ILLINOIS STATE BAR ASSOCIATION

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Mental Health Matters

The newsletter of the Illinois State Bar Association's Section on Mental Health Law

Editor's Note

BY SANDY BLAKE

Illinois Supreme Court Chief Justice Anne Burke recently convened the Illinois Mental Health Task Force Virtual Summit. The Summit, held by the Illinois Supreme Court in cooperation with the State Justice Institute and the National Center for State Courts, is part of the National Judicial Task Force initiative to examine State Courts' response to mental illness.

Justice Burke noted that the goal of the Summit is to "be a forum where representatives from the judicial, executive, and legislative branches, along with key stakeholders within the behavioral health system, such as providers, advocates, and individuals with lived experience, can come together to share information, discuss effective practices already in existence, and collaborate to create new systems for the early diagnosis and treatment of individuals suffering from

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Chief Justice Anne M. Burke Convenes Illinois Mental Health Task Force Virtual Summit

Editor's Note: The headline says it all. What follows is the text of Chief Justice Anne Burke's opening remarks.

"Good afternoon. It is my honor and pleasure to welcome you to the first session of the Illinois Mental Health Task Force Virtual Summit.

In 2019, the State Justice Institute (SJI) funded a three-year National Initiative to Improve the Justice System Response to Mental Illness and Co-Occurring Disorders. As part of that National Initiative, the Conference of Chief

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mental health and substance use issues."

"Inadequate access to medically required treatment should not be a path to incarceration," noted Justice Burke, "yet, presently, far too many individuals entering the criminal justice system are suffering from untreated behavioral health disorders. At the Summit, we hope to identify strategies and develop initiatives to build new pathways leading to treatment, rather than jail, for individuals who suffer from behavioral health disorders. Reform is particularly crucial now because the COVID-19 crisis has only magnified the demand for mental health services across the state."

The Summit is a statewide, multi-disciplinary series, consisting of five sessions. Individuals involved in behavioral health and justice system initiatives or interested in helping to lead the effort to reform and improve our current court and community responses to those with mental illness, are encouraged to attend. Each session will be held virtually on Tuesday afternoons from 3:00-5:00 p.m., beginning on September 29 and continuing through October 27. The sessions are a dynamic mixture of plenary sessions and interactive panel presentations intended to discover ways to improve court and community responses to those with mental illness. All sessions are virtual and free, but registration is required. In addition, MCLE credit is available.

By the time this newsletter is published, the first three sessions will have taken place, but all is not lost if you missed them. See Chief Justice Anne M. Burke's opening remarks and Matthew R. Davison's article in this issue for a report on the first session. Reports on subsequent sessions will follow in future newsletters. Additionally, the recording and materials of the first sessions are available to view at: Illinois Mental Health Virtual Summit Sessions Materials and can be found here: www.ncsc.org/mentalhealth. Registration for the fourth session is at: https://zoom.us/webinar/register/WN_5c7dOyC5RSGCOP49WFNoAw. Registration for the fifth session is yet to be announced. Visit the ISBA Mental Health Law Section Central Online Community for more information and discussion.

Mental health law practitioners also will not want to miss Jud DeLoss's article on the 2020 CARES Act. Among the numerous provisions intended to address the COVID-19 pandemic are significant revisions to the federal regulations governing the Confidentiality of Substance Use Disorder Patient Records.■

Chief Justice Anne M. Burke Convenes Illinois Mental Health Task Force Virtual Summit

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Justices and the Conference of State Court Administrators hosted a Midwest Regional Summit in October 2019. The respective chief justices and state court administrators of the participating states assembled in Deadwood, South Dakota, along with their appointed members of multi-disciplinary teams, to attend educational sessions and to identify state priorities for improving court and community response to mental illness.

The priorities identified by our Illinois State Team included: bringing stakeholders to the discussion table, establishing a Statewide Mental Health Task Force, and planning a statewide Mental Health Summit.

In March 2020, the Illinois Supreme Court officially formed the Illinois Mental Health Task Force and planning began for an in-person Illinois Mental Health Summit. The coronavirus pandemic forced a change

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in plans to a series of Virtual Summit sessions. As a result, we are here today at the first session of the Illinois Mental Health ***Virtual*** Summit.

The Summit is the product of many hours of planning and coordination by Marcia Meis, the director of the administrative office of the Illinois Courts, as well as all the members of our Task Force. I thank everyone for all their hard work, especially Justice Kathryn Zenoff, from the second district appellate court.

I also thank the State Justice Institute and the National Center for State Courts, in particular, Michelle O'Brien. Without them this Summit could not have become a reality.

