

## **Childhood and Adolescence and Mental Health**

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February 2015 (Updated March 2015)  
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## Executive Summary

Mental health is critically important throughout development during childhood and adolescence. Mental illness in youths is a prevalent condition that is associated with serious consequences. There are currently several deficiencies in the way the mental health system diagnoses and treats mental health issues in children and adolescents.

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

- According to the Centers for Disease Control and Prevention (CDC), approximately 13-20% of youths in the U.S. experience a mental disorder and the prevalence of these conditions has increased over the past couple of decades. Common mental disorders in children and adolescents include anxiety disorders, behavior disorders (e.g., attention-deficit/hyperactivity disorder), mood disorders, autism spectrum disorder, and eating disorders. Many youths with mental health issues go without treatment, with only approximately one third of these youths receiving services for their mental illness.
- The youth mental health system is fragmented, with child and adolescent mental health services received in various settings/systems, including: specialty mental health settings, the public mental health system, the education system, general medical settings, the juvenile and criminal justice system, child welfare settings, and domestic settings.
- Poor mental health in children and adolescents has severe physical, social, and economic repercussions, including: negative impacts on quality of life and physical health; stigmatization, even in interpersonal relationships; school difficulty and/or failure; lower educational achievement; criminal behavior and juvenile justice system involvement; risk of suicide and self-harm; and significant societal costs (e.g., the CDC reports that the cost of youth mental disorders is estimated at \$247 billion annually in the U.S.).
- Several of the issues regarding mental health in general are especially relevant to youths, such as: difficulty in the recognition/diagnosis of mental disorders; the presence of distinctive life stressors (e.g., familial/parental, peer/friendship, and school stressors); a shortage of mental health providers; disparity in the utilization of mental health services; fragmentation of mental health services; a lack of funding; safety issues regarding pharmacological treatments for mental health issues; and gaps in prevalence of mental disorders and utilization of mental health services data.
- There have been numerous advances in evidence-based clinical treatment options (e.g., pharmacological and psychosocial interventions) for youths with mental health issues; home and community-based mental health services (e.g., early identification/prevention, intensive case management, family education, and clinical interventions) are essential.
- Research on the costs and outcomes associated with treating youth mental health issues is limited, but the literature that does exist, especially on home and community-based interventions, preventative services, and mental health services in the juvenile justice system, generally indicates positive outcomes (e.g., cost-effectiveness).
- Recent legislation that has supported improvements in the youth mental health system include the Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008, the Children's Health Insurance Program Reauthorization of 2009, 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 needing mental health services, support preventative care and early identification, integrate health services, and strengthen the mental health workforce for children and adolescents.

- In Florida, funding for mental health services for children and adolescents has not been sufficient to meet the growing need for services. In recent years, Florida has maintained one of the lowest per capita mental health expenditures in the nation.
- The Florida Department of Children and Families, the state department that provides and regulates public youth mental health services, is working to improve the youth mental health system by supporting several priorities, including: coordinating care; pursuing the expansion of community-based services (e.g., Community Action Teams); preventing mental health and substance use issues in children of parents abusing prescription drugs; increasing the number of children with mental health issues who regularly attend school and graduate from high school and post-secondary education; and diverting individuals with mental health issues who become involved with the criminal justice system.
- Improvements in the current youth mental health system are critical. There is a need for better prevalence and utilization data, continued research on the diagnosis, etiology, and treatment of mental illnesses in childhood and adolescence, research on cost-effectiveness of different youth mental health interventions, implementation of evidence-based practices, exploration of different methods for increasing access to appropriate care, increased awareness surrounding youth mental health, reduction of stigmatization, and expansion of mental health budgets.

## Section 1. Introduction

Mental health is a critical issue throughout development during childhood and adolescence. Mental illness in children and adolescents is a prevalent condition that can have serious consequences on quality of life, social experiences, and the overall economy. There are various issues surrounding mental health that are especially relevant to children and adolescents, including difficulty in the recognition of mental disorders within this demographic, the presence of distinctive life stressors in youth, and the fragmentation of appropriate mental health services. These issues and several others contribute to the current complications in the way the mental health system diagnoses and treats mental health issues in children and adolescents. Youth mental health services and interventions should be understood and developed and/or modified accordingly. As the occurrence of mental illness in children and adolescents has continued to increase, more attention has been devoted to and more information has been revealed regarding the youth mental health system.

## Section 2. A National Perspective on Child and Adolescent Mental Health

A significant proportion of children and adolescents in the U.S. experience mental illness. According to a recent report by the Centers for Disease Control and Prevention (CDC) (2013),<sup>1</sup> approximately 13-20% of children in the U.S. experience a mental disorder in a given year and the prevalence of these conditions has increased over the past couple of decades. The National Comorbidity Survey-Adolescent Supplement (NCS-A) provides prevalence data on various mental disorders in a nationally representative sample of U.S. adolescents (i.e., individuals aged 13-18 years).<sup>2</sup> As reported by Merikangas et al. (2010)<sup>3</sup> regarding NCS-A data:

Anxiety disorders were the most common condition (31.9%), followed by behavior disorders (19.1%), mood disorders (14.3%), and substance use disorders (11.4%), with approximately 40% of participants with one class of disorder also meeting criteria for another class of lifetime disorders. The overall prevalence of disorders with severe impairment and/or distress was 22.2% (11.2% with mood disorders, 8.3% with anxiety disorders, and 9.6% behavior disorders). (Merikangas et al., 2010, p. 980)<sup>4</sup>

Thus, common mental disorders in children and adolescents include anxiety disorders, behavior disorders (e.g., attention-deficit/hyperactivity disorder [ADHD]), mood disorders, autism spectrum disorder (ASD), and eating disorders.

Another source for current prevalence data on mental health issues in the U.S.'s youth is the 2013 National Survey on Drug Use and Health (NSDUH). According to this survey, in 2013, 10.7% of

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<sup>1</sup> Centers for Disease Control and Prevention. (2013). *Mental health surveillance among children – United States, 2005-2011*, MMWR, 62(2). Atlanta, GA: Office of Surveillance, Epidemiology, and Laboratory Sciences, Centers for Disease Control and Prevention, US Department of Health and Human Services.

<sup>2</sup> Merikangas, K. R., He, J. P., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., ... & Swendsen, J. (2010). Lifetime prevalence of mental disorders in US adolescents: Results from the National Comorbidity Survey Replication–Adolescent Supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry*, 49(10), 980-989.

<sup>3</sup> Ibid.

<sup>4</sup> Ibid.

the population aged 12 to 17, 2.6 million individuals, experienced a major depressive episode (MDE) in the past year.<sup>5</sup> This was a higher percentage than those in 2004 to 2012.<sup>6</sup>

It is important to note that the prevalence of severe emotional and behavior disorders is higher than the most frequent major physical conditions (e.g., asthma or diabetes) in adolescents.<sup>7</sup>

Yet, despite the significant prevalence of mental health conditions in children and adolescents, the utilization of mental health services among this population remains inadequate.

Approximately one third of adolescents with mental disorders received services for their illness (36.2%). Although disorder severity was significantly associated with an increased likelihood of receiving treatment, half of adolescents with severely impairing mental disorders had never received mental health treatment for their symptoms. Service rates were highest in those with attention-deficit/hyperactivity disorder (59.8%) and behavior disorders (45.4%), but fewer than one in five affected adolescents received services for anxiety, eating, or substance use disorders. (Merikangas et al., 2011, p. 32)<sup>8</sup>

Furthermore, of the youths aged 12 to 17 who experienced a past year MDE, only 38.1% received treatment for depression.<sup>9</sup>

Child and adolescent mental health services are received in various settings/systems, including: specialty mental health settings, the public mental health system, the education system, general medical settings (e.g., primary/pediatric care settings), the juvenile and criminal justice system, child welfare settings, and domestic settings. According to the 2013 NSDUH, in 2013, 3.3 million youths aged 12 to 17, 13.6% of this population, received treatment for problems with emotions or behaviors in a specialty mental health setting.<sup>10</sup>

Of the 3.3 million youths aged 12 to 17 in 2013 who received specialty mental health services, the most commonly reported reason for receiving services was feeling depressed (50.2 percent), followed by having problems with home or family (28.2 percent), thinking about or attempting suicide (25.2 percent), then feeling very afraid or tense (22.4 percent), breaking rules and "acting out" (20.3 percent), having problems at school (18.2 percent), and having trouble controlling anger

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<sup>5</sup> 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.

<sup>6</sup> Ibid.

<sup>7</sup> Merikangas et al., *supra*, note 2.

<sup>8</sup> Merikangas, K. R., He, J. P., Burstein, M., Swendsen, J., Avenevoli, S., Case, B., ... & Olfson, M. (2011). Service utilization for lifetime mental disorders in US adolescents: Results of the National Comorbidity Survey–Adolescent Supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry*, 50(1), 32-45.

<sup>9</sup> Substance Abuse and Mental Health Services Administration, *supra*, note 5.

<sup>10</sup> Ibid.

(15.9 percent)... (Substance Abuse and Mental Health Services Administration, 2014, p. 42)<sup>11</sup>

Additionally in 2013, 3.1 million youths, 13.0% of this population, received mental health services in an education setting; 686,000 youths, 2.8% of this population, received mental health services in a general medical setting; and 59,000 youths, 0.2% of this population, received mental health services in a juvenile justice setting in the past 12 months.<sup>12</sup>

### **Section 3. Impact of Poor Mental Health in Children and Adolescents**

Poor mental health in children and adolescents has serious social, physical, and economic repercussions. For example, children and adolescents with mental disorders tend to have a significantly lower quality of life.<sup>13;14</sup> Such children and adolescents can even score lower on certain measures of quality of life than children with physical disorders.<sup>15</sup> Issues related to the managing youth mental disorders can also interfere with the lives and health of parents and family members.

Another repercussion of poor mental health in children and adolescents is stigmatization.<sup>16;17;18</sup> Children and adolescents with mental illness can experience stigma in their interpersonal relationships, which likely undermines their wellbeing.<sup>19</sup> Such stigmatization can occur in relationships with peers, which can lead to friendship losses and transitions, in relationships with family members, which can result in distrust, avoidance, and pity, and in relationships with school staff, which can be expressed as fear, dislike, and under-estimation of the child's abilities.<sup>20</sup> Negative assumptions and discrimination toward children and adolescents with mental health issues can be very detrimental to a child's emotional and social development.

Mental illness in children and adolescents is associated with school difficulty and/or failure.<sup>21</sup> Youth with mental disorders tend to have lower educational achievement than their peers.<sup>22</sup>

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<sup>11</sup> Ibid.

