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

21st Century Cures Bill includes important changes to Federal mental health policy and funding

BY MARK HEYRMAN

On December 13, 2016, President Obama signed into law the "21st Century Cures" Bill (H.R. 34). In additional to many other unrelated health care provisions, this massive (over 500 pages) bill includes provisions from several pieces of mental health legislation which had been under consideration in either the House or the Senate during the 114th Congress. The bill includes most of the provisions from the House-passed "Helping Families in Mental Health Crisis

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Choosing a safe and effective mental health application

Understanding what factors should be considered to protect patients from a lack of FDA regulation

BY SARAH COSTA

FDA Regulation of Medical Mobile Applications

In 2013, the U.S. Food and Drug Administration (FDA) issued a final guidance on the regulation of mobile medical applications.[1] Noting that a majority of apps pose a minimal risk to consumers, the FDA stated that it would not enforce requirements under the Federal Drug and Cosmetic Act. The FDA instead is focusing its oversight on mobile medical apps that:

- are intended to be used as an accessory to a regulated medical device, or
- transform a mobile platform into a

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21st Century Cures Bill includes important changes

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Act" (H.R. 2646 which usually referred to as the "Murphy bill"). It also includes many provisions from the Mental Health Reform Act (S. 2680) which the Senate considered but did not pass. This article will summarize the key changes to Federal mental health law and policy contained in H.R. 34. Although H.R. 34 includes numerous changes to other areas of health care policy, these are beyond the scope of this article.

Mental Health Insurance Parity

The Federal mental health insurance parity laws prohibit private health insurance companies from providing less coverage for mental illnesses than is provided for other healthcare conditions. H.R 34 strengthens these laws by:

- requiring the Department of Health and Human Services (HHS) Inspector General to provide detailed written guidance about what constitutes compliance and non-compliance with the parity laws (Section 13003)
- creating an action plan to improve enforcement (Section 13002)
- specifically covering eating disorders (Section 13006)

Funding Authorizations for Mental Health and Substance Abuse Services

- Substance Abuse Block Grant funding was authorized at $1.86 billion annually for Fiscal Years 2018 through 2022 (Section 8002)
- Community Mental Health Services Block Grant funding was authorized at $532.6 million annually for FY 2018 through 2022. Ten percent of this money is set aside for individuals with early mental illnesses. (Section 8001)
- Funding for Assisted Outpatient Treatment was set for between $15 and $20 million annually through FY2022
- $64.6 million for homeless transition services (Section 9004)
- $41.3 million for treatment and recovery for homeless persons (Section 9001)
- $30 million for adult suicide prevention (Section 9009)
- $30 million for youth suicide prevention under the Garrett Lee Smith Memorial Act (Section 9008)
- $7.2 million for the National Suicide Prevention Lifeline Program (Section 9005)
- $7 million for on-campus suicide prevention services
- $6 million for the Suicide Prevention Technical Assistance Center
- $14.7 million for training law enforcement personnel concerning mental illnesses
- $12.5 million to create a data base of psychiatric hospital beds
- $5 million for new Assertive Community Treatment Programs
- $5 million for maternal depression screening (Section 10005)
- $4.3 for jail diversion programs (Section 9002)

Changes to the Administrative Structure of the Department of Health and Human Services

- The bill creates a new Assistant Secretary for Mental Health and Substance Abuse (Section 6001). This new position is subject to Senate confirmation, reports directly to the Secretary of HHS and is responsible for what has been the Substance Abuse and Mental Health Services Administration (SAMHSA) which was run by an administrator. Also created within HHS is a chief medical officer responsible for promoting evidence-based and promising practices. (Section 6003)
- The new assistant secretary must create a strategic plan by September 30, 2018, to be updated every four years. (Section 6005) Other administrative changes include the creation of a new National Mental Health Policy Laboratory to identify new mental health services and an Interdepartmental Serious Mental Illness Coordinating Committee. (Section 6031)

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Mental Health and Criminal Justice

- Reauthorize the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA) at $50 million annually from 2017 to 2011
- Create a Forensic Assertive Community Treatment initiative to divert persons with mental illnesses from incarceration (Section 14005)
- Create a Federal Mental Health Court pilot program to divert low-level offenders (Section 14003)
- Require training for Federal uniformed services on how to respond to persons with mental illnesses (Section 14008)
- Expand in-prison re-entry programs to cover mental health treatment (Section 14009)
- Create court-ordered outpatient treatment as an alternative to incarceration (Section 14002)
- Require the General Accounting Office to issue a report on the number of mentally ill offenders in prison and the costs of incarcerating this population (Section 14016)
- Require the Department of Justice to collect data on mental illness and violent crime (Section 14015)

