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Redefining the Legal Basis for Mental Health Emergencies[+]

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I. INTRODUCTION

Public health emergencies and natural or man-made disasters are often measured by their impacts on physical health. Recent, large-scale disasters, including the 2011 Japanese tsunami, 2010 Haiti earthquake, 2009/2010 H1N1 pandemic, and Hurricane Katrina in 2005, have collectively impacted the physical health of millions of individuals. Hundreds of thousands died and many more suffered permanent or long-term physical disabilities from these catastrophes. Addressing and preventing these catastrophic effects on communal health and well-being in the future are the focus of emergency planning, preparedness, and response efforts at all levels of government and private sector entities.

Another, hidden epidemic, however, underlies these disasters and is

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pervasive across all affected populations within and outside immediate "danger zones." This epidemic impacts people at all socio-economic levels and may continue for months or years beyond environmental destruction or physical health impacts. Underlying major emergencies are often significant mental and behavioral health effects that may be invisible to many, unspoken among victims and their families, and largely ignored as part of response efforts.[1] Particularly among vulnerable individuals (e.g., children, elderly, ethnic minorities, emergency workers), mental health crises stemming from major emergencies may be crippling without effective surveillance and treatment.

Increasingly emergency planners, mental health providers, and other actors recognize the need to address the debilitating mental and behavioral health impacts of major emergencies. However, they face legal impediments and barriers to effectively detect and treat societal mental and behavioral health conditions. Part of the problem relates to the limited legal support through which mental health conditions may be addressed. National, state, and local governments often declare states of emergency, disaster, or public health emergency to respond to the physical health implications of major catastrophes. These declarations change the legal environment in key ways that facilitate the allocation and provision of health services, including through the detection and treatment of mental health conditions. Yet, emergency declarations are also limited in duration, typically extending no longer than necessary to allow public and private actors to address physical injuries among the population. There is no corresponding legal recognition of a complementary state of "mental health emergency" sufficient to respond to populations' mental and behavioral health conditions. As a result, these needs may go unmet even though they can often be detected and prevented through treatment.

In this comment, we briefly describe the mental health impacts of major emergencies and disasters, assess current legal responses to these conditions, and argue for a new legal approach that supports the long-term detection and treatment of vulnerable individuals whose mental health status is negatively impacted by emergencies and related consequences.

II. MENTAL HEALTH IMPACTS OF MAJOR EMERGENCIES AND DISASTERS

Ancillary mental health impacts across populations affected by major disasters have been documented for years. In 1989, in response to Hurricane Hugo (South Carolina) and the Loma Prieta (San Francisco Bay) earthquake, the American Red Cross (ARC) officially recognized mental health impacts of such disasters. ARC established a Disaster Mental Health

1. Katherine Yun et al., *Moving Mental Health into the Disaster-Preparedness Spotlight*, 363 NEW ENG. J. MED. 1193 (2010).

Services program to provide a framework for treatment of mental health issues in post-disaster relief efforts.[2] Recently, in response to the tornados that devastated parts of Alabama and Missouri in April 2011, ARC used this program to dispatch volunteers trained in psychological first aid.[3]

Despite increased recognition of mental health impacts of disasters, the public has not always supported emergency mental health services. In 1994, for example, FEMA faced public backlash after it allocated $28 million to various efforts in California to provide mental health counseling after the Los Angeles riots, wildfires, and the Northridge Earthquake.[4] Southern California residents argued that mental health services were going unused and the funds should be reallocated to update physical infrastructure and support tangible relief efforts. In 2011, despite reports from New York City's 9/11 health programs that individuals are still suffering from post-traumatic stress almost ten years later, therapeutic efforts and methodology were questioned. One study suggests that therapists overestimated the number of people who would experience mental health issues and that the deluge of counseling led many to recount painful experiences unnecessarily.[5]

Over the last 20 years, emergency mental health services have been gaining traction not only as an element of disaster relief efforts, but also as a subject of studies focused on population impacts.[6] Populations affected by hurricanes in particular, including Hugo (1989), Mitch (1988), and Andrew (1986), have been studied concerning the immediate and the long-term psychological impacts of these natural disasters.[7]

Some disasters and public health emergencies lead to mental health impacts for those who are neither physically injured nor witnesses to the event. The Disaster Mental Health Subcommittee of the United States Department of Health and Human Services ("DHHS") refers to these individuals as the "worried well."[8] These effects may extend for many

2. John D. Weaver et al., *The American Red Cross Disaster Mental Health Services: Development of a Cooperative, Single Function, Multidisciplinary Service Model*, 27 J. BEHAV. HEALTH SERVICES & RES. 314, 316 (2000).