<sup>12</sup> Ibid.

<sup>13</sup> Sawyer, M. G., Whaites, L., Rey, J. M., Hazell, P. L., Graetz, B. W., & Baghurst, P. (2002). Health-related quality of life of children and adolescents with mental disorders. *Journal of the American Academy of Child & Adolescent Psychiatry*, 41(5), 530-537.

<sup>14</sup> Klassen, A. F., Miller, A., & Fine, S. (2004). Health-related quality of life in children and adolescents who have a diagnosis of attention-deficit/hyperactivity disorder. *Pediatrics*, 114(5), e541-e547.

<sup>15</sup> Sawyer et al., supra, note 13.

<sup>16</sup> Moses, T. (2010). Being treated differently: Stigma experiences with family, peers, and school staff among adolescents with mental health disorders. *Social science & medicine*, 70(7), 985-993.

<sup>17</sup> Moses, T. (2009). Stigma and self-concept among adolescents receiving mental health treatment. *American Journal of Orthopsychiatry*, 79(2), 261-274.

<sup>18</sup> Mukolo, A., Heflinger, C. A., & Wallston, K. A. (2010). The stigma of childhood mental disorders: A conceptual framework. *Journal of the American Academy of Child & Adolescent Psychiatry*, 49(2), 92-103.

<sup>19</sup> Moses, supra, note 16.

<sup>20</sup> Ibid.

<sup>21</sup> Centers for Disease Control and Prevention, supra, note 1.

<sup>22</sup> Skowrya, K. R., & Coccozza, J. J. (2006). *Blueprint for change: A comprehensive model for the identification and treatment of youth with mental health needs in contact with the juvenile justice system*. Delmar, NY: The National Center for Mental Health and Juvenile Justice and Policy Research Associates, Inc.

Academic achievement is among the most thoroughly studied social consequences of mental health problems... studies find that youth with mental health problems perform less well in school and attain lower levels of education than other youth. The association holds throughout the early life course—in elementary school... in middle and high school... and into the postsecondary years... (McLeod et al., 2012, p. 483)<sup>23</sup>

When compared to their peers without mental health issues, children in preschool and elementary school with mental health issues are more likely to experience problems at school, be absent, or be suspended and adolescents in high school with mental health issues are more likely to fail or drop out of school.<sup>24</sup> According to a study by Breslau et al. (2008):<sup>25</sup>

Mental disorders were found to be significantly associated with termination of schooling prior to completion of each of four educational milestones (primary school graduation, high school graduation, college entry, college graduation), with odds ratios in the range of 1.3-7.0. The proportion of school terminations attributable to mental disorders was largest for high school graduation (10.2%) but also meaningful for primary school graduation (3.8%), college entry (4.4%) and college graduation (2.6%). (Breslau et al., 2008, p. 708)<sup>26</sup>

Additionally, mental illness in children and adolescent is associated with criminal behavior and juvenile justice system involvement.<sup>27</sup> Skowrya and Coccozza (2006)<sup>28</sup> reports that children and adolescents in the juvenile justice system have significantly higher rates of mental illness than youth in the general population, that research has shown that 65-70% of children and adolescents in juvenile justice facilities have a diagnosable mental disorder, and that approximately one out of every five youths in the juvenile justice system has a serious mental disorder. Liebenberg and Ungar (2014)<sup>29</sup> further supports the finding that incarcerated youths have significantly increased rates of mental health concerns compared to youth in the community.

Children and adolescents with mental disorders experience an increased risk of suicide and self-harm. Both suicide and self-harm are major public health problems in youth, with suicide ranking as the leading cause of death among children aged 12-17 years and self-harm maintaining a high rate of prevalence in the teenage years.<sup>30:31</sup> The interaction of mental disorders (or psychiatric or psychological issues in general) and other factors (e.g., familial, social, and cultural factors)

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<sup>23</sup> McLeod, J. D., Uemura, R., & Rohrman, S. (2012). Adolescent mental health, behavior problems, and academic achievement. *Journal of health and social behavior*, 53(4), 482-497.

<sup>24</sup> Skowrya & Coccozza, supra, note 22.

<sup>25</sup> Breslau, J., Lane, M., Sampson, N., & Kessler, R. C. (2008). Mental disorders and subsequent educational attainment in a US national sample. *Journal of psychiatric research*, 42(9), 708-716.

<sup>26</sup> Ibid.

<sup>27</sup> Centers for Disease Control and Prevention, supra, note 1.

<sup>28</sup> Skowrya & Coccozza, supra, note 22.

<sup>29</sup> Liebenberg, L., & Ungar, M. (2014). A comparison of service use among youth involved with juvenile justice and mental health. *Children and Youth Services Review*, 39, 117-122.

<sup>30</sup> Centers for Disease Control and Prevention, supra, note 1.

<sup>31</sup> Hawton, K., Saunders, K. E., & O'Connor, R. C. (2012). Self-harm and suicide in adolescents. *The Lancet*, 379(9834), 2373-2382.

contributes to suicide and self-harm.<sup>32</sup> Specifically, mood disorders (including depression), anxiety disorders, ADHD, and conduct disorders are commonly associated with suicidal behavior and/or self-harm.<sup>33</sup> It is important to note that rural suicide rates for youths are significantly higher than (nearly double) those of urban suicide rates for youths and that rural-urban youth suicide disparities appear to be increasing over time.<sup>34</sup>

Poor mental health in children and adolescents is also associated with other physical health issues. For example, youth with mental disorders are more likely to experience other chronic health conditions (e.g., asthma, diabetes, and epilepsy) than youth without such disorders.<sup>35</sup> Furthermore, certain mental disorders, such as eating disorders, can have unique and severe direct effects on physical health. Eating disorders are prevalent in the general adolescent population, with lifetime prevalence estimates of anorexia nervosa (AN), bulimia nervosa (BN), and binge-eating disorder at 0.3%, 0.9%, and 1.6%, respectively, in this population.<sup>36</sup> The medical complications of eating disorders, which vary according to each specific disorder, can be highly serious. The complications of AN can include gastrointestinal symptoms (e.g., constipation and bloatedness), dizziness and syncope, amenorrhea, bradycardia, cardiac arrhythmias, and electrolyte disturbances; the complications of BN can include gastric issues (e.g., gastric rupture or rupture of the esophagus), electrolyte disturbance, and dental damage; and the complications of binge-eating disorder can include the secondary complications of comorbid obesity (e.g., high blood pressure and type 2 diabetes).<sup>37</sup> Eating disorders are also associated with high mortality rates. The mortality rates for certain eating disorders (i.e., AN) are much higher than for other psychiatric disorders.<sup>38</sup> According to a study by Arcelus et al. (2011):<sup>39</sup>

The weighted mortality rates (ie, deaths per 1000 person-years) were 5.1 for AN, 1.7 for BN, and 3.3 for EDNOS [eating disorder not otherwise specified]. The standardized mortality ratios were 5.86 for AN, 1.93 for BN, and 1.92 for EDNOS. One in 5 individuals with AN who died had committed suicide. (Arcelus et al., 2011, p. 724)<sup>40</sup>

As previously mentioned, mental illness in children and adolescents has major economic impacts. The costs associated with mental illness in this demographic are very substantial.

In the United States, the cost (including health care, use of services such as special education and juvenile justice, and decreased productivity) of mental disorders

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<sup>32</sup> Ibid.

<sup>33</sup> Ibid.

<sup>34</sup> Fontanella, C. A., Hiance-Steelesmith, D. L., Phillips, G. S., Bridge, J. A., Lester, N., Sweeney, H. A., & Campo, J. V. (2015). Widening rural-urban disparities in youth suicides, United States, 1996-2010. *JAMA Pediatrics*, 10.1001/jamapediatrics.2014.3561.

<sup>35</sup> Centers for Disease Control and Prevention, supra, note 1.

<sup>36</sup> Swanson, S. A., Crow, S. J., Le Grange, D., Swendsen, J., & Merikangas, K. R. (2011). Prevalence and correlates of eating disorders in adolescents: Results from the national comorbidity survey replication adolescent supplement. *Archives of General Psychiatry*, 68(7), 714-723.

<sup>37</sup> Fairburn, C. G., & Harrison, P. J. (2003). Eating disorders. *The Lancet*, 361(9355), 407-416.

<sup>38</sup> Arcelus, J., Mitchell, A. J., Wales, J., & Nielsen, S. (2011). Mortality rates in patients with anorexia nervosa and other eating disorders: A meta-analysis of 36 studies. *Archives of General Psychiatry*, 68(7), 724-731.

<sup>39</sup> Ibid.

<sup>40</sup> Ibid.

among persons aged <24 years in the United States was estimated at \$247 billion annually... In 2006, mental disorders were among the most costly conditions to treat in children... (Centers for Disease Control and Prevention, 2013, p. 2)<sup>41</sup>

#### **Section 4. Issues Surrounding Child and Adolescent Mental Health**

Several of the issues regarding mental health in general are especially relevant to children and adolescents. For instance, difficulty recognizing and diagnosing mental disorders is particularly pertinent in youths. The brain is constantly developing and changing throughout childhood and adolescence, and other physical, mental, emotional, and social developments also occur throughout these growth periods. Thus, characteristics of a youth's mental health may be challenging to understand without knowledge of the complete context. For example:

Because normal behaviors vary from one childhood stage to another, it can be difficult to tell whether a child who shows changes in behavior is just going through a temporary "phase" or is suffering from depression. (National Institute of Mental Health, p. 1)<sup>42</sup>

Children mature at their own unique paces and so "normal" behaviors exist across a wide spectrum. These behaviors should not only be considered with regard to developmental factors, but also other external factors (e.g., socioeconomic and cultural factors). Additionally, younger children may be unable to accurately and/or effectively describe their thoughts/feelings (i.e., their symptoms of mental illness).

Moreover, the symptoms associated with diagnoses of mental disorders in adults can differ from the relevant symptoms displayed by children and adolescents with similar mental health issues. For example:

We now know that youth who have depression may show signs that are slightly different from the typical adult symptoms of depression. Children who are depressed may complain of feeling sick, refuse to go to school, cling to a parent or caregiver, or worry excessively that a parent may die. Older children and teens may sulk, get into trouble at school, be negative or grouchy, or feel misunderstood. (National Institute of Mental Health, p. 1)<sup>43</sup>

Children and adolescents can encounter unique life stressors that can affect mental health. Some of these life stressors include familial/parental stressors, peer/friendship stressors, educational requirements, and school stressors. In regard to school specifically, a recent survey found that teens report that their stress level during the school year far exceeds what they believe to be healthy; this reported stress level tops adults' average reported stress levels.<sup>44</sup> School was the most commonly

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<sup>41</sup> Centers for Disease Control and Prevention, *supra*, note 1.