Pediatric Mental Health

- The Health Resources and Services Administration must provide grants to states to support statewide child psychiatric access programs to include "pediatric mental health teams" and telehealth services
- Authorizes $119 million annually for children with serious emotional disturbance
- Authorizes $20 million for infant and early childhood mental health promotion intervention and treatment
- Makes children in inpatient mental health facilities eligible for early screening and diagnostic services beginning in 2019 (Section 12005)

Confidentiality and Access to Records

- HHS must issue written guidance about the ability to share mental health records with caregivers and family members without violating the Health Insurance Portability and Accountability Act (HIPAA) (Section 11003)
- HHS must also create a training program and materials to clarify HIPAA confidentiality rules (Section 11004)
- Authorizes at total of $7 million to carry out the above provisions

Mental Health Workforce Development

- Creation of demonstration program to train medical residents to integrate mental health and substance abuse services into primary care setting. Authorizes $50 million annually from 2018 to 2022 for this program
- Child and adolescent psychiatrists are eligible for National Health Services Corps loan repayment programs (section 9023)
- Liability limitations created for health care professional who volunteer at community health centers (Section 9025)

Veterans Mental Health

- Creates procedural protections before veterans are determined incompetent to manage their benefits (Section 14017)
- Veterans determined incompetent to manage their benefits are included in the National Instant Criminal Background Check System used to prevent gun purchases
- Creates appeals process to challenge determination of incompetence and loss of firearm privileges.

It is likely that this bill will be the last one signed by President Obama before he leaves office. It is heartening that despite the gridlock in Washington, Republicans and Democrats could work together on mental health and substance use issues. The provisions listed above will help move mental health policy more towards prevention, early intervention and other measures to prevent the worst results of untreated mental health conditions. One could compare this new focus to the treatment of non-psychiatric illnesses. We do not intentionally wait to treat cancer until it reaches Stage Four and death is imminent and certain. This bill show that in the behavioral health field also we are finally beginning to implement the slogan "B4 Stage 4." ■

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Choosing a safe and effective mental health application

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regulated medical device.

For example, an app used in conjunction with an ultrasound wand would be regulated because it is intended to be used as an accessory to a regulated medical device. However, a mental health app that allows users to track their mood and symptoms would not be regulated by the FDA.

Regulation of Mental Health Applications

Most mental health apps do not change a phone into a medical device, nor are they intended to be used as an accessory to an already regulated medical device. As such, most will avoid FDA regulation. Nevertheless, many psychiatrists believe that mobile apps could be a way to reach populations like teenagers and men, who usually do not seek out mental health treatment on their own. Dr. John Torous, chair of the American Psychiatric Association's Smartphone App Evaluation Task Force, advises app users to consider all ASPECTS of mental health apps:[2]

- **Actionable –** To be actionable an app must collect data that can be valuable and clinically useful.
- **Secure –** State and federal laws require that health information be secure. In Illinois, mental health information is protected by the Mental Health and Developmental Disabilities Confidentiality Act as well as HIPAA. However, mental health app providers are not bound by HIPAA, leaving patient information vulnerable to data mining. Apps should be password protected and patient data should be encrypted in case the mobile device is stolen or hacked.
- **Professional –** Mental health apps should follow established professional and ethical standards for clinical use. Apps that do not comply with established professional standards run the risk of negatively affecting a patient's mental state.
- **Evidence based –** Less than 1 % of mental health apps available for download have been clinically tested for efficacy. Apps that have not been studied could have an adverse effect on a patient's mental health. Some apps have been found to contain information that is incorrect. For example, a recent study identified an app for users with bipolar disorder that advised users that the disorder was contagious!
- **Customizable –** Patients and clinicians are more likely to become invested in and adhere to something that they created together.
- **Transparent –** Look for apps that openly report how data is collected, stored, analyzed, used and shared. If uncertainty exists as to what is happening with a patient's health care data, patient data may not be safe and the app may not be dependable.

More information about the regulation of mobile medical apps is available by visiting the FDA's website.[3] ■

Sarah Costa is a 3L at Loyola University Chicago School of Law and an extern at Presence Health.

1. *FDA Issues final guidance on mobile medical apps*, U.S. Food and Drug Administration (Sept. 23, 2013) <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm369431.htm>.

2. *Weighing the Pros and Cons of Mental-Health Apps*, Science Daily (Apr. 26, 2016) <https://www.sciencedaily.com/releases/2016/04/160426144555.htm>.

3. *Mobile Medical Applications*, U.S. Food and Drug Administration (Sept. 22, 2015) http://<www.fda.gov/medicaldevices/digitalhealth/mobilemedicalapplications/default.htm>.