The Task Force and this statewide Summit also have the great benefit of collaboration with Illinois Lt. Governor Juliana Stratton's Justice, Equity and Opportunity (JEO) Initiative, as well as the legislative branch's expertise of Illinois State Senator Sara Feigenholtz. Last, I would be remiss if I did not mention the support of The Kennedy Forum and its executive director, Cheryl Potts. These are just some of the members of our 'Dream Team' that have worked tirelessly on the Summit. This Summit is a convening of representatives from the judicial, executive, and legislative branches, along with key stakeholders within the behavioral health system such as providers, advocates and individuals with lived experiences—who will encourage us all to ***work together***.

Of course, the coronavirus pandemic has had an enormous impact on all our lives. Yet its effect has not always been negative. For our court system, at least, the disruption due to the pandemic has brought about unprecedented innovation in providing access to justice, as well as a renewed spirit of cooperation and collaboration among stakeholders.

I know that everyone participating in this Summit will bring with them that same innovative thinking and cooperative spirit as we share our thoughts and ideas on improving court and community response to mental illness. Thank you so much for attending and for your tireless efforts to improve the lives of those living with mental health issues and those who are their caregivers.

Before we begin with today's presentation, I wish to thank, in advance, the many speakers and panelists who are, and will be, participating in the five sessions of this Summit. We are grateful for your willingness to share your knowledge and expertise and we are eager to listen and learn from you.

Let me leave you today, with some words from my dear friend and mentor, the late Justice Mary Ann McMorrow, the first woman to become an Illinois Supreme Court Justice, and the first woman Chief Justice of the Illinois Supreme Court. Justice McMorrow said: 'Let us never, ever, forget simple humanity. Let us never forget that the law is, first and foremost about human beings and their problems.'

Justice McMorrow was speaking to lawyers, but her words are a reminder to us all—never, ever, forget simple humanity."

Chief Justice Burke went on to introduce the first learning session: 21st-Century Crisis Systems: Strategies for Mental Health and Law Enforcement Collaboration to Prevent Justice Involvement, and the session's moderator, Dr. Lorrie Rickman Jones, the president of Behavioral Health Innovations, LLC, a Chicago-based consulting firm focused on providing evidence-based and data-informed health care solutions to private health care and governmental agencies. Among her responsibilities, Dr. Rickman Jones provides consultation to the Administrative Office of the Illinois Courts and Cook County Health and Hospital Systems on bond reform and diversion strategies for persons with mental illness involved in the criminal justice system.■

The Illinois Mental Health Task Force Virtual Summit Session 1—The 21st Century Crisis System: Strategies for Mental Health and Law Enforcement Collaboration to Prevent Justice Involvement

BY MATTHEW R. DAVISON

On September 29, 2020, the National Judicial Task Force to Examine State Courts' Response to Mental Illness and the State Justice Institute hosted the first of five virtual sessions to support the Illinois Supreme Court's ongoing efforts aimed at coordinating solutions for our community members living with mental illness. The first session's title and focus was: The 21st Century Crisis System: Strategies for Mental Health and Law Enforcement Collaboration to Prevent Justice Involvement. These sessions are free to attend online and are also available on-demand at www.ncsc.org/mentalhealth. The first virtual event had approximately 700 attendees.

Chief Justice Burke personally played a role in overseeing this important program's coordination and provided opening remarks during this first session. She detailed the various stakeholders that have come together

from courts, agencies, and the community to deliver this vital program. Chief Justice Burke also highlighted how critical a coordinated response is to our community problems and thanked those involved for their efforts and willingness to come together.

Grace Hou, Secretary of the Illinois Department of Human Services ("DHS") then provided remarks and detailed how COVID-19 affected the important work of DHS. Ms. Hou stated how DHS ensures nearly 1 in 3 Illinois residents receive food, shelter, or access to medical care. She also detailed that DHS is operating during unique times because of the pandemic and social unrest. DHS is mindful and concerned for how people of color with mental illness are treated differently by our community and law enforcement.