<sup>42</sup> National Institute of Mental Health. *Children's mental health awareness: Depression in children and adolescents fact sheet*. Bethesda, MD: National Institute of Mental Health.

<sup>43</sup> *Ibid.*

<sup>44</sup> American Psychological Association. (2014). *Stress in America™: Are teens adopting adults' stress habits?*. Washington, DC: American Psychological Association.

mentioned source of stress for teens in this survey, with 83% of the teens reporting that school is a somewhat or significant source of stress.

There is an unmet need for mental health services among children and adolescents. Many youths with mental health issues go without treatment. As previously mentioned, according to the NCS-A, approximately only one third of adolescents with mental disorders receive services for their illness.<sup>45</sup> Additionally, data from the CDC's National Health and Nutrition Examination Survey (NHANES) indicates that approximately only one half of the children and adolescents with an assessed mental disorder had sought treatment with a mental health professional.<sup>46</sup> Despite a significant number of mental disorders starting in childhood or adolescence, treatment typically does not begin until several years later.<sup>47</sup>

The mental health workforce in general has been burdened by shortages, high turnover rates, and a lack of diversity.<sup>48</sup> It is particularly difficult to recruit clinicians who specialize in the treatment of children and adolescents' behavioral health issues.<sup>49</sup> There is currently a shortage of youth mental health providers.

... According to the estimates in one analysis, in 2020 there will be 4,312 fewer child and adolescent psychiatrists than will be needed... According to the same analysis, only six states have an adequate supply of child and adolescent psychiatrists... (Hoge et al., 2013, p. 2006)<sup>50</sup>

Stagman and Cooper (2010)<sup>51</sup> further indicates that even of those providers who do handle children's mental health issues, many do not use effective, evidence-based, or empirically supported practices. This detrimentally affects the quality of youth mental health care.

Coverage of mental health services in public and private health insurance programs for children and adolescents is inadequate. Insurance companies may limit access to children's mental health providers because certain health care providers remain reluctant to identify mental illness in children and adolescents.

There is also disparity in the utilization of child and adolescent mental health services. Merikangas et al. (2011)<sup>52</sup> found that, based on data from the NCS-A, Hispanic and non-Hispanic Black adolescents were less likely than their White counterparts to receive treatment for mental disorders, regardless of the degree of impairment associated with the disorders.

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<sup>45</sup> Merikangas et al., supra, note 8.

<sup>46</sup> Merikangas, K. R., He, J. P., Brody, D., Fisher, P. W., Bourdon, K., & Koretz, D. S. (2010). Prevalence and treatment of mental disorders among US children in the 2001–2004 NHANES. *Pediatrics*, 125(1), 75-81.

<sup>47</sup> Kessler, R. C., Amminger, G. P., Aguilar-Gaxiola, S., Alonso, J., Lee, S., & Ustun, T. B. (2007). Age of onset of mental disorders: A review of recent literature. *Current opinion in psychiatry*, 20(4), 359-364.

<sup>48</sup> Hoge, M. A., Stuart, G. W., Morris, J., Flaherty, M. T., Paris, M., & Goplerud, E. (2013). Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. *Health Affairs*, 32(11), 2005-2012.

<sup>49</sup> Ibid.

<sup>50</sup> Ibid.

<sup>51</sup> Stagman, S., & Cooper, J. L. (2010). *Children's mental health: What every policymaker should know*. New York, NY: National Center for Children in Poverty, Mailman School of Public Health, Columbia University.

<sup>52</sup> Merikangas et al., supra, note 8.

Additionally, other child and adolescent populations that have particularly high needs for mental health services (e.g., lesbian, gay, bisexual, or overall sexual minority youth and youth involved with the juvenile justice system) often have significant unmet mental health needs. Sexual minority youths (e.g., lesbian, gay, bisexual youths) tend to have higher prevalence rates of mental disorder diagnoses than youths in national samples.<sup>53</sup> According to a study by Williams and Chapman (2012):<sup>54</sup>

Being a sexual minority youth (SMY) significantly increases the odds of having an unmet need for health or mental health care; female SMY have the highest odds of an unmet mental health need. (Williams & Chapman, 2012, p. 473)<sup>55</sup>

Controlling for all other variables in the final model, SMY had 48% higher odds of having an unmet mental health need compared with peers (OR = 1.48,  $p < .001$ ). (Williams & Chapman, 2012, p. 477)<sup>56</sup>

Youth involved with the juvenile justice system also tend to have higher rates of mental health issues and these mental health needs are not being met.<sup>57</sup>

Studies have shown that whether incarcerated or being supervised in the community, young offenders do not receive referrals and interventions to address the mental health challenges that they experience... This service gap is especially troubling as youth are at greater risk of offending when they carry multiple diagnoses for mental health disorders... (Liebenberg and Ungar, 2014, p. 117)<sup>58</sup>

Youth mental health services are fragmented and poorly coordinated. As aforementioned, mental health care for children and adolescents can be received in various settings/systems (e.g., specialty mental health settings, the public mental health system, the education system, general medical settings, the juvenile and criminal justice system, child welfare settings, and domestic settings). The youth mental health service delivery system requires supportive infrastructure components (e.g., provider training and retention, adequate reimbursement, strong information technology systems, and family involvement in policy) that are not currently present.<sup>59</sup>

Moreover, the quality of youth mental health services is often deficient, and such services remain critically underfunded.<sup>60</sup>

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<sup>53</sup> Mustanski, B. S., Garofalo, R., & Emerson, E. M. (2010). Mental health disorders, psychological distress, and suicidality in a diverse sample of lesbian, gay, bisexual, and transgender youths. *American Journal of Public Health, 100*(12), 2426-2432.

<sup>54</sup> Williams, K. A., & Chapman, M. V. (2012). Unmet health and mental health need among adolescents: The roles of sexual minority status and child-parent connectedness. *American Journal of Orthopsychiatry, 82*(4), 473-481.

<sup>55</sup> Ibid.

<sup>56</sup> Ibid.

<sup>57</sup> Liebenberg & Ungar, supra, note 29.

<sup>58</sup> Ibid.

<sup>59</sup> Stagman & Cooper, supra, note 51.

<sup>60</sup> Ibid.

In recent years, the worst recession in the U.S. since the Great Depression has dramatically impacted an already inadequate public mental health system. From 2009 to 2011, massive cuts to non-Medicaid state mental health spending totaled nearly \$1.6 billion dollars. And, deeper cuts are projected in 2011 and 2012. States have cut vital services for tens of thousands of youth and adults living with the most serious mental illness. These services include community and hospital based psychiatric care, housing and access to medications. (Honberg et al., 2011, p. 1)<sup>61</sup>

More research is needed regarding the safety of pharmacological treatments for mental health issues in children and adolescents, especially psychotropic and antipsychotic medications.<sup>62;63</sup> For example, in regard to psychotropic medications (e.g., selective serotonin reuptake inhibitors [SSRIs]), certain medications can have serious side effects including increased risk of suicidal thoughts and behaviors for adolescents and young adults; thus, youths taking psychotropic medications should be closely monitored by appropriate mental health providers.<sup>64</sup> In regard to antipsychotic medications, advances in the understanding of the safety profile of such medications in children and adolescents has not been matched by the rapid increase in the utilization of such medications in this population.<sup>65</sup> Some of the side effects associated with antipsychotics that are particularly relevant to children and adolescents include metabolic abnormalities, increased prolactin levels, and the risk of tardive dyskinesia.<sup>66</sup>

Overall deficits in prevalence of youth mental disorders and utilization of youth mental health services data remain since childhood and adolescent mental health issues are not typically the sole focus of federal public health surveillance.<sup>67</sup> This shortage of reliable and detailed nationally representative data concerning youth mental health has limited youth mental health policy.<sup>68</sup>

Mental health disorders that begin in childhood can continue into adulthood, so better understating and treatment of these disorders is critically important.<sup>69</sup>

## **Section 5. Current Mental Health Services for Children and Adolescents**

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<sup>61</sup> Honberg, R., Diehl, S., Kimball, A., Gruttadaro, D., & Fitzpatrick, M. (2011). *State mental health cuts: A national crisis*. National Alliance on Mental Illness.

<sup>62</sup> Gruttadaro, D., Burns, B. J., Duckworth, K., & Crudo, D. (2007). *Choosing the right treatment: What families need to know about evidence-based practices*. Arlington, VA: National Alliance on Mental Illness.

<sup>63</sup> Schneider, C., Taylor, D., Zalsman, G., Frangou, S., & Kyriakopoulos, M. (2014). Antipsychotics use in children and adolescents: An on-going challenge in clinical practice. *Journal of Psychopharmacology*, 28(7), 615-623.

<sup>64</sup> Gruttadaro et al., supra, note 62.

<sup>65</sup> Schneider et al., supra, note 63.

<sup>66</sup> Ibid.

<sup>67</sup> Centers for Disease Control and Prevention, supra, note 1.

<sup>68</sup> Merikangas et al., supra, note 8.

<sup>69</sup> Centers for Disease Control and Prevention, supra, note 1.

There have been numerous advances in treatment options, and the empirical support relevant to such options, for children and adolescents with mental health issues.<sup>70;71</sup> Successful clinical child and adolescent mental health treatment interventions include various psychosocial and pharmacological services, and frequently combinations of the two. These evidence-based interventions are applicable to numerous mental disorders (e.g., anxiety, depression, ADHD, ASD, behavior disorders, and eating disorders).<sup>72</sup> Well-supported treatments for anxiety in children and adolescents include cognitive-behavioral therapy (CBT), CBT in combination with medication, exposure therapy, modeling therapy, SSRIs, and benzodiazepines.<sup>73;74;75</sup> Well-supported treatments for depression in children and adolescents include CBT, CBT in combination with medication, CBT with parents, family therapy/education, relaxation therapy, interpersonal therapy (IPT), and SSRIs.<sup>76;77</sup> However, several sources indicate that the most effective treatment for depression in children and adolescents involves a combination of psychotherapy (e.g., CBT) and medication.<sup>78;79</sup> Well-supported treatments for ADHD in children and adolescents include self-verbalization, behavior therapy (in home and in school), behavior therapy in combination with medication, parent management training, and stimulant and non-stimulant medications.<sup>80;81</sup> Again, the most effective treatment for ADHD in children and adolescents often involves a combination of behavior therapy and medication.<sup>82</sup> Well-supported treatments for ASD in children and adolescents include intensive behavioral treatment, intensive communication training, behavior therapy, individual and family therapies that target communication skills, interaction skills, and behavior modification, and antipsychotic medications (to reduce aggression, if necessary).<sup>83;84</sup> Well-supported treatments for behavior disorders (e.g., conduct disorder [CD] and oppositional defiant disorder [ODD]) in children and adolescents include parent management training (PMT), anger coping therapy, brief strategic family therapy (BSFT), functional family therapy (FFT), treatment foster care (TFC), multisystemic therapy (MST), mentoring, CBT, antipsychotic medications, and mood stabilizers.<sup>85;86</sup> Well-supported treatments for eating disorders in children and adolescents include CBT, family-based interventions that focus on weight restoration, reducing blame, and empowering caregivers, individual therapy, and medications in certain

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<sup>70</sup> Southam-Gerow, M. A., & Prinstein, M. J. (2014). Evidence base updates: The evolution of the evaluation of psychological treatments for children and adolescents. *Journal of Clinical Child & Adolescent Psychology, 43*(1), 1-6.