Letter from the Chair

BY JOSEPH T. MONAHAN

Welcome to the latest edition of *Mental Health Matters.* On behalf of the Section Council, a sincere thank you to all who contribute these informative articles, and special thanks to Sandra Blake for her hard work as editor. The Section Council continues to engage with various stakeholders in furtherance of its mission to engage, educate, and lead on the subject of mental health. In this spirit, I would like to share the findings of a recent report by NAMI on the subject of mental health parity titled "Out-of-Network, Out-of-Pocket, Out-of- Options: The Unfulfilled Promise of Parity."

Despite the decision by 32 states to expand Medicaid coverage and federal mental health parity requirements, people with health insurance still struggle to find mental health providers and services in their health plan networks or in their geographic area. They incur greater out-of-pocket costs for all types of mental health care than general medical or specialty care.

Contributing to this problem is a nationwide shortage of mental health professionals. In 2012, there were 3,669 Mental Health Professional Shortage Areas containing almost 91 million people. Further, many mental health providers, particularly psychiatrists, do not accept health insurance. A recent study in JAMA found that only 55% of the nation's psychiatrists accepted insurance compared with 88% of physicians in other medical specialties. Mental health providers cite low reimbursement rates and heavy administrative burden as reasons they do not participate in health plans. Additionally, insured individuals have difficulty finding accurate information about participating providers in their health insurance plans and insurance networks frequently fail to keep up-to-date provider directories.

Joseph T. Monahan

To address these barriers to accessing mental health care, the report recommends that health plans:

- Maintain accurate, up-to-date directories.
- Provide easy to understand information about mental health benefits.
- Promote integration of care.
- Expand provider mental health networks.
- Cover out-of-network care to fill provider gaps.

Insurance and mental health parity is especially crucial as individuals face the impending upheaval of health care policy on both the federal and state levels. Over the rest of the bar year, Mental Health Matters will continue to highlight important issues relating to mental health.

Thank you.

Joseph T. Monahan ■

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A resolution for 2017: Giving serious consideration to outpatient treatment

BY MATTHEW R. DAVISON

Private hospitals and related care facilities should take note: 2017 is a pivotal year for outpatient treatment. Following a federal grant awarded to Cook County Health and Hospitals System, certain state facilities are now able to fundamentally reconfigure how they administer care to individuals with severe mental illnesses through Assisted Outpatient Treatment ("AOT").[1] Providers should embrace this momentum or risk idling in the past, unequipped to navigate an evolving landscape where outpatient care is readily pursued and administered. What's more, unencumbered by the contours articulated by the AOT grant, private providers have the ability to craft creative solutions within the existing statute allowing outpatient treatment. This article highlights the new Cook County Assisted Outpatient Treatment Program and is meant to spur further contemplation and dialogue among those providers not participating in the program about how outpatient treatment demands serious consideration now, more than ever.

Background

As stated in the initial funding opportunity announcement, this new program "is intended to implement and evaluate new AOT programs and identify evidence-based practices in order to reduce the incidence and duration of psychiatric hospitalization, homelessness, incarcerations, and interactions with the criminal justice system while improving the health and social outcomes of individuals with a serious mental illness (SMI)."[2] The project is "designed to work with families and courts, [and] to allow these individuals to obtain treatment while continuing to live in the community and their homes."[3] Initial facility-participants in the AOT project are Chicago-Read Mental Health Center, Madden Mental Health Services and Cermak Health Services. It is a four-year grant and aims to serve 100 individuals per year.

There are several obvious and immediate benefits of the AOT program. One benefit to both respondent and facility is that the project tackles the issue of repeated admissions head-on. In other words, AOT is designed to augment an individual's treatment where it is needed the most: in the community. By not abruptly ceasing care at the facility's exit doors, these state centers mitigate the unfortunate risk of seeing the same client weeks later at intake. Additionally, the AOT project specifically involves the respondent and invites each individual, through counsel, to have input into his or her own care. The opportunity for agreed orders and participation in the process can be pivotal to individuals that routinely have no say in their care.

Eligibility

Screening for AOT eligibility generally occurs at the outset of patient intake. Individuals experiencing a severe mental illness may qualify for AOT if they are over the age of 18, a resident of Cook County, and have a history of non-compliance with treatment as well as recent (within 12 months) admissions to psychiatric facilities.

Process

A case manager will coordinate most of the substantive sequences for AOT-eligible individuals. Such AOT events involve contacting the proposed custodian of the individual and may even include having members of an Assertive Community Treatment ("ACT") team meet with the respondent prior to any discharge. Such instances can bolster the program's credibility in the eyes of the AOT-respondent and provide much-needed familiarity to an otherwise opaque concept.

