

AMERICA'S MENTAL HEALTH SYSTEM: CLOSING THE REVOLVING DOOR BETWEEN HOSPITALS, CORRECTIONAL FACILITIES, & THE STREETS

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I. INTRODUCTION

On November 19, 2013, Senator Creigh Deeds was stabbed multiple times in the head and chest by his very own son, Austin "Gus" Deeds.² After the stabbing, Gus used his father's gun to commit suicide.³ Looking back, this senseless tragedy could have been prevented if Gus had received the necessary treatment for his mental illness.⁴

At the time of the attack, Gus was struggling with bipolar disorder.⁵ Gus was twenty-one years old when he was first diagnosed with bipolar disorder.⁶ In November 2013, mental health professionals evaluated Gus and determined he needed to be placed in a psychiatric facility.⁷ However,

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2. See generally Nikki Schwab, *Creigh Deeds Tells Son's Mental Health Horror Story*, U.S. NEWS (Mar. 31, 2014, 6:38 PM), <http://www.usnews.com/news/blogs/washington-whispers/2014/03/31/creigh-deeds-tells-sons-mental-health-horror-story> (detailing the death of Senator Creigh Deeds).

3. *Id.* (following the events that led up to the stabbing of Senator Creigh Deeds, his son, Gus, committed suicide).

4. See David Chorney, *A Mental Health System in Crisis and Innovative Laws to Assuage the Problem*, 10 J. HEALTH & BIOMEDICAL L. 215, 215 (2014) (discussing America's lack of access to mental healthcare); see also Ashley Killough, *Creigh Deeds introduces mental health legislation*, CNN (Jan. 7, 2014, 6:17 PM), <http://politicalticker.blogs.cnn.com/2014/01/07/creigh-deeds-introduces-mental-health-legislation> (explaining the need for mental health reform in the United States). The death of Senator Deed's son is an example of America's lack of access to mental health care. See Chorney, *supra*.

5. See Schwab, *supra* note 2 (explaining Gus struggled with bipolar disorder for three years prior to attacking his father).

6. See *id.* (explaining Gus did not show any symptoms of bipolar disorder before the age of twenty-one).

7. See Dr. Keith Ablow, *How psychiatry killed Austin "Gus" Deeds*, FOX NEWS (Nov. 22, 2013), <http://www.foxnews.com/health/2013/11/22/how-psychiatry-killed-austin-gus-deeds.html> (determining that he needed to be placed in a psychiatric facility); see also Killough, *supra* note 4 (explaining that medical health professionals evaluated Gus under an emergency custody order).

due to a lack of beds, Gus was turned away from a local facility and released back into the community.⁸ Twenty-four hours later, Gus took his own life.⁹ As a result, his father, who survived the attack, is currently working towards reforming the mental health laws in the United States.¹⁰

In recent years, mental health has become a popular topic amongst federal and state legislatures.¹¹ Today, in the United States, one in four Americans suffers from a mental illness.¹² Unfortunately, mental health and its treatment only receive attention after tragedy occurs, such as the stabbing of Senator Deeds.¹³

8. See Chorney, *supra* note 4, at 216 (stating that Bath Community Hospital in Virginia could not hold Gus because there were no available psychiatric beds, and there was no court order); see also Jim Nolan et al., *Creigh Deeds' son had mental-health evaluation Monday*, RICHMOND TIMES-DISPATCH (Nov. 19, 2013, 9:38 AM), http://www.timesdispatch.com/news/state-regional/virginia-politics/creigh-deeds-son-had-mental-health-evaluation-monday/article_431e61ca-5128-11e3-944a-001a4bcf6878.html (explaining the emergency custody order allowed Gus to be held for as long as four hours).

9. See Killough, *supra* note 4 (detailing how Gus died after turning a gun on himself).

10. See The Honorable Jennifer L. McClellan, *Renewed Commitment: The Latest Chapter in Reforming Virginia's Mental Health System*, 18 RICH. J.L. & PUB. INT. 1, 15–18 (2014) (stating Senator Creigh Deeds has participated in filing several bills regarding mental reform that relates to issues of emergency custody orders, identifying a facility for temporary detention, transportation for temporary detention, change of facility for temporary detention, mandatory outpatient treatment, and acute psychiatric bed registry); see also Killough, *supra* note 4 (stating Senator Creigh Deeds' proposals for new legislation include a psychiatric bed registry and an expansion in the time limit for emergency custody orders).

11. See Kimberly Leonard, *Mental Health Advocates Rally Behind New Bill*, U.S. NEWS (Jan. 27, 2015, 5:38 PM), <http://www.usnews.com/news/articles/2015/01/27/mental-health-advocates-rally-behind-new-bill> (discussing the need for change in mental health law).

12. See *id.* (“One in four Americans suffers from a mental health issue such as anxiety or depression, and one in [eighteen] suffers from more serious mental illness such as bipolar disorder or schizophrenia, according to the National Institute of Mental Health.”).

13. See *id.* (stating the need for mental health reform only arises after extreme events, such as mass shootings); see generally Matthew Lysiak, *Charleston Massacre: Mental Illness Common Thread for Mass Shootings*, NEWSWEEK (June 19, 2015, 6:17 AM), <http://www.newsweek.com/charleston-massacre-mental-illness-common-thread-mass-shootings-344789> (listing several examples of mass shooters who suffered from mental illnesses and how these events call for major reform in mental healthcare). The following events involved perpetrators with mental illnesses: (1) Seung-Hui Cho suffered from severe anxiety disorder and killed thirty-two people at the University of Virginia on April 16, 2007; (2) Jiverly Wong demonstrated paranoid behavior and killed thirteen people at the American Civic Association in Binghamton, New York, on April 3, 2009; (3) Major Nidal Hasan demonstrated paranoid behavior and killed thirteen people at an army base near Fort Hood, Texas, on November 5, 2009; (4) Jared Loughner suffered from schizophrenia and killed six people at a Tucson shopping mall in January 2011; (5) James Holmes suffered from schizophrenia and killed twelve people at a movie theater in Aurora, Colorado, on July 20, 2012; (6) Aaron Alexis demonstrated paranoid behavior and killed twelve people at the Washington Navy Yard on September 16, 2013; and (7) Adam Lanza suffered from Sensory Perception Disorder and autism and killed twenty-six people at Sandy Hook elementary school in Newtown, Connecticut, on December 14, 2014. Lysiak,

Recently, President Barak Obama has taken steps towards addressing the mental health crisis in the United States by including coverage for mental health services in the Patient Protection and Affordable Care Act (“PPACA”).¹⁴ Under the PPACA, mental health services are essential and must be provided by insurance companies.¹⁵ Nevertheless, there is still more work to be done to ensure local facilities are able to provide mentally ill patients with the care they need.¹⁶

This comment focuses on a two-pronged issue with mental healthcare in the United States.¹⁷ First, a balance must be found between involuntary treatment laws and the constitutional right to refuse treatment.¹⁸ With each state having its own mental health laws, there is no national, uniform approach for addressing mental health issues, and it is unclear when it is necessary to commit a mentally ill patient.¹⁹ Second, once it has been determined that a patient qualifies for involuntary treatment, it is crucial that facilities can accommodate that patient.²⁰ This latter requirement has become a difficult task because mental health facilities throughout the

supra.

14. See generally Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2608 (2012) (holding the individual mandate of the Affordable Care Act is constitutionally based on Congress’s power to tax); see also Michele Chesser, *Mental Health Related Provisions of the Patient Protection and Affordable Care Act and the Potential Impact of Medicaid Expansion in Virginia*, 32 DEV. MENTAL HEALTH L. 1, 2 (2013) (“The Affordable Care Act is comprised of a broad range of provisions including health insurance market reforms; the creation of new health insurance marketplaces (exchanges); coverage mandates and incentives; changes to Medicare, Medicaid[,] and the Children’s Health Insurance Program (CHIP); improvements to quality of care and system performance and programs to address workforce shortages.”).

15. See Chesser, *supra* note 14, at 3 (listing several provisions of the PPACA that affect mental healthcare).

16. See Leonard, *supra* note 11 (referring to an investigation conducted by the House Energy and Commerce Committee where it was discovered that the delay between a first showing of psychosis and treatment is about 110 weeks).

