Vulnerable Populations in the Context of COVID-19: Foreword to the *Arizona State Law Journal Online* Symposium

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The widespread global transmission of SARS-CoV-2, the novel coronavirus that causes the disease COVID-19, has altered, injured, and ended the lives of numerous individuals across various communities and nations. It has been well-documented that certain long-neglected populations are particularly susceptible to COVID-19 severe illness and death and, as a result, have been disparately victimized by the pandemic.[1] This *Arizona State Law Journal Online* Symposium, *Vulnerable Populations in the Context of COVID-19*, is a compilation of the work of diverse scholarly voices that aims to raise awareness about—and propose reforms to remedy—the legal and policy challenges that have—and continue to—perpetuate adverse health harms on the most vulnerable in our communities. Symposium contributors include international scholars, medical doctors, clinical law professors litigating on behalf of vulnerable clients, and distinguished senior and junior law professors. This collection of unique scholarly voices is due to outstanding support from the Association of American Law Schools (AALS) Sections on Law and Mental Disability, Indian Nations and Indigenous Peoples, Disability Law, and Poverty Law; the Academy for Justice, a criminal justice policy center at Arizona State University, Sandra Day O'Connor College of Law; and the tireless work of the student editors at the *Arizona State Law Journal*. We hope this foreword provides an overview that encourages readers to engage with the insightful essays in this online symposium.

The essays in this collection explore the mental health of vulnerable populations by examining pre-existing, population-health harming legal and policy obstacles that the COVID-19 national health crisis has exacerbated.

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1. *Health Equity Considerations and Racial and Ethnic Minority Groups*, CTRS. FOR DISEASE CONTROL & PREVENTION (July 24, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html [https://perma.cc/3V3C-MBLM].

The authors propose solutions to these problems aimed at populations that have been disproportionally affected by the crisis, including, but not limited to, indigenous people; individuals with substance use disorders; racial, ethnic, and gender minorities; individuals with disabilities; individuals who are incarcerated or otherwise institutionalized; elderly individuals; pregnant women; and people who suffer other social and economic barriers, including co-morbid mental health conditions.

The criminal justice essays challenge the loss of rehabilitative programming for juveniles in custody, examine pandemic detention and access to care through a disability law framework, provide a series of arguments against solitary confinement, and propose community treatment for competency restoration. The health law essays describe the deregulation of telehealth and telemedicine during the COVID-19 public health crisis, the impact of the pandemic on elderly patients with dementia and Alzheimer's disease, the dearth of support and services to individuals with developmental disabilities, and propose a framework to ensure treatment for people with substance use disorder. The essays on Tribal communities detail federal Indian law's long perpetuation of structural violence and trauma in Indian country, explain how the federal government's failure to abide by its treaty obligations has exacerbated adverse mental health outcomes for Native Americans in the context of the pandemic, and propose solutions to mitigate COVID-19-related mental health harms.

I. INDIVIDUALS WHO ARE INSTITUTIONALIZED

In *COVID-19 in American Prisons: Solitary Confinement Is Not the Solution*,[2] Professors Godfrey and Rovner introduce a theme that runs through several of the essays that discuss institutionalized populations: the reliance on harmful solitary confinement to mitigate the spread of SARS-CoV-2. As the authors point out, prisons and jails are home to some of the worst clusters of COVID-19 outbreaks throughout the country. Prisoners' rights advocates have filed lawsuits across jurisdictions seeking the release of immunocompromised individuals and elderly incarcerated people in the wake of the pandemic. "[I]n response to these lawsuits and public health guidance, crowded prison systems are returning to an old solution to address prison problems: solitary confinement."[3] Professors Godfrey and Rovner

2. Nicole B. Godfrey & Laura L. Rovner, *COVID-19 in American Prisons: Solitary Confinement Is Not the Solution*, 2 ARIZ. ST. L.J. ONLINE (forthcoming 2020).