<sup>71</sup> Chorpita, B. F., Daleiden, E. L., Ebesutani, C., Young, J., Becker, K. D., Nakamura, B. J., ... & Starace, N. (2011). Evidence-based treatments for children and adolescents: An updated review of indicators of efficacy and effectiveness. *Clinical Psychology: Science and Practice, 18*(2), 154-172.

<sup>72</sup> Ibid.

<sup>73</sup> Ibid.

<sup>74</sup> National Institute of Mental Health. *Children's mental health awareness: Anxiety disorders in children and adolescents fact sheet*. Bethesda, MD: National Institute of Mental Health.

<sup>75</sup> Gruttadaro et al., supra, note 62.

<sup>76</sup> Chorpita et al., supra, note 71.

<sup>77</sup> Gruttadaro et al., supra, note 62.

<sup>78</sup> National Institute of Mental Health, supra, note 42.

<sup>79</sup> Gruttadaro et al., supra, note 62.

<sup>80</sup> Chorpita et al., supra, note 71.

<sup>81</sup> Gruttadaro et al., supra, note 62.

<sup>82</sup> Ibid.

<sup>83</sup> Chorpita et al., supra, note 71.

<sup>84</sup> Gruttadaro et al., supra, note 62.

<sup>85</sup> Chorpita et al., supra, note 71.

<sup>86</sup> Gruttadaro et al., supra, note 62.

contexts.<sup>87;88</sup> Full weight restoration (often through high-calorie diets) is also critical in the appropriate youths.<sup>89</sup> Overall, treatment plans for any child or adolescent with a mental disorder should be fitted to specific individual and family preferences/circumstances and should be modified to best serve the youth.

As previously reiterated regarding the utilization of child and adolescent mental health services, there are various settings in which such services can be received. The current continuum of these settings and services includes inpatient hospitalization, residential treatment, group homes, shelters and related facilities, detention centers and related juvenile justice facilities, TFC, foster care, community-based services, school-based services, and in-home services.<sup>90</sup>

Home and community-based mental health services are imperative for children and adolescents.

Historically, the mental health field has developed an over-reliance on institutional settings for children and adolescents with mental health treatment needs.

Research advances in children's mental health have shown that many children and adolescents achieve better outcomes when treatment is delivered in their homes and communities. (Gruttadaro et al., 2007, p. 7)<sup>91</sup>

Gruttadaro et al. (2009)<sup>92</sup> comprehensively lists and describes the following current home and community-based services that are essential to many children and adolescents with mental health issues:

Early Identification and Intervention - early mental health screening, assessment, and evaluation that are culturally and linguistically appropriate must be part of a comprehensive health care system... When mental illness is identified early in the course of the illness, it is easier to treat and early intervention leads to better long-term outcomes.

Intensive case management - professional case managers work closely with the child, family, and other professionals to develop an individualized comprehensive service plan. The case manager assesses and coordinates the services and supports necessary to help keep the child at home, in the community, and receiving the most effective services.

Wraparound - a definable planning process that actively involves the child and family and that results in a unique set of culturally appropriate community services

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<sup>87</sup> Chorpita et al., supra, note 71.

<sup>88</sup> Campbell, K., & Peebles, R. (2014). Eating disorders in children and adolescents: State of the art review. *Pediatrics*, 134(3), 582-592.

<sup>89</sup> Ibid.

<sup>90</sup> 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.

<sup>91</sup> Gruttadaro et al., supra, note 62.

<sup>92</sup> Gruttadaro et al., supra, note 90.

and natural supports individualized for the child and family and designed to achieve positive outcomes. The services typically used in a treatment plan developed by wraparound teams include mental health evaluations, behavioral support and behavioral aide services, crisis planning and intervention services, parent training and education, medication monitoring, intensive in-home therapy, and related services.

Therapeutic Foster Care (TFC) - a placement outside of the family home for youth with serious mental health treatment needs. Therapeutically trained foster parents work with youth in their home to provide a structured and therapeutic environment while enabling the youth to live in a family setting. The trained foster parents work closely with the biological or adoptive family, whenever possible, and receive close supervision and support to help ensure that therapeutic interventions lead to positive results.

Mentoring/Behavioral Aide - a para-professional with strong child relationship skills who works with children to improve and eliminate problem behaviors and to develop more positive behaviors. The work includes increasing positive social involvement and activities in school and in the community. Behavioral aides help youth to develop and improve skills, including anger management, social skills, and problem-solving skills that help a child to function well at home and in the community.

Crisis Stabilization/Mobile Crisis Services - emergency services that include some combination of a crisis hotline; mobile crisis teams available 24-hours a day and seven days a week for services needed at home, in school, or in the community; emergency shelters; and connection with acute care hospitalization and emergency room services.

Respite - family support that provides a relief from child care by bringing a caregiver into the home or placing a child in another setting for a brief period of time.

Family Support and Education - Through relationship building, education, collaboration, and problem solving, these programs help youth and families learn about mental illness and effective treatment options; provide hope, support, and encouragement; and teach caregivers to reduce stress and to take care of themselves. These programs also help families understand how to manage the symptoms of their child's mental illness. (Gruttadaro et al., 2009, p. 10-12)<sup>93</sup>

Gruttadaro et al. (2009)<sup>94</sup> also emphasizes the importance of clinical interventions and supports (e.g., CBT, IPT, PMT, anger coping therapy, BSFT, FFT, MST, and various medications) as home and community-based services for children and adolescents with mental health issues.

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<sup>93</sup> Ibid.

<sup>94</sup> Ibid.

Preventative mental health services are vital for children and adolescents. Early intervention services for youths can be effective in delaying or preventing the onset of mental disorders.<sup>95</sup> Interventions focused on improving parenting and family functioning, reducing the use of harsh discipline practices, increasing parental monitoring, reducing aggressive behavior, avoiding substance use, securing permanent foster care placement, and handling difficult family situations have beneficial effects.<sup>96</sup> School-based interventions focused on promoting positive youth behavior, preventing behavior problems (e.g., violence, aggression, and substance use), skill development to improve peer relationships, self-awareness, decision-making skills, teacher classroom management, and school-family relations also display positive results regarding youth mental disorders.<sup>97</sup> Screening instruments are available to detect youths at risk for developing mental disorders, and such instruments can be readily used in schools and primary care settings.<sup>98</sup>

## Section 6. Cost-Effectiveness of Mental Health Care for Children and Adolescents

Mental health care for children and adolescents is incredibly important from an economic, as well as an ethical/humanistic, perspective. The cost of mental illness in children and adolescents is very high, at an estimated total of \$247 billion annually.<sup>99</sup> Mental illness that remains untreated can have exceptionally expensive consequences, since a lack of care throughout youth can result in a spiral of school failure, poor employment opportunities, and poverty in adulthood.<sup>100</sup> Furthermore, the child and adolescent mental disorders that continue into adulthood can cause relevant individuals to use more health care services and acquire higher health care costs than other adults.<sup>101</sup>

High nonhealth costs in childhood and poor economic outcomes in adulthood make a strong case for increased investment in treatment for childhood psychiatric disorders. (Beecham, 2014, p. 728)<sup>102</sup>

Yet, there is not much research surrounding the economic factors associated with treating mental health needs in children and adolescents. According to Beecham (2014),<sup>103</sup> the need for economic evaluations on this topic remains the same as 15 years ago. A review by Kilian et al. (2010)<sup>104</sup> concludes that there is currently a huge gap in the literature about which programs/services for

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<sup>95</sup> O'Connell, M. E., Boat, T., & Warner, K. E. (Eds.). (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. Washington, DC: National Academies Press.

<sup>96</sup> Ibid.

<sup>97</sup> Ibid.

<sup>98</sup> Ibid.

<sup>99</sup> Centers for Disease Control and Prevention, *supra*, note 1.

<sup>100</sup> American Academy of Child and Adolescent Psychiatry Committee on Health Care Access and Economics and Task Force on Mental Health. (2009). Improving mental health services in primary care: Reducing administrative and financial barriers to access and collaboration. *Pediatrics*, 123(4), 1248-1251.

<sup>101</sup> Ibid.

<sup>102</sup> Beecham, J. (2014). Annual Research Review: Child and adolescent mental health interventions: A review of progress in economic studies across different disorders. *Journal of child psychology and psychiatry*, 55(6), 714-732.

<sup>103</sup> Ibid.

<sup>104</sup> Kilian, R., Losert, C., Park, A. L., McDaid, D., & Knapp, M. (2010). Cost-effectiveness analysis in child and adolescent mental health problems: An updated review of literature. *International Journal of Mental Health Promotion*, 12(4), 45-57.

mental disorder prevention and treatment in children and adolescents provide the greatest benefit for the money invested. Beecham (2014)<sup>105</sup> further states that there are far fewer economic studies for youth mental disorders than for adult mental disorders and that the costs to nonhealth agencies (which are especially relevant to the youth mental health system), such as those providing social care, education, and justice, are high but are not frequently assessed.

