Legal Strategies for Promoting Mental Health and Wellbeing in the COVID-19 Pandemic

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SUMMARY. While mental health is often viewed as a matter of individual treatment of mental illness, mental health and well-being may be promoted throughout the population, including through law and policy. The inadequacy of our mental health care system, including limited public and private insurance coverage and provider shortages, has been apparent during the response to COVID-19, though expanded access to tele-mental health has closed the gap somewhat. Inability to meet basic needs contributes to stress, anxiety, and depression, so COVID-19 response measures to ensure access to employment or unemployment benefits, housing, food, childcare, and the like are critical to community mental health. Interventions aimed at mental health, such as Psychological First Aid, the Crisis Counseling Program, suicide prevention, and violence prevention programs can promote feelings of calm and safety, while supporting collaboration, nurturing problem-solving skills, and increasing hope. Long-standing inequities have contributed to higher infection and mortality rates, especially among African-Americans, Latinos, and Native Americans, while Asian-Americans have been targeted with harassment and discrimination, making legal action to support mental health in communities of color essential. With schools abruptly shifting to remote learning in spring, school-based mental health services and opportunities for social emotional learning were disrupted. Intentional support for the mental health and wellbeing of students, teachers, school employees, and parents is needed this fall, regardless of educational setting. If the COVID-19 pandemic is viewed as a mass trauma, strategies to support posttraumatic growth ought to be at the forefront of pandemic response, recovery, and restructuring.

Introduction

Mental health has not been a major focus of emergency preparedness, despite the fact that mental health harms are frequently among the most severe and long-lasting harms caused by natural disasters and disease outbreaks. The COVID-19 pandemic may be viewed as a mass trauma experienced throughout the world, including throughout the United States. Uncertainty, loss of life, severe illness, lack of personal protective equipment, economic upheaval, structural racism, limitations on daily activities, and isolation have taken a substantial toll. By July, over 50% of respondents to a Kaiser Family Foundation Health Tracking Poll indicated that worry or stress about the new coronavirus had negatively affected their mental health (Hamel et al., 2020). While mental health is often seen through a lens of individual treatment of mental illness, mental health may also be promoted throughout the population, including through law and policy.

The COVID-19 pandemic and ensuing public health measures intended to prevent the spread of the new coronavirus have introduced disruption on a greater scale than many people have seen in their lifetimes. The field of positive psychology posits a "dual continuum" model, in which mental illness may be shown on the x-axis (one either is or is not mentally ill), and mental health may be shown on the y-axis (one is either flourishing or languishing). According to the research, people who describe themselves as flourishing typically engage in six core activities nearly every day: interacting, helping others, playing, moving (physical activity), spiritual activity, and learning something new (Catalino & Fredrickson, 2011). It is jarring to review this list in the context of the closure of most workplaces, schools, faith communities, gyms, restaurants, etc., and realize how precisely COVID-19, physical distancing, and community mitigation combine to threaten the core pillars of wellbeing. Of course, many individuals and communities found ways to interact and continue to learn new things online.

Where concern about COVID-19 was initially described as a fear of infection and a rise in anxiety in response to uncertainty about the disease itself, a more nuanced portrait has emerged. A team of researchers coined the term COVID Stress Syndrome, which includes fear of COVID-19, socioeconomic concerns, traumatic stress symptoms, xenophobia, and compulsive checking and reassurance seeking (Taylor et al., 2020). As Taylor et al. observed: "Our findings suggest that the psychological footprint of COVID–19 is likely to be more substantial than the medical footprint. That is, at the time of conducting this study the number of people emotionally affected by COVID–19 far exceeded the number of people who had been infected." Some of those affected were severely affected, while many were able to employ coping mechanisms, whether adaptive or maladaptive to help them get through the period of self-isolation. The researchers noted that few people in their study reported seeking medical or mental health treatment to support their coping.

