

New Justice Center Publications Provide Guidance to Practitioners and State Mental Health Commissioners

Two recent publications from the Council of State Governments Justice Center offer expert advice for solving problems at the interface of the mental health and criminal justice systems—systems that sometimes collaborate and sometimes collide. First, how can local mental health and criminal justice systems create effective programs when both federal and state privacy laws seem to erect insurmountable barriers to sharing information? Second, how can a state mental health commissioner prepare for and respond to a high-profile, tragic incident involving a person with serious mental illness?

The first publication, *Information Sharing in Criminal Justice–Mental Health Collaborations*, is designed to help jurisdictions comply with federal and state privacy laws. Sharing health and treatment information about people with mental illness or substance use disorders is essential to ensuring appropriate responses within the justice system. However, misperceptions about the privacy laws impede communications between mental health, law enforcement, court, and corrections personnel, and these perceived barriers may contribute to the overrepresentation of people with mental illness in jails and prisons.

The introduction to the 30-page guide describes the federal legal framework for sharing “protected health information.” Understanding the framework is a crucial first step in designing and implementing effective collaborations. Federal laws shape what is permissible at the state and local levels, mainly via HIPAA (Health Insurance Portability and Accountability Act) and 42 CFR Part 2 (privacy regulations related to substance abuse treatment). Many practitioners believe that HIPAA limits information sharing in a far more restrictive way than what the actual regulatory language requires. The guide reminds practitioners that the original intent of the legislation was

to facilitate insurance coverage through the development of an information system for electronic health records that ensured appropriate privacy and security.

The guide is organized into two parts. The first part focuses on each type of practitioner likely to be involved in criminal justice–mental health collaborations: behavioral health care, law enforcement, courts, jail and prison, and probation and parole. For each practitioner type, the guide addresses whether the individual is bound by HIPAA or 42 CFR Part 2. The circumstances under which an individual can provide protected health information and when he or she can receive it are described. Each section concludes with several scenario-based frequently asked questions for the practitioner, including many that are not directly covered by HIPAA regulations. Additional sections provide an overview of other types of entities that request or provide information (“business associates” and “qualified service organizations”) and a review of an individual’s right of access to his or her own health information.

The second part of the guide provides practical advice on working with the privacy laws. Information-sharing tools that jurisdictions typically develop to exchange information are described, such as a uniform authorization and consent form, which is used at various points in the criminal justice process—such as at jail booking or diversion program entry—to obtain an individual’s permission to share information. At the system level, many jurisdictions employ manual processes or management information systems to routinely bring together criminal justice and behavioral health information, and the guide describes examples in several states and how they conform with privacy laws.

The second Justice Center publication, *Responding to a High-Profile Tragic Incident Involving a Person With a Serious Mental Illness*, is a

toolkit for state mental health commissioners. Such incidents place commissioners, other behavioral health professionals, and emergency responders under public, media, legal, and legislative scrutiny. Commissioners, in particular, are called on to account for perceived failures in the public mental health system and to respond to proposed policies and legislative fixes intended to prevent such incidents.

“Although the publication was designed with mental health commissioners in mind, this is an invaluable resource for policy makers, anyone involved in the mental health system, and for law enforcement and other emergency responders to such tragedies,” said Fred Osher, M.D., Justice Center director of health systems and services policy. “The toolkit underscores the benefit to working collaboratively with journalists; family, consumer, and victims’ advocates; and experts in the field and first responders to ensure information is accurately and appropriately shared without undermining ongoing investigations.”

The 88-page toolkit provides specific advice for three separate stages of critical incidents: before (preparing for a future incident), during, and after an incident. For each stage, practical steps for commissioners in four areas are listed: understand your role, understand your agency, understand your state, and understand crisis communications. For example, a commissioner’s role during an incident is that of a “crisis leader,” who activates the agency’s existing crisis management team, consults with state legislators and community leaders, and communicates to the public usually through media outlets. The toolkit offers “backgrounders” and fact sheets, checklists and contact forms, and a list of online resources to help prepare for and manage such incidents and evaluate responses. A particular emphasis is placed on what research shows about the perceived link between mental illness and violence and how to communicate this knowledge.

Both publications are available on the Justice Center Web site at justicecenter.csg.org.