Those studies that have examined the effects of youth mental health interventions, specifically home and community-based interventions, on economic outcomes have generally reported positive results. Gruttadaro et al. (2007)<sup>106</sup> indicates that institutional care is more costly than home and community-based care and that it limits the overall number of children that can be served. Enhanced access to outpatient mental health services among children and adolescents appears to be cost-effective.<sup>107</sup> For example:

Sheidow and colleagues (2004) compared the cost-effectiveness of a community-based multi-systemic therapy (MST) with psychiatric hospital treatment (PHT) for young people following a psychiatric crisis in the USA. The results indicated that, for a four-month period, the costs per clinically relevant (1/10 s.d.) improvement of the externalising behaviour scale were \$395 for MST and \$1525 for PHT, costs per clinically relevant (1/10 s.d.) improvement of the internalising behaviour scale were \$385 for MST and \$1309 for PHT, costs per clinically relevant (1/10 s.d.) improvement of the global severity index were \$1957 for MST and \$2508 for PHT. During a 12-month follow-up period after the initial four-month period, no differences in effects or costs were found between the treatment groups. From these results the authors concluded that multi-systemic therapy was more effective and cheaper than hospital treatment. (Kilian et al., 2010, p. 48)<sup>108</sup>

Moreover:

The Substance Abuse and Mental Health Services Administration reports high levels of cost-effectiveness among community mental health services delivered through systems of care, which require collaboration among the multiple public systems in which children with serious disorders are often involved... The average reduction in per-child hospital days from initial entry into services through 12 months resulted in an average savings of \$2,776.85 per child... From entry into community systems of care through 18 months, the number of children who utilized inpatient facilities decreased by 54%. (American Academy of Child and Adolescent Psychiatry, 2011, p. 1)<sup>109</sup>

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<sup>105</sup> Beecham, supra, note 102.

<sup>106</sup> Gruttadaro et al., supra, note 62.

<sup>107</sup> American Academy of Child and Adolescent Psychiatry Committee on Health Care Access & Economics and Task Force on Mental Health, supra, note 99.

<sup>108</sup> Kilian et al., supra, note 104.

<sup>109</sup> American Academy of Child and Adolescent Psychiatry. (2011). *Cost effectiveness of prevention and early intervention*. Washington, DC: American Academy of Child and Adolescent Psychiatry.

Research on the cost-effectiveness of preventative mental health services for children and adolescents has also demonstrated positive results.<sup>110</sup> O'Connell et al. (2009)<sup>111</sup> argues that increasing youth preventative mental health services is one of the soundest investments a society could make since the benefits include higher productivity, lower treatment costs, less suffering and premature mortality, more cohesive families, and more successful youths. Youth prevention and early intervention services have been shown to have important long-term economic impacts through increased earnings and decreased criminal activity.<sup>112</sup>

Much of the strongest evidence to date is for interventions that improve protective factors or reduce risk factors demonstrated through research to be closely related to MEB disorders [mental, emotional, and behavioral disorders]... For example, multiple economic programs have demonstrated benefits that exceed costs. (O'Connell et al., 2009, p. 259)<sup>113</sup>

There is also research to show that mental health interventions in the juvenile justice system are cost-effective. For example, both FFT and MST have reduced juvenile justice system costs, crime, and recidivism; the savings (benefits minus costs) of these therapies have amounted to \$47,776 for FFT and \$17,694 for MST.<sup>114</sup>

## **Section 7. Recent Changes in Child and Adolescent Mental Health Care Policy/Legislation**

One of the recent changes in mental health care policy in general which is relevant to child and adolescent populations is parity for coverage of mental health/substance use services with physical health services. The Wellstone-Domenici Act of 2008 and the Children's Health Insurance Program Reauthorization of 2009 require mental health benefits to be on par with medical benefits, and the Patient Protection and Affordable Care Act (ACA) of 2010 supports this principle.<sup>115</sup>

The ACA allows for the overall expansion of coverage to numerous individuals for both physical and mental health conditions.

Medicaid is the most important public health program for mental health service delivery, currently financing 27 percent of all mental health services. Medicaid provides access to community mental health care that would otherwise be unavailable to millions of low-income adults and children. Expanding Medicaid to 138 percent of poverty, as allowed under the ACA, is the best strategy available to strengthen the mental health system. (National Alliance on Mental Illness, 2013, p. 8)<sup>116</sup>

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<sup>110</sup> O'Connell et al., *supra*, note 95.

<sup>111</sup> *Ibid.*

<sup>112</sup> American Academy of Child and Adolescent Psychiatry, *supra*, note 109.

<sup>113</sup> O'Connell et al., *supra*, note 95.

<sup>114</sup> American Academy of Child and Adolescent Psychiatry, *supra*, note 109.

<sup>115</sup> Stagman & Cooper, *supra*, note 51.

<sup>116</sup> 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.

Mental health care policy has also recently increased emphasis on preventative interventions and early identification in relation to mental health/illness. The ACA provides support for prevention and early intervention and specifically extends Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services to youths gaining coverage through Medicaid.<sup>117;118</sup> Furthermore:

After the Newtown tragedy NAMI advocated for policies supporting early identification and intervention, training for school personnel, families and the public, mental health services in schools and increased access to care. States' legislation was aimed at providing increased mental health screening services for several populations primarily to identify emerging mental illness in children and adolescents and to ensure adequate access to care. In addition, several states enacted related legislation focused on early intervention, school-based services and staff training to prevent potential tragedies such as the Sandy Hook shootings. (National Alliance on Mental Illness, 2013, p. 10)<sup>119</sup>

The ACA also supports care coordination and the integration of physical and mental health services and strengthening the mental health workforce for children and adolescents.<sup>120</sup> The ACA encourages the development of interdisciplinary mental and behavioral health training programs and provides grants for education, training, and loan repayment for youth mental health care providers.<sup>121;122</sup>

States have recognized that the juvenile justice system often fails to identify and treat mental illness and have enacted legislation to study this system and integrate its modifications with efforts of other youth-serving systems to improve mental health within the juvenile justice system.<sup>123</sup>

There has been much pressure to control funding at the national and state levels, often causing budget cutbacks in mental health services. Several states are currently attempting to improve these critically underfunded mental health budgets.

## **Section 8. Current Child and Adolescent Mental Health Services and Policy/Legislation in Florida**

State data on the prevalence of mental illness in children and adolescents in Florida remains elusive. According to a report by the Florida Department of Children and Families (DCF) (2013),<sup>124</sup> more than 1.4 million children and adults in Florida indicated some level of psychological distress on a recent NSDUH and there are approximately 330,989 children in Florida with serious emotional disturbances based on the SAMHSA methodology for estimating

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<sup>117</sup> Stagman & Cooper, *supra*, note 51.

<sup>118</sup> English, A. (2010). *The Patient Protection and Affordable Care Act of 2010: How does it help adolescents and young adults?*. Chapel Hill, NC: Center for Adolescent Health & the Law.

<sup>119</sup> National Alliance on Mental Illness, *supra*, note 116.

<sup>120</sup> English, *supra*, note 118.

<sup>121</sup> *Ibid.*

<sup>122</sup> Hoge et al., *supra*, note 48.

<sup>123</sup> National Alliance on Mental Illness, *supra*, note 116.

<sup>124</sup> Florida Department of Children and Families. (2013). *Substance abuse and mental health services plan: 2014-2016*. Tallahassee, FL: Department of Children and Families.

prevalence rates. Also, SAMHSA has measured the statewide percentages of persons aged 12 to 17 with at least one past year MDE throughout the past decade, and according to 2012-2013 NSDUH data, this percentage is 9.64% in Florida.<sup>125</sup>

Data regarding Florida's utilization rates of mental health services by children and adolescents has been frequently documented. The Substance Abuse and Mental Health (SAMH) program, located within the DCF, is responsible for managing Florida's mental health and substance abuse services.<sup>126</sup> In 2012, the SAMH programs served 480,352 individuals in total and the Mental Health Program served 216,945 adults and 99,789 children in community settings.<sup>127</sup> SAMHSA's Center for Mental Health Services (CMHS) also provides Uniform Reporting System (URS) Output Tables, via the National Outcome Measures (NOMS), which reveal statistics on the people served by state mental health services. In Florida in 2012, 319,190 total clients were served by the State Mental Health Authority (SMHA) system; there was a 16.75 total utilization rate per 1,000 population.<sup>128</sup> 58,810 of those served were 0-12, with this group having a 20.8 total utilization rate per 1,000 population. 41,283 of those served were 13-17, with this group having a 35.5 total utilization rate per 1,000 population rate. Furthermore, according to results from the National Survey of Children's Health (NSCH) for the 2011/2012 profile, 57.7% of children age 2-17 with problems requiring counseling received mental health care in Florida.<sup>129</sup>

The DCF is Florida's state department that provides and regulates public mental health services for children and adolescents. The DCF thus encompasses the Children's Mental Health Program.

The Children's Mental Health Program is a coordinated network of community-based services and supports that is youth-guided and family-driven to produce individualized, evidence-based, culturally and linguistically competent outcomes that improve the lives of children and their families. (Florida Department of Children and Families)<sup>130</sup>

This program funds home and community-based outpatient services, crisis services, and residential treatment (e.g., psychiatric residential treatment facilities and TFC), and it manages Florida's Juvenile Incompetence to Proceed (JITP) program, which provides competency restoration services to youths who have been charged with a felony and are unable to participate in legal proceedings due to mental illness.<sup>131</sup> Some services in the Children's Mental Health Program include service planning and coordination (led by multi-disciplinary planning teams often called

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<sup>125</sup> 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.

<sup>126</sup> Florida Department of Children and Families, supra, note 124.

<sup>127</sup> Ibid.

<sup>128</sup> Center for Mental Health Services. (2013). *2012 CMHS Uniform Reporting System output table*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

<sup>129</sup> National Survey of Children's Health, 2011/2012: 2011/2012 NSCH national chartbook profile for nationwide vs. Florida (Online). Data Resource Center for Child and Adolescent Health (producer). Available at: <http://childhealthdata.org/browse/snapshots/nsch-profiles?geo=1&geo2=11&rpt=16> (accessed February 6, 2015).

<sup>130</sup> Florida Department of Children and Families. *Children's mental health*. Retrieved from: <http://www.myflfamilies.com/service-programs/mental-health/childrens-mental-health-services>

<sup>131</sup> Ibid.

Family Service Planning Teams to aid with identifying relevant services and supports), residential treatment, and family inclusion (which helps to include families in all decisions regarding the planning and provision of mental health services for their children and adolescents).<sup>132</sup>

The SAMH program develops the standards for quality of care for all services distributed by the DCF and for other state agencies that also provide mental health and substance abuse services.<sup>133</sup>

The DCF has recently released the *Substance Abuse and Mental Health Services Plan: 2015 Annual Plan Update*. This update outlines the direction for Florida's mental health system for 2014-2016 and describes relevant bills from the 2014 legislative session. According to this report, the following 2014 legislative bills impact mental health services and are relevant to youth mental health.<sup>134</sup>

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.

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)<sup>135</sup>

This annual plan update also details the provisos from the 2014 legislative session. The following 2014 proviso is related to youth mental health services in general:

Community Action Treatment (CAT) Teams: 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. (Florida Department of Children and Families, 2015, p. 6)<sup>136</sup>

This annual plan update additionally reports progress on 2014 DCF block grant goals relevant to youth 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

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<sup>132</sup> Ibid.

