

Adult Mental Health Services – Update

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Executive Summary

Mental illness is a serious and prevalent condition in today's society, which has major social and economic implications. The U.S.'s mental health system has changed significantly throughout the past several decades, with a continuous shift from institutionalized to community-based care. Advances in pharmacological, psychosocial, and preventative interventions and developments in mental health policy have helped to improve the mental health system. However, such progress will not be substantial if access to and quality of mental health services remains inadequate.

This report examines many aspects of the national mental health system, with specific focus on adult mental health services in general and the mental health system in Florida. Some of the major findings in this report include:

- According to the Substance Abuse and Mental Health Services Administration (SAMHSA), approximately 18.5% of adults in the U.S. currently experience any mental illness (AMI) and 4.2% experience serious mental illness (SMI).
- Mental illness is associated with many severe consequences, including: negative impacts on quality of life and physical health; significant contributions to disability in the U.S.; strains on familial and other interpersonal relationships; and major societal costs (e.g., through direct costs such as medication and hospitalization and indirect costs such as reduced labor supply and reduced educational attainment).
- The deinstitutionalization movement has allowed more individuals to receive mental health care through community-based services (e.g., supported housing and employment programs, primary care medical services, and community mental health centers) rather than in psychiatric hospitals. Community-based mental health care is generally effective and preferred to institutionalization, but a lack of funding and support for the deinstitutionalization movement has left many individuals with SMI without adequate care. Such individuals often end up homeless or in prisons and jails.
- Continuous research on the etiology, detection, and treatment of mental illness has increased the implementation of evidence-based practices in the mental health system. Several treatment options are available for a broad spectrum of mental disorders.
- Due to the conservative nature of mental health spending in the U.S. (e.g., over the past couple of decades, mental health expenditures have increased overall, but have decreased as a percentage of all health expenditures), the cost-effectiveness of available mental health interventions is critically important. A wide body of evidence supports the cost-effectiveness of several pharmacological and psychosocial treatments for many mental illnesses.
- Recent legislation that has supported improvements in the mental health system include the Mental Health Parity and Addiction Equity Act of 2008 and the Affordable Care Act of 2010. These policies have helped to create parity for coverage of mental health services with physical health services, expand coverage for populations prone to mental health issues, support preventative care/screenings, and integrate health services.
- A substantial proportion of individuals with mental illness do not receive the mental health services they need. According to SAMHSA, only around 44.7% of the adults with AMI and 68.5% of the adults with SMI received mental health services in the past year. These services are very expensive, especially for individuals without insurance, often inaccessible

to those in need (e.g., individuals with low incomes in rural areas), and not adequately assessed for quality. Many states have continued to cut mental health budgets in recent years.

- Florida has long maintained one of the lowest per capita mental health expenditures in the nation. Additionally, Florida has a large population of incarcerated individuals in need of mental health services.
- The Florida Department of Children and Families, the state authority for mental health services, is working to improve the mental health system by supporting several priorities, including: implementing care coordination to reduce the use of emergency behavioral health services; pursuing the expansion of community-based interventions (e.g., Community Action Teams); reintegrating individuals into community settings from institutional placements (e.g., state mental health treatment facilities and prisons); and increasing the diversion of individuals with mental health issues who become involved with criminal justice system.
- Researchers, mental health professionals, advocates, and policymakers must work together to improve the current mental health system. There is a need for continued research on the diagnosis, etiology, and treatment of mental illnesses, comparative research on cost-effectiveness of different mental health interventions, implementation of evidence-based practices, and expansion of mental health budgets.

Section 1. Introduction

Mental illness is a serious and prevalent condition in today's society. This condition has major social and economic implications that range from the manner in which people with mental illness are regarded in the general public to the mental health care policies, and subsequent costs, that are associated with treating mental illness. Accompanying mental health services have changed considerably throughout the past 50 years. The process of deinstitutionalization transitioned the principal setting of mental health services from psychiatric hospitals to community-based programs. Research has supported this transition, deeming that positive mental health outcomes can be achieved by therapeutic interventions at the community-based level. Community-based mental health services include crisis stabilization centers, counseling and medication management, supported housing and employment programs, primary care medical services, community mental health centers, self-help groups for mental health, and Assertive Community Treatment (ACT).

The development of mental health services has been guided by a growing body of research on mental illness. Better understanding of the etiology and presentation of mental illness has allowed for improvements in treatment. Advances have been made in the fields of pharmacological, psychosocial, and psychotherapeutic interventions and preventative care. Furthermore, comparative cost-effectiveness research on the different types of mental health interventions/services will continue to enable efficient mental health spending. Mental health policy has accordingly been transformed. The most recent changes in mental health policy are encompassed in the Affordable Care Act (ACA), which has ushered in a huge expansion of mental health and substance use disorder coverage. Such advances in mental health care and policy will not be substantial, however, if access to and quality of mental health services is not capable of meeting the nation's tremendous need.

Section 2. A National Perspective on Mental Illness

Mental illness and substance use disorders are incredibly widespread in the U.S. A recent report conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) (2014)¹ has revealed staggering statistics on the prevalence of such conditions.

In 2013, an estimated 43.8 million adults aged 18 or older in the United States had any mental illness (AMI) in the past year. This represents 18.5 percent of all adults in this country.

Among adults aged 18 or older in 2013, 10.0 million (4.2 percent) had serious mental illness (SMI) in the past year.

Among the 43.8 million adults aged 18 or older in 2013 with AMI in the past year, 17.5 percent (7.7 million adults) met criteria for a substance use disorder (i.e., illicit drug or alcohol dependence or abuse). Among the 10.0 million adults with SMI in the past year, 23.1 percent also had past year substance dependence or abuse. In

¹ Substance Abuse and Mental Health Services Administration. (2014). *Results from the 2013 National Survey on Drug Use and Health: Mental health findings*, NSDUH Series H-49, HHS Publication No. (SMA) 14-4887. Rockville, MD: Substance Abuse and Mental Health Services Administration.

comparison, 6.5 percent of adults who did not have mental illness in the past year met criteria for a substance use disorder. (Substance Abuse and Mental Health Services Administration, 2014, p. 1)²

Mental illness has a major impact on quality of life, and it is one of the leading contributors to disability in the U.S. Mental illness can affect virtually all aspects of being including familial and other interpersonal relationships, the ability to be productive, and physical health. According to a review by Murray et al. (2013),³ the largest contributors to years lived with disability (YLDs) in the U.S. are the mental and behavioral disorders and the musculoskeletal disorders.

The number of YLDs from the top 18 diseases and injuries increased between 1990 and 2010, driven mostly by the population increase and aging of the US population, as age-standardized rates have largely remained unchanged... The top 8 conditions were the same in 1990 and 2010: low back pain, major depressive disorder, other musculoskeletal disorders, neck pain, anxiety disorders, COPD, drug use disorders, and diabetes. Four more mental and behavioral disorders are in the top 20 YLDs: alcohol use disorders, schizophrenia, bipolar disorder, and dysthymia. (Murray et al., 2013, p. 594)⁴

From this same review, it was also determined that mental and behavioral disorders, specifically major depressive disorder, drug use disorder, and anxiety, are among the top 15 diseases and risk factors contributing to disability-adjusted life-years (DALYs).⁵

Of the 30 leading diseases and injuries contributing to DALYs, 10 (COPD, major depressive disorders, other musculoskeletal, diabetes, drug use disorders, Alzheimer, falls, cirrhosis, CKD, and osteoarthritis) increased by more than 30% from 1990 to 2010... (Murray et al., 2013, p. 596)⁶

Other sources have also concluded that neuropsychiatric disorders are the leading contributors to DALYs, and are thus the foremost causes of disability, in the U.S. and Canada region.⁷

The overall economic costs associated with mental illness are very large, and yet are not well documented. These total costs are comprised of a combination of direct and indirect costs. According to Insel (2008),⁸ direct costs consist of the costs of care, such as medication, clinic visits, or hospitalization. Alternatively:

² Ibid.

³ Murray, C. J., Abraham, J., Ali, M. K., Alvarado, M., Atkinson, C., Baddour, L. M., ... & Gutierrez, H. R. (2013). The state of US health, 1990-2010: Burden of diseases, injuries, and risk factors. *JAMA*, 310(6), 591-606.

⁴ Ibid.

⁵ Ibid.

⁶ Ibid.

⁷ The World Health Organization. (2008). *The global burden of disease: 2004 update*, Table A2: Burden of disease in DALYs by cause, sex and income group in WHO regions, estimates for 2004. Geneva, Switzerland: WHO.

⁸ Insel, T. (2008). Assessing the economic costs of serious mental illness. *American Journal of Psychiatry*, 165(6), 663-665.

Indirect costs are incurred through reduced labor supply, public income support payments, reduced educational attainment, and costs associated with other consequences such as incarceration or homelessness. (Insel, 2008, p. 663)⁹

In 2002, the estimate of serious mental illness costs in the U.S. in lost earnings per year alone was \$193.2 billion.¹⁰ In this same year, the estimate of serious mental illness costs in the U.S. in total, excluding costs associated with comorbid conditions, incarceration, homelessness, and early mortality, was \$317.6 billion.¹¹

The large prevalence of mental illness demands greater federal funding in order to assure access to mental health services, however, another recent report by SAMHSA (2013)¹² indicates that:

Although mental health expenditures have increased in the past two decades (from \$75 billion in 1990 to \$155 billion in 2009), they have fallen as a share of all health expenditures. (Substance Abuse and Mental Health Services Administration, 2013, p. xxiv)¹³

Section 3. Changes in Mental Health Services

Mental health services have changed considerably throughout the past 50 years. Before the advent of deinstitutionalization, individuals with mental illness were largely confined to psychiatric hospitals. Due to advances in psychiatric medications that have allowed for better management of mental disorders and increased social and political concern for the treatment of individuals with mental illness, the transition of mental health services from institutions to community-based facilities was initiated. Research has supported this transition, and empirical evidence shows that community-based mental health services (e.g., supported housing and employment programs, primary care medical services, community mental health centers, and Assertive Community Treatment [ACT]) are effective in managing mental illness. However, there have been consequences to and shortcomings of the deinstitutionalization movement. The costs associated with the implementation of deinstitutionalization have been greater than anticipated. Additionally, the mental health system has been historically criticized for becoming fragmented and disorganized. Unfortunately, without adequate community support or care, many individuals with serious mental illness have ended up homeless or in prison. This situation has caused severe social and economic strain, with various ethical repercussions.

... While deinstitutionalization was first concerned with discharging long-term hospitalized patients, there is now a new generation of severely ill patients for

⁹ Ibid.

¹⁰ Kessler, R., Heringa, S., Lakoma, M., Petukhova, M., Rupp, A., Schoenbaum, M., ... & Zaslavsky, A. (2008). Individual and societal effects of mental disorders on earnings in the United States: Results from the National Comorbidity Survey Replication. *American Journal of Psychiatry*, 165(6), 703-711.

