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## Liability of Professional and Volunteer Mental Health Practitioners in the Wake of Disasters: A Framework for Further Considerations<sup>†</sup>

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**Qualified immunity from civil liability exists for acts of disaster mental health (DMH) practitioners responding to disasters or acts of terrorism. This article reviews current legal regimens dictating civil liability for potentially wrongful acts of DMH professionals and volunteers responding to disasters. Criteria are proposed to inform determinations of civil liability for DMH workers in disaster response, given current legal parameters and established tort law in relevant areas. Specific considerations are examined that potentially implicate direct liability of DMH professionals and volunteers, and vicarious liability of DMH supervisors for actions of volunteer subordinates. The relevance of pre-event DMH planning and operationalization of the plan post-event is linked to considerations of liability. This article concludes with recommendations to minimize liability exposure for DMH workers in response efforts. Copyright © 2005 John Wiley & Sons, Ltd.**

Despite the continuing occurrence of natural disasters and the increased possibility of wide-scale terrorist attacks, there is an absence of a comprehensive framework for analyzing potential liability of mental health practitioners responding to disasters. This absence is significant considering the proliferation of federal, state, and local disaster response planning initiatives following the events of 9/11. Wide-scale terrorist attacks clearly result in physical, environmental, and economic consequences. Yet, the politically motivated objective of terrorist activities is to cause widespread psychological harm, traumatizing entire communities. Survivors of terrorist attacks and natural disasters exhibit a wide range of psychological sequelae that can manifest either immediately or with delayed onset. Disaster response

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planning has thus incorporated contingencies for disaster mental health deployment, including the use of natural helpers as mental health volunteers when an adequate number of licensed professionals may be lacking. Such circumstances are particularly likely to occur in rural areas or other mental health shortage areas characterized by an absence of licensed mental health practitioners. In such communities, both professionals and natural helpers bear significant responsibilities in the mental health response. Determining liability of these disaster mental responders has thus become a critical policy issue.

This article begins with a review of the current state of best practice proposals in the field of disaster mental health. Then, an examination of current liability shields that provide immunity for the actions of disaster mental health workers is outlined, including state emergency management statutes—the principal expression of legislative public policy regarding liability for disaster responders. Finally, a framework is proposed for considering a determination of liability for both formally trained, licensed professionals and trained, non-licensed or untrained disaster mental health workers and their professional supervisors in disaster response. The article concludes with suggested recommendations for effective deployment of disaster mental health resources that minimize liability exposure.

## THE DISASTER MENTAL HEALTH RESPONSE

Survivors of a disaster can be overcome with emotion after witnessing or experiencing environmental destruction, physical injuries or deaths of peers, and loss of property and possibly of livelihoods. Immediate reactions differ from those that are longer-term. Shock and anxiety may initially overwhelm an individual. Symptoms of chronic anxiety may materialize months later (Figley, 1985; Sprang, 2003). Both individual and circumstantial characteristics influence how people respond to disaster events, including variations in personality structure, demographic characteristics, degree of exposure to the experience, personal loss suffered, pre-morbid conditions, and existing mental illness as well as the overall extent of the catastrophe (Cohen, 1990; Cohen & Ahearn, 1980; Green, 1996; Ursano, Fullerton, & Norwood, 2003). Literature has specifically found a prevalence of post-traumatic stress disorder (PTSD) among disaster survivors, and correlations between severity of PTSD and degree of exposure to the disaster (Foy, Sippelle, Rueger, & Carroll, 1984; Galea et al., 2002; Green, 1991; Green, Grace, Lindy, Titchner, & Lindy, 1983; Halligan & Yehuda, 2000; Shore, Tatum, & Vollmer, 1986; Smith, North, McCool, & Shea, 1990).

Disaster mental health (DMH) work includes elements of prevention, crisis intervention, screening, and treatment of trauma. DMH is integrated in all phases of disaster response and recovery for individuals and communities. The type and timing of the intervention, and the appropriate level of training for the DMH responders involved in intervention, depends upon the characteristics of the disaster event and the number and characteristics of survivors affected. Examples of common individual and group DMH interventions include consulting with officials to insure that public communication of risk engenders calm rather than panic; screening adults and children for symptoms of distress; monitoring stress levels of disaster workers in the field; and going door to door in an affected community to

provide information on disaster stress (California Governor's Office of Emergency Services, 2001; Cohen, 1990; Cohen & Ahearn, 1980; DeWolfe & Nordboe, 2000).