Next, the keynote speaker, Dr. Margie Balfour then presented. Dr. Balfour is an associate professor of psychiatry in Arizona. She first highlighted the ongoing dilemma for when someone is experiencing a mental health crisis and what can or cannot be done for that individual. She detailed how some typical solutions like 911 or a local crisis center are not always appropriate. Dr. Balfour explained that a behavioral health crisis is an emergency, and, as such, it requires a systemic response with the same quality and consistency as our responses to a heart attack, stroke, fire, or other emergency. She explained that most communities do not have an appropriate response system in place for such mental health emergencies and, as a result, individuals with mental illness end up in our criminal justice system and jail. Incarceration only compounds existing issues for the individual and even adds new setbacks and issues. For instance, once someone with a mental illness is incarcerated, studies indicate they may be held twice as long as other inmates and are three times more likely to be assaulted while incarcerated. What's more, once that person is released, they likely face a host of other challenges with finding reliable housing and employment. Dr. Balfour also detailed how emergency rooms are also not the ideal solution. She explained that 84 percent of emergency rooms end up holding that person with mental illness until a free bed is available elsewhere and, during that time period, the risk of altercations increases (as well as the costs of holding the person).

Dr. Balfour then highlighted that there are ongoing efforts to establish a national standard for mental health crisis care. Part and parcel of this effort is the need for stakeholders to recognize that a collection of services is not enough. What is needed is for these various services to form a system and work together through collaboration that involves accountability and data. As proof of concept, she then went into detail about how Arizona's system operates with centralized planning and centralized accountability. This type of approach allows for an alignment of clinical and financial goals.

Another key component of Dr. Balfour's presentation was how various law enforcement agencies in her area have reconfigured their approach to mental health crises to divert individuals away from jail and instead to treatment. With the added implementation with a voluntary Crisis Intervention Team ("CIT"), these local agencies have seen higher rates of success and less time-consuming encounters for officers.

Following Dr. Balfour, Kurt Gawrisch from the Chicago Police Department and Dr. Amy Watson from the University of Wisconsin at Milwaukee, presented to the session about crisis intervention team training. This panel explained the importance of stakeholder involvement, collaborative development, and subject matter experts. Further, the presenters detailed how, exactly, Chicago's CIT program works and what each program includes. For example, Chicago's CIT training includes, among other things, education about psychotropic medications and family dynamics for those living with disabilities. Dr. Watson then discussed the ongoing data and research about CIT and its effectiveness. One notable finding is that CIT may improve an officer's knowledge, attitude, and confidence when responding to a mental health crisis. Her research also indicated that a CIT program is more likely to succeed at its stated objectives when it operates as a voluntary model for officer engagement.

The session then turned to Geri Silic, a social worker employed with the Park Ridge Police Department. She indicated that several counties and villages throughout the state are now involving social workers within local police departments with success. In some instances, a social worker may accompany officers on a mental-health call to assist and provide insight into a particular situation. Ms. Silic also works with the various courts about diversion ideas and viable strategies for addressing mental health issues rather than emphasizing incarceration.

Commander Marc Buslik (ret.) then presented about how his former district in Chicago operated in coordinating a proper response to calls that came into the department regarding mental health crises. He found it essential to localize certain features for better community engagement, including a dedicated mental health resource officer.

Finally, Nathan Whinnery from the Rosecrance Mulberry Center in Rockford, Illinois, discussed what his particular crisis center encounters. Mr. Whinnery indicated how his center operates as a resource with local police to coordinate drop-offs and community engagements. This model is less expensive and less time-consuming than an emergency room drop-off. The community members are given access to a comfortable "living room" atmosphere and provided an opportunity to talk one-on-one with a team member from the center to coordinate what level of care may be needed.

Overall, the session was very informative and provided critical data and examples for how systems can be created through collaborative agreements. As daunting as the task ahead is for this new project and task force, this session provided real examples of what can be achieved through joint efforts to address ongoing mental health crises in our communities. If a practitioner is interested in being a part of reconfiguring how we respond and care for our community members, this session should not be overlooked. Consider reviewing it and getting involved.■

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CARES Act Includes Substantial Revisions to the Federal Confidentiality of Substance Use Disorder Patient Records (42 C.F.R. Part 2)

BY GERALD (JUD) E. DELOSS, J.D.

On March 27, 2020, the U.S. Congress passed and the president signed an unprecedented $2 trillion stimulus package in response to the coronavirus pandemic (COVID-19), known as the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). Among the numerous provisions intended to address the COVID-19 pandemic are significant revisions to the federal regulations governing the Confidentiality of Substance Use Disorder Patient Records, under 42 U.S.C. § 290dd-2 and the corresponding regulations found at 42 CFR Part 2 (Part 2). These revisions more closely align Part 2 with the Privacy and Security Regulations under the Health Insurance Portability and Accountability Act ("HIPAA") but also add heightened protections against use or disclosure of Part 2 records in legal or other proceedings, as well as imposing ground-breaking new anti-discrimination protections.