3. *Id.*

query why prisons have chosen solitary confinement over the healthier alterative—release.

Solitary confinement's considerable adverse impacts on mental health, which include the inducement of self-harm and suicide, are well documented.[4] Because prisons are ill-equipped to socially isolate, quarantine, or medically confine individuals, however, prison officials turn instead to the readily-at-hand solution—solitary confinement.[5] Professors Rovner and Godfrey take issue not only with prison officials' refusal to release individuals, but the judiciary's embrace of solitary confinement as a preferred solution.[6]

Professors Rovner and Godfrey examine the courts' deference to prison officials' determinations and their essay details the procedural obstacles that block judges from mandating release even during a highly infectious disease emergency. Courts apply a heightened "deliberate indifference" standard to Eighth Amendment cruel and unusual punishment claims, including virus-exposure claims.[7] The deliberate indifference standard permits prisons to "escape constitutional liability by implementing one set of unconstitutional conditions (conditions of solitary confinement) in order to attempt to address another (conditions creating an increased risk of exposure to COVID-19)."[8] Instead of concluding that the imposition of solitary confinement to mitigate the transmission of SARS-CoV-2 constitutes deliberate indifference, courts have given prison officials credit for "taking *some* steps to fix the problems inside a facility, even if they're insufficient."[9]

Prisons and jails are not alone. This essay collection includes several calls to release vulnerable individuals from various institutional settings in lieu of isolation as a response to the COVID-19 pandemic. As highlighted by other authors in this symposium, juvenile and immigration detention centers, psychiatric institutions, and nursing homes have also resorted to solitary confinement to "protect" their respective populations from exposure to SARS-CoV-2.[10]

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4. *Id.*
5. *Id.*
6. *Id.*
7. *Id.*
8. *Id.*
9. *Id.*
10. *See* Madalyn K. Wasilczuk, *Disaster & Delinquency: Addressing the Trauma of the COVID-19 Response in Youth Jails & Prisons*, 2 ARIZ. ST. L.J. ONLINE (forthcoming 2020) (juvenile detention centers); Adrián E. Alvarez, *Enabling the Best Interests Factors*, 2 ARIZ. ST. L.J. ONLINE (forthcoming 2020) (immigration detention centers); Susan A. McMahon, *Pandemic as Opportunity for Competence Restoration Decarceration*, 2 ARIZ. ST. L.J. ONLINE (forthcoming 2020) (psychiatric institutions); Barbara Pfeffer Billauer, *Mental Health and the Aged in the Era of COVID-19*, 2 ARIZ. ST. L.J. ONLINE (forthcoming 2020) (nursing homes).

The indiscriminate use of solitary confinement in the institutional setting to mitigate COVID-19 is a central feature in Susan McMahon's essay, *Pandemic as Opportunity for Competence Restoration Decarceration*.[11] As one public defender quoted by Professor McMahon points out, "This moment has flipped the script on mass incarceration . . . It's laid bare that caging huge swaths of our society isn't necessary—it's just convenient."[12] Before the pandemic, defendants that were found incompetent to stand trial remained in jail for weeks or months waiting for an inpatient bed at a psychiatric facility. This extended stay in jail generally resulted in a further deterioration of the defendant's mental state, sometimes leading to suicide, self-abuse, or sexual and physical abuse by guards. As Professor McMahon describes the situation, a jail setting is "at best, counter-therapeutic and, at worst, dangerous to [a detainee's] mental and physical well being."[13]

The long wait in jail for defendants with competency issues has lengthened during the pandemic because many psychiatric facilities have stopped accepting new patients. The situation is so dire that some defendants have been placed indefinitely in jail psychiatric lockdown units comparable to solitary confinement. In response to such unconscionably lengthy pre-treatment incarceration, some judges have released these pre-trial defendants to seek outpatient treatment. Others have dismissed the defendant's charges. Professor McMahon argues that the pandemic has incentivized courts to more frequently release defendants to outpatient competency treatment. From the despair of the pandemic, Professor McMahon offers some hope: "an opportunity to begin to realize the unkept promise of community health centers and local supports."[14]

