

A Methodology for Sharing Behavioral Health Information across Justice and Health Systems: Lessons from the District of Columbia

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Introduction

People with mental illness and substance use problems are vastly overrepresented in the criminal justice system. One important step toward addressing this inequity is making behavioral health information (BHI) securely accessible to relevant stakeholders. Presently, decision makers, health care providers, and staff in the justice system work with only a fraction of the information generated throughout the justice and health systems about their clients. Expanding the utility of available behavioral health data has the potential to keep people out of jail and prison by appropriately diverting them from the justice system to treatment in the community. It could also improve prevention, early intervention, and continuity of care at every stage in the justice system through transition back to the community.

There is growing interest but few examples of how to share data across sectors and agencies. This brief describes the methodology used by the Vera Institute of Justice (Vera) in a study that secured, transmitted, matched, de-identified, merged, and harmonized administrative and program data from six agencies across the justice and health sectors in the District of Columbia. The study drew from this data to examine opportunities to share behavioral health information.¹ Vera has used the methodology described in this document in multiple studies, suggesting that it is effective and replicable in practice.²

The study

Access to clients' behavioral health histories is vital for making informed decisions about their care and justice involvement. The episodic nature of many

conditions means that during any particular assessment, a person's symptoms may not be severe enough to lead to diagnosis or referral for treatment. Additionally, a person may feel pressured not to disclose their symptoms because of the threat of stigma or barriers to employment. These factors add up to a challenging set of circumstances for providers and staff in the justice system that could be mitigated by access to historical data that often lies waiting in the health and justice agencies. At the same time, BHI is sensitive. It is essential to ensure the privacy of vulnerable populations. (See "Sharing behavioral health information: Ensuring privacy and security" at page 4.) The goal of Vera's study was to provide empirical evidence to inform the District's ongoing efforts to expand interagency collaboration.

Vera partnered with six government agencies to assess the availability of BHI in the health and justice systems for a cohort of people arrested by the Metropolitan Police Department of the District of Columbia (MPD) in October 2012. In addition to the arrest data from MPD, five other agencies supplied BHI for the arrest cohort for the period 2006 to 2014. Mental health and substance use information was provided by the Pretrial Services Agency for the District of Columbia (PSA), the Department of Corrections (DOC), the Court Services and Offender Supervision Agency (CSOSA), the Department of Behavioral Health (DBH), and the Department of Health Care Finance (DHCF). The study examined the extent to which the agencies held *historical BHI* for people arrested in October 2012. It then focused on the group of people with historical BHI to assess whether a justice agency subsequently generated *follow-up BHI* for them during their encounter for the October 2012 arrest. Lastly, for people with historical BHI but no follow-up BHI, the study

determined which agencies held data on their behavioral health histories. The assumption was while it was unlikely all these people needed treatment, broader access to their historical BHI could have informed decisions about whether to divert or refer them for services.

Data-sharing methodology

To conduct the study, Vera developed a methodology that complied with stringent data-protection statutes, including 42 CFR Part 2 (confidentiality of substance use disorder patient records), the Health Insurance Portability and Accountability Act (HIPAA), and the Federal Privacy Act. In this protocol, Vera never had access to identifiable justice and health information. Nor was it possible for Vera to reverse engineer the process to relink the de-identified confidential information with individual identifiers.

Step 1. Identifying the study cohort

Vera requested only identifying information from MPD for all people arrested during October 2012 (the study cohort). MPD provided a file of identifiers comprising police department identification numbers (PDIDs) created by MPD for each arrest (PDIDs are used by all the justice agencies), as well as names, birthdates, and arrest dates. No other justice or health information was provided at this time.

Step 2. Generating a second ID number

Vera then generated a second unique identification number for each person in the MPD arrest file and merged the new identifiers into the original file provided by MPD. For each member of the October 2012 arrest cohort, the new file contained only the PDIDs, names, birthdates, and arrest dates provided by MPD, along with the Vera-generated identification number.

Step 3. Matching the MPD identifiers in the justice agencies

Vera distributed this new file to the justice agencies: MPD, PSA, DOC, and CSOSA. The four justice agencies

matched the PDIDs to their administrative data and then extracted specified justice and behavioral health information over the study period (2006 to 2014) for every person in the arrest cohort for whom it was available.

Step 4. Matching the MPD identifiers in the health agencies

Unlike the justice agencies, the two health agencies do not use PDIDs, and therefore could not match data using this identifier. Instead, DBH and DHCF used names, birthdates, and arrest dates to match MPD records with administrative data. Having made these matches, the health agencies returned the identifiers-only files to Vera so that researchers could edit the file for any false matches. Vera then returned the respective de-duplicated files to DBH and DHCF. Like the justice agencies, the health agencies then extracted BHI from their administrative data for the study period (2006 to 2014) for every person in the de-duplicated file for whom it was available.

Step 5. Encrypting the identifier in-house

One agency created an encryption algorithm and shared it with the other agencies but not with Vera. Each agency used the algorithm to encrypt the unique identification number that Vera provided in Step 2.