Given the circumstances in which disaster response occurs, there is an absence of controlled research studies focusing on the efficacy of disaster response practices. DMH interventions are thus considered to be less evidence based and more commonly viewed as expert or evidence informed. It has been recommended that a national set of principles and best practices in DMH be developed (American Psychological Association Task Force on the Mental Health Response to the Oklahoma City Bombing, 1997; National Advisory Committee on Children and Terrorism, 2003; National Institute of Mental Health, 2002). To date there is no single definitive guide of proven best practices for clinicians and DMH workers to follow. The most widely accepted set of interventions and training for disaster is the American Red Cross Disaster Mental Health Course (1995). The American Psychological Association and National Association of Social Workers have endorsed the American Red Cross model (American Psychological Association, 2004; Webb, 2000). These organizations encourage members involved in DMH to complete the Red Cross training and work within its structure following a disaster.

The Red Cross staffs the mental health function of disaster response with licensed mental health professionals only and has a flattened clinical hierarchy. There is no differentiation between licensures among personnel, and the level of intervention is no higher than that which the lowest licensed staff member can perform. Clinical interventions commonly used in crisis situations or in treatment of acute stress are not taught in the Red Cross course. Instead, a framework for viewing and communicating the normal reactions to phases of disaster is emphasized. Debriefing and defusing techniques are discussed in the course, but a strict format for delivering the interventions is not demanded in practice. The course is taught in two days and relies on the ability of mental health professionals to adapt their existing skill set to meet the needs of people affected by disaster. The course is not meant to provide crisis intervention skills or specific skill sets to practitioners (American Red Cross, 1995).

In the wake of 9/11, experts in disaster mental health intervention convened on October 30–November 1, 2001, to examine research and make recommendations regarding the use of early psychological interventions in the first four weeks following incidents of mass violence (National Institute of Mental Health, 2002). The report generated from this conference acknowledged the lack of randomized controlled studies that definitively point towards best practices in DMH response. Instead, available research was reviewed and expert consensus reached on several principles related to early intervention, timing, delivery, and expertise required by those delivering it. Another recent example of expert or evidence informed recommendations that guide the field of DMH with principles for practice is the pre-publication version of the World Health Organization guidelines for mental health and social interventions following population exposure to biological or chemical weapons (van Ommeren & Saxena, 2004). These guidelines recommend the application of a public health model to mental health response in the event of disaster. Early interventions in instances of biological or chemical exposure involve significant medical and psychiatric triage in addition to normalization of stress reactions and the provision of non-intrusive "psychological first aid." Though the document is specific to biological or chemical events, the principles of social and

mental health intervention are very similar to those of the expert informed practice recommendations following mass violence.

Both the NIMH and WHO recommendations move practitioners and agencies toward planned use of non-licensed personnel to augment the mental health response. They also recognize the need for selective application of clinical interventions as survivors progress through a normal response course following the event. This is a departure from traditional mental health practice that focuses on identification and treatment of pathology. The recommendations suggest an approach that recognizes that the vast majority of people affected by a disaster will recover with assistance only from normal social networks and connections. According to the NIMH and WHO frameworks, applied clinical interventions in disaster should blend traditional practice with education and symptom normalization in recognition that most survivors will respond in this manner. DMH clinicians should focus on facilitating this normalization process while identifying the minority of individuals at risk for developing maladaptive or longer term pathological response sets and intervene with appropriate treatment at an early stage. Thus, the disaster mental health clinician or volunteer must also have adequate knowledge of clinical indicators that fall outside normal reactions to disaster so they can adequately screen and intervene with those at risk for developing longer term problems such as post-traumatic stress disorder.

## **CURRENT LIABILITY SHIELDS FOR CRISIS RESPONDERS**

Although a detailed review of immunity regimens for crisis response is not warranted, a brief outline of the most oft-cited immunity sources provides a needed background prior to discussion of liability for disaster mental health workers. The principal liability shields include the doctrine of sovereign immunity, state “Good Samaritan” statutes, and state disaster emergency response statutes.

### **Sovereign Immunity**

The English doctrine of sovereign immunity was well entrenched in American law and finally codified in 1946 (Federal Tort Claims Act of 1946; Huffman, 1986). Following the cases of *Dalehite v. United States* (1953) and *Berkovitz v. United States* (1988), application of the largest liability shield for the government—the discretionary function exemption—turned on whether or not the government entity’s act or omission was based on considerations of public policy. A finding that the government discretionary action at issue is based on public policy immunizes the government from tort suits in order to prevent excessive judicial review of executive or legislative action. Subsequent cases, such as *In re Ohio River Disaster Litigation* (1988), *Kennewick Irrigation District v. United States* (1989), *Flynn v. United States* (1990), *Lockett v. United States* (1990), and *Myers v. United States* (1994)—all involving accidents or environmental disasters—further developed the discretionary function exemption by focusing on factual circumstances related to the government entities’ activities preceding or in response to hazardous events. Notably, *In re Ohio*

*River Disaster Litigation* accorded the government with a wide breadth of immunity from liability, if the government acted with policy discretion, even if its activities could be deemed negligent. Other decisions, such as that in *Myers* and *Kennewick*, have recognized a distinction in government activity, in which consequences of decisions based on public policy would be shielded from liability, but responsibility for the consequences of decisions based on the lack of appropriate professional and technological judgment would not.