Similarly, Professor Madalyn Wasilczuk's essay, *Disaster & Delinquency: Addressing the Trauma of the COVID-19 Response in Youth Jails & Prisons*, frames the pandemic despair that has attended to detained children and teenagers.[15] Professor Wasilczuk focuses on the "approximately 48,000 children confined away from home on any given night;" these children may be in custody for simple status offenses such as truancy or technical violations of probation.[16] Approximately 20% of these children are incarcerated pre-adjudication. As she points out, the purpose of state juvenile legal systems is rehabilitation not punishment. During the pandemic, however, these "rehabilitative" facilities have suspended visitation,

11. McMahon, *supra* note 10.
12. *Id.*
13. *Id.*
14. *Id.*
15. Wasilczuk, *supra* note 10.
16. *Id.*

eliminated communal meals, and replaced in-person education with dramatically variable distance education.[17] And like adult institutions, juvenile facilities have placed children in solitary confinement quarters they characterize as "medical isolation."[18] As Professor Wasilczuk explains, "[i]n Louisiana . . . OJJ violated its own policies by holding children in 'behavioral intervention rooms' for more than eight hours at a time."[19]

As Professor Wasilczuk notes, the poor health outcomes that attend to incarceration are disparately borne by Black and other minority communities. She further explains that the rate of release for white and Black children has widened during the pandemic. "As of June 2020, the white [ ] rate [of release] had increased to 17% higher than that of Black children . . . . Disaster sociologists have long understood that disasters are not 'equal opportunity events.'"[20] Children, generally, and institutionalized juveniles, more specifically, are projected to experience post-traumatic stress disorder, depression, anxiety, and other mental health disruptions derivative of the public health crisis. Professor Wasilczuk concludes by contending that courts ought to reconsider whether the confinement of children during the pandemic is reasonably related to the rehabilitative purposes of juvenile facilities. Courts should likewise take into account the trauma and mental health harm of ongoing pandemic detention, which is disproportionately visited on children of color.

Professor Adrián Alvarez discusses the impact of COVID-19 on juveniles detained in the immigration system, particularly those with mental health conditions. Although the United States applies the "the best interests of the child" standard to immigrant children, the standard impacts children differently depending on their disability status.[21] Many unaccompanied minors who come to the United States experienced severe trauma before, during, or after their migration. Under current U.S. policy, mental health counselors must disclose the confidential therapy notes they take during counseling sessions with migrant children to the Department of Homeland Security to use against those children in deportation proceedings.

Professor Alvarez applies a disability rights framework to illustrate that children do not receive appropriate accommodations for their mental health conditions in a system where mental health counselors are required to disclose the contents of confidential counseling sessions to enforcement agencies. Professor Alvarez then identifies how health treatment for

17. *Id.*
18. *Id.*
19. *Id.*
20. *Id.*
21. Alvarez, *supra* note 10.

unaccompanied minors in detention is insufficient if it fails to address the barriers that prevent these children from being released from custody or granted asylum. The mental health treatment itself reinforces and heightens such barriers. The President of the American Psychological Association was so concerned about the retributive use of therapists' notes in the system that he wrote to the Secretaries of the Departments of Health and Human Services and Homeland Security to explain that such practice causes "distrust and impede[s] children from accessing evidence-based mental health care."[22] Professor Alvarez's essay advocates for an often-overlooked population of detainees during the pandemic: unaccompanied minors in immigration detention with disabilities.