Step 6. De-identifying the BHI file

All agencies deleted the PDID and names provided by MPD, as well as the Vera-generated identification number provided in Step 2. They then sent their final de-identified files to Vera. At this point, the agency files contained the encrypted identification number as the only identifier, as well as the relevant demographic, justice, and health information.

Step 7. Merging the de-identified BHI files

The final step taken by researchers in preparation for analyzing the individual-level data involved merging the six agency files based on the encrypted identification number.

Key findings

BHI was widely generated throughout the justice and health systems. Seven in 10 people arrived at PSA with historical BHI, nine in 10 people at DOC, and eight in 10 people at CSOSA. (Figure 1, blue bars.)

The justice agencies generated follow-up BHI during contact for a minority of people who arrived with historical BHI. For example, PSA and DOC generated follow-up BHI for about one quarter of people who had historical BHI upon arrival. (Figure 1, red bars.)

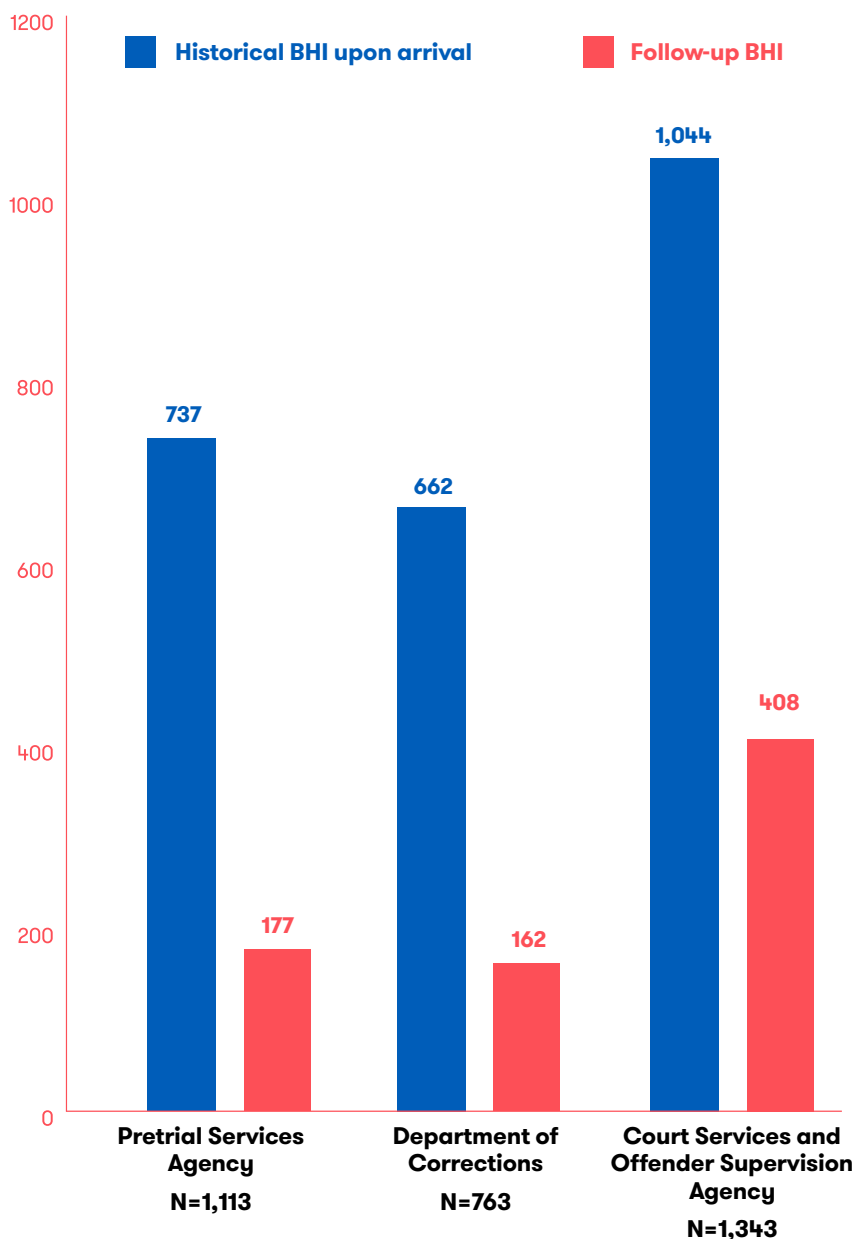
Assuming that clients' behavioral health histories could inform agency decisions, access to historical BHI may be especially relevant for cases where the agency did not generate follow-up BHI. Historical BHI could potentially be retrieved from the agency's own archives for some of these clients. For instance, CSOSA itself held historical BHI for 85 percent of this group.

Historical BHI could also be retrieved from other health and justice agencies. To illustrate, DBH held historical BHI for half of CSOSA's people with no follow-up BHI, while CSOSA held BHI for more than three quarters of PSA's group.