Distinguishing between soundness in discretionary actions based on public policy versus technical or professional conduct is a complex factual question for courts, particularly when it focuses on emergency response. Lerner's review of cases involving alleged negligence by firefighters demonstrates the varied approaches state courts have adopted (1991). In suits for alleged negligent firefighting resulting in unnecessary property loss, some courts have abandoned the distinction and immunized fire departments from liability by recognizing technical judgment as an exercise of discretion essential to the function of fighting fires. Both *City of Daytona Beach v. Palmer* (1985) and *Ayres v. Indian Heights Volunteer Fire Department* (1986) demonstrate state courts' deference to the professional and technical judgment of firefighters in combating fires—immunizing them from resulting property loss occurring after plans went awry. In contrast, other courts have distinguished between the technical judgments made by fire fighters—shielded from liability—and clearly negligent behavior involving intoxicated fire fighters or an inadequate firefighting response due to missing personnel—behavior which was not immunized from liability because it did not involve the exercise of professional discretion (*Gordon v. City of Henderson*, 1989; Lerner, 1991). Similar considerations exist in emergency law enforcement response. In the case of a plane hijacking, for example, the Sixth Circuit found that the actions of a Federal Bureau of Intelligence were not covered by the discretionary function immunity when they resulted in the deaths of hijacked passengers (*Downs v. United States*, 1975). The FBI officer had failed to comply with standard bureau procedures regarding hostage safety, and therefore his actions did not further official policy (Keeton, Dobbs, Keeton, & Owen, 1984; Kellmann, 2002).

### Good Samaritan Laws

The difficulty facing courts in reviewing factual and technical circumstances of emergency response has been addressed at the statutory level by the passage of "Good Samaritan" laws that bypass tort litigation relating to negligent emergency medical response. This development recognizes that courts are not adequately suited to review such highly technical scenarios and acknowledges a public policy preference to encourage private individuals to provide emergency medical care in good faith without fear of tort law suits. These statutes typically provide immunity for treatment in which (A) care is rendered gratuitously; (B) care is rendered in good faith; (C) care is rendered in direct response to emergency medical conditions; and (D) the acts or omissions of the care giver do not amount to gross negligence or further culpability (Reuter, 1999; see, e.g., Ark. Code Ann. § 17-95-101, WESTLAW through 2003 Second Extraordinary Sess.; Mass. Gen. Laws Ann. ch. 112, § 12B, 2003; Mich. Comp. Laws Ann. § 691.1501 sec.1(1), WESTLAW through

2004; Mo. Rev. Stat. § 537.037(1)-(2), WESTLAW through 2004 Second Reg. Sess.; Wash. Rev. Code Ann. § 4.24.300, WESTLAW through 2004).

### **State Emergency Management Statutes**

Recognizing that the occurrence of disasters may result in wide-scale disorder and difficulties in immediate response, states have passed emergency management statutes that provide wide berths of immunity for state actors and their agents or political subdivisions. State actors have a wide degree of discretion to exercise police powers that typically include suspending state regulations, commandeering private property, directing evacuations, and prohibiting private commerce (Swanson, 2000). Immunity typically extends to both state agents and volunteer responders working within the scope of their duties and in furtherance of disaster response for actions resulting in property damage or personal injury including death, with the exception of acts or omissions that constitute gross negligence or willful misconduct (see, e.g., Ala. Code § 31-9-16, 2003; Neb. Rev. Stat. § 81-829.55, 2003; Okla. Stat. tit. 63, § 683.14, 2003). Some statutes provide further immunity by allowing liability exposure only for acts constituting willful misconduct committed by particular classes (see, e.g., Cal. Gov't. Code §§ 8655-8660, 2003; Mich. Comp. Laws § 30.411, 2003). Cases have been litigated involving state emergency management statutes over immunity and establishment of duties to plaintiffs (*Lawry v. County of Sarpy*, 1998; *Sharp v. Town of Highland*, 1996). In the case of *Stinson v. City of Lincoln* (2000), the Nebraska Court of Appeals addressed injuries caused by a city snow plow during a blizzard. The city sought the protection of Nebraska's emergency management act immunity provision, but because the mayor had improperly filed a declaration of emergency the statute was inapplicable. *Stinson* reflects the importance of government entities adhering to emergency management act procedures for them to apply.

### **PROPOSING CRITERIA FOR DETERMINING LIABILITY FOR PROFESSIONAL AND VOLUNTEER DISASTER MENTAL HEALTH PRACTITIONERS**

The framework for determining professional negligence is well established in American tort law. The essential elements include (A) creation of a duty of care; (B) breach of that duty through a professional's act or omission; (C) injury sustained to the victim; and (D) cause of the injury due to the professional's act or omission. Plaintiffs in professional negligence cases must establish the applicable standard of care and prove that the defendant's act or omission fell short of this standard and caused the alleged injury (*Lama v. Borrás*, 1994). Justice Cardozo's majority opinion in *Palsgraf v. Long Island* (1928) grounded negligence in the reasonable person's ability to foresee that her act or omission could injure a plaintiff. Justice Andrews' dissenting opinion, however, shifted the focus from the negligent actor to the negligent act and its public policy considerations.