¹¹ Insel, supra, note 8.

¹² Substance Abuse and Mental Health Services Administration. (2013). *Behavioral health, United States, 2012*. HHS Publication No. (SMA) 13-4797. Rockville, MD: Substance Abuse and Mental Health Services Administration.

¹³ Ibid.

whom community services provide insufficient care. (Fakhoury and Priebe, 2007, p. 314)¹⁴

Deinstitutionalization has succeeded in allowing for very few individuals to live in psychiatric institutions, however policy change, and the necessary funding, is needed to challenge the current problems associated with deinstitutionalization and to ensure a greater range of support and services for those in need.

Change in mental health services has also been prompted by the continued expansion of research on the etiology, detection, and treatment of mental illness. There is greater evidence to support treatment with pharmacological and/or psychosocial and other options for a broad spectrum of mental disorders. In conjunction, over the past few decades there has been pressure at the national level, specifically from the U.S. Surgeon General, the President's New Freedom Commission on Mental Health, and the Institute of Medicine, to increase the implementation of research and evidence-based practices when deciding on policies for mental health services.¹⁵

Because the service system as a whole, as opposed to treatment services considered in isolation, dictates the outcome of recovery-oriented mental health care, it is imperative to expand the supply of effective, evidence-based services throughout the Nation. (U.S. Department of Health and Human Services, 1999, p. 22)¹⁶

This evidence-based orientation in terms of mental health services has been recognized in the ACA:

... By extending the concepts of treatment and related supportive care to such entities as health homes, the Affordable Care Act provides new pathways for incorporating evidence-based treatments, such as supported employment, that are commonly neglected. (Mechanic, 2012, p. 378)¹⁷

Another change in mental health services that has accompanied advances in research has been the expansion of preventative care and health care integration. Research on mental illness prevention is relatively novel and has really expanded over the past decade. Additionally, integrating mental health, substance abuse, and primary care services has recently received much attention and might provide the most effective approach to mental health care.

Section 4. Comparative Cost-Effectiveness of Mental Health Services/Interventions

¹⁴ Fakhoury, W., & Priebe, S. (2007). Deinstitutionalization and reinstitutionalization: Major changes in the provision of mental healthcare. *Psychiatry*, 6(8), 313-316.

¹⁵ Gruttadaro, D., Markey, D., & Duckworth, K. (2009). *Reinvesting in the community: A family guide to expanding home and community-based mental health services and supports*. Arlington, VA: National Alliance on Mental Illness.

¹⁶ U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

¹⁷ Mechanic, D. (2012). Seizing opportunities under the Affordable Care Act for transforming the mental and behavioral health system. *Health Affairs*, 31(2), 376-382.

Comparative cost-effectiveness research on the different types of mental health services/interventions continues to affect mental health policy and spending and, to a certain extent, dictates which mental health services are available. Over the past couple of decades, mental health expenditures have increased overall, but have decreased as a percentage of all health expenditures.

MHSA treatment spending as a share of all-health spending declined from 9.3 percent in 1986 to 7.4 percent in 2004, where it remained through 2009. (Substance Abuse and Mental Health Services Administration, 2013, p. iii)¹⁸

Mental health treatment expenditures grew from \$33 billion in 1986 to \$100 billion in 2003. In real 2003 dollars, spending per capita on mental health treatment rose from \$205 to \$345. The average annual nominal total mental health growth rate was 6.7%. In comparison, total health care expenditures increased by 8.0%. As a result of the slower growth rate of mental health expenditures compared with all health spending, mental health fell from 8% of all health expenditures in 1986 to 6% in 2003. Total national health spending increased by approximately \$1.175 trillion from 1986 to 2003; of this, 6% is attributed to an increase in mental health spending. (Mark et al., 2007, p. 1041)¹⁹

Thus, due to the conservative nature of mental health spending, cost-effectiveness in terms of available mental health interventions/treatments is of critical importance.

Deinstitutionalization was anticipated to essentially reduce necessary mental health spending, but the associated costs for implementation have been somewhat greater than expected.

Policymakers had intended deinstitutionalization to benefit taxpayers by reducing costs. There is no doubt that closing institutions has saved significant resources (although merely closing down beds has not). But while the issue of whether community care is less expensive than institutional care has been researched many times, results are mixed. Some studies find savings, others find approximately equal costs, depending on the services used. (Koyanagi, 2007, p. 13)²⁰

Despite whether community-based care as a whole is currently less expensive than institutionalized care, various community-based services offer more cost-effective, ethical, and successful care for individuals with severe mental illness.

¹⁸ Substance Abuse and Mental Health Services Administration. (2013). *National expenditures for mental health services and substance abuse treatment, 1986–2009*. HHS Publication No. SMA-13-4740. Rockville, MD: Substance Abuse and Mental Health Services Administration.

¹⁹ Mark, T., Levit, K., Buck, J., Coffey, R., & Vandivort-Warren, R. (2007). Mental health treatment expenditure trends, 1986–2003. *Psychiatric Services*, 58(8), 1041-1048.

²⁰ Koyanagi, C. (2007). *Learning from history: Deinstitutionalization of people with mental illness as precursor to long-term care reform*. Henry J Kaiser Family Foundation.

There is a wide body of evidence that supports the cost-effectiveness of pharmacological and psychosocial treatments/interventions for a variety of mental illnesses.^{21;22;23;24} Comparative cost-effectiveness research of different pharmacological options and different psychosocial options is available for common mental disorders including mood disorders,^{25;26} schizophrenia,²⁷ anxiety disorders,²⁸ and eating disorders.²⁹ There is conflicting evidence, however, as to whether pharmacological or psychosocial treatment in general is more cost-effective in treating mental illness.^{30;31} Cognitive-behavioral therapy in particular has been suggested as an especially cost-effective intervention.^{32;33;34} Moreover, additional research on the cost-effectiveness of adjunct, or combination, therapy is needed.^{35;36}

Family psychoeducation has also been shown to be a cost-effective intervention, especially in cases involving serious mental illness.³⁷

For individuals that require more extensive mental health treatments/interventions, research indicates that various, alternative community-based services are cost-effective. One such type of these services is crisis services. Day hospital/crisis respite care and residential crisis care have been

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- ²¹ Knapp, M., Barrett, B., Romeo, R., McCrone, P., Byford, S., Beecham, J., Patel, A., & Simon, J. (2004). *An international review of cost-effectiveness studies for mental disorders*. London: Centre for the Economics of Mental Health, Institute of Psychiatry.
- ²² Chisholm, D. (2005). Choosing cost-effective interventions in psychiatry: Results from the CHOICE programme of the World Health Organization. *World Psychiatry*, 4(1), 37-44.
- ²³ Gabbard, G. O., Lazar, S. G., Hornberger, J., & Spiegel, D. (1997). The economic impact of psychotherapy: A review. *American Journal of Psychiatry*, 154(2), 147-155.
- ²⁴ Hunsley, J. (2003). Cost effectiveness and medical cost-offset considerations in psychological service provision. *Canadian Psychology/Psychologie canadienne*, 44(1), 61-73.
- ²⁵ Barrett, B., Byford, S., & Knapp, M. (2005). Evidence of cost-effective treatments for depression: A systematic review. *Journal of Affective Disorders*, 84(1), 1-13.
- ²⁶ Miklowitz, D. J., & Scott, J. (2009). Psychosocial treatments for bipolar disorder: Cost-effectiveness, mediating mechanisms, and future directions. *Bipolar Disorders*, 11(s2), 110-122.
- ²⁷ O'Day, K., Rajagopalan, K., Meyer, K., Pikalov, A., & Loebel, A. (2013). Long-term cost-effectiveness of atypical antipsychotics in the treatment of adults with schizophrenia in the US. *ClinicoEconomics and outcomes research: CEOR*, 5, 459-470.
- ²⁸ Mavranzouli, I., Meader, N., Cape, J., & Kendall, T. (2013). The cost effectiveness of pharmacological treatments for generalized anxiety disorder. *PharmacoEconomics*, 31(4), 317-333.
- ²⁹ Agras, W. S. (2001). The consequences and costs of the eating disorders. *Psychiatric Clinics of North America*, 24(2), 371-379.
- ³⁰ Knapp et al., supra, note 21.
- ³¹ Hunsley, supra, note 24.
- ³² Gould, R. A., Ott, M. W., & Pollack, M. H. (1995). A meta-analysis of treatment outcome for panic disorder. *Clinical Psychology Review*, 15(8), 819-844.
- ³³ Antonuccio, D. O., Thomas, M., & Danton, W. G. (1997). A cost-effectiveness analysis of cognitive behavior therapy and fluoxetine (Prozac) in the treatment of depression. *Behavior therapy*, 28(2), 187-210.
- ³⁴ Otto, M. W., Pollack, M. H., & Maki, K. M. (2000). Empirically supported treatments for panic disorder: Costs, benefits, and stepped care. *Journal of consulting and clinical psychology*, 68(4), 556-563.
- ³⁵ Otto, M. W., Smits, J. A., & Reese, H. E. (2006). Combined psychotherapy and pharmacotherapy for mood and anxiety disorders in adults: review and analysis. *FOCUS: The Journal of Lifelong Learning in Psychiatry*, 4(2), 204-214.
- ³⁶ Miklowitz & Scott, supra, note 26.
- ³⁷ Knapp et al., supra, note 21.

found to be more cost-effective than inpatient hospitalization for individuals with mental illness.^{38;39} A recent and expansive report by SAMHSA (2014)⁴⁰ confirmed that:

The research base on the effectiveness of crisis services is growing. There is evidence that crisis stabilization, community-based residential crisis care, and mobile crisis services can divert individuals from unnecessary hospitalizations and ensure that the least restrictive treatment option is available to people experiencing behavioral health crises. Additionally, a continuum of crisis services can assist in reducing costs for psychiatric hospitalization, without negatively impacting clinical outcomes. (Substance Abuse and Mental Health Services Administration, 2014, p. 5)⁴¹

Another example of these alternative community-based services is supported employment. There is research to support the potential cost-effectiveness of supported employment for individuals with mental illness.^{42;43}

ACT is also an example of these alternative community-based services. ACT is a span of services that are especially relevant for individuals with serious or persistent mental illness and are provided by community-based, mobile mental health treatment teams. This system-level intervention is one of the most well researched approaches to mental health service dissemination.⁴⁴ Research supports the cost-effectiveness of this approach.⁴⁵

ACT is identified by the Substance Abuse and Mental Health Services Administration as an evidence-based practice that consistently demonstrates positive outcomes and is considered by experts as an essential treatment option... Research studies have shown that assertive community treatment is a cost-effective solution when teams adhere closely to the ACT model and serve individuals as high risk. (National Alliance on Mental Illness, 2007, p. 1)⁴⁶

There is a need for updated and methodically rigorous, comparative cost-effectiveness research for the different mental illness interventions, especially as treatment options continue to emerge

³⁸ Sledge, W. H., Tebes, J., Wolff, N., & Helminiak, T. W. (1996). Day hospital/crisis respite care versus inpatient care, part II: Service utilization and costs. *American Journal of Psychiatry*, 153(8), 1074-1083.