Expanding access to historical BHI may especially benefit some groups. The justice agencies were one-third to one-half as likely to generate follow-up BHI for men as for women. Therefore, men's behavioral health, in particular, may benefit from data-sharing initiatives.

Figure 1.

Number of people from the October 2012 arrest cohort with historical BHI upon arrival at the justice agencies and follow-up BHI generated during agency contact



Actionable insights

Collaborative studies that integrate cross-sector data can provide empirical evidence for a wide range of initiatives, such as those described below.

Laws and regulations promoting cross-agency and cross-sectoral information-sharing arrangements. Vera's study will inform legislation presently under discussion that would require D.C. agencies to share information for

legitimate government purposes related to carrying out the mission of the agency, evaluating the effectiveness of the agency's work, and improving services.

Targeted Medicaid enrollment strategies for groups that are at higher risk of needing behavioral health services. The current study can inform the District's ongoing efforts to connect to Medicaid people released from the justice system. Over half the study cohort that was eventually released from DOC was enrolled in Medicaid at or after

release. However, the health and justice systems held BHI for eight out of 10 people who were *not* enrolled. People in this group could be targeted for Medicaid enrollment under the assumption that they are more likely to need behavioral health services after release.

Estimating the service capacity required of community providers to respond to the full range of behavioral health needs of people returning to their communities. As the impulse toward decarceration grows, it is increasingly important that the communities to which people return are equipped to offer the services and supports people and their families need to thrive. Previous efforts to de-institutionalize vulnerable populations with behavioral health conditions have been ill conceived and under-resourced, with regrettable consequences. Information from cross-sectoral data collaborations could potentially help avoid a repetition of those outcomes.³

Importantly, the great advantage of multisector data-sharing projects is that they offer a more holistic view of the lives of vulnerable people and thereby provide crucial information that can more effectively lessen the burdens, costs, and suffering of individual people, communities, and society.

Endnotes

- 1 Marilyn Sinkewicz, Yu-Fen Chiu, and Leah Pope, *Sharing Behavioral Health Information across Justice and Health Systems: Opportunities in the District of Columbia*, (New York, NY: Vera Institute of Justice, 2018) www.vera.org/behavioral-health-dc-justice-health-systems.
- 2 See Jim Parsons and Talia Sandwick. *Closing the Gap: Using Criminal Justice and Public Health Data to Improve the Identification of Mental Illness*. (New York: Vera Institute of Justice, 2012).
- 3 Richard G. Frank and Sherry A. Glied, *Better but Not Well: Mental Health Policy in the United States Since 1950* (Baltimore: Johns Hopkins University Press, 2006).

For more information

For more information about this report, contact Leah Pope, director, Substance Use and Mental Health Program, at lpope@vera.org. The Vera Institute of Justice is a justice reform change agent. Vera produces ideas, analysis, and research that inspire change in the systems people rely upon for safety and justice, and works in close partnership with government and civic leaders to implement it. Vera is currently pursuing core priorities of ending the misuse of jails, transforming conditions of confinement, and ensuring that justice systems more effectively serve

America's increasingly diverse communities. For more information, visit www.vera.org.

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Sharing behavioral health information: Ensuring privacy and security

Behavioral health information is highly sensitive. While sharing BHI is important, agencies must take care to protect the subjects of the data. Information sharing needs to be secure and confidential in order to:

- > avoid stigma and the negative consequences of labeling,
- > ensure legal rights are not unnecessarily curtailed,
- > foster unbiased educational and employment opportunities, and
- > support fair treatment inside the justice system from other justice-involved people and staff.

Implementing strict privacy and security protocols will benefit organizations that share information by:

- > ensuring adherence to federal and local laws and regulations,
- > maximizing professional credibility, and
- > helping to prevent harm from being inflicted on vulnerable populations.

Federal and local legal protections

Jurisdictions work under various federal, state, and local regulatory regimes to protect health information. Laws and regulations such as the Privacy Act of 1974, HIPAA, and 42 CFR Part 2 cannot be overruled with a data-sharing agreement.^a However, it is necessary to comply with these legal protections while, at the same time, moving forward to establish justice and health information exchanges to improve access to treatment and diversion. Some jurisdictions are doing so successfully.^b Ongoing studies are needed to determine how much progress has been made and what challenges remain in order to resolve the tension between ensuring confidentiality and the need to know.

^a The Privacy Act of 1974 regulates the use of personal information by federal executive branch agencies. The Health Insurance Portability and Accountability Act (HIPAA) regulates the use and disclosure of protected health information. Federal regulations in 42 CFR Part 2 protect information about alcohol and substance use treatment. For a thorough discussion of the relevant issues in D.C., see Criminal Justice Coordinating Council (CJCC), *Mental Health Information Sharing in the District of Columbia Criminal Justice System* (Washington, DC: CJCC, 2015).

^b See *Justice and Health Connect: A national resource for justice and health data sharing*. www.jhconnect.org/wp-content/uploads/2013/06/LegalHssue-Paper-Final.pdf

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