This dichotomy continues to permeate legal analysis of alleged negligence, as courts have included public policy concerns in negligence actions (Keeton et al.,

1984). For example, in *Lester v. Hall* (1998), the New Mexico Supreme Court found that a psychiatrist owed no duty to a third party injured by his patient after increasing a prescribed dosage of lithium. Imposing such a duty implicated policy concerns affecting a physician's willingness to prescribe medication to patients, and the burden of weighing potential effects of forcing physicians to balance duties of treatment owed to patients against unknown third parties. Similar to *Lester*, other state supreme courts have relied on public policy considerations in negligence cases, particularly in physician duty to third party claims (*Kirk v. Michael Reese Hospital*, 1987; *Praesel v. Johnson*, 1998; *Webb v. Jarvis*, 1991).

We believe that both established principles of tort law and policy considerations should provide guidance in examining claims of alleged liability against DMH workers. Our proposal is necessarily mindful that public policy is principally a legislative assignment and that statutory intent should provide a basis for jurisprudential analysis. Given the unique nature of disasters and mental health disaster response, we propose that courts adopt a dynamic model of analysis in which traditional negligence theories and policy concerns are informed with considerations specific to disaster mental health response. This framework includes potential liability considerations for acts or omissions of both licensed DMH professionals, and non-licensed DMH volunteers and the clinicians supervising them.

### **Acts or Omissions of Licensed DMH Professionals**

Unlike typical medical malpractice scenarios involving diagnoses and treatment of physical conditions, the mental health context obligates professionals with a variety of exceptional responsibilities. Such commonly cited obligations include the duty to evaluate, duty to commit, duty to protect patients from themselves, and duty to protect third parties from patients (*Commonwealth v. Nassar*, 1980; Furrow, Greaney, Johnson, Jost, & Schwartz, 1995; *Hill v. County Board of Mental Health*, 1979; Isele, 1975; *Leedy v. Hartnett*, 1981; *Mayock v. Martin*, 1968; Nicholi, 1988; Reisner, Slobogin, & Rai, 2004; *Tarasoff v. Regents of the University of California*, 1976). The application of the negligence framework in determining potential liability for mental health professionals poses clear challenges. This is due in part to the prevalence of multiple schools of thought in psychiatric care, and the profession's general practice of approaching each patient's disorders with a personally tailored treatment regimen. In addition, the stigma of mental illness may discourage individuals from reporting, or lead to under-reporting, the degree of symptoms suffered (Fishalow, 1975; Furrow, 1980; Shuman, 1993; Simon, 1987; Simon & Sadoff, 1992).

A number of potentially problematic issues arise in this context. DMH workers maintain a significant advantage over survivors who may be traumatized and seeking emotional intimacy, creating more potential for sexual indiscretion and other abuses. Establishing and terminating individual treatment relationships is difficult to discern in post-disaster environments that are characterized by an abundance of survivors and a minimum of DMH workers. Provision of traditionally recognized forms of informed consent may be lacking or absent.

Current disaster-specific mental health response practices encourage DMH workers to talk and listen to survivors and response workers while developing a

normalizing atmosphere. DMH workers offer water, sunscreen, and suggestions for stress management, rather than explicitly discussing emotions or symptoms (Weaver, 1995). DMH clinicians concurrently screen and assess individuals for potential problems, but typically identify themselves only as disaster workers or emergency volunteers when approaching or working with survivors or emergency workers. There is a widely held belief among DMH workers that hiding their labeled role of "mental health" will minimize stigma and create an environment that encourages sharing of experiences. This position is actually contrary to a recommendation from the American Psychological Association that DMH professionals self-identify in the field (American Psychological Association Task Force on the Mental Health Response to the Oklahoma City Bombing, 1997). Three reasons were cited for readily identifying DMH workers. First, the actual effect of not identifying as a DMH practitioner may increase rather than decrease the stigma associated with getting help. Second, recipients of DMH service have an ethical right to know who they are talking to so they have the opportunity to decline service. Third, those who desire DMH service should be able to readily identify who to approach for assistance if it is desired. To date these recommendations have not been incorporated as a regular part of the American Red Cross DMH training.