In most situations, Part 2 currently requires that patient consent or a valid court order be obtained prior to disclosure of Part 2 records. The legislation would retain the consent requirement but now only requires initial patient consent before a Covered Entity, Business Associate, or Part 2 Program may use or disclose the Part 2 records for Treatment, Payment, and most Health Care Operations, as each of those terms is defined under HIPAA or Part 2. The legislation excludes from permissible Health Care Operations uses or disclosures for the creation of de-identified health information or a limited data set, and fundraising for the benefit of a Covered Entity. However, the legislation does permit the use or disclosure of de-identified information for certain public health purposes.

Currently, Part 2 imposes the same patient consent or court order requirement upon most disclosures of Part 2 records by a recipient of those records (a "Lawful Holder") and applies those restrictions to downstream recipients of the data indefinitely. Under the new legislation, a recipient would be permitted to re-disclose the Part 2 records in accordance with HIPAA. Specifically, it will be permissible for a patient's prior written consent to be given once for all future uses or disclosures for purposes of Treatment, Payment, and Health Care Operations, until the patient revokes such consent in writing. Each of the disclosures will be subject to the Health Information Technology for Economic and Clinical Health Act ("HITECH Act") accounting of disclosures requirements.

Currently, Part 2 prohibits the use of Part 2 records in criminal or civil proceedings without patient consent or a stringent court order protocol that imposes certain procedural requirements meant to address privacy concerns. The legislation creates an even stronger set of protections and prohibitions which mandates that records may not be disclosed or used in any civil, criminal, administrative, or legislative proceeding conducted by any Federal, State, or local authority, against a patient, including that:

- The record or testimony shall not be entered into evidence in any criminal prosecution or civil action before a Federal or State court
- The record or testimony shall not form part of the record for decision or otherwise be taken into account in any proceeding before a Federal, State, or local agency
- The record or testimony shall not be used by any Federal, State, or local agency for a law enforcement purpose or to conduct any law enforcement investigation
- The record or testimony shall not be used in any application for a warrant

These protections are critical as disclosures to third parties would not necessarily fall under Treatment, Payment, or Health Care Operations.

The legislation introduces explicit protections against discrimination based upon Part 2 records or information about the patient disclosed under Part 2—either inadvertently or intentionally. Specifically, no entity may discriminate against a patient about whom the Part 2 records relate in:

- Admission, access to, or treatment for health care
- Hiring, firing, or terms of employment, or receipt of worker's compensation
- Sale, rental, or continued rental of housing
- Access to Federal, State, or local courts
- Access to, approval of, or maintenance of social services and benefits provided or funded by Federal, State, or local governments

Furthermore, no recipient of Federal funds may discriminate against the patient based upon the Part 2 records in affording

access to the services provided with such funds.

The HIPAA Breach Notification Rule is now directly applicable to Part 2 programs, regardless of whether they are considered Covered Entities.

Part 2 has historically been enforced criminally by the U.S. Attorney. The legislation modifies the penalties, moving the penalties from Title 18 of the U.S. Code to sections 1176 and 1177 of the Social Security Act (42 U.S.C. 1320d–5 and 42 U.S.C. 1320d–6), which are the penalties imposed for HIPAA violations.

The legislation includes "the sense of Congress", aspirational goals, rules of construction, and interpretive guidance for the regulations which will need to be issued by the Substance Abuse and Mental Health Services Administration ("SAMHSA"). Among the Congressional intent indicated is:

- No limit upon a patient's right, under HIPAA, to request a restriction on the use or disclosure of a record (45 C.F.R. § 164.522)
- No restriction on a Covered Entity's right, under HIPAA, to utilize the patient consent process (45 C.F.R. § 164.506)
- A simplified Notice of Privacy Practices
- The encouragement of Part 2 programs to access State Prescription Drug Monitoring Programs when clinically appropriate
- Incentives for Part 2 programs to explain the consent process and its benefits

These substantial modifications should allow for greater flow of information among and between health care providers and payors and further the goal of integrated care across behavioral health and medical health. Data exchange for reimbursement, Health Information Exchanges ("HIEs"), Accountable Care Organizations ("ACOs"), and similar care models should benefit. The addition of clear protections in criminal, civil, administrative, and legislative proceedings should be lauded by privacy advocates, along with brand new anti-discrimination protections. Further, the ability of the patient to revoke consent to the flow of Part 2 records at any time grants unprecedented control to patients over their health information. However, care must be taken to identify the unique distinctions that remain between Part 2 and HIPAA, and professionals should carefully review the legislation and any proposed regulations in addition to State mental health and substance use disorder laws to ensure proper uses and disclosures of all health information.■

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