AOT may be pursued by petition through adversarial hearing[4] or by agreement.[5] Those practitioners involved in the AOT program (this author included) are optimistic that the majority of AOT petitions will be by agreement. Even if such outpatient care is sought by agreement, the Court will apply a variety of safeguards such as reviewing the written report, assessing the custodian's understanding, and further ensuring the respondent is informed of the agreement's conditions. If the agreed order contemplates medication, then an additional determination by the Court is required.[6]

An agreed outpatient order remains enforceable for 180 days with the possibility of an agreed extension.[7] Throughout this period, the individual is represented by counsel and status updates are provided to the Court regarding the individual's progress, including any compliance issues. Non-compliance with an agreed care and custody order may result in the custodian orchestrating the respondent's return to a facility where the individual may be admitted as voluntary.[8]

Conclusion

The AOT project provides infrastructure and opportunity for mental health practitioners in the form of a long-ignored method of treatment. Indeed, many would argue that outpatient treatment is a frontier that should not be a "frontier" at all. Consequently, it is time to resolve to embrace a treatment that can fundamentally bridge the gap between hospital and home so that more individuals (and facilities) can break an outdated cycle of inpatient admissions and frustration.

Matthew R. Davison is contract counsel for Legal Advocacy Service, a division of the Illinois Guardianship and Advocacy Commission. Pursuant to the AOT grant, he represents respondents throughout the AOT process. He may be reached via email at Matthew.Davison@illinois.gov and by phone at (847) 272-8481.

1. Other grantees include facilities from Alabama, California, Florida, Kentucky, Maryland, Mississippi, Nevada, Ohio, Oklahoma, Puerto Rico, Texas, Utah, Washington, and Wyoming.
2. http://www.samhsa.gov/grants/grant-announcements/sm-16-011 (last visited December 20, 2016).
3. *Id.*
4. Involuntary admission on an outpatient basis may be sought for an individual that is either:

> A person who would meet the criteria for admission on an inpatient basis as specified in Section 1-119 in the absence of treatment on an outpatient basis and for whom treatment on an outpatient basis can only be reasonably ensured by a court order mandating such treatment;
> *or*
> A person with a mental illness which, if left untreated, is reasonably expected to result in an increase in the symptoms caused by the illness to the point that the person would meet the criteria for commitment under Section 1-119, and whose mental illness has, on more than one occasion in the past, caused that person to refuse needed and appropriate mental health services in the community.

405 ILCS 5/1-119.1.
5. *See* 405 ILCS 5/3-801.5.
6. *See* 405 ICLS 5/3-801.5(a)(5).
7. *See* 405 ILCS 5/3-801.5(g).
8. *See* 405 ILCS 5/3-801.5(b).

Can a defendant be compelled to submit to a Rule 215 physical or mental examination?

BY ALBERT E. DURKIN, MIROBALLI, DURKIN & RUDIN, CHICAGO

Plaintiffs have long been required to submit for physical or mental examinations by a physician of defendants choosing upon motion within a reasonable time before trial in accordance with the provisions of Illinois Supreme Court Rule 215. Under those circumstances, typically the defendant obtains a report favorable to the defense and then designates the examining physician as a Supreme Court Rule 213 expert on behalf of the defense. The question then arises, are there circumstances where a plaintiff can request that the Court compel the defendant to submit to a physical or mental examination by a physician designated by the plaintiff? The case of *Jane Doe v. Norman Weinzweig*, 2015 IL App (1st) 133424-B, answers that question in the affirmative.

The case of *Jane Doe v. Norman Weinzweig* involved circumstances wherein the plaintiff and the defendant met through a dating service, It's Just Lunch, and after their second date engaged in sexual relations. The plaintiff claimed that both parties affirmed to one another, prior to engaging in physical activity; that neither had any sexually transmitted diseases. Shortly after the physical encounter, plaintiff developed symptoms of an STD. After going to her physician and undergoing testing, a diagnosis of the herpes 2 virus was confirmed. Thereafter, plaintiff Doe contacted defendant Weinzweig to advise him of the diagnosis at which time he neither admitted nor denied that he too was infected but asked her not to contact an attorney and that he would pay for her medical expenses. Rather than follow the defendant's request, plaintiff did contact an attorney in order to ascertain her rights, which resulted in a complaint being filed against the defendant and the dating service. The defendant dating service filed a Motion to Dismiss and ultimately settled its liability and therefore was not a party at the time of the Appeal.