### *Informed Consent*

Providing informed consent for DMH interventions is made difficult by the lack of evidence-based practices available to clinicians and non-licensed DMH workers. As DMH interventions become less acceptable from the standpoint of professionally accepted standards, provision of informed consent becomes more important. For example, one intervention questioned in the National Institute of Mental Health report on early interventions following mass violence (2002b) was critical incident stress debriefing (CISD). Popularized by Mitchell and Everly as part of a set of interventions called Critical Incident Stress Management (Everly Jr., Flannery, & Eyster, 2002; Mitchell, 2003, 2004), CISD is a widely accepted systematic group intervention used with emergency response and military personnel following a traumatic event to decrease risk of post-traumatic stress disorder (PTSD) (Baker, 1996; Budd, 1997; Fitzgerald et al., 1993). Questions about the efficacy of CISD have arisen as research has indicated that it may actually be positively associated with PTSD (Arendt & Elklit, 2001; Lewis, 2003). The lack of evidence that CISD prevents PTSD may be offset by other research indicating that the debriefing process promotes group cohesion, a sense of normalcy, and self-reporting by participants of positive feelings about participating in the process (Budd, 1997; Shalev, Rogel-Fuchs, Ursano, & Marlowe, 1998). This inconsistency in findings has resulted in mixed endorsements of CISD by disaster response organizations. Although variations of debriefing that depart from CISD are still recommended, it is also recommended that the risks and benefits of participating in CISD and its alternatives be disclosed when obtaining informed consent (National Institute of Mental Health, 2002; Waits, 2002).

The use of CISD in group disaster treatment would be one such treatment that would obligate obtainment of informed consent (Litz, 2004). For DMH interventions in general, workers should be prepared to communicate the known risks and

benefits of participating in the intervention based on expert and evidence-informed information. In the post-disaster environment, DMH workers may either not initiate a process of obtaining informed consent, or survivors may be unable to provide informed consent given a temporary absence of competency (Hampton, 1985). Nonetheless, it should be incumbent upon DMH workers to communicate the risks and benefits of treatment to survivors when establishing a treatment relationship. If the risks and benefits of an intervention are unknown or debated, DMH workers should disclose this to survivors prior to initiating the treatment at issue. Further research is needed to identify uniform, accepted standards for obtaining informed consent in disaster settings.

### *Causation of Harm*

Because DMH intervention is primarily verbal, it is difficult to identify causation between negligent acts or omissions and actual harm than for forms of non-verbal treatment such as prescription of medication. Additionally, psychological harm experienced by a disaster survivor may be a result of a DMH worker's act or omission, the trauma of the event, or a combination of both. For example, the suicide of a disaster survivor with a known history of depression and suicide may initially point to some level of negligence by the DMH clinician who screened/assessed the person in the field. However, this is tempered by the amount of stress and trauma experienced by the individual as a result of just being exposed to the disaster event. The foreseeability of suicide, and degree to which the DMH clinician monitored and evaluated the survivor for suicide risk and made appropriate interventions, would inform judicial review of a claim for failing to prevent suicide (Baerger, 2001; *Bates v. Denny*, 1990; *Dinnerstein v. United States*, 1973; *Kockelman v. Segal*, 1998; *Rudolph v. Lindsay*, 1993). Courts have previously relied on a rigorous variation of gross negligence that rises to a level of "deliberate indifference" to find entities liable for prevention of suicide or harm to third parties. Liability based on deliberate indifference commonly occurs in prisons, schools, or other controlled environments where employees had clear knowledge that harm would occur as a result of an act or omission (Fossey & Zirkel, 2004; Giller, 2004; Lucero & Bernhardt, 2002). The uncontrolled field environment and initial disorder following a disaster in which clinical assessment and monitoring for self-harm or harm to third parties would occur should mediate against exposure to liability, as opposed to a controlled in-patient setting where monitoring and evaluation would be easier to conduct (Simon & Sadoff, 1992).

The degree to which evidence-based, evidence-informed, or expert-informed data exists about interventions used by DMH workers should be assessed in any determination of liability for acts or omissions in the field. Standards of care established through literature, peer conferences, and clinical practice protocols should weigh into the analysis. Practices deemed well accepted should provoke less judicial scrutiny than those which are not. A practice deemed to be part of a school of thought constituting a respectable minority of opinion may warrant greater scrutiny. Actions considered grossly negligent and a violation of reasonable standards of duty should elicit stricter judicial scrutiny and potential liability exposure. Beyond failure to prevent suicide scenarios, other examples might include grossly

negligent acts performed while intoxicated, and other conduct that cannot be reasonably interpreted as professional or in furtherance of disaster response (Furrow et al., 1995; Keeton et al., 1984). It must be noted that a DMH professional's conduct must rise at least to a level of gross negligence in order to lose statutory immunity from emergency management laws, if not greater degrees of culpability.

As opposed to inadequate assessment or treatment or other forms of gross negligence, a stronger case for provoking strict judicial scrutiny would involve instances of positive willful misconduct that violate professional guidelines. Unwanted sexual battery and/or other forms of exploitation of survivors might warrant such a finding. Examples might include gathering personal data for financial gain, engaging in criminal activity, aiding or abetting a survivor to commit criminal activity, or engaging in unethical or professionally unacceptable therapeutic practices (Burgess, 1981; Furrow et al., 1995; Keeton et al., 1984; Simon, 1989; Simon & Sadoff, 1992). Such conduct would also not be covered by state emergency management statute immunity as it amounts to willful misconduct and does not further effective disaster response or reasonable attempts to comply with disaster response goals.