17. See generally BRIAN STETTIN ET AL., MENTAL HEALTH COMMITMENT LAWS A SURVEY OF THE STATES 3 (2014), <http://www.tacreports.org/storage/documents/2014-state-survey-abridged.pdf> [hereinafter TAC, *Commitment*] (focusing on involuntary treatment laws, and the obstacles associated with the use of involuntary treatment).

18. See O’Connor v. Donaldson, 422 U.S. 563, 576 (1975) (“[A] State cannot constitutionally confine without more a non[-]dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.”); TAC, *Commitment*, *supra* note 17, at 5 (explaining that a balance must be found between individual rights and societal imperatives).

19. See TAC, *Commitment*, *supra* note 17, at 6 (highlighting the fact that state laws must be reexamined in order to “affirm that there are circumstances other than the imminent risk of violence or suicide that warrant hospital commitment; and [t]o minimize the need for such involuntary hospitalizations through the lesser liberty intrusion of court-ordered outpatient treatment, where appropriate.”).

20. See *id.* at 9 (explaining that a lack of beds is a chronic problem in psychiatric facilities).

United States have insufficient funding.²¹ It is imperative that we reach a solution that not only helps this at-risk population, but protects society as a whole.²²

Part II provides general background information on the history of deinstitutionalization, and how the right to refuse treatment has developed over time in the United States Supreme Court.²³ Part III discusses the Mental Health Parity and Addiction Equity Act (“MHPAEA”),²⁴ the PPACA, and the type of coverage provided for mental health services.²⁵ Part IV focuses on three different states that have been ranked by Mental Health America (“MHA”) from highest to lowest, based on the prevalence of mental illness in their state and the rate of access to care.²⁶ Finally, Part V suggests implementing a federal mental health system that operates successfully by combining state mental health laws and programs.²⁷

II. BACKGROUND

A. HISTORY OF THE DEINSTITUTIONALIZATION MOVEMENT IN THE UNITED STATES

In the early 1900s, the majority of the mentally ill population in the United States was confined to state-run institutions.²⁸ Most citizens believed that these individuals were dangerous and could not be rehabilitated.²⁹ The deinstitutionalization movement commenced after

21. See *id.* at 16 (stressing the importance of state legislators in funding mental health programs).

22. See *id.* at 14 (stating that the medical needs of mentally ill patients must be addressed as many fall victim to homelessness or the state prison system).

23. See discussion *infra* Part II.

24. See discussion *infra* Part III.A.

25. See discussion *infra* Part III.

26. See discussion *infra* Part IV.

27. See discussion *infra* Part V.

28. See Lisa Dannewitz, *Deinstitutionalization: How the State Budget Has Overshadowed Public Policy in Caring for Illinois' Mentally Ill*, 22 ANNALS HEALTH L. 133, 135 (2013) (stating nearly 559,000 mentally ill patients lived in state-run institutions prior to the deinstitutionalization movement); see also H. Richard Lamb & Leona L. Bachrach, *Some Perspectives on Deinstitutionalization* (No. 8), 52 PSYCHIATRIC SERVICES 1039, 1039 (2001) (“In 1955, when numbers of patients in state hospitals in the United States reached their highest point, 559,000 persons out of a total national population of 165 million were institutionalized in state mental hospitals.”).

29. See Dannewitz, *supra* note 28, at 133 (stating that the public feared the mentally ill population because the public believed these patients were incapable of engaging with society); see also Meghan K. Moore, *Piecing the Puzzle Together: Post-Olmstead Community-Based Alternatives for Homeless People with Severe Mental Illness*, 16 GEO. J. ON POVERTY L. & POL'Y

much protest by civil rights groups and patients who questioned the condition of state-run institutions.³⁰ Deinstitutionalization refers to the process of closing state-run institutions and moving the mentally ill patients back into the community.³¹ The deinstitutionalization movement reached its peak in 1955 when the first antipsychotic drug, chlorpromazine,³² was introduced into the pharmaceutical market.³³ During that year, there were approximately 560,000 mentally ill patients living in state-run institutions.³⁴ Many of these patients were released into the community with no follow-up plan regarding their medication or rehabilitation.³⁵

Ten years later, in 1965, the federal government enacted Medicare and Medicaid.³⁶ However, these programs did not provide coverage for

249, 251 (2009) (“Fear and stigma also played a major role in the perpetuation of institutionalization as a standard of care for people with psychiatric diagnoses.”).

30. See Norman Dain, *Critics and Dissenters: Reflections on “Anti-Psychiatry” in the United States*, 25 J. HIST. BEHAV. SCI. 3, 9 (1989) (“The most persistent critics of psychiatry have always been former mental hospital patients”); see also Dannewitz, *supra* note 28, at 133 (stating civil rights groups protested the deplorable conditions at state-run institutions). Elizabeth P. W. Packard became famous in the 1860s for campaigning for a law that would protect married women from civil commitment by requiring a jury trial in sanity hearings. Dain, *supra*, at 9.

31. See *Deinstitutionalization*, TREATMENT ADVOCACY CENTER, <http://www.treatmentadvocacycenter.org/a-failed-history> (last visited Nov. 15, 2015) (defining deinstitutionalization as “the name given to the policy of moving people with serious brain disorders out of large state institutions and then permanently closing part or all of those institutions.”).

32. See Deanna Pann, *TIMELINE: Deinstitutionalization and its Consequences*, MOTHERJONES (Apr. 29, 2013, 5:00 AM), <http://www.motherjones.com/politics/2013/04/timeline-mental-health-america> (describing chlorpromazine, also known as thiorazine, as the first antipsychotic drug approved by the Food and Drug Administration).

33. See *id.* (explaining that, in 1954, the introduction of chlorpromazine into the market began the deinstitutionalization movement).

34. See *id.* (illustrating that, in 1955, “[t]he number of mentally ill people in public psychiatric hospitals peaks at 560,000.”).

35. See *generally id.* (explaining how from, 1965–1967, the deinstitutionalization movement helped fuel the mental illness crisis in America because the patients who were released from state-run institutions did not have a treatment follow-up plan).

36. See *What’s Medicare?*, CENTERS FOR MEDICARE AND MEDICAID SERVICES 1 (2015) <https://www.medicare.gov/Pubs/pdf/11306.pdf> [hereinafter CFMAMS, *Medicaid*] (defining Medicare as a federal and state funded program that provides health insurance for people sixty-five or older, people under sixty-five with certain disabilities, and people of all ages that suffer from End-Stage Renal Disease).

Medicaid is a joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid may also cover services not normally covered by Medicare (like long term supports and services and personal care services). Each state has different rules about eligibility and applying for Medicaid.

Id. at 3.

patients living in state-run institutions.³⁷ Instead, Medicaid only provided coverage for mentally ill patients who received treatment in private facilities.³⁸ Patients who were not fortunate enough to be transferred to private facilities became homeless, incarcerated, or were transported to ill-equipped nursing homes.³⁹

Thus, deinstitutionalization has created a rift between state-run institutions and private facilities.⁴⁰ Most states do not have the proper funding to run and maintain mental health facilities.⁴¹ Likewise, private facilities do not have the resources to accommodate mentally ill patients who do not have insurance and need long-term care.⁴² In the last three decades, funding for mental health treatment has continued to plummet.⁴³

37. See Dannewitz, *supra* note 28, at 134 (stating Medicaid did not reimburse patients who received treatment in state-run institutions); see also Nancy K. Rhoden, *The Limits of Liberty: Deinstitutionalization, Homelessness, and Libertarian Theory*, 31 EMORY L. J. 375, 384 (1982) (“Medicaid does not cover treatment for mental illness in a state mental hospital . . .”).

38. See Dannewitz, *supra* note 28, at 134 (stating Medicaid reimbursed seventy-five percent of costs if a patient received treatment in a private facility); see also Rhoden, *supra* note 37, at 384 (“Medicaid . . . will reimburse up to seventy-eight percent of a mentally ill person’s health care costs if he or she resides in a certified private facility such as a nursing home.”).