II. INDIVIDUALS WITH HEALTH CONDITIONS AND DISABILITIES

Co-authors Professor A. Cano Linares and Doctor R. Paricio del Castillo bring an international perspective to their essay focused on pregnant women, *Mental Health and Vulnerable Populations in the Era of COVID-19: Containment Measures Effects on Pregnancy and Childbirth*.[23] They question how efforts to halt the spread of COVID-19 disproportionately affect women, and detail the heightened harms that attend to pregnant women who are isolated at home and unable to access vital health services while in mandated quarantine. As the authors explain, certain hospital-adopted restrictions on pregnant women are not evidence-based. Instead, they are aimed at curtailing reproductive health treatment and women's rights.

The right to health is an international human right under the Universal Declaration of Human Rights, the International Covenant on Economic, Social, and Cultural Rights, and the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), which require signatory states to "ensure to women appropriate services in connection with pregnancy."[24] The core characteristics of adequate reproductive healthcare are availability, accessibility, acceptability, and quality. Pregnant women and newborns are particularly vulnerable populations to SARS-CoV-2 infection. Professor Cano Linares and Doctor Paricio del Castillo highlight a number of troubling and traumatic practices that have been prevalent during the pandemic in this context, including upticks in caesarean delivery, induced

22. *Id.*

23. A. Cano Linares & R. Paricio del Castillo, *Mental Health and Vulnerable Populations in the Era of COVID-19: Containment Measures Effects on Pregnancy and Childbirth*, 2 ARIZ. ST. L.J. ONLINE (forthcoming 2020).

24. *Id.*

labor without medical indication, separations of mothers and children, stillbirths, and the discouragement of breast feeding. As the authors conclude, many countries have now adopted "inappropriate protocols, not based in current reputable evidence, for pregnancy management, as well as for birth and postnatal care in response to the COVID-19 pandemic, has meant the violation of the human rights of women and their babies when quality health services should always be safe and assured."[25]

In *COVID-19 and Individuals with Developmental Disabilities: Tragic Realities and Cautious Hope*, Professor Samuel J. Levine shines a light on the disparate impact that the pandemic has wrought on individuals with development disabilities.[26] He begins his essay by explaining that "the crisis has exposed the underlying reality of society's failure to provide appropriate services and supports to individuals with developmental disabilities, in at least three separate but interrelated areas: special education, mental health, and physical health."[27] Individuals with developmental disabilities have either been deprived of—or subject to inconsistent—special education services throughout the public health emergency because the effective delivery of those services is challenging in the online learning environment.

As Professor Levine teaches, a similar problem has plagued individuals with development disabilities in need of mental health treatment services. In addition to the rampant shortages of such services during the pandemic, online treatment is often substandard and disruptive to a population that struggles with dramatic changes in structure and routine. Beyond being vulnerable to disparately adverse mental health outcomes, individuals with development disabilities are more likely to have preexisting health conditions and live in the group home setting. As a result, they have experienced severe COVID-19 illness and death at a disproportionately higher rate than most other groups. Professor Levine concludes his essay with "cautious hope," contending that the fact that large segments of American society have faced pandemic-related education, mental health, and physical health challenges may provoke more empathy and enhanced concern for individuals with developmental disabilities, who face these types of obstacles on a routine basis.[28]

Doctor Barbara Pfeffer Billauer's essay, *Mental Health and the Aged in the Era of COVID-19*, details the concerning age-related policies and practices that various countries have adopted in response to the pandemic,

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25. *Id.*

26. Samuel J. Levine, *COVID-19 and Individuals with Developmental Disabilities: Tragic Realities and Cautious Hope*, 2 ARIZ. ST. L.J. ONLINE (forthcoming 2020).