³⁹ Fenton W. S., Hoch J. S., Herrell J. M., Mosher L., Dixon L. (2002) Cost and cost-effectiveness of hospital vs residential crisis care for patients who have serious mental illness. *Arch Gen Psychiatry*, 59, 357-364.

⁴⁰ Substance Abuse and Mental Health Services Administration. (2014). *Crisis services: Effectiveness, cost-effectiveness, and funding strategies*. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration.

⁴¹ Ibid.

⁴² National Alliance on Mental Illness. (2010). *Unemployment*. Arlington, VA: National Alliance on Mental Illness.

⁴³ Substance Abuse and Mental Health Services Administration. (2009). *Supported employment: The evidence*. DHHS Pub. No. SMA-08-4364, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

⁴⁴ Mueser, K. T., Bond, G. R., Drake, R. E., & Resnick, S. G. (1998). Models of community care for severe mental illness. *Schizophrenia bulletin*, 24(1), 37-74.

⁴⁵ National Alliance on Mental Illness, Fact Sheet. (2007). *Assertive Community Treatment: Investment yields outcomes*. Arlington, VA: National Alliance on Mental Illness.

⁴⁶ Ibid.

and as it is necessary to assess the extent to which international cost-effectiveness studies are generalizable to the U.S.'s mental health system. It is important to remember that the cost-effectiveness, and efficacy in general, of specific pharmacological, psychosocial, and other community-based services will vary according to the particular mental disorder of concern. Although cost-effectiveness is significant when deciding on policy regarding mental health services, choosing treatments and interventions that relieve suffering and allow for better quality of life is of principal importance. Furthermore, there is a need for mental health policies at large to undergo comparative cost-effectiveness analysis.

Section 5. Utilization of Mental Health Services

The magnitude of the overall use of mental health services is very large. According to the report by SAMHSA (2014):⁴⁷

In 2013, 34.6 million adults (14.6 percent of the population aged 18 or older) received mental health care during the past 12 months. The number and the percentage were similar to those in 2012 (34.1 million adults and 14.5 percent). (Substance Abuse and Mental Health Services Administration, 2014, p. 1)⁴⁸

The percentages of the types of mental health services being utilized are changing. The same report states that:

In 2013, the type of mental health service most commonly used by adults in the past year was prescription medication (12.5 percent or 29.5 million adults), followed by outpatient services (6.6 percent or 15.6 million adults), then by inpatient services (0.9 percent or 2.2 million adults)... The percentages of adults who used prescription medication, outpatient services, or inpatient services in 2013 were similar to those in 2012 (12.4, 6.6, and 0.8 percent, respectively). Note that respondents could report using more than one type of mental health care.

Between 2002 and 2013, the percentage of adults using outpatient services in the past year declined from 7.4 to 6.6 percent... The percentage of adults using prescription medication in 2013 (12.5 percent) was greater than the percentages from 2002 to 2011 (ranging from 10.5 to 11.7 percent). (Substance Abuse and Mental Health Services Administration, 2014, p. 20)⁴⁹

Unfortunately, not all individuals with mental illness receive the necessary mental health services. The report also indicates that:

Among the 43.8 million adults aged 18 or older with AMI in 2013, 19.6 million (44.7 percent) received mental health services in the past year... Also, among the 10.0 million adults aged 18 or older with SMI in 2013, 6.9 million (68.5 percent) received mental health services in the past year. Mental health services were

⁴⁷ Substance Abuse and Mental Health Services Administration, *supra*, note 1.

⁴⁸ *Ibid.*

⁴⁹ *Ibid.*

received by 48.9 and 31.9 percent of adults with moderate mental illness and low (mild) mental illness, respectively.

In 2013, there were 11.0 million adults aged 18 or older (4.6 percent of all adults) who perceived an unmet need for mental health care at any time in the past year. Among adults who reported a need for mental health care, 5.1 million adults did not receive any mental health services in the past year. (Substance Abuse and Mental Health Services Administration, 2014, p. 21-24)⁵⁰

Section 6. Recent Changes in National Mental Health Care Policy

Throughout the past decade, many of the efforts regarding mental health care policy have focused on increasing access to adequate mental health services. Some of the recent legislation that has supported this issue includes the Mental Health Parity and Addiction Equity Act and the ACA.

The Affordable Care Act will provide one of the largest expansions of mental health and substance use disorder coverage in a generation. Beginning in 2014 under the law, all new small group and individual market plans will be required to cover ten Essential Health Benefit categories, including mental health and substance use disorder services, and will be required to cover them at parity with medical and surgical benefits. (Beronio et al., 2013, p. 1)⁵¹

The ACA also prohibits insurance plans from denying coverage to or charging more for individuals with pre-existing mental illness conditions and gives attention to preventative mental health services. The National Prevention, Health Promotion, and Public Health Council, as created by the ACA, has released a Nation Prevention Strategy (NPS).⁵²

Several of the priorities of the NPA pertain to prevention in the areas of mental health and substance abuse, including priorities such as preventing drug abuse and excessive alcohol use, preventing injury and promoting violence-free living, and promoting emotional and mental well-being. (Shim et al., 2012, p. 1232)⁵³

According to Mechanic (2012),⁵⁴ some of the additional promising features that the ACA supports include interdisciplinary care teams, the broadening of the Medicaid Home and Community-Based Services option, proximity of physical health and behavioral sources, the usage of relevant technological tools, and the implementation of evidence-based interventions.

Section 7. Issues with Current Mental Health Services/Policy

⁵⁰ Ibid.

⁵¹ Beronio, K., Po, R., Skopec, L., & Glied, S. (2013). *ASPE issue brief: Affordable Care Act expands mental health and substance use disorder benefits and federal parity protections for 62 million Americans*. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation.

⁵² Shim, R. S., Koplan, C., Langheim, F. J., Manseau, M., Oleskey, C., Powers, R. A., & Compton, M. T. (2012). Health care reform and integrated care: A golden opportunity for preventive psychiatry. *Psychiatric Services*, 63(12), 1231-1233.

⁵³ Ibid.

⁵⁴ Mechanic, supra, note 17.

Despite the recent developments in mental health services and policy, there are still many problems within the U.S.'s mental health system. The increased mental health coverage for previously uninsured individuals and the parity for mental health care will not be substantial if access to and quality of mental health services is not capable of meeting the nation's need. The extent of the increased coverage varies across the U.S., due to each state having the ability to decide on whether or not to implement Medicaid Expansion.

Under the terms of the New ACA Medicaid Expansion effort, all services administered by health care providers that are covered through an "Essential Health Benefits" package-which includes mental health and substance abuse care-will be covered at 100 percent by the federal government during the first three years of expansion initiative (2014-2016), 95 percent in 2017, eventually leveling off at 90 percent after 2020. (Miller, 2014, p. 7)⁵⁵

Twenty-four states have not yet chosen to expand Medicaid at this time, leaving many individuals without mental health insurance. According to Miller (2014),⁵⁶ this lack of Medicaid Expansion initiation in 25 states (note: since the time of this report, New Hampshire has decided to expand Medicaid, currently leaving 24 states opting out of this program) allows for almost four million uninsured individuals with a serious mental illness, in serious psychological distress, or with a substance use disorder that would have been eligible for coverage under the Medicaid Expansion policy to potentially remain uninsured.

Expansion of mental health coverage, however, does not necessarily translate into unlimited access to treatment and/or quality mental health care. A recent report from early Medicaid expansion states (i.e., California, Connecticut, the District of Columbia, Minnesota, New Jersey, and Washington) indicate that there are:

... Greater than anticipated need for behavioral health services in the expansion population, administrative challenges of expansion, and persistent barriers to enrollment and access after expanding eligibility-though officials overall felt the expansions increased access for beneficiaries. (Sommers et al., 2013, p. E1)⁵⁷

Additionally, SAMHSA (2013)⁵⁸ reveals that, as of 2012, the majority of adults that have mental illness or substance use disorders do not receive treatment. This report also specifies that less than one-third of adults with mental illness receive a minimally adequate, as defined by different national organizations, type or amount of treatment.

⁵⁵ Miller, J. E. (2014). *Dashed hopes; Broken promises; More despair: How the lack of state participation in the Medicaid Expansion will punish Americans with mental illness*. Alexandria, VA: American Mental Health Counselors Association.

⁵⁶ Ibid.

⁵⁷ Sommers, B. D., Arntson, E., Kenney, G. M., & Epstein, A. M. (2013). Lessons from early Medicaid expansions under health reform: Interviews with Medicaid officials. *Medicare & medicaid research review*, 3(4), E1-E19.

⁵⁸ Substance Abuse and Mental Health Services Administration, *supra*, note 12.

Mental health services are incredibly expensive, especially for individuals without insurance. These high costs can prove to be an immense barrier for people seeking mental health treatment.

In 2013, the most commonly reported sources of payment for outpatient mental health services among adults aged 18 or older who received outpatient mental health services in the past year were private health insurance (36.2 percent) and self-payment or payment by a family member living in the household (35.7 percent), followed by Medicare (17.1 percent), then by Medicaid (11.6 percent), followed by an employer (7.6 percent), then by the VA or other military program (5.0 percent). (Substance Abuse and Mental Health Services Administration, 2014, p. 20)⁵⁹

Among the 5.1 million adults aged 18 or older in 2013 who had a perceived unmet need for mental health care and did not receive mental health services in the past year, several reasons were reported for not receiving mental health services. These included an inability to afford the cost of care (48.3 percent), believing at the time that the problem could be handled without treatment (26.5 percent), not knowing where to go for services (24.6 percent), and not having the time to go for care (15.8 percent)... (Substance Abuse and Mental Health Services Administration, 2014, p. 24)⁶⁰

Mental health services are often inaccessible to those in need. People with low incomes are disproportionately likely to need mental health services and yet are unlikely to receive them.

