects and potential for abuse, federal and state governments strictly regulate their use.[453] During emergencies, these regulations can impede individuals with mental and behavioral health issues from accessing needed medications for several reasons. First, although the drugs may be available, emergencies can limit prescribers' and patients' abilities to comply with federal regulations. For example, certain psychotropic medications must be dispensed directly to the person for whom they were prescribed.[454] Individuals whose movement is restricted in an emergency may be unavailable for in-person pick-up of the drugs. These regulations should be revised during emergencies to allow previously-designated surrogates to pick up psychotropic medications for patients. Alternatively,

407, 411 (2008) (recommending the establishment of specialized training and delivery of disaster mental health services).

451. *Developments in the Law*, *supra* note 35, at 1193-95.

452. WORLD HEALTH ORG., IMPROVING ACCESS AND USE OF PSYCHOTROPIC MEDICINES 2 (2005), *available at* http://www.who.int/mental_health/policy/services/10_improving%20access_WEB_07.pdf; *see* 21 U.S.C. § 801(1) (2006).

453. *See supra* Part IV.D.

454. 21 C.F.R. §§ 290.1, 290.5 (2010).

regulations requiring the use of written prescriptions for certain psychotropic medications may be temporarily waived or altered.[455]

A second challenge involves individuals' ability to access psychotropic medications if supplies are scarce. This may be remedied through the inclusion of psychotropic medications in CDC's SNS. While the precise contents of the SNS are not publicly known, primary contents include drugs and supplies to treat mostly physical injuries.[456] Psychotropic medications and other effective medications should be included as well for those who depend on these drugs for their mental and behavioral health stability.

Access to psychotropic medications may also be compromised in an emergency if qualified individuals are unavailable to prescribe these drugs. Many states (1) prohibit psychologists from prescribing drugs and (2) require mental and behavioral health providers such as APNs and physician assistants to establish collaborative agreements with physicians and/or undergo supervision to prescribe psychotropic medications.[457] During an emergency, states may consider temporary changes in the scope of practice requirements for these professionals to meet surge capacity.

F. Protections from Claim Denials for Mental and Behavioral Health Conditions

Mental and behavioral health injuries are an inherent risk for frontline responders in declared emergencies. Yet, as noted above, many states do not recognize mental and behavioral harms as compensable injuries under workers' compensation programs.[458] Even in states that allow workers' compensation claims for mental injuries, emergency responders may find it difficult to prove their injuries are directly related to their work and not generally caused by the emergency itself. Consequently, states should ease the burden of proof for all emergency responders raising mental health claims via workers' compensation. If an emergency responder can demonstrate that a mental health injury occurred while assisting during a declared emergency, the presumption should be that the injury is attributable to the work performed.

Health insurance regulations, as well, should not exclude mental and behavioral health claims during emergencies. Notwithstanding existing and forthcoming mental health parity protections at the federal level, the

455. 21 U.S.C. § 829(a) (2006).

456. *Strategic National Stockpile: What It Means to You* (2009), CTRS. FOR DISEASE CONTROL & PREVENTION, www.bt.cdc.gov/stockpile. CDC has stated that the SNS contains "antibiotics, chemical antidotes, antitoxins, life-support medications, IV administration, airway maintenance supplies, and medical/surgical items." *Id.*

457. *See supra* Part III.B.

458. *See supra* Part III.E.

potential for claim denials stems from the limited coverage of parity requirements. Additionally, mental health injuries arising during a declared emergency may not be covered contractually. Denying coverage for mental health harms is understandable from the insurance perspective. Health insurers cannot guarantee coverage for all mental health injuries affecting the population during a national epidemic or other emergency. Until national health care reform (or alternative state-based reforms) prohibits denials of pre-existing claims in mental health, health insurance companies may lawfully continue to deny coverage. Systemic reforms are needed so that related mental and behavioral health conditions can be effectively treated over prolonged periods.

VI. CONCLUSION

In addition to significant impacts of major emergencies on human morbidity and mortality, a hidden epidemic of mental and behavioral health harms particularly affects vulnerable populations. Individuals suffering from mental illness or behavioral conditions stemming from emergencies are equally entitled to screening, diagnoses, and treatment as persons with physical injuries during and after emergencies. However, mental health preparedness and response efforts implicate numerous legal and policy issues that may impede effective care.

Through enhanced planning and response activities that prioritize mental and behavioral health needs among vulnerable populations, federal, state, and local governments can better use existing emergency powers, such as screening, surveillance, and reporting, to protect and promote individuals' physical *and* mental health during emergencies. Because major emergencies impact multiple jurisdictions, governments must address legal issues that can thwart mental and behavioral health providers' abilities to respond, such as professional licensure requirements and liability protections. To ensure that mental and behavioral providers can offer treatment to impacted populations, laws regulating psychotropic medications, compelled treatment of non-adherent persons, and assisted therapies must be revisited and appropriately altered consistent with a crisis standard of care in emergencies.

In the immediate aftermath of a declared emergency, the long-term plight of impacted individuals in vulnerable populations concerning mental and behavioral health issues cannot be forgotten. Diagnoses and treatment for these individuals will extend well beyond the state of emergency. Commitment of governments, mental health professionals, insurers, employers, and others to support mental health improvements across populations after major emergencies is core to recovery efforts. Effective legal and policy changes consistent with this support may contribute to mental and behavioral health improvements.