The Law of Mental Health and Wellbeing During the COVID-19 Pandemic

In general, emergency preparedness laws are nearly silent with respect to mental health treatment and promotion. For example, the Pandemic and All Hazards Preparedness and Advancing Innovation Act of 2019 only touches on mental health in a few provisions related to the role of the assistant secretary for mental health and substance abuse, consultation with mental health facilities during emergency preparedness planning, and inclusion of an expert in pediatric mental health in the membership of a national advisory committee on children and disaster. Notably, the Act authorizes the hospital preparedness program, which provides funds and technical assistance for healthcare coalitions, whose efforts to encourage a resilient healthcare workforce may include training in psychological first aid. Additional funding for hospital preparedness was provided in the Coronavirus Aid, Relief, and Economic Security (CARES) Act. Its predecessor, the Pandemic and All Hazards Preparedness Act of 2006, provided funding for Preparedness and Emergency Response Learning Centers, university-based centers that developed and disseminated trainings on psychological first aid, but this funding was not continued.

Substantial federal authority was invoked when the president declared a nationwide emergency under the Stafford Act on March 13, and when he approved major disaster declarations for all 50 states, the District of Columbia, and four territories. Numerous Tribes are collaborating with the federal government under the emergency declaration. The Crisis Counseling Program is authorized under a major disaster declaration, but not an emergency declaration, including a public health emergency declaration. The Crisis Counseling Program provides federal funding and technical assistance to states, so that they may provide crisis counseling.

The Mental Health Parity and Addiction Equity Act of 2008 and the Affordable Care Act provide that to the extent private health insurers provide insurance coverage for physical health concerns, their coverage for mental health concerns must be comparable. However, these laws have not yet resulted in parity in coverage for mental health treatment.

A number of laws address mental health promotion among children and adolescents. The maternal, infant, and early childhood home visiting programs support education and coaching in parenting skills among new parents, promoting greater connection with their very young children, reducing stress, and preventing adverse childhood experiences. The federal Every Student Succeeds Act provides authority for grants to state and local education agencies to create the conditions for student learning and improve the school climate. State laws and benchmarks may advance social and emotional learning. These educational approaches can be implemented online, too (CASEL, 2020). Other state laws may promote school mental health in the context of the COVID-19 pandemic—these laws include a law requiring instruction in mental health first aid for teachers in Florida; a law requiring that mental health be addressed in health education courses, in New York and Virginia; and an Oregon law recognizing student absences from school in order to protect and care for their mental health, just as they may have absences in order to care for their physical health.

Finally, most people will navigate the pandemic, but some will not. Suicide rates, which were at historic highs prior to the COVID-19 pandemic, may increase substantially, particularly if unemployment benefits and eviction moratoria are permitted to lapse (Petterson et al., 2020). Evidence-based laws that decrease the risk of suicide include the Garrett Lee Smith Act, which provides for grants from the federal government to state and Tribal governments. In addition, red flag laws that limit the access to guns of people found to be a danger to themselves or others have been effective in preventing deaths by suicide in states as politically and culturally diverse as Indiana and Connecticut.

Assessment

The literature and scientific opinion have coalesced around five key principles in response to mass trauma:

- Promote Sense of Safety
- Promote Calming
- Promote Sense of Self- and Collective Efficacy
- Promote Connectedness
- Promote Hope

(Hobfoll et al., 2007). These principles provide valuable guidance for assessing and strengthening the legal response to the COVID-19 pandemic.

Federal legislation enacted in response to the COVID-19 pandemic sought to address many of the practical conditions that might otherwise have contributed to even poorer mental health (Purtle et al., 2020). This assistance is discussed in other chapters of this Report and includes unemployment benefits; moratoria on evictions; SNAP and a modified National School Lunch Program; sick leave for those remaining at home while ill with the new

coronavirus; and paid family leave for those caring for those ill with the new coronavirus or home from school. Because many of these legal interventions are time-limited, however, recipients may experience anxiety and uncertainty about when and whether these social supports may disappear. Congress should promptly act to extend these vital interventions in order to maintain a sense of safety; a lapse in these supports will make it more difficult to restore a sense of safety.