The percentage of adults in 2013 with AMI in the past year was highest among those with a family income that was below the Federal poverty level (26.1 percent), followed by those with a family income at 100 to 199 percent of the Federal poverty level (20.9 percent), then by adults with a family income at 200 percent or more of the Federal poverty level (16.0 percent). (Substance Abuse and Mental Health Services Administration, 2014, p. 11)⁶¹

Moreover, many psychiatrists will not accept insurance. A recent study by Bishop et al. (2014)⁶² found that:

The percentage of psychiatrists who accepted private noncapitated insurance in 2009-2010 was significantly lower than the percentage of physicians in other specialties (55.3% [95% CI, 46.7%-63.8%] vs 88.7% [86.4%-90.7%]; $P < .001$) and had declined by 17.0% since 2005-2006. Similarly, the percentage of psychiatrists who accepted Medicare in 2009-2010 was significantly lower than that for other physicians (54.8% [95% CI, 46.6%-62.7%] vs 86.1% [84.4%-87.7%]; $P < .001$) and had declined by 19.5% since 2005-2006. Psychiatrists'

⁵⁹ Substance Abuse and Mental Health Services Administration, *supra*, note 1.

⁶⁰ *Ibid.*

⁶¹ *Ibid.*

⁶² Bishop, T. F., Press, M. J., Keyhani, S., & Pincus, H. A. (2014). Acceptance of insurance by psychiatrists and the implications for access to mental health care. *JAMA psychiatry*, 71(2):176-181.

Medicaid acceptance rates in 2009-2010 were also lower than those for other physicians (43.1% [95% CI, 34.9%-51.7%] vs 73.0% [70.3%-75.5%]; $P < .001$) but had not declined significantly from 2005-2006. (Bishop et al., 2014, p. 176)⁶³

Rural areas with large low-income populations are lacking in mental health providers that will accept Medicaid. Cummings et al. (2013)⁶⁴ concluded that in more than one-third of U.S. counties there are no outpatient mental health services that accept Medicaid.

Besides individuals with low incomes, there are other special populations that are unlikely to receive the necessary mental health services. One such population is individuals in the military and veterans. Military mental health is plagued by high rates of posttraumatic stress, depression, and suicide and a critical shortage of mental health providers and services.⁶⁵ Other such special populations include homeless and incarcerated individuals. These two populations in particular place a strain on the economy as a result of the lack of mental health services. The higher rates of mental illness and substance use disorders in these populations are believed to be somewhat associated with the shortcomings of the process of deinstitutionalization, namely, the absence of access to adequate mental health care.⁶⁶ These insufficiencies have major social implications for these populations.

Few successful initiatives have been generated to assess mental health service/care quality. A fairly recent study by Herbstman and Pincus (2009)⁶⁷ found that there were:

... 36 initiatives incorporating mental and/or substance use (M/SU) indicators with efforts from the federal and state government, health plans, nongovernmental and professional organizations.

Although there has been much activity in recent years in the development of M/SU indicators, efforts have lacked coordination, have focused on limited areas of clinical activity, and have not been clearly linked to quality improvement activity. The study recommends that the United States government forms an entity to better coordinate efforts and address these concerns. Clinicians and provider organizations should also increase the use of already developed M/SU indicators to improve quality of care delivered. (Herbstman and Pincus, 2009, p. 623)⁶⁸

Many states have continued to cut mental health budgets. According to a report by Honberg et al. (2011):⁶⁹

⁶³ Ibid.

⁶⁴ Cummings, J. R., Wen, H., Ko, M., & Druss, B. G. (2013). Geography and the Medicaid mental health care infrastructure: Implications for health care reform. *JAMA psychiatry*, 70(10), 1084-1090.

⁶⁵ National Alliance on Mental Illness. (2012). *Parity for patriots: The mental health needs of military personnel, veterans and their families*. Arlington, VA: National Alliance on Mental Illness.

⁶⁶ Substance Abuse and Mental Health Services Administration, supra, note 12.

⁶⁷ Herbstman, B. J., & Pincus, H. A. (2009). Measuring mental healthcare quality in the United States: A review of initiatives. *Current Opinion in Psychiatry*, 22(6), 623-630.

⁶⁸ Ibid.

⁶⁹ Honberg, R., Kimball, A., Diehl, S., Usher, L., & Fitzpatrick, M. (2011). *State mental health cuts: The continuing crisis*. Arlington, VA: National Alliance on Mental Illness.

States such as California, Illinois, Nevada and South Carolina, which made devastating cuts to mental health services previously, have made further cuts for fiscal year (FY) 2012, putting tens of thousands of citizens at great risk. States have cut more than \$1.6 billion in general funds from their state mental health agency budgets for mental health services since FY2009, a period during which demand for such services increased significantly. These cuts translate into loss of vital services such as housing, Assertive Community Treatment, access to psychiatric medications and crisis services. In contrast, some states increased their state general fund appropriations for mental health in FY2012. However, these increases do not mitigate the damage that has been done by cuts to the infrastructure of services for people living with the most serious mental illnesses. (Honberg et al., 2011, p. 1)⁷⁰

Previous National Alliance on Mental Illness (NAMI) reports indicate that the U.S.'s health care system for adults with serious mental illness has only remained stagnant over the years.

In 2006, NAMI published *Grading the States: A Report on America's Mental Health Care System for Serious Mental Illness*, to provide a baseline for measuring progress toward the transformation envisioned by the New Freedom Commission. In 2006, the national average was a D grade. Three years later, this second report finds the national average to be stagnant- again a D. Fourteen states have improved their grades since 2006, but not enough to raise the national average. Twelve states have fallen back. Twenty-three states have stayed the same. (Aron et al., 2009, p. ix)⁷¹

Section 8. Current/Future Trends in State Mental Health Policy/Legislation

As a result of the many problems within the mental health system, numerous state legislatures have recently begun to more fully address mental health policy. Social pressure combined with improving economic standings has allowed for the initiation of the restoring of state mental health budgets.

Many legislatures in the 2013 session recognized the importance of stronger and more responsive public mental health service systems and the risks of allowing the system to erode. Mental health legislation was enacted in 2013 along the following themes: mental health system improvement; crisis and inpatient care; community mental health; criminal justice and mental health; and civil rights and stigma reduction. (National Alliance on Mental Illness, 2013, p. 6)⁷²

⁷⁰ Ibid.

⁷¹ Aron, L., Honberg, R., Duckworth, K., et al. (2009). *Grading the states 2009: A report on America's health care system for adults with serious mental illness*. Arlington, VA: National Alliance on Mental Illness.

⁷² National Alliance on Mental Illness. (2013). *State legislation report, 2013: Trends, themes and best practices in state mental health legislation*. Arlington, VA: National Alliance on Mental Illness.

According to this NAMI (2013)⁷³ report, the majority of the states increased or maintained state mental health budgets. However, mental health systems are still critically underfunded. NAMI (2013)⁷⁴ made the following recommendations regarding 2014 state policy priorities for mental health:

- Actively engage in outreach and enrollment
- Comply with mental health parity
- Expand Medicaid
- Increase integrated care
- Increase mental workforce capacity
- Identify mental illness and intervene early
- Build the bridge from Medicaid to private health coverage
- Increase access to supported employment services
- Increase housing with supportive services
- Increase justice system diversion strategies

It is important to understand the national mental health system in order to review and critique any state health system in particular.

Section 9. Mental Illness in Florida

A recent report, SAMHSA (2014),⁷⁵ has revealed the most recent statistics on the prevalence of mental illness in Florida. The percentage of people with any mental illness in the past year (based on 2012 and 2013 National Surveys on Drug Use and Health [NSDUHs]) among persons aged 18 or older in the state of Florida was 16.91%. The percentage of people with serious mental illness in the past year (based on 2012 and 2013 NSDUHs) among persons aged 18 or older in the state of Florida was 3.96%.

Section 10. Brief History of Mental Health Services in Florida

There has always been a need for mental health services throughout Florida's history. Large-scale measurements of the prevalence of mental disorders were initiated in the U.S. in the 1980s. The first three large-scale surveys of this nature were the Epidemiological Catchment Area (ECA) survey, the National Comorbidity Survey (NCS), and the National Comorbidity Survey Replication (NCS-R). However, these surveys did not categorize prevalence rates by state. Thus, the prevalence of mental illness during the 1990s was reported only at the national level. According to Kessler et al. (2005),⁷⁶ mental disorder prevalence was 29.4% in 1990-1992 and 30.5% in 2001-

⁷³ Ibid.

⁷⁴ Ibid.

⁷⁵ Substance Abuse and Mental Health Services Administration. (2014). *State estimates of substance abuse and mental disorders from the 2012 and 2013 National Surveys on Drug Use and Health*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

⁷⁶ Kessler, R. C., Demler, O., Frank, R. G., Olfson, M., Pincus, H. A., Walters, E. E., ... & Zaslavsky, A. M. (2005). Prevalence and treatment of mental disorders, 1990 to 2003. *New England Journal of Medicine*, 352(24), 2515-2523.

2003, so it was determined through statistical analysis that the disorder prevalence did not change over time.

In 2001, the National Household Survey on Drug Abuse (NHSDA) began to measure serious mental illness for all persons aged 18 or older by state.⁷⁷ Therefore, the Office of Applied Studies through SAMHSA began reporting state mental illness prevalence rates. These reports have revealed that the estimate of the percentage of adults reporting past year SMI in Florida was 6.81% in 2001⁷⁸ and 7.61% in 2002.⁷⁹ Based on 2002 and 2003 NSDUHs, the estimate of the percentage of adults reporting past year SMI in Florida was 7.94%.⁸⁰

In 2004, NSDUHs began referring to the measure of SMI as a measure of serious psychological distress (SPD), for nonspecific psychological distress, instead.⁸¹ Therefore, based on 2003 and 2004 NSDUHs, the estimate of the percentage of adults with SPD in the past year in Florida was 9.04%.⁸² Furthermore, the estimate of the percentage of adults with SPD in the past year in Florida based on 2004 and 2005 NSDUHs was 11.12%,⁸³ based on 2005 and 2006 NSDUHs was 10.30%,⁸⁴ and based on 2006 and 2007 NSDUHs was 10.21%.⁸⁵

Around 2008, changes were made to the adult mental health section of the NSDUHs, causing direct comparisons with the previous prevalence rates to be misleading. Based on 2008 and 2009 NSDUHs, the estimate of the percentage of adults with SMI in the past year in Florida was 3.64%; the estimate of any mental illness (AMI) was 16.99%.⁸⁶ Based on 2009 and 2010 NSDUHs, the estimate of the percentage of adults with SMI in the past year in Florida was 3.62%; the estimate

⁷⁷ Wright, D. (2003). *State estimates of substance use from the 2001 National Household Survey on Drug Abuse: Volume II. Individual state tables and technical appendices* (DHHS Publication No. SMA 03-3826, NHSDA Series H-20). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

⁷⁸ Ibid.

⁷⁹ Wright, D. (2004). *State estimates of substance use from the 2002 National Survey on Drug Use and Health* (DHHS Publication No. SMA 04-3907, NSDUH Series H-23). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

⁸⁰ Wright, D., & Sathe, N. (2005). *State estimates of substance use from the 2002-2003 National Surveys on Drug Use and Health* (DHHS Publication No. SMA 05-3989, NSDUH Series H-26). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

⁸¹ Wright, D., & Sathe, N. (2006). *State estimates of substance use from the 2003-2004 National Surveys on Drug Use and Health* (DHHS Publication No. SMA 06-4142, NSDUH Series H-29). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

⁸² Ibid.