27. *Id.*

28. *Id.*

which "demonstrat[e] a culture of disposable elder-care."[29] She begins her piece by exposing the widespread prevalence of dementia and Alzheimer's disease in the United States and beyond and explaining how COVID-19 social isolation has exponentially enhanced death in dementia and Alzheimer's patients across the globe. Moreover, because nearly half of long-term care residents in the United States live with dementia or Alzheimer's, "these individuals became one of the most disproportionately vulnerable groups" to SARS-CoV-2.[30]

Doctor Pfeffer Billauer enumerates the myriad global COVID-19-related policies aimed at elderly individuals that have disparately impacted their mental and physical health outcomes. Such "disposable oldsters" practices range from imposing stricter and harsher lockdowns on people above a particular age threshold to denying older citizens ventilators to engaging in "active euthanasia" in palliative care.[31] Not only are many of these policies blatantly unethical, they were provoked by misleading data suggesting that the elderly were more susceptible to death from COVID-19. As Doctor Pfeffer Billauer ably explains, there is no evidence that "older age, in the absence of confounding factors or co-morbidities, is an independent risk factor for elder-deaths."[32] As a result, "[p]olicies designed to protect the elderly from dying of a physical disease inadvertently triggered unintended mental health effects in those otherwise healthy—and worsened the conditions of those already suffering . . . dementia and Alzheimer's."[33] Doctor Pfeffer Billauer's essay concludes with a call for a therapeutic justice approach to evaluating governmental interventions in public health emergencies going forward to avoid the cascade of health-harming unintended consequences suffered by older individuals.

III. TRIBAL COMMUNITIES IN THE PANDEMIC

The next two essays in the series explain that federal Indian law and policy is a structural determinant of health that has perpetuated adverse health outcomes for American Indians and Alaska Natives during the COVID-19 pandemic. Professor Aila Hoss opens her essay, *COVID-19 and Tribes: The Structural Violence of Federal Indian Law*, by describing how the principles of federal Indian law "have undermined Tribal political and cultural

29. Billauer, *supra* note 10.
30. *Id.*
31. *Id.*
32. *Id.*
33. *Id.*

sovereignty in a myriad of ways, including termination recognition, denying access to ancestral and sacred lands and waters, denying rights to engage in cultural practice, [and, among countless other things,] separating children and families from their Tribes."[34] These legal practices have resulted in structural violence and historical trauma to Tribal communities which, in turn, "perpetuate adverse health outcomes," including "depression, suicide, anxiety, disordered eating, commercial tobacco use, lack of contraception use, and substance use disorder."[35]

As Professor Hoss details, the federal government's failure to live up to its treaty obligations with the Tribes has long exacerbated poor health outcomes for Tribal communities, including in the wake of COVID-19. The federal government, for example, has long underfunded the Indian Health Service (IHS), whose "budget meets little more than half of the health care needs in Indian country."[36] Inadequate federal health care programming has resulted in the inadequate and faulty supply of personal protective equipment (PPE) to health care workers as well as shortages in test kits, ventilators, and other critical equipment throughout the pandemic. The federal government has also deprived Tribal communities of their fair share of COVID-19 relief funding due to census under-reporting and a lack of public health surveillance. The federal government has refused to share critical COVID-related epidemiological data with Tribes notwithstanding its legal obligation to do so and has long-diverted Tribal waters to other communities. Lack of access to running water is health-harming during non-pandemic times but doubly so when facing a disease that is mitigated with routine handwashing. Professor Hoss ends her essay by imploring the federal government to comply with its fiduciary duties to the Tribes so that federal Indian law can advance Tribal health rather than continue to "perpetuate health harm."[37]

Professor Heather Tanana's essay, *Learning from the Past and the Pandemic to Address Mental Health in Tribal Communities*, echoes several of the themes raised by Professor Hoss.[38] Professor Tanana frames up her piece by providing an overview of the historic federal Indian law policies—from the Removal Era to the modern-day Self-Determination Era—that have operated for centuries to perpetuate trauma on American Indians and Alaska Natives and instigate poor health outcomes. As she reports, "Tribal

34. Aila Hoss, *COVID-19 and Tribes: The Structural Violence of Federal Indian Law*, 2 ARIZ. ST. L.J. ONLINE (forthcoming 2020).