<sup>133</sup> Florida Department of Children and Families, *supra*, note 124.

<sup>134</sup> 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.

<sup>135</sup> Ibid.

<sup>136</sup> Ibid.

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.<sup>137</sup>

The following table<sup>138</sup> displays the Fiscal Year 2014-2015 Approved Operating Budget for Mental Health Services in Florida:

<b>Mental Health Services</b>							
<b>Regions</b>	<b>Adult Community Mental Health</b>	<b>Children's Community Mental Health</b>	<b>Executive Leadership and Support Services</b>	<b>Civil Commitment Program</b>	<b>Forensic Commitment Program</b>	<b>Sexual Predator Program</b>	<b>Total</b>
Headquarters	\$11,872,587	\$23,969,761	\$5,722,536	\$40,630,100	\$54,995,927	\$30,174,259	<b>\$167,365,170</b>
Northwest	\$27,963,532	\$6,314,573	\$464,318	\$0	\$0	\$0	<b>\$34,742,423</b>
Northeast	\$43,161,703	\$11,657,296	\$1,328,862	\$0	\$0	\$0	<b>\$56,147,861</b>
Suncoast	\$96,514,259	\$20,656,072	\$441,575	\$0	\$0	\$0	<b>\$117,611,906</b>
Central	\$31,209,072	\$11,932,853	\$335,117	\$0	\$0	\$0	<b>\$43,477,042</b>
Southeast	\$50,205,612	\$13,581,584	\$490,123	\$0	\$0	\$0	<b>\$64,277,319</b>
Southern	\$37,105,645	\$13,004,620	\$524,780	\$0	\$0	\$0	<b>\$50,635,045</b>
West Florida Community Care Center	\$0	\$0	\$0	\$5,823,881	\$0	\$0	<b>\$5,823,881</b>
Florida State Hospital	\$6,130,215	\$0	\$0	\$56,379,966	\$57,929,532	\$0	<b>\$120,439,713</b>
Northeast Florida State Hospital	\$0	\$0	\$0	\$66,341,499	\$0	\$0	<b>\$66,341,499</b>
North Florida Evaluation and Treatment Center	\$0	\$0	\$0	\$0	\$22,936,076	\$0	<b>\$22,936,076</b>
Control	\$980,928	\$693,882	\$0	\$0	\$129,709	\$0	<b>\$1,804,519</b>
Reserve	\$0	\$0	\$83,791	\$347,430	\$247,951	\$27,463	<b>\$706,635</b>
Unfunded Budget	\$9,570	\$3,155,675	\$266,803	\$0	\$0	\$0	<b>\$3,432,048</b>
<b>Total</b>	<b>\$305,153,123</b>	<b>\$104,966,316</b>	<b>\$9,657,905</b>	<b>\$169,522,876</b>	<b>\$136,239,195</b>	<b>\$30,201,722</b>	<b>\$755,741,137</b>

The following table<sup>139</sup> displays the FY 2013-2014 GAA [General Appropriations Act] Measures and Clients Served through Children's Mental Health Services in Florida:

<b>FY 2013-2014 GAA Measures and Clients Served – Children's Mental Health Services</b>					
<b>Population</b>	<b>MCode</b>	<b>Measure</b>	<b>Target</b>	<b>FY 2013-2014 Performance</b>	<b>Target Met</b>
At Risk of Emotional Disturbance	M0033	Number of at-risk children to be served	4,330	1,330	NO
	M0780	Percent of children at risk of emotional disturbance who live in stable housing environment	96	99	YES
	M0032	Number of ED children to be served	27,000	13,911	NO

<sup>137</sup> Ibid.

<sup>138</sup> Ibid.

<sup>139</sup> Ibid.

Emotionally Disturbed	M0377	Percent of children with emotional disturbances who improve their level of functioning	64	55	NO
	M0778	Percent of children with emotional disturbance (ED) who live in stable housing environment	95	99	YES
Juvenile Incompetent to Proceed	M0019	Percent of children with mental illness restored to competency and recommended to proceed with a judicial hearing	75	99	YES
	M0020	Percent of children with mental retardation or autism restored to competency and recommended to proceed with a judicial hearing	50	81	YES
	M0030	Number of children served who are incompetent to proceed	340	418	YES
Seriously Emotionally Disturbed	M0012	Percent of school days seriously emotionally disturbed (SED) children attended.	86	89	YES
	M0031	Number of SED children to be served	46,000	21,394	NO
	M0378	Percent of children with serious emotional disturbances who improve their level of functioning.	65	60	NO
	M0779	Percent of children with serious emotional disturbance (SED) who live in stable housing environment	93	99	YES

The SAMH program has identified initiatives to meet several established priorities for services and funding over the next five years. Some of these relevant initiatives include:

- Use Project Linking Actions for Unmet Needs in Children’s Health (LAUNCH) Grant to build on the existing use and experience of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) Program. Project LAUNCH is a partnership between SAMH and primary care to prevent mental health and substance use issues in children of parents abusing prescription drugs. Primary care and behavioral health treatment will be coordinated through interagency agreements and fidelity to the SBIRT model will be ensured through training and quality improvement clinical reviews. Use of evidence-based Screening, Brief Intervention, Referral and Treatment (SBIRT) will be expanded through substance abuse service integration with primary health care, veterans’ services, and the child welfare system.
- Increase the number of children in the community and foster care system affected by severe emotional disturbances that regularly attend school and graduate from high school and post-secondary education through participation on the Department of Education’s Statewide Steering Committee and Dropout Prevention Subcommittee.
- 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.

- 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. (Florida Department of Children and Families, 2013, p. 35-37)<sup>140</sup>

## **Section 9. Comparative Analysis of the History of Child and Adolescent Mental Health Services in Florida versus Other States**

As previously stated, state data on the prevalence of mental illness in children and adolescents has not been rigorously recorded. National and state estimates on youth mental illness have been collected by SAMHSA throughout the past decade in the form of measurements of the percentage of persons aged 12 to 17 with at least one past year MDE.

- Based on 2005-2006 NSDUH data, the estimate of the percentage of persons aged 12 to 17 with a past year MDE in Florida was 8.9%; this percentage was higher than the national estimate, at 8.4%<sup>141</sup>
- Based on 2006-2007 NSDUH data, the estimate of the percentage of persons aged 12 to 17 with a past year MDE in Florida was 7.6%; this percentage was lower than the national estimate, at 8.0%<sup>142</sup>
- Based on 2007-2008 NSDUH data, the estimate of the percentage of persons aged 12 to 17 with a past year MDE in Florida was 7.7%; this percentage was lower than the national estimate, at 8.2%<sup>143</sup>
- Based on 2008-2009 NSDUH data, the estimate of the percentage of persons aged 12 to 17 with a past year MDE in Florida was 8.5%; this percentage was higher than the national estimate, at 8.2%<sup>144</sup>

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<sup>140</sup> Florida Department of Children and Families, *supra*, note 124.

<sup>141</sup> Substance Abuse and Mental Health Services Administration. (2012). *Mental health, United States, 2010*. HHS Publication No. (SMA) 12-4681. Rockville, MD: Substance Abuse and Mental Health Services Administration.

<sup>142</sup> *Ibid.*

<sup>143</sup> *Ibid.*

<sup>144</sup> *Ibid.*

- Based on 2009-2010 NSDUH data, the estimate of the percentage of persons aged 12 to 17 with a past year MDE in Florida was 8.76%; this percentage was higher than the national estimate, at 8.07%<sup>145</sup>
- Based on 2010-2011 NSDUH data, the estimate of the percentage of persons aged 12 to 17 with a past year MDE in Florida was 8.11%; this percentage was lower than the national estimate, at 8.15%<sup>146</sup>
- Based on 2011-2012 NSDUH data, the estimate of the number, in thousands, of persons aged 12 to 17 with a past year MDE in Florida was 111; the total national estimate was 2,161<sup>147</sup>
- And again, based on 2012-2013 NSDUH data, the estimate of the percentage of persons aged 12 to 17 with a past year MDE in Florida was 9.64%; this percentage was lower than the national estimate, at 9.86%<sup>148</sup>

Overall, extensive updates are needed on the prevalence data of youth mental health issues in Florida.

A consistent trend throughout Florida’s history of mental health services is that there is an unmet need for all individuals.

In 2001, the Florida Commission on Mental Health and Substance Abuse reported that “Despite limitations in our current management system, we can reasonably estimate that annually only about 20% of all children and adults with need for MHSA services receive treatment from DCF providers. (Florida Commission on Mental Health and Substance Abuse, 2001, p. 21)<sup>149</sup>

As aforementioned, SAMHSA’s CMHS provides URS Output Tables which reveal statistics on the people served by state mental health services. The data from 2007-2012 detail that:

- In Florida in 2007, 262,917 total clients were served by the SMHA system; there was a 14.5 total utilization rate per 1,000 population, whereas the U.S. rate was 20.1. In Florida, 52,832 of those served were 0-12, with this group having an 18.6 total utilization rate per 1,000 population, whereas the U.S. rate for this group was 16.9. 38,332 of those served were 13-17, with this group

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<sup>145</sup> 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*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

<sup>146</sup> 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.

<sup>147</sup> Substance Abuse and Mental Health Services Administration. (2014). *State estimates of substance use and mental disorders from the 2011-2012 National Surveys on Drug Use and Health*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

<sup>148</sup> Substance Abuse and Mental Health Services Administration, supra, note 125.

<sup>149</sup> Florida Commission on Mental Health and Substance Abuse. (2001). *Final report: January 2001*. Tampa, FL: Florida Commission on Mental Health and Substance Abuse.