39. See Dannewitz, *supra* note 28, at 136 (explaining, as a result of deinstitutionalization, many patients ended up homeless, in nursing homes, or in prison); see also John Fallon & Corinne Rearer, *The corrections system has become The Nation’s Largest Mental Health Provider: Housing with Services is the Cost-Effective Solution*, 21 HOMELESS HEADLINES 1 (Feb. 2011), http://www.iacaanet.org/docs/uploads/hd_feb_11.pdf (explaining many patients became homeless or incarcerated due to a lack of preparation, support, and funding for the transition from hospital to community).

40. See TAC, *Commitment*, *supra* note 17, at 16 (discussing fiscal challenges associated with deinstitutionalization); see also Barbara A. Weiner, *History of Treatment for Mental Illness—Shortage of Public Beds for Most Severally Ill*, 1 HEALTH L. PRAC. GUIDE § 17:8 (2015) (discussing the issue of the shortage of public beds for mentally ill patients); see also Fuller Torrey, et al., *The Shortage of Public Hospital Beds for Mentally Ill Persons*, TREATMENT ADVOCACY CENTER 9–10, <http://www.treatmentadvocacycenter.org/documents/TheShortageofPublicHospitalBeds.pdf> (last visited Nov. 15, 2015) [hereinafter Torrey, *Shortage*] (providing statistics for the shortage of psychiatric beds in the United States).

41. See Weiner, *supra* note 40 (explaining states are not willing to spend the money to operate mental health facilities when these patients can receive treatment at community facilities).

42. See *id.* (explaining community facilities have difficulties providing treatment to mentally ill patients that have no money, need long term care, are violent, or have other complicated medical problems).

43. See Pann, *supra* note 32 (providing a brief history of budget cuts for mental health care: (1) spending decreases by thirty percent in 1981; (2) spending decreases to eleven percent of community mental-health agency budgets in 1985; and (3) spending cut by \$4.35 billion in 2009).

B. HISTORY OF THE RIGHT TO REFUSE TREATMENT IN THE UNITED STATES SUPREME COURT

Whether an involuntarily committed mentally ill patient has a constitutional right to refuse treatment has been an issue deeply debated in the United States Supreme Court.⁴⁴ Prior to the 1960s, if a patient needed treatment, it was legal for him or her to be committed indefinitely.⁴⁵ Courts across the country have spent much time discussing where to draw the line between civil commitments and protecting a patient's liberty interests.⁴⁶ Because mental health laws vary from jurisdiction to jurisdiction, the United States Supreme Court will typically defer to state laws regarding civil commitment and will only hold a mentally ill patient if he or she has demonstrated some conduct that is dangerous to himself, herself, or others.⁴⁷

For example, in 1957, Kenneth Donaldson ("Donaldson") was civilly committed to a state-run mental health facility in Florida.⁴⁸ After being held against his will for nearly fifteen years, Donaldson filed a lawsuit against the facility claiming it violated his constitutional right to liberty.⁴⁹

44. See *Youngberg v. Romeo*, 457 U.S. 307, 309 (1982) (determining the Due Process rights of a mentally retarded individual who is involuntarily committed.); *O'Connor v. Donaldson*, 422 U.S. 563, 564–65 (1975) (evaluating the constitutionality of involuntarily confining a nondangerous individual); see generally TAC, *Commitment*, *supra* note 17, at 5–6 (stating that subjecting a person to involuntary examination or treatment may override that person's constitutional liberty interests).

45. See *Youngberg*, 457 U.S. at 322 (using a deferential professional judgment standard to analyze the use of restraints at a facility); *Rennie v. Klein*, 458 U.S. 1119, 1119 (1982) ("The judgment is vacated and the case is remanded to the United States Court of Appeals for the Third Circuit for further consideration in light of *Youngberg v. Romeo*, 457 U.S. 307, 102 S.Ct. 2452, 73 L.Ed.2d 28 (1982)."); TAC, *Commitment*, *supra* note 17, at 5 (stating involuntary treatment used to be very straightforward, and judicial interference was not necessary).

46. See TAC, *Commitment*, *supra* note 17, at 5 (stating we rely on common law to strike a balance between civil commitment and constitutional rights).

47. See *Mills v. Rogers*, 457 U.S. 291, 300 (1982) (deferring to state law to recognize liberty interests); TAC, *Commitment*, *supra* note 17, at 5 ("The deinstitutionalization movement of the 1960's brought a national trend to reform these laws, shifting the focus to the person's 'dangerousness to self or others' as the basis for civil commitment."); Hal S. Wortzel, *The Right to Refuse Treatment*, PSYCHIATRIC TIMES 1 (Dec. 1, 2006), <http://www.psychiatrictimes.com/articles/right-refuse-treatment> (explaining how the country started moving towards the "dangerous patient" justification).

48. See *O'Connor*, 422 U.S. at 564 (stating Donaldson was civilly committed to Florida State Hospital at Chattahoochee); see also JOHN Q. LA FOND & MARY L. DURHAM, *BACK TO THE ASYLUM* 97 (Oxford Univ. Press, 1992) (recognizing the *O'Connor v. Donaldson* case as the first non-criminal civil commitment case to reach the United States Supreme Court).

49. See *O'Connor*, 422 U.S. at 565 (stating Donaldson filed a lawsuit against the superintendent of the hospital, *O'Connor*, as well as other staff members).

Donaldson asserted that he was not a danger to himself or anyone else, and therefore, should be released.⁵⁰ Furthermore, at trial, the jury agreed that Donaldson did not pose a threat to himself or to society, and that the mental health facility should have released him.⁵¹

Donaldson's case reached the Supreme Court in 1975.⁵² The issue before the Court was whether the state could indefinitely confine a person who was diagnosed with a mental illness.⁵³ Ultimately, the Court held that it was unconstitutional to hold an individual against his or her will simply because he or she is mentally ill.⁵⁴ In order to confine a mentally ill patient and subject him or her to involuntary treatment, a court must first determine whether that person is dangerous to himself, herself, or others.⁵⁵

In comparison, in 1976, Walter Harper ("Harper") was sentenced to prison for robbery in Washington.⁵⁶ Harper originally began his stay in the prison's mental health unit and consented to taking antipsychotic drugs.⁵⁷ In 1982, after being transferred to the Special Offender Center ("SOC"), Harper refused to continue taking the drugs, but nevertheless, was subjected to involuntary treatment.⁵⁸ Eventually, in February of 1985, Harper filed a lawsuit against the state of Washington and various individual defendants claiming they had violated his constitutional rights.⁵⁹

50. *Id.* at 565 (stating Donaldson repeatedly demanded his release from the hospital because he was not mentally ill, and that even if he was, the hospital failed to provide him with medical treatment).

51. *See id.* at 573 (noting that the jury found no grounds for continued confinement, and that Donaldson was not a danger to himself or others).

52. *See id.* at 563 (noting the opinion for this case was published in 1975).

53. *See id.* at 575 (questioning whether the State can confine a mentally ill patient "merely to ensure them a living standard superior to that they enjoy in the private community.>").

54. *See id.* (holding that "[a] finding of 'mental illness' alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement."); *see also* Jackson v. Indiana, 406 U.S. 715, 720 (1972) (holding it is unconstitutional to confine someone indefinitely solely because he or she is incompetent to stand trial); McNeil v. Dir., Patuxent Institution, 407 U.S. 245, 252 (1972) (holding the petitioner was no longer eligible for civil commitment because he was not classified as a defective delinquent).

55. *See O'Connor*, 422 U.S. at 576 (holding a non-dangerous individual cannot constitutionally be confined if the individual is capable of surviving safely in freedom by himself, or with the help of willing and responsible family members or friends).

56. *Washington v. Harper*, 494 U.S. 210, 213 (1990) (stating Harper was incarcerated at Washington State Penitentiary).

57. *See id.* at 213–14 (stating Harper consented to taking antipsychotic drugs, also known as "neuroleptics" or "psychotropic drugs," to treat schizophrenia).

58. *See id.* at 214 (stating Harper was transferred to the SOC, and his treating physician medicated him against his will pursuant to SOC Policy 600.30).