The lack of enforcement of mental health parity laws, and the lack of focus on mental health in emergency preparedness laws, made the response less effective. For those seeking individual mental health treatment, however, administrative changes by the Centers for Medicare and Medicaid Services and the Office of Civil Rights within the Department of Health and Human Services expanded access to telehealth, including tele-mental health, by adjusting eligibility for reimbursement for telehealth and by suspending requirements related to privacy and security of platforms for telehealth. The rapid steps taken to expand access to telehealth appear to have been largely successful, though the extent to which people are taking advantage of these services for mental health care is unclear. Joining the Psychology Interjurisdictional Compact may be one means for states to support expanded access to tele-mental health following the pandemic.

The unprecedented issuance of a major disaster declaration for a public health emergency, and subsequent availability of the Crisis Counseling Program, was a bold step and commensurate with the scope and nature of the need. However, crisis counseling services have not been funded at adequate levels or promoted and advertised consistently in the states, and an April 28 presidential memo approving the Crisis Counseling Program ordered funds to be allocated in unnecessarily complex ways. Moreover, the Crisis Counseling Program is limited to a period of nine months following a disaster, which presupposes a single, finite disaster event, not an ongoing pandemic. Crisis counseling is often explicitly focused on enhancing self-efficacy through providing support with problem-solving and coping skills. In order to be better prepared for a future pandemic, Congress should amend the Stafford Act to authorize the Crisis Counseling Assistance and Training Program under public health emergencies when appropriate, and remove the limitation of assistance to nine months following the disaster.

Prior investments in emergency preparedness research had resulted in online curriculum and trainings in Psychological First Aid, and even policy adoption (Birkhead & Vermeulen, 2018). Renewed investment in research and training is needed, including investment in culturally competent approaches and trainers. Healthcare preparedness coalitions should be invited to provide feedback on whether psychological first aid training strengthened their emergency preparedness and response, and how these efforts could be improved (Birkhead & Vermeulen, 2018).

Though the CARES Act authorized an additional $50 million for suicide prevention, the legislation enacted to date has not centered mental health as a priority. Future legislation should prioritize mental health promotion, commensurate with the detrimental impact of COVID-19 on mental health. The legislation should address mental health literacy and stigma reduction; structural racism and the social determinants of health; public safety, including suicide and injury prevention; and access to care and treatment. In order to inspire hope, as it begins to focus on a longer-term vision for recovery, Congress should search for models that support posttraumatic growth among populations, such as interventions with veterans. As the experience of elderly residents of nursing homes demonstrates, promoting social connections to combat loneliness should be as much a priority as infectious disease control measures.

State and local governments provided messaging and enforcement regarding discrimination against Asian-Americans, and other individuals based upon race, ethnicity, and national origin, with some local governments such as New York City establishing task forces to address discrimination and COVID-19. These efforts must continue and expand. Left unchecked, racial discrimination, harassment, and bullying have a corrosive effect on mental health.

Limited data collection by race and ethnicity in most jurisdictions in the early stages of the pandemic impeded a proactive response to racial disparities. Milwaukee was one of the first jurisdictions to adopt a statement naming racism as a public health crisis in 2019, and it is no coincidence that it was one of the first cities to note racial disparities in infection and mortality rates. Higher infection and mortality rates reflect disproportionate representation in low-wage jobs at high risk for COVID-19, as well as higher rates of chronic disease such as diabetes, asthma, and cardiovascular disease. They have resulted in a greater weight of grief for many people of color who have lost multiple loved ones, and increased anxiety for those worried about the high levels of risk to themselves and their communities. These effects were compounded by highly publicized police killings of Black Americans, including George Floyd and Breonna Taylor. Repeated exposure to police violence directed toward Black people on social media have harmful mental health impacts upon Black people. Black Americans may possess unique protective factors, including social support and culturally specific coping skills (Novacek, 2020). Evidence-based legal strategies to address structural racism and strengthen protective factors are needed to increase health equity.

Schools scrambled to transition to remote learning and most were not focused upon mental health in the early months of the pandemic. Whether or not students return to in-person school in the fall, the mental health of all persons within school, university, and community college systems—from teachers and school employees, to students, to parents – warrants sustained legal and policy attention. Investments in home visiting programs, parenting skills programs, and universal pre-kindergarten are all strategies that can reduce adverse childhood experiences, nurture coping skills, and promote emotional wellbeing. A growing body of evidence supports the importance of access to nature for mental health, such that outdoor learning initiatives may support physical distancing, reduce stress, and increase equity. Implementing continuing education requirements regarding mental health and suicide prevention for health care providers may provide an early warning system for individuals and the population as a whole. Health departments may wish to become trauma informed systems in order to more effectively respond to the mental health impacts of COVID-19.