3. Campbell Robertson & Kim Severson, *Hundreds of Thousands Are Without Power, and Many Without Homes*, N.Y. TIMES, Apr. 30, 2011, at A14.

4. Gordon Dillow, *Post-Disaster Mental Health Efforts Debated*, L.A. TIMES, Mar. 21, 1994, *available at* http://articles.latimes.com/1994-03-21/news/mn-36781_1_mental-health-programs.

5. Benedict Carey, *Sept. 11 Revealed Psychology's Limits, Review Finds*, N.Y. TIMES, July 29, 2011, at A18; Anemona Hartocollis, *10 years and a Diagnosis Later, 9/11 Demons Haunt Thousands*, N.Y. TIMES, Aug. 10, 2011, at A1.

6. U.S. Dep't of Veterans Affairs, National Center for PTSD: The Effects of Natural Disasters (Jul. 5, 2007), http://www.ptsd.va.gov/public/pages/effects-natural-disasters.asp.

7. Fran H. Norris et al., *Prevalence and Consequences of Disaster-Related Illness and Injury from Hurricane Ike*, 55 REHABILITATION PSYCHOL. 221, 222-23 (2010).

8. U.S. Dep't of Health & Human Servs., Public Health Emergency: Disaster Mental

years – even decades – after the initial trauma even though no physical harm occurred.[9] Oil spills and other environmental disasters exemplify emergencies that do not necessarily cause physical injuries to individuals, but can result in substantial mental health harms.[10] After the Exxon Valdez oil spill off of Prince William Sound in 1989, several studies found increased rates of depression, anxiety, and post-traumatic stress disorder ("PTSD") among nearby residents.[11] In particular, one study found that Native Americans in the affected area suffered from particularly high rates of PTSD associated with the loss of their subsistence lifestyle that relied heavily on the local fisheries and wildlife.[12]

After Hurricane Katrina, many residents suffered from symptoms of PTSD.[13] Studies also found that thirty percent of students at schools in Louisiana continued to experience mental health problems five years after Katrina landed. The Louisiana Department of Health and Human Services launched the Louisiana Spirit Costal Recovery Counseling Program with federal funds to provide mental health support;[14] however, the program ended in 2010. After the Deepwater Horizon oil spill in 2010, state officials scrambled to reopen the program using response funds from British Petroleum to create mental health hotlines, among other services.[15] The spill in particular has increased awareness that economic and cultural disruptions following a disaster have negative mental health effects that may require intervention and treatment.[16]

III. LEGAL RESPONSES TO MENTAL HEALTH IMPACTS OF MAJOR EMERGENCIES

During a declared state of emergency or disaster, the legal environment changes to facilitate response efforts, especially across jurisdictions.

Health Subcommittee (Sept. 16, 2009), http://www.phe.gov/Preparedness/legal/boards/nbsb/wg/Pages/mentalhealth.aspx.

9. Hartocolis, *supra* note 5, at A1.

10. Campbell Robertson, *Oil Spills May Leave More Emotional Than Physical Scars, Study Finds*, N.Y. TIMES, Apr. 7, 2011, at A15.

11. Duane A. Gill & J. Steven Picou, *Technological Disaster and Chronic Community Stress*, 11 SOC. NAT. RESOURCES 795 (1998); Lawrence A. Palinkas et al., *Community Patterns of Psychiatric Disorders after the Exxon Valdez Oil Spill*, 150 AM. J. PSYCHIATRY 1517 (1993).