⁸³ Wright, D., Sathe, N., & Spagnola, K. (2007). *State estimates of substance use from the 2004-2005 National Surveys on Drug Use and Health* (DHHS Publication No. SMA 07-4235, NSDUH Series H-31). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

⁸⁴ Hughes, A., Sathe, N., & Spagnola, K. (2008). *State estimates of substance use from the 2005-2006 National Surveys on Drug Use and Health* (DHHS Publication No. SMA 08-4311, NSDUH Series H-33). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

⁸⁵ Hughes, A., Sathe, N., & Spagnola, K. (2009). *State estimates of substance use from the 2006-2007 National Surveys on Drug Use and Health* (Office of Applied Studies, Substance Abuse and Mental Health Services Administration, NSDUH Series H-35, HHS Publication No. SMA 09-4362). Rockville, MD.

⁸⁶ Substance Abuse and Mental Health Services Administration. (2011). *State estimates of substance use and mental disorders from the 2008-2009 National Surveys on Drug Use and Health*, NSDUH Series H-40, HHS Publication No. (SMA) 11-4641. Rockville, MD: Substance Abuse and Mental Health Services Administration.

of AMI was 17.02%.⁸⁷ Based on 2010 and 2011 NSDUHs, the estimate of the percentage of adults with SMI in the past year in Florida was 3.41%; the estimate of AMI was 16.15%.⁸⁸ Based on 2011 and 2012 NSDUHs, the estimate of the percentage of adults with SMI in the past year in Florida was 3.75%; the estimate of AMI was 16.87%.⁸⁹ Based on 2012 and 2013 NSDUHs, the estimate of the percentage of adults with SMI in the past year in Florida was 3.96%; the estimate of AMI was 16.91%.⁹⁰

As the need levels for mental health services in Florida have changed over the past few decades, the number of people served by Florida's mental health system has also changed. According to the NCS, although mental health treatment increased from 1990 to 2003, most mental illness remained untreated.⁹¹ In 1990-1992, 20.3% of individuals with a mental disorder received treatment; in 2001-2003, 32.9% of individuals with a mental disorder received treatment.⁹²

A consistent trend throughout Florida's history with mental health services is that there is an unmet need. According to the Florida Commission on Mental Health and Substance Abuse (2001):⁹³

Despite limitations in our current management system, we can reasonably estimate that annually only about 20% of all children and adults with needs for MHSA services receive treatment from DCF providers. (Florida Commission on Mental Health and Substance Abuse, 2001, p. 21)⁹⁴

A subsequent review of the mental health services in Florida, conducted by NAMI's Campaign for the Mind of America (2004)⁹⁵ stated:

Our examination leads us to conclude that while the state has taken steps to implement the Commission's recommendations, the vast majority of individuals with severe and persistent mental illness remain ill-served. (NAMI's Campaign for the Mind of America, 2004, p. 3)⁹⁶

⁸⁷ Substance Abuse and Mental Health Services Administration. (2012). *State estimates of substance use and mental disorders from the 2009-2010 National Surveys on Drug Use and Health*, NSDUH Series H-43, HHS Publication No. (SMA) 12-4703. Rockville, MD: Substance Abuse and Mental Health Services Administration.

⁸⁸ Substance Abuse and Mental Health Services Administration. (2012). *State estimates of substance use and mental disorders from the 2010-2011 National Surveys on Drug Use and Health*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

⁸⁹ Substance Abuse and Mental Health Services Administration. (2014). *The NSDUH report: State estimates of adult mental illness from the 2011 and 2012 National Surveys on Drug Use and Health*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

⁹⁰ Substance Abuse and Mental Health Services Administration, *supra*, note 75.

⁹¹ Kessler et al., *supra*, note 76.

⁹² *Ibid.*

⁹³ Florida Commission on Mental Health and Substance Abuse. (2001). *Final report: January 2001*. Tampa, FL: Florida Commission on Mental Health and Substance Abuse.

⁹⁴ *Ibid.*

⁹⁵ NAMI's Campaign for the Mind of America. (2004). *The state of mental health services in Florida*. NAMI National and NAMI Florida.

⁹⁶ *Ibid.*

SAMHSA's Center for Mental Health Services (CMHS) provides Uniform Reporting System (URS) Output Tables that have revealed the number of people served by Florida's mental health system from 2007-2012:

- In Florida in 2007, 262,917 total clients were served by the State Mental Health Agency (SMHA) system; there was a 14.53 total utilization rate per 1,000 population⁹⁷
- In Florida in 2008, 262,292 total clients were served by the SMHA system; there was a 14.37 total utilization rate per 1,000 population⁹⁸
- In Florida in 2009, 270,617 total clients were served by the SMHA system; there was a 14.77 total utilization rate per 1,000 population⁹⁹
- In Florida in 2010, 285,323 total clients were served by the SMHA system; there was a 15.39 total utilization rate per 1,000 population¹⁰⁰
- In Florida in 2011, 294,988 total clients were served by the SMHA system; there was a 15.91 total utilization rate per 1,000 population¹⁰¹
- In Florida in 2012, 319,190 total clients were served by the SMHA system; there was a 16.75 total utilization rate per 1,000 population¹⁰²

The policy priorities regarding mental health in Florida have also changed over time. The Florida Supreme Court (2007)¹⁰³ released a report that gives a detailed timeline of Florida mental health policy/legislation.

In 1968, the Florida Constitution was revised and health and social services were assigned to the Department of Health and Rehabilitative Services (DHRS).

In 1970, the Florida Legislature enacted the Community Mental Health Act to establish ways and means for the distribution of federal funds through the state to community mental health centers.

In 1971, the State Legislature passed the Florida Mental Health Act, which became better known as the Baker Act, to provide due process in involuntary civil

⁹⁷ Center for Mental Health Services. (2008). *2007 CMHS Uniform Reporting System output table*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

⁹⁸ Center for Mental Health Services. (2009). *2008 CMHS Uniform Reporting System output table*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

⁹⁹ Center for Mental Health Services. (2010). *2009 CMHS Uniform Reporting System output table*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

¹⁰⁰ Center for Mental Health Services. (2011). *2010 CMHS Uniform Reporting System output table*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

¹⁰¹ Center for Mental Health Services. (2012). *2011 CMHS Uniform Reporting System output table*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

¹⁰² Center for Mental Health Services. (2013). *2012 CMHS Uniform Reporting System output table*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

¹⁰³ Florida Supreme Court. (2007). *Transforming Florida's mental health system*. Retrieved from: http://www.floridasupremecourt.org/pub_info/documents/11-14-2007_Mental_Health_Report.pdf

commitment proceedings and to establish uniform criteria for people being admitted to state hospitals.

In 1984, the legislature made sweeping changes to the Florida Mental Health Act revising the Baker Act and eliminating the mental health boards, which were replaced with planning councils that had similar planning and evaluation duties but did not allocate funds.

In 1996 the Legislature reorganized DHRS, creating a separate Department of Health and creating the Department of Children & Families (DCF).

In 2003, the legislature enacted changes that represented the next step in the evolution of Florida's human services delivery system. In response to concerns that the mission of the mental health and substance abuse programs was not a high priority within the department, the legislature created a Deputy Secretary for Substance Abuse and Mental Health within DCF, with accountability directly to the Secretary. In an effort to elevate the importance of services to people with mental illness and substance abuse problems, the Legislature established the Florida Substance Abuse and Mental Health Corporation, independent of the department, to review the service delivery system, assess needs for services, staff and resources, and provide a forum for direct advocacy with policymakers.

During the 2007 regular session, the Florida Legislature again took up legislation relating to the public mental health system, authorizing DCF to modify its organizational structure to improve the effectiveness and efficiency of the agency. (Florida Supreme Court, 2007, p. 17-20)¹⁰⁴

The Florida Department of Children and Families (DCF) contains the Substance Abuse and Mental Health Program (SAMH).¹⁰⁵ The SAMH Program:

... Is recognized as the single state authority for substance abuse and mental health services. This office develops standards for the quality of care across the system of care and within the other state agencies that also provide substance abuse and mental health services. (Florida Department of Children and Families, 2013, p. 1)¹⁰⁶

The DCF was authorized to implement Behavioral Health Managing Entities in 2001 by the Florida Legislature.¹⁰⁷ Florida has continued the expansion of managed mental health care, especially through Medicaid managed mental health program.

Throughout the past decade, Florida's mental health policy has focused on the restructuring that is demanded by a shift toward a community-based approach to mental health services. There are

¹⁰⁴ Ibid.

¹⁰⁵ Florida Department of Children and Families. (2013). *Substance abuse and mental health services plan: 2014-2016*. Tallahassee, FL: Department of Children and Families.

¹⁰⁶ Ibid.

¹⁰⁷ Ibid.

numerous distinct districts in Florida that each deliver the mental health system, however, funding has been disproportionate across these districts, causing inconsistent systems of care. Increased funding and access to mental health care are continuous concerns, as is evidenced by two of the most recent NAMI supported advocacy and legislative priorities for Florida: medicaid expansion; and increased state funding for public mental health and substance abuse services.¹⁰⁸

Additionally, when reviewing the history of Florida's mental health system, it is important to examine the program funding level trends.

In Florida, total state mental health appropriations increased from \$219 million to \$370 million between FY96-97 and FY06-07, an increase of \$151 million. When adjustments are made for inflation, total expenditures rose from \$219 million in FY96-97 to \$248 million in FY06-07, an increase of \$29 million. Trends in per capita state appropriations indicate an increase in funding between FY96-97 and FY06-07 from \$14.90 to \$20.10; however when adjusted for inflation, per capita state appropriations increased from \$14.90 to \$17.27 between FY96-97 and FY01-02 and then decreased to \$13.47 in FY06-07, a net loss of \$1.43 per capita across the prior decade. (Florida Supreme Court, 2007, p. 26)¹⁰⁹

In Florida in 2005, the SMHA expenditure total was \$647,169,422 and the FY 2005 per capita amount was \$36.56.¹¹⁰ In Florida in 2007, the SMHA expenditure total was \$722,660,669 and the FY 2007 per capita amount was \$39.87.¹¹¹ The average annual change (in total SMHA controlled mental health expenditures) in current dollars from FY 06 to '07 is 5.3% and from FY 01 to '07 is 3.8%, whereas this change in constant dollars from FY 06 to '07 is 0.8% and from FY 01 to '07 is -0.5%.¹¹²

In Florida, SMHA Mental Health Expenditures (actual expenditures rather than government appropriation values) have been reported for FY 2004 to 2010:¹¹³

- FY 2004 = \$623,000,000
- FY 2005 = \$647,200,000
- FY 2006 = \$686,600,000
- FY 2007 = \$722,700,000

¹⁰⁸ National Alliance on Mental Illness Florida. (2014). *2014 NAMI Florida advocacy and legislative priorities*. Retrieved from:

http://www.nami.org/Content/Microsites361/NAMI_Tallahassee_Inc_/Home361/Events8/Tally_Ties_Gala/File_Links/NAMIPOLICYPriorities2014.pdf

¹⁰⁹ Florida Supreme Court, supra, note 103.