59. *See id.* at 217 (stating Harper's lawsuit against the State alleged that the State's failure to provide him with a judicial hearing prior to administering the antipsychotic drugs was a violation

In this case, the United States Supreme Court recognized that Harper had a liberty interest in avoiding involuntary treatment under the Due Process Clause of the Fourteenth Amendment of the United States Constitution.⁶⁰ However, based on the state's interest, the Supreme Court held that the SOC's policy regarding involuntary treatment was permissible under the Due Process Clause.⁶¹ Ultimately, the prison was allowed to force the administration of drugs if an inmate suffered from a serious mental disorder and posed a threat to himself, herself, or others.⁶²

III. FEDERAL MENTAL HEALTH LAWS

Prior to the enactment of the MHPAEA and the PPACA, the only public insurance options for mentally ill patients were available through Medicaid and Medicare.⁶³ Today, to qualify for mental health service coverage under Medicaid, a patient must be of low-income status.⁶⁴ In

of his constitutional rights).

60. See U.S. CONST. amend. XIV, § 1 ("No state shall make or enforce any law which shall abridge the privileges or immunities of citizens . . . nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."); *Washington*, 494 U.S. at 221–22 (holding in addition to the liberty interest created by the State's Policy, respondent possesses a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment); see also *Youngberg*, 457 U.S. at 315 (explaining being committed under proper procedures does not deprive a person of his or her constitutional rights under the Fourteenth Amendment).

61. See *Washington*, 494 U.S. at 222 ("Upon full consideration of the state administrative scheme, however, we find that the Due Process Clause confers upon respondent no greater right than that recognized under state law."); see also *Turner v. Safley*, 482 U.S. 78, 89 (1987) (holding a prison regulation that may challenge an inmate's constitutional rights is valid if it is reasonably related to legitimate penological interests); *O'Lone v. Estate of Shabazz*, 482 U.S. 342, 349 (1987) (holding the evaluation of penological objectives should be left to the prison administrators).

62. See *Washington*, 494 U.S. at 236 (holding the SOC's policy was valid because it was "an accommodation between an inmate's liberty interest in avoiding the forced administration of antipsychotic drugs, and the State's interests in providing appropriate medical treatment to reduce the danger that an inmate suffering from a serious mental disorder represents to himself or others."). But see *Riggins v. Nevada*, 504 U.S. 127, 137 (1992) (reversing and remanding the decision of the Nevada Supreme Court due to a strong possibility that defendant's defense was impaired due to the forced administration of an antipsychotic drug).

63. See *Schweiker v. Hogan*, 457 U.S. 569, 572 (1982) (participating states are required to provide coverage for individuals classified as "categorically needy" and have the option to provide coverage for individuals classified as "medically needy"); Olukunle Fadipe, *Affordable Mental Health Care in the Post Healthcare Reform Era*, 57 WAYNE L. REV. 575, 578 (2011) (stating federal and state funded Medicaid provides the best insurance coverage for mental health care benefits).

64. See *Schweiker*, 457 U.S. at 571 (explaining when Medicaid was originally created in 1965, it was for the purpose of providing financial assistance to "needy persons"); Fadipe, *supra*

order to qualify for Medicare, a patient must be over the age of sixty-five (65) or disabled.⁶⁵ Mentally ill patients who do not qualify for Medicaid or Medicare have to rely on their private insurance companies.⁶⁶ However, the main issue with private insurance companies is that they offer fewer mental health services and higher premiums.⁶⁷ Additionally, each company defines “mental illness” differently, which gives them the ability to dictate which mental illnesses will be covered.⁶⁸

A. MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

“Mental health parity” refers to the public’s demand for equal coverage for both mental health benefits and other general health care benefits.⁶⁹ Many insurance companies rejected the concept of mental health parity because they believed that providing more mental health coverage would cause more high-risk patients to enroll in insurance, which would raise costs.⁷⁰ Furthermore, insurance companies also argued that if

note 63, at 578 (“[S]tates retain discretion to provide medical benefits to [‘]less needy[‘] individuals whose income makes them ineligible for aid, but who do not have the resources to meet the cost of necessary medical care.”).

65. See *Schweiker v. McClure*, 456 U.S. 188, 190 (1982) (“Only persons [sixty-five] or older or disabled may enroll [in Medicare], and eligibility does not depend on financial need.”).

66. See Fadipe, *supra* note 63, at 579 (stating beyond Medicare and Medicaid there are private health insurance plans available, for example, employer-based insurance plans); see also Robert W. Fairlie & Rebecca A. London, *The Dynamics of Health Insurance Coverage: Factors Correlated with Insurance Gain and Loss Among Adults*, U.S. DEP’T OF LAB. (Aug. 31, 2005), <http://www.dol.gov/ebsa/pdf/DOLHealthDynamics.pdf> (“Among those with insurance . . . [seventy-two] percent of covered individuals had an employment-based plan.”).

67. See Fadipe, *supra* note 63, at 579 (“Most private insurance companies offer some form of mental health coverage, but with fewer services, higher premiums, and shorter time periods.”); see also Stacey A. Tovino, *Neuroscience and Health Law: An Integrative Approach?*, 42 AKRON L. REV. 469, 477–78 (2009) (discussing the scope of health insurance benefits).

68. See *Simonia v. Glendale Nissan/Infiniti Disability Plan*, 378 Fed. Appx. 725, 727 (9th Cir. 2010) (defining a “mental disorder” as any disorder listed in the American Psychiatric Association’s manual); *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534, 536 (9th Cir. 1990) (defining “mental illness” as “a behavioral disturbance with no demonstrable organic or physical basis”); *Brewer v. Lincoln Nat. Life Ins. Co.*, 921 F.2d 150, 154 (8th Cir. 1990) (defining “mental illness” as what a layperson would consider a mental illness); Fadipe, *supra* note 63, at 577 (explaining insurance plans do not have a universal definition for the term “mental illness”).

69. See Maria A. Morrison, *Changing Perceptions of Mental Illness and the Emergence of Expansive Mental Health Parity Legislation*, 45 S.D. L. REV. 8, 8 (2000) (“Stigma, misinformation, and costs concerning mental illness limit the public’s demand that mental health benefits offered by insurers and employers equal other health care benefits, a concept commonly referred to as mental health parity.”).

70. See *id.* at 10 (“Opponents of mental health parity contend that increasing mental health coverage would attract more high risk enrollees and ultimately raise costs.”); see also Christopher A. Jones, *Legislative “Subterfuge”?: Failing To Insure Persons with Mental Illness Under the*

mental health coverage increased, the demand for mental health services would increase as well.⁷¹

The MHPAEA was enacted in 2008 to ensure health plans offer the same amount of coverage for mental health benefits as they do for medical and surgical benefits.⁷² Originally, the MHPAEA only applied to group health plans and insurance coverage, but after the PPACA was enacted, the MHPAEA was amended and expanded to cover individual insurance coverage as well.⁷³ Even though the MHPAEA is a federal law, the majority of states have adopted some form of their own state parity law.⁷⁴ State parity laws differ based on specificity, affected policies, covered conditions, and exemptions.⁷⁵ Some states have narrowed the scope of their parity laws through statutory legislation.⁷⁶

Mental Health Parity Act and the Americans with Disabilities Act, 50 VAND. L. REV. 753, 759 (1997) (defining a “moral hazard” as an increase in demand for services because insurance covers the services).

71. See Morrison, *supra* note 69, at 10 (“Opponents of parity cite examples showing that increasing the supply of mental health services increases the demand for mental health services.”); see also Brian D. Shannon, *Paving The Path to Parity in Health Insurance Coverage for Mental Illness: New Law or Merely Good Intentions?*, 68 U. COLO. L. REV. 63, 92 (1997) (explaining adequate coverage should lead to greater utilization of services).

72. See 45 C.F.R. §§ 146–47 (2008); Chorney, *supra* note 4, at 225–26 (“The purpose of MHPAEA is to ensure the standards used by health plans to determine coverage are equally applied to both mental health benefits and medical and surgical benefits.”).