12. Palinkas et al., *supra* note 11, at 1522.

13. John Manuel, *In Katrina's Wake*, 114 ENVTL. HEALTH PERSP. A32, A39 (2006).

14. Louisiana Spirit Hurricane Recovery, What was Our Role in Community Efforts? http://www.dhh.state.la.us/offices/apps/apps-231/Docu2010/role.html.

15. Kim Murphy, *Oil Spill Stress Starts to Weigh on Gulf Residents*, L.A. TIMES, June 20, 2010, *available at* http://articles.latimes.com/2010/jun/20/nation/la-na-oil-spill-mental-health-20100621.

16. Yun et al., *supra* note 1, at 1193-95.

Planning, training, and interjurisdictional coordination at all levels of government ensure that legal authorities are in place to provide access to additional resources during and immediately after an emergency.[17] These legal authorities may enhance the government's authority or create temporary, emergency powers. Non-emergency laws may also play an important role in response activities in areas such as workers' compensation benefits and access to health care services. Though not explicitly designed to respond to mental health harms accompanying emergencies, the current legal environment is supportive in many ways.

A. Interjurisdictional Emergency Plans

Interjurisdictional preparedness and response efforts most often focus on the need to meet surge capacity during emergencies. Surge capacity involves two components: (1) access to increased personnel, including physicians, nurses, and other healthcare professionals; and (2) access to resources, including vaccines and other healthcare supplies.[18]

Personnel needs are met through federal, state, and local response mechanisms. At the federal level, DHHS' Assistant Secretary for Preparedness and Response ("ASPR") operates the National Disaster Medical System ("NDMS"). Through NDMS, the federal government can deploy health care professionals to supply medical care for an emergency response.[19] ASPR also oversees the At-Risk Individuals, Behavioral Health, and Human Services Coordination ("ABC") program.[20] Through ABC, ASPR provides technical assistance regarding mental and behavioral health issues that may arise during an emergency response. Several federal agencies, including the Administration on Aging and the Substance Abuse and Mental Health Services Administration assist in coordinating ABC's work.

State-based Emergency Systems for the Advance Registration of Volunteer Health Professionals ("ESAR-VHP") are used to register health care volunteers who are willing to participate in emergency responses. Medical Reserve Corps units, coordinated through the U.S. Surgeon

17. 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, 251-63 (2008).

18. James G. Hodge, Jr. et al., *The Pandemic and All-Hazards Preparedness Act: Improving Public Health Emergency Response*, 297 JAMA 1708, 1709 (2007).

19. U.S. Dep't of Health & Human Servs., Office of Asst. Sec'y for Preparedness & Response, National Disaster Medical System (June 14, 2010), http://www.phe.gov/Preparedness/responders/ndms/Pages/default.aspx.

20. U.S. Dep't of Health & Human Servs., Office of the Asst. Sec'y for Preparedness & Response, Office for At-Risk Individuals, Behavioral Health, & Human Servs. Coordination (March 26, 2009), http://www.phe.gov/Preparedness/planning/abc/Documents/ABC.pdf.

General's Office, serve a similar purpose at the local level.[21] These registration systems collect licensure and other information about volunteer health professionals – including mental healthcare providers – which is used to assist in their deployment during emergencies.

Supply needs are met through resources such as the Strategic National Stockpile ("SNS"). The Centers for Disease Control and Prevention maintains the SNS, which contains health care supplies that can be transported anywhere in the U.S. as needed during an emergency.[22] However, because the precise contents of the SNS are not publicly known, the extent to which it contains medicines or supplies (e.g., psychotropic or other drugs commonly used to treat mental conditions) that may assist during mental health emergency responses is not clear.

B. Emergency and Disaster Laws

Federal, state, and local laws authorize an array of powers during a declared emergency or disaster. Many federal emergency powers derive from the Robert T. Stafford Disaster Relief and Emergency Assistance Act ("Stafford Act") of 1988.[23] The Stafford Act empowers FEMA[24] to assist states and localities affected by an emergency once the President declares an "emergency" or "major disaster." This includes funding for the Crisis Counseling Assistance and Training Program ("CCATP"), which may offer mental health services such as diagnosis and counseling for up to nine months after an emergency. A related law, the National Emergencies Act, establishes procedures for Presidential declarations (and terminations) of national emergencies with similar authority to guide federal responses.[25]

Pursuant to the federal Public Health Services Act, DHHS' Secretary can also declare a separate "public health emergency."[26] Upon such declaration, DHHS can investigate the disease or event behind the emergency and supplement other federal, state, or local response activities, including, for example, deploying mental and behavioral healthcare providers across state

21. 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 (2008), http://www.medicalreservecorps.gov/File/ESAR_VHP/ESAR-VHPMRCIntegrationFactSheet.pdf.