35. *Id.*

36. *Id.*

37. *Id.*

38. Heather Tanana, *Learning from the Past and the Pandemic to Address Mental Health in Tribal Communities*, 2 ARIZ. ST. L.J. ONLINE (forthcoming 2020).

communities have been hit hard" by the pandemic: Native Americans are 3.5 times more likely to contract COVID-19 and are at higher risk of developing severe COVID-19 illness than their white counterparts.[39]

Professor Tanana identifies several health and socioeconomic factors attendant to Tribal communities that may contribute to increased COVID-19 transmission rates and adverse health outcomes in Indian country, including overcrowded households, the routine use of shared transportation to travel long distances to shop, lack of access to running water, and the prevalence of preexisting conditions in the population. Native Americans are also likely to suffer disproportionate mental health harm due to the special impacts of COVID-19 social isolation on cultural norms.

Professor Tanana's essay concludes with several recommendations aimed at mitigating negative COVID-19-related mental health outcomes in Tribal communities. Among other things, she contends that the federal government should make its public health emergency telehealth reforms permanent beyond the pandemic, fully fund the IHS, provide Tribes adequate resources to build necessary telehealth infrastructure, including access to broadband services and other utilities, throughout Indian country, and "establish telehealth programs that incorporate the recruitment and training of mental health professionals to provide culturally appropriate telehealth services."[40]

IV. TELEHEALTH AND INDIVIDUALS WITH SUBSTANCE USE DISORDER

In the final essay in our series, *COVID-19, Telehealth, and Substance Use Disorder*, Professor Stacey Tovino details the "the rapid and unprecedented de-regulation of telehealth and telemedicine in the United States during the . . . COVID-19 pandemic" and queries whether these pandemic reforms have enhanced access to treatment for individuals with substance use disorder.[41] Professor Tovino investigates numerous examples of pandemic telehealth de-regulation, including enhanced payment parity; relaxation of the originating sites mandate, communication systems requirements, and in-person medical evaluation demands; expansion of reimbursements to a wider variety of telehealth services and providers; waiver of in-state licensure requirements; and privacy and security reforms.

As Professor Tovino details, the pandemic has instigated certain public and private payors, including Medicare and various state Medicaid plans, to

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39. *Id.*

40. *Id.*

41. Stacey A. Tovino, *COVID-19, Telehealth, and Substance Use Disorder*, 2 ARIZ. ST. L.J. ONLINE (forthcoming 2020).

reimburse telehealth services at the same rate as in-person patient visits. Regulators have also eliminated a panoply of technical obstacles during the public health emergency that have long limited access to telehealth treatment. Medicare, for example, has waived its requirement that limited reimbursement for telehealth services to those provided at narrowly-defined "originating sites" during the pandemic and has authorized beneficiaries to receive such services across the United States, including in their own homes.[42] Payors have expanded both the number and types of services and the number and types of providers eligible for telehealth reimbursement while federal and state regulators have waived in-state licensure requirements to enhance access to telehealth treatment. The Drug Enforcement Agency (DEA) has even waived the long-standing requirement that individuals with opioid use disorder initiate buprenorphine treatment in-person to stem the transmission of SARS-CoV-2.

Professor Tovino queries whether these telehealth reforms have had a meaningful impact on the mental and physical health of individuals with substance use disorder (SUD). As she points out, pandemic telehealth deregulation efforts ought to have enhanced access to treatment for individuals with SUD while mitigating their exposure risk to SARS-CoV-2 but it is difficult to state such a claim with certainty at the moment due to the lack of sufficient, applicable data. Consequently, Professor Tovino concludes her essay by advocating for "[t]he collection and analysis of data relevant to the furnishing of telehealth to individuals with substance use disorders during the [public health emergency]" because "the health outcomes of such individuals would inform debates about the desirability of permanent, versus temporary, telehealth de-regulation."[43]

V. CONCLUSION

The essays in this collection identify COVID-19's disparate impact on vulnerable populations, propose solutions, and offer hope for reform. We thank each of the authors for their meaningful contributions to this project.

42. *Id.*
43. *Id.*