Defendant Weinzweig filed a Motion to Dismiss plaintiff's complaint pursuant to Section 2-619 of the Code of Civil Procedure (735 ILCS 5/2-619) to which he attached copies of certain medical records containing a lab report and a signed declaration on his part averring that as of October 2010 he had undergone a battery of tests and did not have the herpes 2 virus. He further averred that he had no signs or symptoms of the herpes 2 virus and that based upon his medical education, prior medical testing and his lack of symptoms, he believed that he was not infected with the herpes 2 virus at the time of the physical encounter with the plaintiff. Thereafter, the plaintiff filed an Amended Complaint to which the Court allowed discovery. Defendant, Weinzweig filed an Answer to the Amended Complaint that did not include Counterclaims, Affirmative Defenses or any other affirmative matter. He denied in his Answer that he exposed the plaintiff to the herpes 2 virus and further denied telling her that he was free from the disease at the time of their encounter. In her discovery, plaintiff sought information regarding the defendant's prior medical condition. The defendant objected to those discovery requests on the basis of relevance and protected by physician-patient privilege. The motion Court sustained defendant's objections on the grounds of physician-patient privilege. This left the plaintiff with her only recourse of asking the Court to compel the defendant to submit to a Rule 215 physical examination of the defendant that would include a diagnostic blood test, which would definitively rule or rule out that the defendant was infected with the herpes 2 virus. Defendant filed a written response to the Motion for Rule 215 Examination claiming that he had not placed his physical condition in controversy; that the plaintiff failed to show good cause to justify an order requiring him to undergo evasive testing and that the plaintiff's motion was simply an attempt to circumvent the physician-patient privilege. Defendant further argued that the compulsory examination would violate his right to privacy under the Illinois Constitution.

After extensive argument on the motion, the Circuit Court entered an Order granting plaintiff's Rule 215 Motion and ordered the parties to schedule the examination by a date certain. The defendant refused to schedule the examination but instead sought a friendly contempt order from the Court authorizing him to file a Rule 308 appeal to the Appellate Court appealing the Court's order compelling him to submit to the exam. The Court found defendant, Weinzweig in civil contempt and ordered a sanction of $1,000. Defendant filed his Notice of Appeal shortly thereafter.

In a decision filed on February 24, 2015, authored by late Justice, Laura Liu, the Appellate Court found that the Circuit Court had the authority to compel the Rule 215 Examination of defendant Weinzweig relying upon the case of *Estate of Stevenson*, 44 Ill. 2d 525 (1970), that the defendant had placed his physical condition in controversy by virtue of the conflicting medical testimony, reports and other documentation being offered as proof and that such an examination would "materially aid in the just determination of the case." The Court in *Weinzweig* relied upon the declaration filed by the defendant and the voluntary submittal of his medical records as constituting more than a denial of an unsubstantiated allegation on the part of the plaintiff

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and by doing so, the defendant placed his physical condition squarely at issue in an effort to rebut the plaintiff's claim. The Court further cited, under *Stevenson* it is irrelevant who placed defendant's physical condition at issue as long as it is at issue. The Court then found that since the defendant's physical condition was at issue the Circuit Court was within its sound discretion to order the Rule 215 Examination; since such an examination would materially aid in the just determination of the case. The Court further noted that there is no longer a requirement of showing the Court "good cause" which was eliminated from the Amended Supreme Court Rule 215.

After determining that the defendant had placed his physical condition at issue, the Court then moved on to address defendant's other defenses of physician-patient privilege and constitutional right to privacy. With reference to the claim of physician-patient privilege the Court summarily ruled that the 215 Examination does not render the examining physician to be a treating physician covered by the patient-physician privilege. Citing *Dole v. Shlensky*, 120 Ill. 3d 807 (1983); and *Salingue v. Overturf*, 269 Ill. App. 3d 1102 (1995). With reference to the defendant's final objection to the Rule 215 compelled exam that it would invade his constitutional right to privacy. The Court cited Supreme Court Rule 19(a) that requires a party challenging the constitutionality of a Statute to serve notice on the Attorney General or proper state agency in cases where the State is not a party and the defendant having failed to do so, the Court found that he has waived his claim of invasion of right to privacy. *In Re the Marriage of Winter*, 2013 IL App (1st) 112836.

Lastly, at the time of the appeal the defendant argued the Rule 215 Examination violated public policy, which was not part of his original argument and therefore the Court declined to consider the same. The remainder of Justice Liu's decision dealt with the applicability of the contempt citation.

The Court then affirmed the granting of the Rule 215 Motion and remanded it to the Circuit Court for further proceedings consistent with its ruling. The matter settled shortly thereafter. ■

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