73. See *The Mental Health Parity and Addiction Equity Act*, CENTERS FOR MEDICARE & MEDICAID SERVICES, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html (last visited Nov. 15, 2015) (“MHPAEA originally applied to group health plans and group health insurance coverage and was amended by the Patient Protection and Affordable Care Act . . . to also apply to individual health insurance coverage.”); see also discussion *infra* Part III.B.

74. See Morrison, *supra* note 69, at 11 (showing how, in the 1990s, states started creating their own mental parity laws).

75. See *id.* at 14 (“State parity laws differ in terms of the mental illnesses covered, the specificity of parity, minimum benefits required, and exemptions to the parity laws.”); Richard Cauchi & Karmen Hanson, *Mental Health Benefits: State Laws Mandating or Regulating*, NATIONAL CONFERENCE OF STATE LEGISLATURES, <http://www.ncsl.org/research/health/mental-health-benefits-state-mandates.aspx#2> (last visited Nov. 15, 2015) [hereinafter NCOSL, *Benefits*] (listing each state and the type of benefit it receives, illnesses covered, insurance policies affected by the law, exemptions, and the parity law and date when it became effective).

76. See Morrison, *supra* note 69, at 15 (using Maine as an example of how some state parity laws are narrowly tailored).

In Maine, parity law defines mental illness to cover only serious mental illnesses and specifies providers who may offer services under the mandate. The statute narrows the scope of the parity law by stating that a person suffering from a mental condition “means a person whose psychobiological processes are impaired severely enough to manifest problems in the areas of social, psychological or biological functioning.” The statute lists only serious mental illnesses as covered under the law, including schizophrenia, bipolar disorder, autism, paranoia, panic disorder, obsessive-compulsive disorder, and major depressive disorder. In addition, Maine exempts

B. PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

The PPACA was enacted in 2010, and although it was not specifically created to reform mental health law, it did extend the reach of the MHPAEA significantly.⁷⁷ The PPACA requires small groups and individual market plans to comply with the MHPAEA.⁷⁸ Additionally, the PPACA categorizes mental health disorders as one of ten categories of essential health benefits, and provides several provisions related to behavioral health care.⁷⁹

employers with twenty employees or fewer from the parity law requirements.

Id.

77. See Patient Protection and Affordable Care Act, Pub. L. No. 111–148, 124 Stat. 119 (2010); Chorney, *supra* note 4, at 226 (“The Affordable Care Act . . . is the most recent federal statute that attempts to improve coverage for mental health services and substance abuse services as well as increase parity protections in health plans.”); NCOSL, *Benefits*, *supra* note 75. The PPACA achieves the following goals with respect to mental health parity:

(1) [T]hey expand the reach and applicability of the federal mental health parity requirements; and (2) they create an “essential health benefit” or mandated benefit for the coverage of mental health and substance abuse disorder services in a number of specific insurance financing arrangements . . . the [PP]ACA expands the reach of federal mental health parity requirements to three main types of health plans: qualified health plans as established by the ACA[,] Medicaid non-managed care benchmark and benchmark-equivalent plans[, and] [p]lans offered through the individual market.

NCOSL, *Benefits*, *supra* note 75.

78. See Chesser, *supra* note 14, at 2 (“All health insurance plans, both within and outside of the health insurance exchanges, must comply with the Domenici-Wellstone Mental Health Parity Act of 2008.”).

79. See *generally id.* at 2–4 (listing the provisions of the PPACA related to behavioral health care). The following provisions allow easier access to mental health care: (1) insurers can no longer deny coverage or charge a higher premium due to pre-existing conditions; (2) health insurance enrollees can no longer have annual or lifetime dollar limits placed on their coverage or have their coverage rescinded; (3) children are allowed to stay on their parents’ plan until their twenty-sixth birthday; (4) prior authorization is no longer required for emergency care; (5) all health insurance plans must comply with the MHPAEA; (6) mental health and substance abuse treatments must be included among the essential health benefits for all individual and small group plans; (7) medications for mental health disorders must be included among the essential health benefits for all individual and small group plans; (8) smoking cessation drugs, barbiturates, and benzodiazepines will be removed from Medicaid’s excludable drug list; (9) coverage for prescription medications has been reduced; (10) preventive care will be provided without patient cost-sharing obligations; (11) loan repayment programs are funded for pediatric subspecialists; (12) grant programs provide funding to schools for the development, expansion, or enhancement of training programs in various fields of health; (13) provides education for mothers, support services to women experiencing post-partum depression and to their families, and funding for research on the causes, diagnoses, and treatment of post-partum depression; (14) grant funding has been provided for co-locating primary and specialty care in community-based mental health settings; and (15) includes provider incentives for adopting service delivery models that replace the fee-for-service system with quality outcome-based, coordinated, and comprehensive person-centered care. *Id.*

The PPACA also focuses on improving the quality of Medicaid for patients and providers.⁸⁰ For example, Section 2707 of the PPACA established the Medicaid Emergency Psychiatric Demonstration Project (“MEPDP”).⁸¹ The MEPDP was developed to help increase the number of emergency beds for psychiatric patients.⁸² Furthermore, the MEPDP allows Medicaid to reimburse privately owned institutions that provide emergency medical care for mentally ill patients with Medicaid.⁸³ As a result, it will be easier for mentally ill patients with Medicaid to access emergency medical care at any location.⁸⁴

IV. STATE MENTAL HEALTH LAWS & PROGRAMS

The mental health crisis stems from both the number of mentally ill patients in the United States who need treatment, and the difficulties of accessing mental healthcare in each state.⁸⁵ The lack of uniformity in mental health laws across the nation is also contributing to the crisis.⁸⁶ Below, I examine three states that MHA has ranked differently based on the prevalence of mental illness and the rate of access to care in each state, which are as follows: (1) Massachusetts, which ranked highest; (2) Florida, which ranked in the middle; and (3) Arizona, which ranked lowest.⁸⁷

80. See Barry D. Alexander, et al., *HRS § 1:1. Patient Protection and Affordable Care Act of 2010 as amended by the Health Care and Education Reconciliation Act of 2010*, HEALTH L. PRAC. GUIDE HRS § 1:1 (2010) (outlining various sections of the PPACA that were enacted to improve the quality of Medicaid).

81. See *id.* (“Section 2707 authorize[d] and appropriate[d] \$75 million in fiscal year 2011 for the creation of a Medicaid demonstration project . . .”).

82. See *id.* (stating the purpose of the Medicaid demonstration project was to increase the number of emergency psychiatric beds available in communities).

83. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, 326 at § 2707(a)-(d); Fadipe, *supra* note 63, at 586 (stating Medicaid will even provide reimbursement for emergency mental health services for patients who are between the ages of twenty-one and sixty-five years old).

84. See Fadipe, *supra* note 63, at 586 (stating mentally ill patients experiencing medical emergencies will be able to receive treatment at any emergency care center).

85. See *Parity or Disparity: The State of Mental Health in America*, MENTAL HEALTH AM. (2015), <http://www.mentalhealthamerica.net/sites/default/files/Parity%20or%20Disparity%20Report%20FINAL.pdf> [hereinafter *Parity or Disparity*, MHA] (reporting national survey data that measures the community's needs, access to care, and outcomes, regardless of the differences between state mental health laws).

86. See *id.* (identifying the following policy priorities as related to insurance and access to care: enrollment, Medicaid expansion, access to care, early intervention, network adequacy, transparency in insurance coverage, focus on recovery, parity compliance, and more mental health data).

87. See *id.* (giving Massachusetts an overall ranking of one, Florida an overall ranking of twenty-six, and Arizona an overall ranking of fifty-one).

A. MASSACHUSETTS RECOGNIZED FOR SPECIALIZED TASKFORCE AND EMERGENCY SERVICES PROGRAM

Massachusetts is recognized for its focus on reducing mental health care costs and its innovative state funded programs.⁸⁸ In an effort to control health care costs, Massachusetts passed legislation in August 2012, creating a special task force to assess mental health reimbursement systems.⁸⁹ The main goal of the task force was to research health care cost-saving measures.⁹⁰ Their research showed that an inadequate mental health system actually increased health care costs.⁹¹

The Massachusetts Behavioral Health Partnership (“MBHP”) was created to manage mental health and substance abuse services, and to reduce lengthy emergency room wait times.⁹² The MBHP has taken a

88. See 2012 Mass. Acts ch. 224, <https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter224>; Chorney, *supra* note 4, at 231 (stating Massachusetts has taken the appropriate steps towards reforming its mental health system).