The framework for viewing acts and omissions of DMH licensed and non-licensed workers in the field can be conceptualized as a continuum (see Table 1).

### Acts or Omissions of Non-licensed DMH Workers

Non-licensed personnel may augment the planned disaster mental health response in a community. The Federal Emergency Management Agency's Crisis Counseling Program recommends deployment of both mental health professionals and indigenous workers who understand the culture of the community they are working in (DeWolfe & Nordboe, 2000). These indigenous workers may include human service workers, school personnel, clergy and other faith leaders, or other natural helpers in the community. Such volunteers may already have developed positions of authority and social relationships within communities that can facilitate effective

Table 1. Factors informing liability exposure for acts or omissions of DMH workers

← Less liability exposure	Greater liability exposure →
<ul style="list-style-type: none"> <li>• DMH worker's act or omission comports with well accepted professional practices supported by evidence-based research.</li> <li>• DMH worker's act or omission amounts to furtherance of effective disaster response or good faith attempt to further effective disaster response.</li> <li>• Informed consent is obtained.</li> </ul>	<ul style="list-style-type: none"> <li>• DMH worker's act or omission amounts to willful misconduct that does not further goal of effective disaster response (e.g., sexual battery, criminal activity).</li> <li>• DMH worker's act or omission amounts to gross negligence or deliberate indifference in failure to diagnose and treat survivor and causes foreseeable injury (e.g., commission of suicide or harm incurred to third parties).</li> <li>• DMH worker's act or omission is not a well accepted professional practice and/or evidence-based or evidence-informed research indicates potential for aggravation of injury (e.g., CISD).</li> <li>• Informed consent is not obtained.</li> </ul>

response following the occurrence of a disaster. The National Institute of Mental Health (2002) recognizes that these DMH workers, often volunteers, are crucial in places with few licensed professionals, such as rural areas or mental health shortage areas. Although not formally trained to independently deliver professional-level service, DMH volunteers can provide basic forms of screening and referral, assist survivors with basic needs, provide comfort, and help calm the overall situation (National Institute of Mental Health, 2002a). However, involvement of these non-licensed DMH workers also poses liability problems because of their lack of formal professional and ethical training. Previously established positions of authority and relationships can also potentially increase the risk of malfeasance (Israel, 1985; Kelley & Kelley, 1985; Patterson, Germain, Brennan, & Memmott, 1988; Patterson, Memmott, Brennan, & Germain, 1992; Timpson, 1983; Vallance & D'Augelli, 1982).

In recognition that volunteers play a crucial role in disaster response, state emergency management acts provide the same liability shields to volunteers as they do to state officials and professionals responding to disastrous events (Ala. Code § 31-9-16, 2003; Neb. Rev. Stat. § 81-829.55, 2003; Okla. Stat. tit. 63, § 683.14, 2003). Acts or omissions amounting to gross negligence or willful misconduct that would exclude the professional DMH worker from statutory immunity would similarly apply to the non-licensed DMH worker. However, the wrongful actions of non-licensed DMH workers might implicate liability for licensed professionals who supervise the non-licensed volunteer or worker.

### **Liability of the Licensed DMH Clinical Supervisor**

Two theories of liability might be pursued in the context of supervising DMH workers. A DMH professional might be directly liable, if it can be shown that the professional was grossly negligent in failing to supervise the workers when there is clear evidence that professional-level therapeutic intervention is necessary. For instance, a DMH professional who deliberately ignores communications from a supervisee about a survivor's symptoms could create potential liability exposure if that information should prompt a reasonable DMH professional to personally intervene. This would occur if the lack of intervention could be construed as gross negligence or deliberate indifference.

As opposed to direct liability, a DMH supervisor might be held vicariously liable for the actions of a supervised volunteer. The imposition of vicarious liability is principally a decision based on public policy considerations to allocate risk from supervised individuals to supervising employers. For such a finding to exist, the first critical inquiry to be determined is whether or not an employment-like relationship existed between the DMH professional and volunteer. This could be demonstrated by a right to control or supervise the DMH worker, or documents that would color such a relationship with authority, such as previously drawn contracts, memorandums of understanding, and written plans or protocols. A plan denoting that a local church's clergy should work under and with trained professionals in DMH response might indicate that such a relationship exists.