¹¹⁰ Lutterman, T., Berhane, A., Phelan, B., Shaw, R., & Rana, V. (2009). *Funding and characteristics of state mental health agencies, 2007*. HHS Pub. No. (SMA) 09-4424. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

¹¹¹ Substance Abuse and Mental Health Services Administration. (2011). *Funding and characteristics of state mental health agencies, 2009*. HHS Publication No. (SMA) 11-4655. Rockville, MD: Substance Abuse and Mental Health Services Administration.

¹¹² Ibid.

¹¹³ Kaiser Family Foundation. *State Mental Health Agency (SMHA), mental health services expenditures*. Retrieved from: <http://kff.org/other/state-indicator/smha-expenditures/#graph>

- FY 2008 = \$768,900,000
- FY 2009 = \$755,300,000
- FY 2010 = \$742,200,000

According to the Florida Council for Community Mental Health (2013):¹¹⁴

Community mental health system funding has remained relatively flat with only a 3% increase in the past 5 years. During the same time period, adult mental health declined by 7.9%.

The FY 2012-2013 Appropriations reduced mental health and substance abuse funding by \$12 million. DCF has further reduced service funding by 3-5%, depending on the district, to secure administrative funds for the new managing entities. (The Florida Council for Community Mental Health, 2013, p. 2)¹¹⁵

Section 11. Comparative Analysis of the History of Mental Health Services in Florida versus Other States

To better understand the condition of the mental health service system in Florida, it is helpful to conduct a comparative analysis of the historical changes of this system with the systems of the other states.

As was previously mentioned, the records on the prevalence data on mental illness in the U.S. up until the early 2000s did not give state-by-state breakdowns, so comparative prevalence data for this time period is not available. However, using information from SAMHSA, it is possible to rank Florida's mental illness prevalence rates according to the other states from 2001 onward.

- In 2001, the estimate of the percentage of adults reporting past year SMI in Florida was 6.81%; this percentage was lower than that of the national estimate, at 7.41%. Florida was one of the states with the lowest SMI percentages¹¹⁶
- In 2002, the estimate of the percentage of adults reporting past year SMI in Florida was 7.61%; this percentage was lower than that of the national estimate, at 8.31%. Florida remained one of the states with the lowest SMI percentages¹¹⁷
- Based on 2002 and 2003 National Surveys on Drug Use and Health (NSDUHs), the estimate of the percentage of adults reporting past year SMI in Florida was 7.94%; this percentage was lower than the national estimate, at 8.76%. Florida again remained one of the states with the lowest SMI percentages¹¹⁸
- Based on 2003 and 2004 NSDUHs, the estimate of the percentage of adults with SPD in the past year in Florida was 9.04%; this percentage was lower than the

¹¹⁴ The Florida Council for Community Mental Health. (2013). *Strengthening Florida's behavioral health system*. Retrieved from: <http://www.fccmh.org/legislative/docs/StrengtheningFloridasBHSsystem1-24-13.pdf>

¹¹⁵ Ibid.

¹¹⁶ Wright, supra, note 77.

¹¹⁷ Wright, supra, note 79.

¹¹⁸ Wright & Sathe, supra, note 80.

national estimate, at 9.63%. Florida was one of 10 states that showed significant increases in SPD during this period. Florida was no longer among the states with the lowest SPD percentages¹¹⁹

- Based on 2004 and 2005 NSDUHs, the estimate of the percentage of adults with SPD in the past year in Florida was 11.12%; this percentage was lower than the national estimate, at 11.63%. Florida was one of the states with the lowest SPD percentages¹²⁰
- Based on 2005 and 2006 NSDUHs, the estimate of the percentage of adults with SPD in the past year in Florida was 10.30%; this percentage was lower than the national estimate, at 11.29%. Florida was again one of the states with the lowest SPD percentages¹²¹
- Based on 2006 and 2007 NSDUHs, the estimate of the percentage of adults with SPD in the past year in Florida was 10.21%; this percentage was lower than the national estimate, at 11.10%¹²²
- Based on 2008 and 2009 NSDUHs, the estimate of the percentage of adults with SMI in the past year in Florida was 3.64%; the estimate of any mental illness (AMI) was 16.99%. These percentages were lower than the national estimates, at 3.70% and 17.92% respectively¹²³
- Based on 2009 and 2010 NSDUHs, the estimate of the percentage of adults with SMI in the past year in Florida was 3.62%; the estimate of AMI was 17.02%. These percentages were lower than the national estimates, at 3.88% and 18.10% respectively¹²⁴
- Based on 2010 and 2011 NSDUHs, the estimate of the percentage of adults with SMI in the past year in Florida was 3.41%; the estimate of AMI was 16.15%. These percentages were lower than the national estimates, at 3.95% and 17.90% respectively¹²⁵
- Based on 2011 and 2012 NSDUHs, the estimate of the percentage of adults with SMI in the past year in Florida was 3.75%; the estimate of AMI was 16.87%. These percentages were lower than the national estimates, at 3.97% and 18.19% respectively¹²⁶
- Based on 2012 and 2013 NSDUHs, the estimate of the percentage of adults with SMI in the past year in Florida was 3.96%; the estimate of AMI was 16.91%. These percentages were lower than the national estimates, at 4.14% and 18.53%, respectively¹²⁷

¹¹⁹ Wright & Sathe, *supra*, note 81.

¹²⁰ Wright et al., *supra*, note 83.

¹²¹ Hughes et al., *supra*, note 84.

¹²² Hughes et al., *supra*, note 85.

¹²³ Substance Abuse and Mental Health Services Administration, *supra*, note 86.

¹²⁴ Substance Abuse and Mental Health Services Administration, *supra*, note 87.

¹²⁵ Substance Abuse and Mental Health Services Administration, *supra*, note 88.

¹²⁶ Substance Abuse and Mental Health Services Administration, *supra*, note 89.

¹²⁷ Substance Abuse and Mental Health Services Administration, *supra*, note 75.

Overall, throughout the past decade, Florida has had some of the lowest estimates of mental illness in comparison with the other states. However, the rate of utilization of mental services has also remained lower in Florida than in the nation at large.

- In Florida in 2007, there was a 14.53 total utilization rate per 1,000 population, whereas the U.S. rate was 20.14¹²⁸
- In Florida in 2008, there was a 14.37 total utilization rate per 1,000 population, whereas the U.S. rate was 20.69¹²⁹
- In Florida in 2009, there was a 14.77 total utilization rate per 1,000 population, whereas the U.S. rate was 20.85¹³⁰
- In Florida in 2010, there was a 15.39 total utilization rate per 1,000 population, whereas the U.S. rate was 21.94¹³¹
- In Florida in 2011, there was a 15.91 total utilization rate per 1,000 population, whereas the U.S. rate was 22.10¹³²
- In Florida in 2012, there was a 16.75 total utilization rate per 1,000 population, whereas the U.S. rate was 22.67¹³³

Historically, the trends for the number of mental health services in Florida have mimicked those of the nation.

Between 1970 and 1998 the total number of mental health organizations in the United States increased from 3,005 to 5,722. Between 1998 and 2002, the number of organizations decreased from 5,733 to 4,301. Similarly, the total number of mental health organizations in Florida between 1992 and 1998 increased from 177 to 223. Between 1998 and 2002, this number decreased from 223 to 152. (Florida Supreme Court, 2007, p. 24)¹³⁴

As previously mentioned, NAMI released its first *Grading the States* report in 2006. This report ranked the state adult public mental healthcare systems. The U.S. received the national grade of a D. Florida, however, received the grade of a C-.¹³⁵ Although Florida received a category grade of a D+ for services, the state was commended for its efforts to support employment for individuals with mental illness.

Nearly 20 percent of adults with severe persistent mental illness are employed in the state of Florida, significantly higher than the national average. (National Alliance on Mental Illness, 2006, p. 61)¹³⁶

¹²⁸ Center for Mental Health Services, *supra*, note 97.

¹²⁹ Center for Mental Health Services, *supra*, note 98.

¹³⁰ Center for Mental Health Services, *supra*, note 99.

¹³¹ Center for Mental Health Services, *supra*, note 100.

¹³² Center for Mental Health Services, *supra*, note 101.

¹³³ Center for Mental Health Services, *supra*, note 102.

¹³⁴ Florida Supreme Court, *supra*, note 103.

¹³⁵ National Alliance on Mental Illness. (2006). *Grading the states: A report on America's health care system for serious mental illness*. Arlington, VA: National Alliance on Mental Illness.

¹³⁶ *Ibid.*

In 2009, NAMI again released a *Grading the States* report. The U.S. again received the national grade of a D. However, Florida was one of the states that fell back in ranking, receiving the grade of a D.¹³⁷ Florida received a category grade of a D for services, under Category II, “Financing & Core Treatment/Recovery Services.” The urgent need for more inpatient psychiatric beds was emphasized, and the state was chided for somewhat filling this need with additional prisons and jails.

These two NAMI reports also allow for the mental health policy priorities, or lack thereof, in Florida to be analyzed. NAMI (2006)¹³⁸ indicates that:

The state could ease pressure on its Medicaid program and community mental health services if it would advance and sign a mental health parity bill. Florida is one of a handful of states that have yet to make this important public policy commitment. (National Alliance on Mental Illness, 2006, p. 61)¹³⁹

Aron et al. (2009)¹⁴⁰ indicates that:

In Florida, advocates pushed through legislation to redirect dollars from the criminal justice system into mental health and substance abuse services. (Aron et al., 2009, p. 43)¹⁴¹

A mental health insurance parity law remains stalled in the legislature. (Aron et al., 2009, p. 75)¹⁴²

One prominent problem within Florida’s mental health system has been the overwhelming incarceration of individuals with mental illness, whom it is assumed did not have adequate access to mental health services when experiencing a crisis. Florida has since expanded its Crisis Intervention Teams (CIT) and mental health courts.

“Florida Partners in Crisis,” a non-profit collaboration between public officials in the criminal justice system and mental health advocates, has taken bold steps to respond to the crisis in Florida’s jails and prisons. It has advocated for the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant program, which provides state matching grants to counties for police Crisis Intervention Teams (CIT), mental health courts, and other programs to reduce the criminalization of people with mental illnesses. In addition, the state’s Supreme Court justices have taken the lead drafting a plan for targeting intensive mental health services to people who are at the greatest risk of criminal justice system involvement. (Aron et al., 2009, p. 75)¹⁴³

¹³⁷ Aron et al., supra, note 71.