22. Ctrs. for Disease Control & Prevention, Office of Public Health Preparedness & Response, Strategic National Stockpile: What it Means to You (Feb. 28, 2011), http://www.bt.cdc.gov/stockpile/#means.

23. Robert T. Stafford Disaster Relief and Emergency Assistance Act, Pub. L. No. 100-707 (1988).

24. U.S. Dep't of Homeland Sec., Fed. Emergency Mgmt. Agency, A Guide to the Disaster Declaration Process and Federal Disaster Assistance, http://www.fema.gov/pdf/rrr/dec_proc.pdf.

25. National Emergencies Act, 42 U.S.C. §§ 1601-1651 (2010).

26. Public Health Services Act, 42 U.S.C. § 247d(a)(1)-(2) (2010).

lines.

Many states feature their own emergency preparedness laws to allow the governor to declare a "disaster" or "emergency," thus activating the state's emergency powers.[27] Twenty-six states explicitly authorize the declaration of a "public health emergency," based in part on the Model State Emergency Health Powers Act ("MSEHPA"), developed in 2001 to establish the parameters for a state-level public health emergency.[28] MSEHPA provides model statutory language for emergency powers to procure supplies, deploy personnel, screen and test populations, and provide treatment, among other authorities. State provisions based on MSEHPA may allow governments to respond to the mental health impacts of emergencies through surveillance for health conditions (including mental health conditions) and deployment of mental healthcare providers. Some states, however, have incorporated provisions of MSEHPA in ways that only cover certain health care professionals to the exclusion of mental healthcare providers. Other laws, such as the Emergency Management Assistance Compact[29] and the Uniform Emergency Volunteer Health Practitioners Act,[30] facilitate licensure portability among healthcare professionals, allowing them to temporarily provide care and receive liability protections during declared emergencies. States and localities may also enact mutual aid agreements to allow for resource sharing. These agreements may function even if a state's emergency powers have not been activated.[31]

C. The Mental Health Preparedness Vacuum

To date, the emergency preparedness legal environment has been shaped and interpreted primarily to facilitate a rapid and effective response to physical injuries and disabilities that result from emergencies. Emergency powers at the federal and state levels ensure that personnel and supplies are available quickly to meet surge capacity for physical injuries. Federal programs like ABC address mental health impacts of emergencies, but do not offer a comprehensive legal approach to these pervasive, often long-lasting health concerns. At all levels of government, the legal environment

27. Hodge & Anderson, *supra* note 17, at 263–67.

28. The Model State Emergency Health Powers Act (Jan. 27, 2010), http://www.publichealthlaw.net/ModelLaws/MSEHPA.php.

29. Emergency Mgmt. Assistance Compact, What Is EMAC? (2011), http://www.emacweb.org/index.php?option=com_content&view=article&id=80&Itemid=26.

30. Nat'l Conference of Commissioners on Unif. State Laws, Uniform Emergency Volunteer Health Practitioners Act (2007), http://www.law.upenn.edu/bll/archives/ulc/uiehsa/2007act_final.htm.

31. Mid-American Alliance, Mission Statement (2011), http://www.unmc.edu/apps/midamerica/index.cfm?L1_ID=1&CONREF=1.

must be re-examined to determine how laws might be interpreted, amended, or created to guarantee that sufficient legal infrastructure exists to address the immediate and long-term mental health impacts of emergencies.

IV. A NEW LEGAL APPROACH TO MENTAL HEALTH EMERGENCIES

Filling the legal vacuum related to actual or perceived failures of emergency laws to support mental health impacts is essential. Arguably, this may be achieved by creating a distinct statutory or regulatory definition of "mental health emergency," sufficient to guide law- and policy-makers seeking its declaration to respond in earnest to recognized mental health needs. Creating another emergency classification may only add to an already complex array of emergency declarations at the federal and state levels that muddies response efforts.