Recommendations for Action

Federal government:

- Extend investment in measures to address the economic disruptions associated with COVID-19 and the public health response, including employment (Paycheck Protection Program) and unemployment benefits, SNAP and modified National School Lunch Program, eviction moratoria, and paid sick leave and family medical leave for those ill with COVID and those caring for those ill with COVID-19.
- Amend the Stafford Act to authorize the Crisis Counseling Assistance and Training Program under public health emergencies when appropriate, and remove the limitation of assistance to nine months following the disaster.
- Provide greatly increased financial support, technical assistance, and marketing for the Crisis Counseling Program in every state.
- Renew and increase investment in research and culturally competent training in Psychological First Aid.
- Require regular training in Psychological First Aid as a condition of receipt of emergency preparedness funds, such as Healthcare Preparedness Coalitions.
- Increase investment in maternal, infant, and early childhood home visiting programs, and provide technical assistance and guidance to prevent the spread of COVID-19.
- Increase investment in suicide prevention programs funded through the Garrett Lee Smith Act.
- Extend regulatory flexibility related to reimbursement, privacy and security, and licensure portability for tele-mental health beyond the response to this pandemic.

State governments:

- Adopt and enforce mental health parity requirements that are at least as strong as federal requirements.
- Extend regulatory flexibility related to reimbursement, privacy and security, and licensure portability for tele-mental health.
- Consider joining the Psychology Interjurisdictional Compact.
- Increase investment in maternal infant and early childhood home visiting programs, and provide technical assistance and guidance to support physical distancing and other measures to prevent the spread of COVID-19.
- Make free, public pre-kindergarten available to all children in the state, and establish guidelines regarding social and emotional learning.
- Support education about mental health in K-12 schools, including providing Mental Health First Aid training for teachers and addressing mental health as an aspect of health in K-12 health education courses. Adapt requirements for remote learning environments.
- Provide education and practice in social and emotional learning skills for all adults involved in school settings, including online learning, and integrate social and emotional learning and skills practice in preschool-12 instruction.
- Fund mental health education and services in public universities and community colleges.
- Incorporate information and skills related to mental health assessment and suicide prevention in continuing education requirements for health care providers.
- Expand funding and efforts toward trauma informed care and suicide prevention, including targeted efforts to support African American, Native American, and LGBTQ youth, and other groups at heightened risk
- Enact and implement laws to limit access to guns among those who are shown to pose a danger to themselves or others (extreme risk protection orders or red flag laws).
- Actively enforce anti-discrimination laws and provide proactive education regarding their requirements.
- Increase the minimum wage.
- Identify and fund gaps in practical assistance at the federal level, such as diaper need, which may be addressed through grants and assistance to diaper banks, assistance to families receiving work support, and exemptions from state sales tax.

Local governments:

- Health departments should consider integrating trauma-informed approaches in all of their work and programming and becoming trauma informed systems (San Francisco Department of Public Health).
- Provide periodic training in psychological first aid, as well as evidence-based stress management and mindfulness training, to all employees. Adapt training to online modalities.
- Review Employee Assistance Programs for adequacy to meet increased need among government employees, including first responders, as a result of COVID-19.
- Increase capacity of teachers and first responders to identify and refer persons experiencing mental health challenges through mental health first aid and crisis intervention training.
- Provide education and practice in social and emotional learning skills for all adults involved in school settings, including remote learning, and integrate social and emotional learning and skills practice in preschool-12 instruction.
- Actively enforce anti-discrimination laws and provide proactive education regarding its requirements.
- Consider whether declaring racism to be a public health crisis in the jurisdiction could focus efforts to address racial disparities and increase health equity.

Local government recommendations, continued:

- Implement measures to ensure equitable access to nature and green space, including through temporary road closures, use of public golf courses, and outdoor learning initiatives.
- Consider initiatives to increase social connection and reduce loneliness, including among senior citizens.