¹³⁸ National Alliance on Mental Illness, supra, note 135.

¹³⁹ Ibid.

¹⁴⁰ Aron et al., supra, note 71.

¹⁴¹ Ibid.

¹⁴² Ibid.

¹⁴³ Ibid.

Mental health service funding in Florida has been notoriously low. In Florida in 2005, the SMHA expenditure per capita amount was \$36.56, giving Florida a per capita spending rank of 48th among the other states.¹⁴⁴ Furthermore:

In 2005, an estimated \$6.5 billion was spent on MHSA treatment in Florida, or about 5.2% of all MHSA treatment spending in the United States. This translates into \$365 spent per person in Florida, below the national average of \$423 per person and close to the Southeast regional average of \$394 per person. (Substance Abuse and Mental Health Services Administration, 2012, p. 37)¹⁴⁵

In Florida in 2007, the SHMA expenditure per capita amount was \$39.87, giving Florida a state rank of 46th.¹⁴⁶ In 2009, the U.S. average for per capita mental health spending was \$122.90; the Florida average for per capita mental health spending was \$40.90, making it one of the states with the lowest per capita mental health spending.¹⁴⁷

Florida currently has one of the highest rates of percentage of its mental health budget being spent on institutional care in the nation, thus reducing the amount of the budget that can be spent on community-based services.¹⁴⁸

Section 12. Recent Changes in Mental Health Services and Policy in Florida

The Florida Department of Children and Families (DCF) has recently released the *Substance Abuse and Mental Health Services Plan: 2015 Annual Plan Update*.¹⁴⁹ This update outlines the direction for Florida's mental health system for 2014-2016 as well as it describes the bills from the 2014 legislative session.

The following 2014 legislative bills impacted substance abuse and mental health services.

HB 7141 – Human Trafficking: The bill requires that residential treatment centers licensed under s. 394.875, F.S., and hospitals licensed under chapter 395 that provide residential mental health treatment, provide specialized treatment for sexually exploited children in the custody of the Department who are placed in these facilities.

¹⁴⁴ Lutterman et al., *supra*, note 110.

¹⁴⁵ Substance Abuse and Mental Health Services Administration. (2012). *State-level spending on mental health services and substance abuse treatment, 1997-2005*. DHHS Publication No. (SMA) 12-4702. Rockville, MD: Center for Mental Health Services and Center for Substance Abuse Treatment, SAMHSA.

¹⁴⁶ Substance Abuse and Mental Health Services Administration, *supra*, note 111.

¹⁴⁷ Honberg et al., *supra*, note 69.

¹⁴⁸ The Florida Council for Community Mental Health, *supra*, note 114.

¹⁴⁹ Florida Department of Children and Families. (2015). *2015 Substance abuse and mental health annual plan update: Compliance with annual reporting requirements per Section 394.75, Florida Statutes*. Tallahassee, FL: Office of Substance Abuse and Mental Health, Department of Children and Families.

HB 5003 – Implementing Bill: Section 10 provides that, notwithstanding any other law, behavioral health managing entities may not conduct provider network procurements during the 2014-2015 fiscal year. (Florida Department of Children and Families, 2015, p. 6)¹⁵⁰

This DCF (2015)¹⁵¹ annual plan update also detailed relevant provisos from the 2014 legislative session, including:

Community Action Teams (CATs): Specific Appropriation 349 allocates \$12,000,000 to continue funding ten (10) existing CAT Teams and implement six (6) new CAT Teams. These programs provide intensive, community-based services to families with children ages 11 to 21 with a mental health diagnosis or co-occurring substance abuse diagnosis who are considered high risk for out-of-home care.

Mental Health Transitional Beds: Specific Appropriation 351 allocates \$3,000,000 to three community mental health treatment providers to transition eligible individuals in state mental health treatment facilities to community-type settings as an alternative to more costly institutional placement. (Florida Department of Children and Families, 2015, p. 6)¹⁵²

This annual plan update additionally reports progress on 2014 DCF block grant goals relevant to mental health, including: the DCF publishing policy guidance and managing entities (ME) contracts incorporating documents on evidence-based practices; the DCF initiating six new county-based CAT programs to increase access to community-based services for children and adolescents delivered in a team approach; the DCF holding monthly telephone conferences with all providers and the Florida Council for Community Mental Health; and the mental health system providing services to 165,831 individuals with severe and persistent mental illness of a severe emotional disturbance in FY13-14, which was a 2.1% increase in such individuals served over the prior fiscal year.¹⁵³

The following table¹⁵⁴ displays the Fiscal Year 2014-2015 Approved Operating Budget for Mental Health Services in Florida:

Mental Health Services							
Regions	Adult Community Mental Health	Children’s Community Mental Health	Executive Leadership and Support Services	Civil Commitment Program	Forensic Commitment Program	Sexual Predator Program	Total
Headquarters	\$11,872,587	\$23,969,761	\$5,722,536	\$40,630,100	\$54,995,927	\$30,174,259	\$167,365,170
Northwest	\$27,963,532	\$6,314,573	\$464,318	\$0	\$0	\$0	\$34,742,423
Northeast	\$43,161,703	\$11,657,296	\$1,328,862	\$0	\$0	\$0	\$56,147,861
Suncoast	\$96,514,259	\$20,656,072	\$441,575	\$0	\$0	\$0	\$117,611,906

¹⁵⁰ Ibid.

¹⁵¹ Ibid.

¹⁵² Ibid.

¹⁵³ Ibid.

¹⁵⁴ Ibid.

Central	\$31,209,072	\$11,932,853	\$335,117	\$0	\$0	\$0	\$43,477,042
Southeast	\$50,205,612	\$13,581,584	\$490,123	\$0	\$0	\$0	\$64,277,319
Southern	\$37,105,645	\$13,004,620	\$524,780	\$0	\$0	\$0	\$50,635,045
West Florida Community Care Center	\$0	\$0	\$0	\$5,823,881	\$0	\$0	\$5,823,881
Florida State Hospital	\$6,130,215	\$0	\$0	\$56,379,966	\$57,929,532	\$0	\$120,439,713
Northeast Florida State Hospital	\$0	\$0	\$0	\$66,341,499	\$0	\$0	\$66,341,499
North Florida Evaluation and Treatment Center	\$0	\$0	\$0	\$0	\$22,936,076	\$0	\$22,936,076
Control	\$980,928	\$693,882	\$0	\$0	\$129,709	\$0	\$1,804,519
Reserve	\$0	\$0	\$83,791	\$347,430	\$247,951	\$27,463	\$706,635
Unfunded Budget	\$9,570	\$3,155,675	\$266,803	\$0	\$0	\$0	\$3,432,048
Total	\$305,153,123	\$104,966,316	\$9,657,905	\$169,522,876	\$136,239,195	\$30,201,722	\$755,741,137

The following table¹⁵⁵ displays the FY 2013-2014 GAA [General Appropriations Act] Measures and Clients Served through Adult Community Mental Health Services in Florida:

FY 2012-2013 GAA Measures and Clients Served - Adult Community Mental Health Services					
Population	MCode	Measure	Target	FY 2013-2014 Performance	Target Met
Forensic Involvement	M0018	Number of adults with forensic involvement served	3,328	3,025	NO
	M0743	Percent of adults in forensic involvement who live in stable housing environment.	67	90	YES
Mental Health Crisis	M0017	Number of adults in mental health crisis served	30,404	19,386	NO
	M0744	Percent of adults in mental health crisis who live in stable housing environment.	86	100	YES
Serious Mental Illness	M0703	Percent of adults with serious mental illness who are competitively employed.	24	34	YES
	M0709	Percent of adults with serious mental illness readmitted to a civil state hospital within 180 days of discharge	8	4	YES
	M0777	Percent of adults with serious mental illness readmitted to a forensic state treatment facility within 180 days of discharge	8	2	YES
Severe and Persistent Mental Illness	M0003	Average annual days worked for pay for adults with severe and persistent mental illness	40	23	NO
	M0016	Number of adults with a serious and persistent mental illness in the community served	136,480	144,437	YES

¹⁵⁵ Ibid.

	M0742	Percent of adults with severe and persistent mental illnesses who live in stable housing environment.	90	96	YES
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Additionally, in this DCF (2015)¹⁵⁶ update the Department outlined priorities for FY15-16. Some of these priorities include:

- The Department with the MEs, will redesign the delivery of services to minimize the use of emergency behavioral health services as primary care through care coordination, to ensure that people get the services they need and choose... Care coordination efforts will also focus on adults re-integrating into community settings from institutional placements, such as state mental health treatment facilities and prisons.
- Based on recent legislative initiatives, the Department will pursue expansion of family driven, team-based community interventions such as Community Action Teams (CAT) and Family Intervention Teams (FIT), to focus on the entire family and prevent out of home placements in the child welfare, behavioral health, and justice systems.
- The Department will implement the Level of Care Utilization System (LOCUS) to standardize discharge recommendations for community levels of care.
- The Department will pursue migration of service reporting to standardized healthcare reporting systems, using Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Technology (CPT) reporting codes.
- The Department will train and provide technical assistance to service providers, using evidence-based standards of care which focus on recovery and community integration. (Florida Department of Children and Families, 2015, p. 3-4)¹⁵⁷

The Substance Abuse and Mental Health (SAMH) Program also identified initiatives to meet several established priorities for services and funding over the next five years.¹⁵⁸ Some of these initiatives include the following:

- Use the LBR process to seek funds to assist over 130 persons in the civil State Mental Health Treatment Facilities who have been determined ready for community placement for 60 days or longer to be successfully reintegrated back into the community with appropriate treatment and necessary services.
- Provide a system of care that supports and promotes competitive employment opportunities for adults with behavioral health needs.
- Continue to implement the use of National Outcome Measures (NOMs), evidence based practices and quality indicators as the standard for system performance measurement and accountability.

¹⁵⁶ Ibid.

¹⁵⁷ Ibid.

¹⁵⁸ Florida Department of Children and Families, *supra*, note 105.