Alternatively, we recommend a different approach, one that seeks to accentuate mental health responses under current emergency laws. By integrating mental and behavioral health priorities into existing emergency laws and policies, public and private sector actors can respond authoritatively to the physical *and* mental health impacts of any emergency event.[32]

A. Interpreting Existing Emergency Laws and Policies to Address Mental and Behavioral Health Priorities

Many existing federal and state "emergency," "disaster," or "public health emergency" laws do not explicitly prioritize mental and behavioral health issues.[33] Current laws can be interpreted more broadly to address these needs.[34] The Federal Emergency Management Agency ("FEMA"), for example, defines the term "disaster" in a way that acknowledges potential non-physical impacts on populations.[35] State public health emergency laws modeled after MSEHPA offer similar flexibility to authorize mental health responses. Section 104(m) of MSEHPA defines "public health emergency" as:

> . . . an occurrence or imminent threat of an illness or health condition

32. James G. Hodge, Jr. et al., *A Hidden Epidemic: Assessing the Legal Environment Underlying Mental and Behavioral Health Conditions in Emergencies*, 4 ST. LOUIS J. HEALTH L. & POL'Y 33 (2011).

33. *See* Nat'l Council on Disability, Saving Lives: Including People With Disabilities in Emergency Planning (Apr. 15, 2005), http://www.ncd.gov/publications/2005/04152005.

34. *See id.*

35. B. WAYNE BLANCHARD, GUIDE TO EMERGENCY MANAGEMENT AND RELATED TERMS, DEFINITIONS, CONCEPTS, ACRONYMS, ORGANIZATIONS, PROGRAMS, GUIDANCE, EXECUTIVE ORDERS & LEGISLATION 275-85 (Oct. 22, 2008), *available at* http://training.fema.gov/EMIWeb/edu/doc/terms%20and%20definitions/Terms%20and%20Definitions.pdf.

> that: (1) is believed to be caused by . . . bioterrorism; the appearance of a novel or previously controlled or eradicated infectious agent or biological toxin [*or other causes*]; . . . 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.[36]

Under this definition, an "illness" or "health condition" is not limited to physical injuries; mental health conditions may also be included. Further, the occurrence of an illness or health condition is not essential to declare a public health emergency. It is sufficient that their diagnoses may be "imminent," such as the predictable future onset of mental health conditions for persons directly impacted by natural disasters, epidemics, or other causes. Finally, mental health conditions across affected populations also may pose a "high probability" of a "large number of serious or long-term disabilities," particularly mental health disabilities, among the "affected population."[37]

The plain meaning of these terms of the model act, on which numerous state public health emergency laws are based, reveals the potential for declarations of public health emergency to be made even when the primary or sole "illness" or "health condition" underlying the declaration is of a mental or behavioral nature. As a result, states confronting long-term mental health impacts of emergency events, such as the 2010 Deepwater Horizon oil spill, which have few physical impacts, may still declare states of public health emergency to mobilize resources, personnel, and funds to address critical mental health needs.

B. Creating a New Standard Through Revised Statutory or Regulatory Language

Although the plain meaning of certain federal and state emergency laws allows governmental emergency declarations to include considerations of mental health, revised statutory or regulatory language may facilitate a truly comprehensive response to an emergency's mental and behavioral health impacts.

The Stafford Act already contains explicit provisions to address mental health impacts through authorization of the CCATP. While this program's mental health services may assist individuals experiencing mental health impacts from a particular emergency, they are terminated by law after nine months. States and localities, however, may need federal assistance to

36. The Model State Emergency Health Powers Act § 104(m) (Dec. 21, 2001), *available at* http://www.publichealthlaw.net/MSEHPA/MSEHPA.pdf.

37. *Id.*

address mental health impacts for much longer than nine months after an emergency occurs. Conditions like PTSD may take several months to emerge and many more months to treat. The federal government could address this by extending the short-term nature of the CCATP. It could also consider granting states or localities extensions, under the Stafford Act, for on-going crisis counseling services, particularly if mental health capacities continue to be overwhelmed and operating in excess of surge capacity.