- having a 32.5 total utilization rate per 1,000 population rate, whereas the U.S. rate for this group was 37.7<sup>150</sup>
- In Florida in 2008, 262,292 total clients were served by the SMHA system; there was a 14.4 total utilization rate per 1,000 population, whereas the U.S. rate was 20.7. In Florida, 47,862 of those served were 0-12, with this group having a 16.7 total utilization rate per 1,000 population, whereas the U.S. rate for this group was 16.9. 33,808 of those served were 13-17, with this group having a 28.8 total utilization rate per 1,000 population rate, whereas the U.S. rate for this group was 37.6<sup>151</sup>
  - In Florida in 2009, 270,617 total clients were served by the SMHA system; there was a 14.8 total utilization rate per 1,000 population, whereas the U.S. rate was 20.8. In Florida, 49,067 of those served were 0-12, with this group having a 17.2 total utilization rate per 1,000 population, whereas the U.S. rate for this group was 17.4. 34,582 of those served were 13-17, with this group having a 30.2 total utilization rate per 1,000 population rate, whereas the U.S. rate for this group was 37.8<sup>152</sup>
  - In Florida in 2010, 285,323 total clients were served by the SMHA system; there was a 15.4 total utilization rate per 1,000 population, whereas the U.S. rate was 21.9. In Florida, 53,644 of those served were 0-12, with this group having an 18.3 total utilization rate per 1,000 population, whereas the U.S. rate for this group was 17.9. 38,842 of those served were 13-17, with this group having a 34.2 total utilization rate per 1,000 population rate, whereas the U.S. rate for this group was 40.6<sup>153</sup>
  - In Florida in 2011, 294,988 total clients were served by the SMHA system; there was a 15.9 total utilization rate per 1,000 population, whereas the U.S. rate was 22.1. In Florida, 55,101 of those served were 0-12, with this group having an 18.8 total utilization rate per 1,000 population, whereas the U.S. rate for this group was 20.0. 39,272 of those served were 13-17, with this group having a 34.6 total utilization rate per 1,000 population rate, whereas the U.S. rate for this group was 41.1<sup>154</sup>
  - In Florida in 2012, 319,190 total clients were served by the SMHA system; there was a 16.7 total utilization rate per 1,000 population, whereas the U.S. rate was 22.7. In Florida, 58,810 of those served were 0-12, with this group having a 20.8 total utilization rate per 1,000 population, whereas the U.S. rate for this group was 21.4. 41,283 of those served were 13-17, with this group

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<sup>150</sup> Center for Mental Health Services. (2008). *2007 CMHS Uniform Reporting System output table*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

<sup>151</sup> Center for Mental Health Services. (2009). *2008 CMHS Uniform Reporting System output table*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

<sup>152</sup> Center for Mental Health Services. (2010). *2009 CMHS Uniform Reporting System output table*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

<sup>153</sup> Center for Mental Health Services. (2011). *2010 CMHS Uniform Reporting System output table*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

<sup>154</sup> Center for Mental Health Services. (2012). *2011 CMHS Uniform Reporting System output table*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

having a 35.5 total utilization rate per 1,000 population rate, whereas the U.S. rate for this group was 41.2<sup>155</sup>

Also as previously mentioned, the NSCH reveals the percentage of children, typically age 2-17, with issues requiring counseling who received mental health care according to each state. For the 2003 profile, 54.7% of children age 0-17 with current emotional, developmental, or behavioral problems who received some type of mental health care during the past year in Florida compared to the nationwide percentage of 58.7%.<sup>156</sup> For the 2007 profile, 52.0% of children age 2-17 with problems requiring counseling received mental health care in Florida compared to the nationwide percentage of 60.0%.<sup>157</sup> For the 2011/2012 profile, 57.7% of children age 2-17 with problems requiring counseling received mental health care in Florida compared to the nationwide percentage of 61.0%.<sup>158</sup>

Overall, the rate of the utilization of state mental health services for children and adolescents has remained lower in Florida than in the nation at large.

Political support for the recognition and improvement of youth mental health issues really emerged during the 1960s, and in 1965, Congress established the Joint Commission on the Mental Health of Children.<sup>159</sup>

In its 1970 report, *Crisis in Child Mental Health*, the Joint Commission laid the framework for a child advocacy approach to children's services. This approach was to be based on the child guidance principles of development, emotional needs, and family support, and it also was to reflect the special needs of children, including needs met by child welfare, corrections, education, health, and mental health agencies. (Lourie and Hernandez, 2003, p. 6)<sup>160</sup>

Then, in the early 1970s, the Community Mental Health Center (CMHC) program began funding relevant youth services, and in 1978, the President's Commission on Mental Health convened.<sup>161</sup>

The Commission's recommendations were implemented through the development of the National Plan for the Chronically Mentally Ill (President's Commission on

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<sup>155</sup> Center for Mental Health Services, *supra*, note 128.

<sup>156</sup> National Survey of Children's Health, 2003: 2003 NSCH national chartbook profile for nationwide vs. Florida (Online). Data Resource Center for Child and Adolescent Health (producer). Available at: <http://childhealthdata.org/browse/snapshots/nsch-profiles?geo=1&geo2=11&rpt=1> (accessed February 6, 2015).

<sup>157</sup> National Survey of Children's Health, 2007: 2007 NSCH national chartbook profile for nationwide vs. Florida (Online). Data Resource Center for Child and Adolescent Health (producer). Available at: <http://childhealthdata.org/browse/snapshots/nsch-profiles?geo=1&geo2=11&rpt=6> (accessed February 6, 2015).

<sup>158</sup> National Survey of Children's Health, 2011/2012: 2011/2012 NSCH national chartbook profile for nationwide vs. Florida (Online), *supra*, note 129.

<sup>159</sup> Lourie, I. S., & Hernandez, M. (2003). A historical perspective on national child mental health policy. *Journal of Emotional and Behavioral Disorders*, 11(1), 5-9.

<sup>160</sup> *Ibid.*

<sup>161</sup> *Ibid.*

Mental Health, 1978). Even though the children's section of the National Plan was relegated to the status of an appendix (Lourie et al., 1980), the President's Commission and the National Plan highlighted two underserved mental health populations: adults with chronic mental illness (today referred to as serious and persistent mental illness) and children with SED. (Lourie and Hernandez, 2003, p. 7)<sup>162</sup>

In 1984, the National Institute of Mental Health funded the Child and Adolescent Service System Program (CASSP), which set out to encourage local and state governments to create interagency systems of mental health care for youth and their families.<sup>163</sup> These interagency systems coordinated services among mental health, child welfare, juvenile justice, and special education agencies and were applied at the community level. CASSP also helped to bring youth mental health awareness to state government to increase state youth mental health budgets and to improve community distribution of youth mental health services. In 1992, the Comprehensive Community Mental Health Services for Children and Their Families Program was enacted to fund community development of services within system-of-care approaches.<sup>164</sup>

Recent and substantial policy to support children's mental health has been lacking. Policy to aid in the development of the youth mental health workforce, the utilization of early identification strategies by primary care pediatricians, and the improvement of school-based mental health services is needed.<sup>165</sup> More support is necessary to enact bills similar to HR 628 – Mental Health in Schools Act of 2013 and S 689 – Mental Health Awareness and Improvement Act of 2013 to make notable changes in the youth mental health system.

Specific youth mental health policy in Florida has also been deficient. A timelines of the development of the state's mental health system is as follows:

In 1968, the Florida Constitution was revised and health and social services were assigned to the Department of Health and Rehabilitative Services (DHRS). This newly-created agency was notable in that it represented one of the first attempts nationally to integrate health and human services, and was intended to address the emerging realization that many individuals accessing publicly funded programs and service often had complex health and social needs that weren't adequately served through categorically distinct programs.

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.

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<sup>162</sup> Ibid.

<sup>163</sup> Ibid.

<sup>164</sup> Ibid.

<sup>165</sup> Promoting children's mental health (Online). American Academy of Pediatrics (producer). Available at: <http://www.aap.org/en-us/advocacy-and-policy/federal-advocacy/Pages/mentalhealth.aspx> (accessed February 6, 2015).

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

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)<sup>166</sup>

Funding for mental health services in general in Florida have historically been low. Florida has continuously had one of the lowest per capita mental health expenditures in the U.S.

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)<sup>167</sup>

In Florida, SMHA Mental Health Expenditures (actual expenditures rather than government appropriation values) have been reported for FY 2004 to 2010:<sup>168</sup>

- FY 2004 = \$623,000,000
- FY 2005 = \$647,200,000
- FY 2006 = \$686,600,000
- FY 2007 = \$722,700,000
- FY 2008 = \$768,900,000
- FY 2009 = \$755,300,000
- FY 2010 = \$742,200,000

In Florida in 2005, the SMHA expenditure per capita amount was \$36.56, giving Florida a per capita state rank of 48.<sup>169</sup> In Florida in 2007, the SHMA expenditure per capita amount was \$39.87, giving Florida a state rank of 46.<sup>170</sup> In 2009, the U.S. average for per capita mental health spending

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<sup>166</sup> 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](http://www.floridasupremecourt.org/pub_info/documents/11-14-2007_Mental_Health_Report.pdf)

<sup>167</sup> Ibid.

<sup>168</sup> Kaiser Family Foundation. *State Mental Health Agency (SMHA), mental health services expenditures*. Retrieved from: <http://kff.org/other/state-indicator/smha-expenditures/#graph>

<sup>169</sup> 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.

<sup>170</sup> 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.

was \$122.90; the Florida per capita mental health spending was \$40.90, making it one of the states with the lowest per capita mental health spending.<sup>171</sup>

Overall, spending on youth mental health care, especially in Florida, has failed to meet the need for services and the gap appears to be growing.

## **Section 10. The Future of Child and Adolescent Mental Health**

The youth mental health system needs to be rigorously monitored and assessed; better prevalence and utilization data is necessary to inform these processes and the quality of current available youth mental health services needs to be considered. For example, standardization of the definitions of mental disorders, categorization according to age and state, and inclusion of additional and specific mental health conditions within future surveillance of youth mental health would improve prevalence data.<sup>172</sup>

Continued research on the most beneficial and cost-effective services to ensure mental health in children and adolescents would also help to improve the current state of the youth mental health system. Specifically, research regarding the development and etiologies of certain mental disorders in childhood and adolescence could strengthen the efficacy of preventative interventions and diagnostic measures. For example, imaging, molecular biology, and genetics research has revealed information on the brain mechanisms involved in anxiety disorders, and accordingly, the biomarkers that could help identify people at risk and be used to aid in early intervention and determining which treatments are more likely to work for different patients.<sup>173</sup> Similarly, genetics and neuroscience research has also suggested identified common roots in the presentation of depression.<sup>174</sup> Belden et al. (2015),<sup>175</sup> one of the first studies to evaluate the volumetric alteration in the anterior insula as a potential biomarker for childhood major depressive disorder, found that structural abnormalities in anterior insula volume are related to the neurobiology of depressive disorders that begin in early childhood.

The safety of pharmacological treatment options in children and adolescents requires additional consideration. Medications with fewer side effects should be needed, and understanding of the long-term effects of psychological medications on mental and physical health throughout development and into adulthood is critical. Research regarding these issues should be supported. For example, research that identifies the brain mechanisms involved in anxiety disorders, as previously discussed, could allow for the formation of medications with less side effects.<sup>176</sup>

Research on the comparative cost-effectiveness of various youth mental health interventions is imperative to improve the efficiency of the youth mental health system. Since funding is limited

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<sup>171</sup> 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.