NEWS BRIEFS

CDC analysis indicates 59 million uninsured:

A total of 59.1 million Americans went without health insurance for at least part of 2010, according to a Centers for Disease Control and Prevention (CDC) analysis of data from the National Health Interview Survey for 2006, 2007, 2008, 2009, and the first quarter of 2010. More than 80% of the uninsured Americans are adults aged 18 to 64 (Medicare covers persons aged 65 and older). One in five American adults under age 65 (22%) is currently uninsured. Four million more Americans went without insurance in the first quarter of 2010 than during the first quarter in 2008. When the new data were released, CDC Director Thomas Frieden, M.D., M.P.H., said that the data “allow us to debunk two myths about health care coverage. The first myth is that it’s only the poor who are uninsured.” He noted that half of the 59 million uninsured individuals are over the poverty level and that one in three uninsured adults is in the middle-income range (\$44,000–\$65,000 a year for a family of four). The other myth—that only the healthy risk going without insurance—also does not square with the data: more than 40% of those who were uninsured at some point during the past year had one or more chronic diseases. For example, 15 million had high blood pressure, diabetes, or asthma. The data also show an increase in the number of people who go for a year or more with no insurance: from 27.5 million in 2008 to 30.4 million in the first quarter of 2010. The data analysis is available on the CDC Web site at www.cdc.gov/vitalsigns/healthcareaccess/latestfindings.html.

Revised guidelines for treating childhood depression: The American Psychiatric Association (APA) and the American Academy of Child

and Adolescent Psychiatry (AACAP) have released a revised and expanded version of *The Use of Medication in Treating Childhood and Adolescent Depression: Information for Patients and Families*. The guide, which was originally published in 2005, is intended to help families make informed decisions about care for a child or adolescent with depression. The new version uses a question-and-answer format to present current findings on the effectiveness of various treatments. The guide has been expanded to address a range of medications and other treatments and suicide risk. It was developed jointly by APA and AACAP in consultation with a national coalition of parents, clinicians, and professional associations and has been endorsed by the National Alliance on Mental Illness, the Suicide Prevention Action Network, Mental Health America, and the Depression and Bipolar Support Alliance. The 15-page guide is available for download from a joint APA-AACAP Web site at parents.medguide.org.

Fourth edition of Kaiser Foundation’s Medicare Chartbook:

The 2010 edition of the *Medicare Chartbook* has been released by the Kaiser Family Foundation. The 108-page book provides the most recent and reliable data available about the Medicare program, which currently covers 47 million people, including 39 million aged 65 and older and eight million nonelderly people with a permanent disability. The latest data indicate that about one in five Medicare beneficiaries is dually eligible for Medicaid, which includes a large portion of people with psychiatric disabilities. “Dual eligibles” have a different demographic profile than other Medicare beneficiaries: a larger percentage have a cognitive or mental impairment (61% versus 27%) and are in fair or poor health (51% versus 23%). Dual eligibles represent a varying share of state Medicare populations, ranging from a low of 8% in North Dakota to a high of 31% in Maine. The *Medicare Chartbook* is available on the Kaiser

Web site at www.kff.org/medicare/8103.cfm.

New resources on mental health care reform:

The National Council for Community Behavioral Healthcare has posted two new resources on its health care reform blog (mentalhealthcarereform.org) to help state officials, providers, and consumers prepare for changes under reform. The new “Roadmap for State Associations” describes strategies that advocates can use in their efforts to influence implementation of reform at the state level. Focusing on five areas of reform—health insurance exchanges, medical health homes, Medicaid expansion, home- and community-based waivers, and accountable care organizations—the roadmap provides a brief summary, a list of action items, and helpful resources in each area. It is designed to help advocates and state associations position themselves as key resources for state agencies, state legislators, and other advocacy groups. A second resource, the updated “Health Reform Summary Chart,” describes major provisions that will affect behavioral health organizations and consumers. This chart has been updated to include information about the effective date of each provision and the levels of appropriated or authorized funding for each program. Another organization the National Conference of State Legislatures (NCSL), has compiled a useful overview of state legislative and executive branch implementation efforts related to reform (www.ncsl.org/?tabid=20231). According to data in the report, since September 27, 2010, at least 25 states have enacted or adopted legislation to form a committee or task force regarding health care reform and at least 14 governors have issued executive orders to begin the process. The report links to examples of state legislation, state press releases and reports, and summaries of executive orders, as well as to a new NCSL resource—a summary of recent state legislation and actions that challenge provisions of health reform (www.ncsl.org/?tabid=18906).