89. See Mass. Acts ch. 224; Chorney, *supra* note 4, at 230 (stating Chapter 224 created a special task force to examine behavioral treatment, substance use treatment, and mental health treatment). The details of the special task force and its duties are outlined in Section 275 of Chapter 224, which states:

[T]he task force shall review: (i) the most effective and appropriate approach to including behavioral, substance use[,] and mental health disorder services in the array of services provided by provider organizations . . . (ii) how current prevailing reimbursement methods and covered behavioral, substance use[,] and mental health benefits may need to be modified to achieve more cost effective . . . (iii) the extent to which and how payment for behavioral health services should be included under alternative payment methodologies . . . (iv) how best to educate all providers to recognize behavioral, substance use[,] and mental health conditions and make appropriate decisions regarding referral to behavioral health services; (v) how best to educate all providers about the effects of cardiovascular disease, diabetes, and obesity on patients with serious mental illness; and (vi) the unique privacy factors required for the integration of behavioral, substance use[,] and mental health information into interoperable electronic health records.

Mass. Acts ch. 224.

90. See Chorney, *supra* note 4, at 231 (stating the Executive Office of Health and Human Services was given the task of researching costs); see also Exec. Office of Health & Human Serv., *ED Length of Stay Issues for Behavioral Health Patients*, EXEC. OFFICE OF HEALTH AND HUMAN SERV. 19 (Jan. 2, 2013), <http://www.mass.gov/eohhs/docs/eohhs/behavioral-health/bh-discussion-01022013.pdf> (presenting findings and recommendations of Massachusetts psychiatric patients’ length of stay in emergency departments).

91. See Chorney, *supra* note 4, at 231 (“Through the Behavioral Health Task Force, Massachusetts has recognized that lengthy delays for mental health patients in emergency rooms are a serious problem driving increasing health care costs within the Commonwealth.”); see also Exec. Office of Health & Human Serv., *supra* note 90, at 18 (outlining future behavioral health strategies in Massachusetts).

92. See Chorney, *supra* note 4, at 235–36 (explaining the MBHP provides services such as: detox management, crisis counseling, medication management, community support, integrated

unique approach to dealing with emergency mental health situations by implementing the Emergency Services Program/Mobile Crisis Intervention (“ESP/MCI”).⁹³ The main purpose of the ESP/MCI is to serve as an alternative to emergency room care.⁹⁴ If a person is experiencing a mental health emergency, he or she can contact the ESP/MCI and receive crisis assessment, intervention, and stabilization services.⁹⁵ Most importantly, these services are available to people who have Medicare or are uninsured.⁹⁶

B. FLORIDA RECOGNIZED FOR STATUTORY LAW GOVERNING INVOLUNTARY INPATIENT TREATMENT

In 1971, Florida enacted the Florida Mental Health Act, also known as the Baker Act, or Chapter 394 of the Florida Statutes.⁹⁷ The main purpose of the Baker Act is to ensure placement for mentally ill patients in community facilities and to confine those who are a danger to themselves or others.⁹⁸ Treatment includes (1) voluntary admission; (2) involuntary

medical, mental health, and substance use disorder care management); *see also Available Services*, MASS. BEHAVIORAL HEALTH P'SHIP, <http://www.masspartnership.com/member/AvailableServices.aspx> (last visited Nov. 15, 2015) (listing the services MBHP provides).

93. *See* Chorney, *supra* note 4, at 235–36 (encouraging lawmakers to identify mental health programs that have been successful in other states).

94. *See Emergency Services Program Mobile Crisis Intervention*, MASS. BEHAVIORAL HEALTH P'SHIP, <http://www.masspartnership.com/member/ESP.aspx> (last visited Nov. 15, 2015) (advertising “[i]nstead of going to the emergency room, you can get these services in your home or at other locations in the community.”).

95. *See id.* (advertising “the Emergency Services Program/Mobile Crisis Intervention ([“]ESP/MCI[“]) is available 24 hours a day, [seven] days a week, 365 days a year.”).

96. *See id.* (advertising that these services are covered if you have MassHealth, Medicare, are uninsured, or have a different health plan).

97. FLA. STAT. § 394.451 (2015); *see also* Lester J. Perling, *Health Care Advance Directives: Implications for Florida Mental Health Patients*, 48 U. MIAMI L. REV. 193, 219 (1993) (“Florida’s Mental Health Act establishes the rights of all civil patients in psychiatric hospitals as well as the criteria and procedures for involuntary hospitalization, examination, and treatment.”); *see generally Florida’s Baker Act: 2013 Fact Sheet*, DEP’T OF CHILDREN AND FAMILIES, <http://www.dcf.state.fl.us/programs/samh/mentalhealth/docs/Baker%20Act%20Overview%202013.pdf> (last visited Nov. 15, 2015) [hereinafter DCF, *Baker Act*] (explaining the Baker Act).

98. FLA. STAT. § 394.453; *see also* Perling, *supra* note 97, at 222 (explaining the extent to which a patient can determine the treatment he or she needs). The following standards call for involuntary treatment:

- (1) the patient has refused voluntary examination or treatment or is unable to determine for herself whether examination or treatment is necessary; and (2) without care or treatment she is likely to neglect herself and this neglect poses a real threat of substantial harm to her well[-]being; or there is a substantial likelihood that without

examination; (3) involuntary inpatient placement; and (4) involuntary outpatient treatment.⁹⁹

The involuntary inpatient placement portion of the Baker Act is perhaps the most controversial because mentally ill patients can be held against their will.¹⁰⁰ Under the Baker Act, receiving facilities have the power to hold a mentally ill patient for up to seventy-two (72) hours if he or she qualifies for involuntary inpatient placement.¹⁰¹ According to the statute, patients must meet a specific criteria in order to qualify for involuntary inpatient placement.¹⁰² The process for involuntary inpatient placement begins with an involuntary examination that can be initiated by a court, law enforcement officer, or medical professional.¹⁰³ In 2013, courts were responsible for two percent of involuntary examinations, law

care or treatment she will cause serious bodily harm to herself or others.

Perling, *supra* note 97, at 222; *Executive Summary*, FLA. SUPREME COURT, http://www.floridasupremecourt.org/pub_info/documents/BakerSummary.pdf (last updated July 6, 2015) [hereinafter FLA. S. CT., *Executive Summary*] (stating the Baker Act was specifically created to protect the liberty interests of mentally ill patients, as well as to ensure public safety).

99. See DCF, *Baker Act*, *supra* note 97 (listing the different sections of the Baker Act).

100. See FLA. S. CT., *Executive Summary*, *supra* note 98 (stating the Baker Act needed to be revisited because two-thirds of the patients involuntarily committed were over the age of sixty-five and mental health advocates believed the law was being used improperly to detain the elderly population who were confused and unable to take care of themselves).

101. See Karl Menninger, *Wrongful Confinement to a Mental Health or Developmental Disabilities Facility*, 44 AM. JUR. PROOF OF FACTS 3D, 217, 73 (1997) (stating that the need for treatment and refusal to take medication alone is not enough to justify involuntary commitment); FLA. S. CT., *Executive Summary*, *supra* note 98 (“To qualify for an involuntary examination, persons must have a mental illness as defined in the statute and be unable or unwilling to provide express and informed consent to voluntary examination.”).

102. FLA. STAT. § 394.467(1) (2015) [hereinafter Fla. Stat., *Baker*]. A person may be placed in involuntary inpatient treatment if:

[h]e or she is mentally ill and because of his or her mental illness . . . has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment; or . . . is unable to determine for himself or herself whether placement is necessary; and . . . is manifestly incapable of surviving alone or with the help of willing and responsible family or friends . . . and, without treatment, is likely to suffer from neglect or refuse to care for himself or herself, and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; or . . . [t]here is substantial likelihood that in the near future he or she will inflict serious bodily harm on himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm; and . . . [a]ll available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.

Id.