<sup>172</sup> Centers for Disease Control and Prevention, supra, note 1.

<sup>173</sup> National Institute of Mental Health, supra, note 74.

<sup>174</sup> National Institute of Mental Health, supra, note 42.

<sup>175</sup> Belden, A. C., Barch, D. M., Oakberg, T. J., April, L. M., Harms, M. P., Botteron, K. N., & Luby, J. L. (2015). Anterior insula volume and guilt: Neurobehavioral markers of recurrence after early childhood major depressive disorder. *JAMA Psychiatry*, 72(1), 40-48.

<sup>176</sup> National Institute of Mental Health, supra, note 74.

and wider economic pressures are a major challenge for commissioners and service providers in the U.S., cost-effective approaches can permit greater utilization of the restricted services via evidence to support decisions about resource allocation.<sup>177</sup>

Exploration of different methods for disseminating mental health care for children and adolescents with mental health issues is important to potentially increase access to care. For example, telemedicine options could prove to be especially beneficial in rural and low-income demographics.

Increased funding for child and adolescent mental health services is vital, as is overall increased access to care for this population. More evidence-based practices, and especially community-based services, should be implemented. Preventative and early intervention services are especially significant for children and adolescents.<sup>178</sup> Parents, health care providers (e.g., primary care pediatricians), and teachers/school administrators should be better informed regarding childhood and adolescent mental health in order to effectively and rapidly identify mental health issues. Acknowledging and recognizing risk factors, such as receiving public assistance, having unemployed or teenage parents, living in low-income households, or being in the foster care and juvenile systems, could help to address mental health issues in the early years.<sup>179</sup> For example:

Different aspects of childhood SES predicted onset, persistence, and severity of mental disorders. Childhood financial hardship predicted onset of all classes of disorders at every life-course stage with odds-ratios (ORs) of 1.7-2.3. Childhood financial hardship was unrelated, in comparison, to disorder persistence or severity. Low parental education, although unrelated to disorder onset, significantly predicted disorder persistence and severity, whereas parental occupation was unrelated to onset, persistence, or severity. (McLaughlin et al., 2011, p. 1088)<sup>180</sup>

Recognizing childhood financial hardship as a mental health risk factor is especially relevant in the education system because:

For the first time in recent history, a majority of the schoolchildren attending the nation's public schools come from low income families. The latest data collected from the states by the National Center for Education Statistics (NCES), evidence that 51 percent of the students across the nation's public schools were low income in 2013. (Suits et al., 2015, p. 2)<sup>181</sup>

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<sup>177</sup> Beecham, supra, note 102.

<sup>178</sup> Stagman & Cooper, supra, note 51.

<sup>179</sup> Ibid.

<sup>180</sup> McLaughlin, K. A., Breslau, J., Green, J. G., Lakoma, M. D., Sampson, N. A., Zaslavsky, A. M., & Kessler, R. C. (2011). Childhood socio-economic status and the onset, persistence, and severity of DSM-IV mental disorders in a US national sample. *Social Science & Medicine*, 73(7), 1088-1096.

<sup>181</sup> Suits, S., Barba, P., & Dunn, K. (2015). *A new majority research bulletin: Low income student now a majority in the nation's public schools*. Atlanta, GA: Southern Education Foundation.

Childhood adversities are also strongly associated with the onset of mental disorders in children and adolescents, and interventions to reduce exposure to such adversities and to provide support to youths who have experienced adversities are important.<sup>182</sup>

Mental health screenings should be routine in school and primary care settings.<sup>183</sup>

Not only should access to mental health services be improved for children and adolescents, but also the quality of such services. Strategies to improve the quality of this care include implementing more evidence-based practices and setting more rigorous quality standards and regularly checking to ensure that current care meets these standards.<sup>184</sup>

Mental health awareness campaigns should be promoted to help reduce the stigma surrounding youth mental health issues and to facilitate access to care. Such interventions could have particularly beneficial effects within this population, as demonstrated in a study by Ke et al. (2014).<sup>185</sup>

This study aimed to test the effects of a 1-h classroom-based workshop, led by medical students, on mental illness stigma amongst secondary school students. Students (aged 14–17) from three public secondary schools in British Columbia participated in the workshop. A questionnaire measuring stigma (including stereotype endorsement and desire for social distance) was administered immediately before (T1), immediately after (T2), and 1-month after the workshop (T3). A total of 279 students met the study inclusion criteria. Total scores on the stigma scale decreased by 23 % between T1 and T2 ( $p < 0.01$ ). This was sustained 1-month post-workshop with a 21 % stigma reduction compared to pre-intervention ( $p < 0.01$ ). This effect was primarily due to improvements in scores that measured desire for social distance. There were no significant changes in scores that measured stereotype endorsement. Adolescents' stigmatizing attitudes can be effectively reduced through a 1-h easily implementable and cost-effective classroom-based workshop led by medical students. (Ke et al., 2014)<sup>186</sup>

Suicide and self-harm prevention measures must be strengthened to minimize its occurrence in the youth population, especially in rural populations. Psychosocial and pharmacological options for prevention should be examined and should include internet-based interventions.<sup>187</sup>

Policies to promote the restriction of access to the means of suicide, including access to firearms and safer storage of pesticides, should be implemented.

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<sup>182</sup> McLaughlin, K. A., Green, J. G., Gruber, M. J., Sampson, N. A., Zaslavsky, A. M., & Kessler, R. C. (2012). Childhood adversities and first onset of psychiatric disorders in a national sample of US adolescents. *Archives of general psychiatry*, 69(11), 1151-1160.

<sup>183</sup> National Alliance on Mental Illness, supra, note 116.

<sup>184</sup> Stagman & Cooper, supra, note 51.

<sup>185</sup> Ke, S., Lai, J., Sun, T., Yang, M. M., Wang, J. C. C., & Austin, J. (2014). Healthy young minds: The effects of a 1-hour classroom workshop on mental illness stigma in high school students. *Community mental health journal*, 10.1007/s10597-014-9763-2.

<sup>186</sup> Ibid.

<sup>187</sup> Hawton et al., supra, note 31.

Development and assessment of new media and telephone support sources of help are essential as use of electronic media increases. The reduction of stigma associated with mental health problems and help-seeking is also a major challenge. (Hawton et al., 2012, p. 2380)<sup>188</sup>

Methods to prevent children and adolescents with mental health issues from unnecessarily ending up in the juvenile justice system should also be further explored. Liebenberg and Ungar (2014)<sup>189</sup> found that earlier mental health intervention may help divert youth from the legal system. Youth mental health services should be improved for incarcerated juveniles and assistance with continuity of treatment should be provided to help reduce rates of recidivism.

The issue of the shortage of youth mental health professionals should be further addressed and amended. Providing incentives to encourage more mental health professionals to specialize in child and adolescent mental health could help.

Disparity in youth mental health care should be minimized and/or eliminated. Identifying and combatting barriers to treatment for underrepresented groups is necessary. Cultural and linguistic diversity should also be incorporated into youth mental health services and mental health outreach that targets families/parents.

Child and adolescent health care should become more integrated to ensure that both physical and mental health issues are screened and treated. Integrated/coordinated care also tends to be more efficient for the public health system.

Continuity of mental health care into adulthood is especially important as adolescents age. Programs to assist with this continuity could help adolescents with mental health issues become more successful young adults.

Coordination of services/care between various government departments/agencies is especially critical to the effectiveness and efficiency of the youth mental health system since it is so fragmented. For example, state agencies in charge of mental health care should work with state educational, juvenile justice, and child welfare agencies to confirm that all children and adolescents with mental health issues are identified (and no one slips through the cracks), that all possible venues for youth mental health service distribution are being maximized, and that all such services, regardless of setting, are properly regulated.

Policy is needed to protect and support all of the abovementioned endeavors and to overall improve the system of mental health care for children and adolescents.

## **Section 11. Conclusion**

The U.S.'s youth mental health system is of vital importance, especially considering the widespread and serious consequences of youth mental illness and since childhood and adolescent mental health issues can continue into adulthood. Some positive recent changes that have been

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<sup>188</sup> Ibid.

<sup>189</sup> Liebenberg & Ungar, supra, note 29.

made in the U.S. regarding this system include increased awareness surrounding youth mental health and outreach to disseminate such information and reduce stigmatization, continuous improvement in the understanding of the etiology and presentation of youth mental illness, advancements in treatment options, implementation of evidence-based practices, expansion of preventative and early identification services, increased distribution of mental health services in diverse settings (e.g., the education system, the juvenile justice system, and the child welfare system), parity for mental health services, expansion of youth mental health coverage, emphasis on the integration of health care, and recognition of the shortage in the youth mental health workforce. State mental health budgets are also improving as economic standings progress.

However, the U.S.'s youth mental health system, and its mental health system in general, is still critically underfunded. There is also a significant unmet need in regard to access to youth mental health services. Some of the barriers to the U.S.'s youth mental health system include difficulty in recognition and diagnosis of youth mental illness, deficiency of detailed and accurate prevalence data relevant to youth mental illness, the presence of stigma surrounding mental illness in children and adolescents, significant levels of perceived stress in the education system by children and adolescents, high rates of suicide and self-harm, disparity in the utilization of child and adolescent mental health services, the incidence of safety issues regarding certain pharmacological treatments, fragmentation of the service delivery system, and an inadequate workforce of trained youth mental health providers.

The condition of the youth mental health system is also important in Florida. Although recent positive efforts have been made to better address the needs of younger Floridians, certain inadequacies remain in the state youth mental health system. Florida has notoriously lacked in funding for mental health services. Expansion of expenditures on mental health services in general, with particular consideration for youth mental health services, is critical. Additional research and consequent supportive policy on comparative effectiveness and cost-effectiveness of youth mental health services might provide the opportunity for more efficient spending of the limited resources. Recommendations for the movement toward a more effective youth mental health system include better assessment of the prevalence of mental illness in children and adolescents (e.g., through the inclusion of additional and specific mental health conditions in future public surveillance), increased implementation of preventative, early identification, and screening interventions (especially in school and primary care settings), support for the investigation of comparative cost-effectiveness of available youth mental health services, application of frameworks designed to improve the ability to measure quality of youth mental health care (e.g., employing evidence-based interventions), expansion of integrated care, continued collaborative efforts between the DCF and the education, juvenile justice, and child welfare departments, combatting barriers to disparity in youth mental health services utilization, and strengthening the youth mental health workforce (e.g., through supporting financial incentives for youth mental health providers, such as grants for education, training, and loan repayment, and promoting cultural competency). Continued improvement of the youth mental health system will provide numerous health, social, and economic benefits.