The other consideration is whether or not the supervisee was working within the scope of employment while the alleged act occurred. In the DMH response

context, this should include a factual inquiry reviewing the intention of the supervisee to further effective disaster response and whether a reasonable supervisor could foresee a wrongful act or omission by the supervisee in this endeavor. The supervisee's culpability behind the act or omissions, the professional's ability to control the supervisee, and the circumstances in which the supervisee was acting are also important. Willful misconduct and intentional torts by the supervisee, such as commission of sexual battery, may impute liability to the supervisee. Determining whether willful misconduct of an employee can be vicariously attributed to employers depends on jurisdiction case law regarding the alleged activity (Keeton et al., 1984; Saccuzzo, 1997). For example, in *Simmons v. U.S.* (1986), the Ninth Circuit found that sexual battery initiated by a counselor arose out of the provision of therapy, and consequently fell within the scope of employment and imputed vicarious liability to the counselor's government employer. However, in *P.S. v. Psychiatric Coverage, Ltd.* (1994), the Missouri Court of Appeals overturned a trial court's judgment that an employer was vicariously liable for a therapist's sexual battery. Even though sexual acts were committed during therapy sessions, the court held that the acts were not part of a legitimate therapy program and that they were the result of purely individual motivations.

A crucial factor implicating the DMH supervisor's potential vicarious liability exposure is the extent to which the professional had actual control over the DMH worker's actions. The degree of communication between the DMH supervisor and worker in the field about worker activities and the degree to which the supervisor personally monitored and evaluated the conduct of workers in the field are key elements informing an analysis of whether or not control exists (Allen, 2003; Clark, 1997) (see Table 2). In the post-disaster environment, maintaining this degree of control or good faith attempts at maintaining control might be difficult, depending on the severity of the disaster event and number of available licensed supervisors and DMH workers workers. The American Psychological Association recommends that inexperienced licensed professionals, unlicensed mental health workers, and paraprofessionals be supervised by licensed personnel with DMH experience. It is further noted that a clear and precise line of supervision should be in place and that all DMH workers have knowledge and understanding of chain of command concepts (American Psychological Association Task Force on the Mental Health Response to the Oklahoma City Bombing, 1997).

Table 2. Factors informing liability exposure of DMH professionals for conduct of DMH volunteers

← Less liability exposure	Greater liability exposure →
<ul style="list-style-type: none"> <li>• Direct liability: DMH professional's act or omission comports with well accepted professional practices of supervising volunteers.</li> <li>• Vicarious liability: DMH professional does not have effective control over DMH volunteer's conduct.</li> </ul>	<ul style="list-style-type: none"> <li>• Direct liability: DMH professional is directly liable for being grossly negligent in supervising act or omission of DMH.</li> <li>• Vicarious liability: DMH professional is vicariously liable for grossly negligent conduct of supervised volunteer if professional has effective control over DMH volunteer.</li> </ul>

## Liability Associated with DMH Plans and Implementation

A number of professional, private, and public entities have developed plans specific to DMH response. Plan elements cover deployment and coordination of interstate, state, and local resources; recommended clinical practices; and frameworks for integrating non-licensed DMH workers under professional umbrellas (see, e.g., DeWolfe & Nordboe, 2000; Ehrenreich & McQuaide, 2001; Myers, 1994; Young, Ford, Ruzek, Friedman, & Gusman, 2001). The U.S. Department of Health and Human Services has recommended guidelines for the development of state DMH response and recovery plans that include considerations for role assignment, communication, conveyance of public information, and resource management (Flynn, 2003).

Although the principal factors in determining liability for DMH workers should focus on individual acts or omissions and causation of harm, plan characteristics and degree of deviance from plans in their actual operationalization should inform judicial review of individual responsibility for alleged wrongful acts. Lerner (1991) distinguished between circumstances in which response planning was either negligently drafted or properly drafted but negligently followed. Noting the sparseness in legal precedent specifically addressing liability implications flowing from this distinction, he recommended that response plan drafting incorporate due consideration of how specific the response guidelines are and the degree to which response activities are defined as either mandatory or discretionary (Lerner, 1991).

Proving gross negligence in plan drafting could be argued on considerations of the foreseeability of post-disaster needs and how adequately these needs are addressed by plan drafters. Plaintiffs could assert a claim alleging gross negligence in plan drafting by failing to adequately prepare for post-disaster contingencies that are abundantly documented in evidence-based or evidence/expert-informed research (see Table 3). For example, a plan that fails to provide for any post-disaster DMH mobilization for the possibility of addressing treatment needs of survivors at risk for PTSD could be deemed grossly negligent, because an abundance of literature indicates that incidence of PTSD has been documented among disaster survivors (Foy et al., 1984; Galea et al., 2002; Green, 1991; Green et al., 1983; Smith et al., 1990).