103. *Addington v. Texas*, 441 U.S. 418, 426 (1979) (explaining involuntary examination criteria reflects two forms of civil commitment, police power and *parens patriae*); see also DCF, *Baker Act*, *supra* note 97 (listing who can initiate an involuntary examination).

enforcement officers were responsible for forty-nine percent, and medical professionals were responsible for the remaining forty-nine percent.¹⁰⁴

C. ARIZONA RECOGNIZED FOR SPECIALIZED TASKFORCE AND HEFTY MENTAL HEALTH BUDGET CUTS

In 1973, the Arizona Legislature created the Arizona Department of Health Services (“ADHS”) with a specific division to oversee mental health services.¹⁰⁵ Despite the ADHS’s best efforts, a Phoenix attorney, Charles Arnold (“Arnold”), initiated a class-action lawsuit against the department in 1981.¹⁰⁶ Arnold asserted that the ADHS breached its statutory duty of providing mentally ill patients with comprehensive mental health care services, and the trial court agreed.¹⁰⁷ The ADHS argued that it lacked the appropriate funding to establish an adequate mental health care system.¹⁰⁸ Ultimately, the Arizona Supreme Court decided the ADHS’s argument was invalid, and the ADHS was obligated to coordinate and fund programs to provide mentally ill patients with health care services.¹⁰⁹

Thirty (30) years after the Arizona Supreme Court’s decision, Arizona continues to be unsuccessful in maintaining and funding its mental health care programs.¹¹⁰ Between 2008 and 2011, Arizona was forced to cut

104. Judy A. Clausen, *Bring Ulysses to Florida: Proposed Legislative Relief for Mental Health Patients*, 16 MARQ. ELDER’S ADVISOR 1, 14 (2014) (“In 2013, law enforcement officers initiated approximately [forty-nine percent], physicians initiated approximately [forty-nine percent], and circuit court ex parte orders initiated approximately [two percent] of involuntary detentions for the purposes of involuntary examination.”).

105. Shijie Feng, *Madness and Mayhem: Reforming the Mental Health Care System in Arizona*, 54 ARIZ. L. REV. 541, 546 (2012) (stating a specific subdivision, the Division of Behavioral Health Services, was created to oversee mental health services).

106. *See Arnold v. Ariz. Dep’t of Health Servs.*, 775 P.2d 521, 522 (Ariz. 1989) (“On March 26, 1981, the Arizona Center for Law in the Public Interest (the Center) filed this action on behalf of five chronically mentally ill individuals.”).

107. *See id.* at 528 (stating the trial court issued an order that required defendants to fulfill their mandatory non-discretionary duties, provide a continuum of care, and provide a cohesive system of community mental health care); Feng, *supra* note 105, at 547 (stating the trial court agreed with Arnold’s argument and ordered the state to provide comprehensive mental health services to the class members).

108. *Arnold*, 775 P.2d at 533 (“Defendants argue that, even if a duty exists and even if that duty was breached, the breach was justifiable because lack of funds rendered the duty impossible to perform.”); *see* Feng, *supra* note 105, at 548 (stating the state failed to present direct evidence to prove it was impossible to fund a comprehensive mental health system).

109. *See Arnold*, 775 P.2d at 533 (affirming the trial court’s decision that the county breached its duty of providing mental health services); Feng, *supra* note 105, at 547 (“In 1989, the Arizona Supreme Court affirmed, holding that the state failed to meet its moral and legal obligations to establish a unified, integrated, and coordinated mental health system.”).

110. *See* Mary K. Reinhart, *Here’s what was lost in mental-health care*, AZCENTRAL (Sept.

millions of dollars from its mental health care funding¹¹¹ in an effort to reduce its budget gap.¹¹² As a result of the budget cuts, Arizona began eliminating mental health services.¹¹³ Mentally ill patients who did not qualify for Medicaid were the people who suffered most from these budget cuts.¹¹⁴

Beginning in July 2010, approximately 12,000 mentally ill patients lost their mental health services in the state of Arizona.¹¹⁵ These services included: (1) brand-name drugs; (2) case management; (3) housing; (4) transportation; (5) therapy; (6) drop-in centers; and (7) job training.¹¹⁶ Today, the only services offered are generic drugs and crisis services.¹¹⁷

21, 2011, 12:00 AM), <http://www.azcentral.com/news/election/azelections/articles/2011/09/21/20110921mental-health-care-whats-lost.html> [hereinafter Reinhart, *Lost in Mental-Health Care*] (explaining Arizona agreed to a two-year stay in the *Arnold v. Ariz. Dep't of Health Servs.* case in March 2010).

111. See Feng, *supra* note 105, at 543 (stating Arizona cut its mental health funding because it had a billion-dollar budget gap); see also Stephanie Innes, *Mental-Health Cuts Are Life-Threatening for Some*, ARIZ. DAILY STAR (Dec. 5, 2010, 12:00 AM), http://azstarnet.com/news/science/health-med-fit/article_1404e540-646e-5155-90d0-5b6274f1068d.html (“The cuts, which amount to a \$65 million drop since 2008, affect Arizonans who need behavioral-health services . . .”).

112. See Feng, *supra* note 105, at 543 (stating Arizona cut its mental health funding by \$108.4 million between 2008 and 2011); see generally Ron Honberg et al., *State Mental Health Cuts: A National Crisis*, NAT'L ALLIANCE ON MENTAL ILLNESS (Mar. 2011), <http://il.nami.org/NAMISateBudgetCrisis2011.pdf> (analyzing mental health cuts state-by-state).

113. See Feng, *supra* note 105, at 543 (stating Arizona eliminated services for 14,000 mentally ill patients between 2008 and 2011); see also Honberg, *supra* note 112, at 5 (listing the ten states that cut the most in general funds from their mental health budgets between 2009 and 2011).

114. See Mary K. Reinhart, *States, critics disagreeing on impact of mental health cuts*, AZCENTRAL (Sept. 21, 2011, 12:00 AM), <http://www.azcentral.com/news/articles/2011/09/21/20110921mental-health-cuts-toll-debated.html> [hereinafter Reinhart, *Disagreement Among States & Critics*] (stating in the beginning of July 2010, there were 12,000 people with serious mental illnesses who did not qualify for Medicaid).

115. See *id.* (stating those 12,000 mentally ill patients who did not qualify for Medicaid lost mental health services).

116. See Reinhart, *Lost in Mental-Health Care*, *supra* note 110 (outlining the services lost when Arizona cut its mental health funding). About 3,000 mentally ill patients taking brand-name antipsychotic drugs switched to generic drugs. *Id.* More than 300 case managers and support staff lost their jobs. *Id.* About 255 mentally ill patients were at risk of losing their housing. *Id.* Many mentally ill patients missed their appointments or did not pick up their prescriptions due to the elimination of free bus passes and cab rides. *Id.* Thousands of mentally ill patients lost access to group and individual therapy. *Id.* Mentally ill patients lost state-funded job training and access to community drop-in centers. Reinhart, *Lost in Mental-Health Care*, *supra* note 110.

117. See Reinhart, *Disagreement Among States & Critics*, *supra* note 114 (stating that Arizona Governor Jan Brewer eliminated all mental health services except for generic drugs and

The elimination of services has put a strain on mentally ill patients who have ended up incarcerated or hospitalized due to psychotic breakdowns.¹¹⁸ The mentally ill population continues to suffer from these budget cuts, and unfortunately, Arizona is not the only state that has reduced its mental health care funding.¹¹⁹

V. IMPLEMENTING A MENTAL HEALTH SYSTEM THAT WORKS

The first step in solving the mental health care crisis in the United States is to promote uniformity amongst the states through the creation of a uniform law.¹²⁰ In order to accomplish this type of uniformity, a combination of successful state laws and programs must be implemented on a federal level.¹²¹ A federal mental health statute, specifically focused on enforcing a uniform mental health care system, will aid in improving

crisis services); Reinhart, *Lost in Mental-Health Care*, *supra* note 110 (“The state now provides \$40 million for generic medication and \$16 million for a beefed-up statewide crisis-response system, which fields hotline calls and dispatches mobile teams of counselors when necessary.”).