Other types of emergency declarations, such as a federal declaration by the DHHS Secretary of a "public health emergency," should be modified to explicitly encompass mental health impacts. States adopting MSEHPA or similar laws could develop regulations on mental health surveillance or counseling requirements to clarify the government's ability to respond to a public health emergency's mental or behavioral health impacts. In a recent case in Los Angles, a federal district court admonished the county for failing to accommodate persons with disabilities as part of its emergency planning efforts.[38] Under the Americans with Disabilities Act, persons with disabilities may include those with mental or physical health impairments.[39]

C. Parameters of a "Mental Health Emergency" Standard

Devising legal routes to declaring and implementing an emergency based largely on community mental health impacts must be coupled with appropriate guidance. Unfettered declarations of emergency not only lose meaning societally, but may also be decried by civil libertarians and others for potential infringements of individual interests related to due process, privacy, or other concerns. To be sure, we are not proposing the use of emergency legal powers during a mental health crisis to accomplish unlawful, unethical ends. The overriding goal is to authorize precise uses of enhanced, emergency powers that facilitate emergency response efforts to improve mental health across populations without constraining individual freedoms or rights unnecessarily. To this end, specific clarification of the trigger, duration, services, and authorities of a "mental health emergency" is needed.

Emergency powers to respond to mental health impacts should be based on identifiable factors that "trigger" the emergency declaration. One potential benchmark is the ongoing failure of a mental healthcare system in any jurisdiction to adequately meet the population's treatment needs stemming from an underlying emergency event. In essence, where actual (or prospective) mental health patient surge exceeds the capacity of the jurisdiction (whether federal, state, or local) to meet demand, a state of

38. Communities Actively Living Independent and Free, et al. v. City of Los Angeles, et al., No. 09-0287 (C.D. Ca. 2011).

39. 42 U.S.C.A. § 12102(1) (2009).

emergency may be declared. Whether based on specific surveillance of mental health impacts or known, predictable outcomes from prior research, meeting patient surge capacity is a possible trigger, which sustains an emergency declaration.

The emergency declaration may extend as long as needed to ensure legal norms that support response efforts. While most emergency declarations extend no longer than sixty to ninety days (subject to re-declaration), the duration of a mental health emergency should not be governed by a concrete number of days, months, or even years. Rather, it should depend on whether patient surge capacity is being adequately met. Accomplishing this objective justifies termination of the declaration so long as it is based on the best available evidence that mental health treatment needs can be met routinely.

Guidance on which services should be funded, available, or amplified in a mental health emergency is also key. Because a mental health emergency will likely continue far beyond a natural disaster or other emergency event, mental health screening, counseling services, and enhanced access to trained psychologists and psychiatrists must be extended. In addition, adequate insurance or entitlement coverage for prescription drugs must be assured (for those who may lack coverage for mental health treatments despite forthcoming mental health parity provisions of the Affordable Care Act).[40]

Legal authorities in support of mental health response efforts may vary according to each jurisdiction and population needs, but may include: (1) active surveillance efforts to gauge the prevalence of mental health conditions among populations; (2) ongoing liability protections for mental health counselors, clinics, and others treating patients under a crisis standard of care; (3) greater access to public sector resources to fund or reimburse providers for their response efforts; (4) continued licensure reciprocity of trained mental health workers across affected jurisdictions; and (5) additional real-time training opportunities for volunteers and employees attempting to screen, diagnose, and treat impacted individuals.

V. CONCLUSION

Additional steps, whether through interpretation or revision of existing legal language can address gaps in legal preparedness in support of responses to alleviate mental and behavioral health effects during and after emergencies. Within reasonable parameters to guide emergency legal responses, the mental health impacts of major emergencies can be addressed over time without the need for a new classification of emergency.

40. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1302(b) (2010) (to be codified 42 U.S.C. § 18022).

The goal is to improve mental health legal preparedness and response efforts so affected individuals are identified through screening, receive psychological consultation and essential medications, and enjoy an amelioration of their short- and long-term mental health conditions.