About the Author

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References

Birkhead, G. S., & Vermeulen, K. (2018). Sustainability of Psychological First Aid Training for the Disaster Response Workforce. *American Journal of Public Health,* 108(S5), S381-S382.

Brooks, S. K., Webster, R. K., Smith, L. E., Woodland, L., Wessely, S., Greenberg, N., & Rubin, G. J. (2020). The Psychological Impact of Quarantine and How To Reduce It: Rapid Review of the Evidence. *The Lancet*, 395, 912-920.

Catalino, L. I., & Fredrickson, B. L. (2011). A Tuesday in the Life of a Flourisher: The Role of Positive Emotional Reactivity in Optimal Mental Health. *Emotion*, 11(4), 938-950.

Collaborative for Academic, Social and Emotional Learning (CASEL) (2020). *An Initial Guide to Leveraging the Power of Social and Emotional Learning: As You Prepare to Reopen and Renew Your School Community*. Retrieved July 20, 2020, from https://casel.org/wp-content/uploads/2020/05/CASEL_Leveraging-SEL-as-You-Prepare-to-Reopen-and-Renew.pdf

Hamel, L., Kearney, A., Kirzinger, A., Lopes, L., Munana, C., & Brodie, M. (2020). Coronavirus: Schools, Reopening, and the Government Response. Retrieved July 29, 2020 from Kaiser Family Foundation, https://www.kff.org/coronavirus-covid-19/report/kff-health-tracking-poll-july-2020/

Hobfoll, S. E., Watson, P., Bell, C. C., Byrant, R. A., Brymer, M. J., Friedman, M. J., Friedman, M., Gersons, B. P. R., de Jong, J. T. V. M., Layne, C. M., Maguen, S., Neria, Y, Norwood, A. E., Pynoos, R. S., Reissman, D., Ruzek, J. I., Shalev, A. Y., Solomon, Z., Steinberg, A. M., & Ursano, R. J. (2007). Five Essential Elements of Immediate and Mid-Term Mass Trauma Intervention: Empirical Evidence. *Psychiatry: Interpersonal and Biological Processes*, 70(4), 283-315.

Novacek, D. M., Hampton-Anderson, J. N., Ebor, M. T., Loeb, T. B., & Wyatt, G. (2020). Mental Health Ramifications of the COVID-19 Pandemic for Black Americans: Clinical and Research Recommendations. *Psychological Trauma: Theory, Research, Practice, and Policy* (forthcoming).

Petterson, S., Westfall, J. M., & Miller, B. F. (2020). Projected Deaths of Despair from COVID-19. Retrieved July 20, 2020 from Well Being Trust, https://wellbeingtrust.org/wp-content/uploads/2020/05/WBT_Deaths-of-Despair_COVID-19-FINAL-FINAL.pdf

Purtle, J., Nelson, K. L., Counts, N. Z., & Yudell, M. (2020). Population-Based Approaches to Mental Health: History, Strategies, and Evidence. *Annual Review of Public Health*, 41, 201-221.

Schechter, A., Diaz, F., Moise, N., Anstey, D. E., Ye, S., Agarwal, S., Birk, J. L., Brodie, D., Cannone, D. E., Chang, B., Claassen, J., Cornelius, T., Derby, L., Dong, M., Givens, R. C., Hochman, B., Homma, S., Kronish, I. M., Lee, S. A. J., Manzano, W., Mayer, L. E. S., McMurry, C. L., Moitra, V., Pham, P., Rabbani, L., Rivera, R. R., Schwartz, A., Schwartz, J. E., Shapiro, P. A., Shaw, K., Sullivan, A. M., Vose, C., Wasson, L., Edmondson, D., & Abdalla, M. (2020). Psychological Distress, Coping Behaviors, and Preferences for Support Among New York Healthcare Workers During the COVID-19 Pandemic. *General Hospital Psychiatry,* 66, 1-8.

Taylor, S., Landry, C. A., Paluszek, M. M., Fergus, T. A., McKay, D., & Asmundson, G. J. G. (2020). COVID Stress Syndrome: Concept, Structure, and Correlates. *Depression and Anxiety* (forthcoming).