118. Reinhart, *Disagreement Among States & Critics*, *supra* note 114 (“[T]he loss of services has caused harm to people, including hundreds who have become incarcerated, hospitalized due to psychotic breakdowns[,] or fallen through the tattered safety net and disappeared.”).

119. See Kristen Wyatt, *State Budget Cuts Decimate Mental Health Services*, CNS NEWS (Mar. 9, 2011, 6:02 AM), <http://www.cnsnews.com/news/article/state-budget-cuts-decimate-mental-health-services> (listing other states that experienced mental health budget cuts). The following budget cuts were made:

[thirty-two] states and Washington, D.C., cut funding just as economic stressors such as layoffs and home foreclosures boosted demand for services. California slashed funding by more than \$587 million, or [sixteen] percent. Kentucky gutted its mental health budget by an astounding [fourty-seven] percent over the last two years Eleven states simply treat fewer people. States with a net reduction in both inpatients and community settings between 2007 and 2009 were Alabama, Alaska, California, Idaho, Illinois, Nebraska, New Jersey, New Mexico, North Carolina, Virginia and Wyoming Texas is debating an additional twenty percent cut next year, which would leave some 2,800 youth and adults in eight central Texas counties without services. Tennessee may close community health programs and drug abuse treatment facilities to save \$15 million. Massachusetts may eliminate a quarter of the beds in state psychiatric hospitals. And in Kansas, nine of [twenty-seven] Community Mental Health Centers may have to close their doors.

Id.

120. *Frequently Asked Questions*, UNIFORM LAW COMMISSION, <http://www.uniformlaws.org/Narrative.aspx?title=Frequently%20Asked%20Questions> (last visited Nov. 15, 2015) (explaining the Uniform Law Commission (“ULC”) is responsible for drafting state laws relating to subjects on which uniformity throughout the states is both desirable and practicable). “The [ULC] drafts uniform [state] laws for states to consider and enact.” *Id.* The goal of the ULC is to establish uniform laws that are similar on a subject among the various jurisdictions. *Id.*

121. See *Parity or Disparity*, *MHA supra* note 85, at 4 (noting that the federal government has the responsibility to ensure uniformity in mental health care laws).

mental health services across the nation.¹²² This federal statute should include: (1) a special taskforce to oversee mental health services; (2) specific guidelines for civil commitment; (3) emergency mental health services; and (4) increased funding for mental health facilities.¹²³

Similar to the taskforces created in Massachusetts and Arizona, the federal government relies on the Substance Abuse and Mental Health Services Administration (“SAMHSA”) to reduce the impact of substance abuse and mental illness in America’s communities.¹²⁴ The SAMHSA, which is a branch of the United States Department of Health and Human Services, focuses on improving accessibility to substance use and mental disorder information, services, and research.¹²⁵ The SAMHSA initiative should be incorporated into this proposed federal statute.¹²⁶ Furthermore, the SAMHSA should be responsible for implementing and maintaining a comprehensive plan that focuses on treatment for mental illnesses.¹²⁷

In order to find a balance between involuntary treatment laws and the constitutional right to refuse treatment, this proposed federal statute must include a process to determine when it is necessary to commit a mentally ill patient.¹²⁸ The Florida Mental Health Act is a good model to follow because it addresses each step of the involuntary inpatient placement process.¹²⁹ Under the Florida Mental Health Act, a mentally ill person will only be placed in involuntary patient treatment if he or she is unable to determine whether placement is necessary, and he or she poses a threat of substantial harm to himself, herself, or another person.¹³⁰

122. See TAC, *Commitment*, *supra* note 17, at 17 (explaining the role of federal agencies tasked with improving the quality of health care services for the mentally ill).

123. See *supra* Part III (describing the different mental health care statutes).

124. See 42 U.S.C. § 290aa (explaining the different agencies and their duties in reducing substance abuse and serving those with mental illnesses); *Who We Are*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, <http://www.samhsa.gov/about-us/who-we-are> (last visited Nov. 15, 2015) [hereinafter SAMHSA, *Who We Are*] (explaining the purpose, vision, and mission of the SAMHSA).

125. See SAMHSA, *Who We Are*, *supra* note 124 (stating that the SAMHSA helps teach the United States population that behavioral health is essential for overall well-being, prevention does work, treatment is effective, and people recover from disorders).

126. See *id.* and accompanying text (listing the benefits of SAMHSA).

127. See *id.* (explaining why SAMHSA should implement and maintain a plan focusing on the treatment of the mentally ill).

128. See generally TAC, *Commitment*, *supra* note 17, at 9 (explaining two critical aspects of inpatient commitment process); see also *supra* Part IV.B. (discussing the criteria for commitment, the right of the mentally ill, and the duration of an order to commit a patient).

129. See *supra* Part IV.B (discussing treatments during the Baker Act placement process).

130. See *supra* note 102 and accompanying text (listing the criteria needed for involuntary patient treatment); see also *supra* Part IV.B (stating the main purpose of the Baker Act).

This proposed federal statute must include a provision that provides funding for states to increase their bed capacities, which will address the problems associated with the lack of beds available to those who are committed to mental health facilities.¹³¹ Increased funding for community facilities will increase the number of available beds to accommodate patients who need treatment.¹³² Additionally, the services provided by these facilities will continue to be covered by Medicare, Medicaid, and insurance companies in adherence to the MHPAEA and the PPACA.¹³³

However, even with an increased amount of psychiatric beds, it will probably be impossible to provide a bed for every single patient who needs treatment.¹³⁴ In order to address this issue, it is crucial to implement an emergency service program to assist mentally ill patients who are unable to find placement at a facility and are in need of immediate medical attention.¹³⁵ Massachusetts' ESP/MCI initiative is an example of a successful and effective emergency program.¹³⁶ Providing emergency services to mentally ill patients outside of hospitals and community facilities will help alleviate overcrowding, while providing much needed treatment.¹³⁷

VI. CONCLUSION

Currently, America's mental health system is similar to a revolving door.¹³⁸ Mentally ill patients enter this revolving door on a daily basis looking for treatment to help them deal with their diseases.¹³⁹ Instead of finding the help they need, these patients find themselves in a constant

131. See generally U.S. CONST. art. I, § 8, cl. 1 (demonstrating Congress has the power to lay and collect taxes for the general welfare of the United States).

132. See generally TAC, *Commitment*, supra note 17, at 4 (discussing how there are bed shortages for mentally ill patients all over the nation).

133. See supra Part III (discussing the MHPAEA and PPACA's enactment and coverage).

134. See TAC, *Commitment*, supra note 17, at 19 ("Given the decimation of the public hospital bed supply over the last half-century at the same time the country nearly doubled its population, it should come as no surprise that there are not enough public inpatient beds for all the individuals in acute psychiatric crisis.").

135. See supra Part IV.A (explaining Massachusetts established emergency program).

136. See supra Part IV.A.

137. See supra Part IV.A (stating that the purpose of the ESP/MCI is to serve as an alternative to emergency room care, thereby alleviating overcrowding of patients).

138. See TAC, *Commitment*, supra note 17, at 10 ("[I]t must be understood that non-adherence to prescribed treatment is the single largest reason that people get caught in the mental health system's 'revolving door,' shuttling endlessly between hospitals, correctional facilities[,] and the streets.").

139. See *id.* and accompanying text (explaining that the reason that patients get caught in the system's "revolving door" is that some patients fail to recognize their illness).

rotation between hospitals, correctional facilities, and the streets.¹⁴⁰ If a patient is not lucky enough to find placement at a community facility, there is nowhere else for him or her to go.

The amount of mentally ill patients varies from state-to-state, but one issue remains constant—no state has developed a successful, foolproof law to ensure mentally ill patients are receiving the treatment they need.¹⁴¹ The solution to this problem can be achieved through the creation of a federal mental health statute, which encompasses various state mental health laws and programs.¹⁴² Creating a uniform law will provide each state with the guidelines it needs to successfully treat its mentally ill patients.¹⁴³

140. *Id.*

141. *See generally Parity or Disparity*, MHA *supra* note 85, at 5, 7 (collecting data from all fifty states to show the difficulties of accessing care in each state).

142. *See supra* Part V (proposing a viable mental health system).

143. *See supra* Part V.