However, we believe that claims for gross negligence in plan drafting would be found unsuccessful if adjudicated. Attention to statutory text authorizing plan creation would be the critical focus of such a determination. For example, under Nebraska's emergency management statute, the legislature requires the executive to create a disaster response plan and makes recommendations for substantive elements to be addressed. However, it affords a wide degree of discretion in plan substance by not mandating the inclusion of any of its recommendations (Neb. Rev. Stat. § 81-829.41, 2003). Discretionary acts or omissions furthering public safety concerns as a matter of policy would be shielded under discretionary exemption immunity, and legislatures traditionally enjoy near absolute immunity from civil liability (Keeton et al., 1984). The stated purpose of Nebraska's act is to reduce vulnerability of harm preceding or following a disaster and provide for cooperation and coordination of response activities. However, nothing in Nebraska's act, or those of other states, expressly guarantees that no harm will occur as a result of disaster response planning or operationalization (Ala. Code § 31-9, 2003; Mich.

Table 3. Plan drafting and operationalization

← Less liability exposure	Greater liability exposure →
<ul style="list-style-type: none"> <li>• Conduct of DMH workers deviating from adequately drafted plan amounts to good faith attempts that further professionally accepted practices of DMH response.</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct of DMH workers deviating from adequately drafted plan amounts to gross negligence or willful misconduct that does not further professionally accepted practices of DMH response.</li> </ul>

Comp. Laws § 30.401, 2003; Neb. Rev. Stat. § 81-829.55, 2003; Okla. Stat. tit. 63, § 683, 2003). Such a guarantee would amount to the imposition of strict liability upon state executive entities for the occurrence of any harm caused through disaster response activity. Nebraska's act provides qualified immunity for the state, its political subdivisions, and emergency management workers except in cases of gross negligence, bad faith, and willful misconduct (*Lawry v. County of Sarpy*, 1998; Neb. Rev. Stat. § 81-829.55, 2003).

Claims of tort liability would thus not focus on the DMH plan itself but on acts or omissions committed in implementation of plans in the field. Such claims should turn on the degree of individual culpability behind the act or omission itself and not the degree to which deviance from the plan occurs. The existence of explicit guidelines in disaster planning which outline acceptable and ethical field practices based on professional standards of conduct could thus serve as an additional criterion to be determined in findings of alleged liability, but should not in itself serve as an absolute criterion determining liability.

## RECOMMENDATIONS

DMH workers (both licensed and non-licensed) should consider the following general recommendations to limit potential liability when serving in the field as part of a disaster mental health response.

- (1) Incorporate the use of informed consent in the delivery of DMH interventions. This can be accomplished through verbal or written disclosure of the known efficacy and risks at the onset of more formal interventions (e.g., debriefing), or by having the clinician disclose when a specific intervention may be used (e.g., cognitive behavioral therapy in the field) prior to actual treatment delivery. Disclosure is particularly recommended if the risks and benefits of participating in a treatment are unknown.
- (2) Clearly identify your DMH profession or role in the field. It is unethical to hide your affiliation and true purpose in the response. The right to refuse intervention is obscured when the DMH worker is "disguised." Introduce yourself as a psychologist, social worker, chaplain, or mental health worker—not as an "escort" or "worker" or other generic term that does not reflect your role, licensure or qualifications.
- (3) Insist on adequate supervision of DMH workers by trained, licensed professionals. Supervisors should likewise insist on manageably sized groups of workers to supervise. This ratio may be dictated by a number of factors including the nature of the disaster and characteristics of the workforce.

Appropriate mechanisms should be established for timely monitoring and evaluation of DMH worker conduct.

- (4) Become involved in DMH response planning efforts to create administrative structures that reflect known and evolving best practices. Make an effort to understand the DMH plan and the parameters for practice it contains.
- (5) DMH workers operating outside of formal structures such as the American Red Cross should be subject to emergency management organizing structures using incident management systems that identify a clear chain of command, inclusive of DMH personnel. Lines of communication within DMH ranks with supervisory authority should be clearly delineated within the overall disaster response. DMH professionals and volunteers should be exposed to incident management system training prior to deployment in disaster response.

## CONCLUSION

Through the passage of emergency management acts, state legislatures have indicated a policy preference encouraging individuals to assist in disaster response without fear of being subject to civil actions. Convincing mental health professionals and others to serve as part of a disaster response team is much easier if liability issues are adequately addressed. The field of disaster mental health is evolving as we learn more about people's reactions to different types or phases of disaster and how to effectively address them.

The functional role of the DMH practitioner is often secondary to that of the traditional clinician, clergy-member, teacher, case worker, or other day to day worker. Thus, DMH work is less familiar and less practiced by those who assume it. The issue of liability is particularly pertinent in the field of disaster mental health because of the high number of individuals volunteering for this role, the low number of proven efficacious DMH interventions, and relative paucity of legal tests directly related to the field. The framework presented in this article sets forth a possible framework to view liability exposure that is understandable to the clinicians and practitioners who must assume it. The recommendations are practical and hopefully pertinent to planners and practitioners alike. When the next disaster occurs and a DMH response is needed, those who serve should be afforded adequate protection from liability through appropriate administrative structures, proper supervision, and personal knowledge of ethical, effective practices.

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