- Develop statewide and local community service frameworks that promote a “no wrong door” approach to care for individuals and families affected by co-occurring substance use and mental disorders, cross-training substance abuse and mental health professionals, and protocols/policies that are welcoming and engaging for these individuals/families.
- Advance a system of care that sustains stable housing for adults and children with behavioral health disorders.
- Increase the diversion of people with substance dependence and/or mental health illnesses who become involved with the criminal justice system through expanding cost-effective community-based treatment alternatives to incarceration and forensic hospitalization.
- Continue to implement Managing Entity contracts throughout the state to promote a more efficient, locally controlled, responsive system of care. (Florida Department of Children and Families, 2013, p. 35-37)¹⁵⁹

The Florida Council for Community Mental Health released a 2014 legislative issue priority list with budget comparisons from the different Florida political groups.¹⁶⁰ Some of the priorities/budget issues on this spreadsheet include:

- Restoration of nonrecurring funding for adult community mental health and CATs
- Expanding mental health residential capacity to address individuals waiting for discharge from state hospitals
- CAT expansion and adjustment
- Crisis Stabilization Unit (CSU) expansion
- Funding for public education about mental illness for Mental Health First Aid (MHFA)
- Additional Mental Health, Substance Abuse and Criminal Justice County Reinvestment Grants

Section 13. Issues with Current Mental Health Services in Florida

One of the biggest problems with Florida’s current mental health system is that it contains one of the largest uninsured and underserved populations. As of now, Florida has chosen not to implement Medicaid Expansion. According to Miller (2014),¹⁶¹ 34% (535,000 people) of the entire Medicaid Expansion eligible population in Florida has a mental health condition.

¹⁵⁹ Ibid.

¹⁶⁰ The Florida Council for Community Mental Health. (2014). *The Florida Council for Behavioral Healthcare top priorities budget comparisons and legislative issue spreadsheet*. Retrieved from: http://www.fccmh.org/legislative/docs/2014_session/Council_priority_list.pdf

¹⁶¹ Miller, supra, note 55.

Florida has a critical lack of funding, as it always has, for community-based mental health and substance abuse services. Also, mental health services are not readily available, especially for individuals residing in rural areas.

Furthermore, there are currently an abundant amount of incarcerated individuals in need of mental health services. This creates a vicious and economically draining cycle, especially on the state's limited mental health services budget, whereby many of Florida's scarce inpatient psychiatric beds are used for individuals with criminal charges to help restore competency before such individuals withstand a trial. However, many of these individuals enter the criminal justice system in the first place when they experience a crisis and do not have access to adequate mental health services. Once these individuals with mental illness are driven through the criminal justice system, they are often placed back in the community without access to further mental health services, creating a very cost-ineffective pattern.

Additionally, Florida has one of the highest proportions of adults aged 65 years and older. The specific concerns regarding mental health care for older adults need to be considered when creating/implementing Florida's health care policy. Numerous older adults go untreated for mental illness as many of their mental disorders are either not sufficiently diagnosed or attended to by the available services.

Section 14. The Future of Mental Health Services

There is a need for continued research on the diagnosis, etiology, and treatment of mental illness. The 2013 publication of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) will most likely change the diagnostic process and statistics surrounding mental illness in the years to come. Hansen et al. (2013)¹⁶² argues that important considerations that need to be taken into account regarding mental illness, which are not adequately addressed in the DSM-5, include:

... Social determinants of mental health disorders and their diagnosis; environmental factors triggering biological responses that manifest themselves in behavior; differing cultural perceptions about what is normal and what is abnormal behavior; and institutional pressures related to such matters as insurance reimbursements, disability benefits, and pharmaceutical marketing. (Hansen et al., 2013, p. 984)¹⁶³

Technological advances (e.g., telemedicine) that might help expand needed mental health services should be utilized. An example of this includes the development of online psychotherapy options. However, privacy issues regarding this type of treatment can create complications.

Some of the most promising advancements in the delivery of rural health care services have been in the area of telecommunication technology. These applications

¹⁶² Hansen, H. B., Donaldson, Z., Link, B. G., Bearman, P. S., Hopper, K., Bates, L. M., ... & Teitler, J. O. (2013). Independent review of social and population variation in mental health could improve diagnosis in DSM revisions. *Health Affairs*, 32(5), 984-993.

¹⁶³ Ibid.

have the potential to reduce the disparities in the delivery of substance abuse and mental health services between urban and rural communities. (Benavides-Vaello, et al., 2013, p. 111)¹⁶⁴

Continued improvement on the quality of mental health services should be organized and monitored. Implementation of frameworks designed to advance the ability to measure the quality of mental health care is necessary.¹⁶⁵ It is of increasing significance to establish care programs that are based on empirical findings. Preventative activities and public health strategies to reduce the burden of mental illness should be evaluated and incorporated. Sustained expansion of integrated care will also most likely prove to be of vital importance.

Integrated mental health, addiction and primary care for children and adults with multiple chronic conditions improves overall health, reduces costs, prevents duplication and gaps in care and makes more efficient use of service providers. States should create incentives, remove barriers and allocate Medicaid resources to promote integrated care through health homes based in community mental health centers and federally qualified health centers. (National Alliance on Mental Illness, 2013, p. 18-19)¹⁶⁶

Strategies to enroll uninsured individuals, especially through opportunities under the ACA, should be considered.

Comparative research on cost-effectiveness of different mental health interventions to inform policy accordingly is needed. Policy-oriented comparative effectiveness research is also necessary. Differential effectiveness of mental health programs and policies has not yet received much attention, especially in relation to patient-centered outcomes. However, this type of data would allow for the creation of incredibly efficient mental health services. Some challenges to collecting this type of data include the complexity of the current mental health system, scattered sources of funding, variation and lack of strict definition in the research on the methods and characteristics of mental health care services and delivery systems for mental illness, weak evidence for the effectiveness of quality improvement activities regarding the mental health system, and disconnect between the perspectives of providers, families/caregivers, researchers, and consumers.¹⁶⁷ Green et al. (2014)¹⁶⁸ offers the following recommendations for the future of comparative effectiveness research in relation to severe mental illness:

We lack sufficient outcome measures that have been developed by or in concert with service users, or evaluated rigorously by service users. Development of these

¹⁶⁴ Benavides-Vaello, S., Strode, A., & Sheeran, B. C. (2013). Using technology in the delivery of mental health and substance abuse treatment in rural communities: A review. *The journal of behavioral health services & research*, 40(1), 111-120.

¹⁶⁵ Pincus, H. A., Spaeth-Rublee, B., & Watkins, K. E. (2011). The case for measuring quality in mental health and substance abuse care. *Health Affairs*, 30(4), 730-736.

¹⁶⁶ National Alliance on Mental Illness, *supra*, note 72.

¹⁶⁷ Green, C. A., Estroff S. E., Yarborough B. H., Spofford M., Kitson R. S., Perrin N. A. (2014) Directions for future patient-centered and comparative effectiveness research for people with serious mental illness in a learning mental health care system. *Schizophrenia Bulletin*, 40(Suppl 1), S1-S94.

¹⁶⁸ *Ibid*.

measures is crucial and should be a primary aim of mental health research in the near future.

Some attempts have been made to link individual outcomes to service packages, service characteristics (eg, continuity, therapeutic relationship), and performance measures, but consistency within and across outcome measures is lacking, and the measures used are fraught with problems when viewed from a patient-centered perspective. The mental health system needs feedback methods based on new patient-centered outcome measures that are causally linked to services, processes, and structures.

More research is needed to compare the relative effectiveness of the many interventions that have been developed for individuals with serious mental illness. Such studies must include real-world patients with complex problems.

Financing of care and services are complicated and structured in ways that prevent coherent, coordinated, and integrated service delivery. Health care reform is providing rare opportunities for researchers to compare innovative methods of organizing and financing care. (Green et al., 2014, p. x-xi)¹⁶⁹

Furthermore:

In the context of systems, information alone is not adequate to produce system changes, although it is essential to the redesign processes. Complexity science provides an alternative perspective, highlighting factors likely to produce system-level changes and subsequent improvements in the outcomes those systems produce. In particular, complexity theory suggests that the focus of quality improvement efforts should not be on methods of providing information or incentivizing providers or organizations, but rather on the culture and climate of organizations, how to support teams and employees in ways that allow them to flourish, and how to create structures that promote high-quality interactions and teamwork that allow patient-centered information to be used to its fullest. (Green et al., 2014, p. S75-S76)¹⁷⁰

Mental illness has a big economic impact, and research being conducted implies that mental illness and unhappiness in general are some of the largest burdens on the global economy and affecting virtually all aspects of life.

... Mental health is a major factor of production. It is the biggest single influence on life satisfaction, with mental health eight years earlier a more powerful explanatory factor than current income. Mental health also affects earnings and

¹⁶⁹ Ibid.

¹⁷⁰ Ibid.

educational success. But, most strikingly, it affects employment and physical health. (Layard, 2013, p. i)¹⁷¹

Adult mental health services in the U.S., and in Florida, warrant much attention and continued improvement.

Section 15. Conclusion

The U.S.'s mental health services system is of critical importance. It has evolved throughout the past few decades, but many changes are still needed. Some of the recent strengths of this system include few individuals with mental illness still living in psychiatric hospitals, reliance on and broadening of effective community-based services, continuous improvement in the understanding of the etiology and presentation of mental illness, advancements in treatment options, implementation of evidence-based practices, expansion of mental health and substance use disorder coverage, parity for mental health services, and development of preventative care and health care integration programs. Improving economic standings has also allowed for the restoring of long depleted, state mental health budgets.

However, the U.S.'s mental health system is still critically underfunded and there is a continuous need for increased access to better quality adult mental health services. Some other major shortcomings of the U.S.'s mental health services system include mental health services remaining incredibly expensive, lack of mental health insurance and services for many individuals in need, and unsuccessful assessment of mental health service/care quality and system performance.

Florida's mental health service system also has inadequacies, especially the significant lack of funding for mental health services, insufficient investment in community-based mental health services, and a crisis of mental health care in the state's correctional system. Urgent policy and budget change that is needed in Florida involve: improving the forensic system to divert individuals with mental illness from jails and prisons into structured community placements or services; increasing crisis intervention services, psychiatric beds, and caregivers to decrease the number of individuals with mental illness in emergency departments and forensic facilities; and expanded funding for state mental health services. This expansion of funding for mental health services in general is also needed at the national level. However, since the U.S. and Florida's mental health systems have chronically remained significantly underfunded, it might be of more benefit and more realistic to shift the focus of mental health research and policy to cost-effectiveness and comparative effectiveness, while still emphasizing the quality of care. Recommendations for the movement toward a more effective mental health system include continuous investigation of the comparative cost-effectiveness of available mental health services, implementation of frameworks designed to improve the ability to measure quality of mental health care, development of patient-centered outcomes, formation of feedback methods based on the patient-centered outcome measures that are causally linked to services and performance measures, comparison of the new methods of organizing and financing care that have been initiated by recent health care reform, and creation of a coordinated strategy to implement the comparative effectiveness information (i.e., through complexity science). The discovery of the most effective

¹⁷¹ Layard, R. (2013). *Mental health: The new frontier for labour economics*. London: Centre for Economic Performance, London School of Economics and Political Science.

interventions, treatments, programs, and policies to inform emerging mental health policy will allow for more efficient spending of the limited funds, perhaps increasing the much needed access to and quality of mental health services.