Recommendations for Ending the Long Neglect of Persons Needing Metal Health Care

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Section 1. Introduction

Mental illness is a common but undertreated health condition in the United States. According to the Center for Behavioral Health Statistics and Quality, in 2014, approximately in 1 in 5 adults aged 18 or older in the U.S., around 43.6 million adults (18.1% of all adults in this country), had any mental illness (AMI) in the past year and approximately 9.8 million adults in the U.S. (4.1% of all adults in this country) had serious mental illness (SMI) in the past year.[1] Despite the magnitude of the prevalence of this condition and the numerous evidence-based opportunities for relevant treatment and care, a substantial proportion of individuals with mental illness do not receive the mental health services that they need. A report by the Substance Abuse and Mental Health Services Administration (SAMHSA) (2014)[2] has revealed that less than half of adults with AMI and around two-thirds of adults with SMI received mental health services in the past year, in 2013.

The insufficient treatment of mental health problems is particularly puzzling and concerning given the major public and individual financial, physical, and social costs of mental illness. Mental illness is one of the most significant contributors to disability.[3] The financial consequences of mental illness are substantial and are composed of both direct costs, such as costs associated with medications, clinical visits and psychotherapy sessions, and hospitalization, and indirect costs, such as costs associated with reduced labor supply, increased physical health care, public income support payments, educational underachievement, homelessness, and incarceration. For example, it has been estimated that SMI costs the U.S. over $193.2 billion per year in lost earnings alone.[4]

According to SAMHSA, mental health expenditures have increased in the past two decades, from around $75 billion in 1990 to around $155 billion in 2009, but these expenditures have fallen in relation to all-health expenditures.[5] Furthermore, the mental health share of all-health spending is predicted to continue to fall through 2020, because of slowing mental health spending growth.[6] Expenditures on mental health-related treatments are projected to reach around $239 billion in 2020.[7]

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[1] Center for Behavioral Health Statistics and Quality. (2015). *Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health,* NSDUH Series H-50, HHS Publication No. (SMA) 15-4927. Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.

[2] 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.

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

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

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

[6] Substance Abuse and Mental Health Services Administration. (2014). *Projections of national expenditures for treatment of mental and substance use disorders, 2010–2020,* HHS Publication No. SMA-14-4883. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[7] Ibid.

MH [mental health] treatment spending is expected to increase at a 4.5-percent average annual rate between 2009 and 2020, which is slower than the rate of 5.8 percent for all-health spending. (Substance Abuse and Mental Health Services Administration, 2014, p. 18)[8]

Besides the financial costs, other consequences of untreated/inadequately treated mental illness are severe and include: negative impacts on quality of life and physical health; decreased lifespans and increased mortality rates; decreased life satisfaction and increased unhappiness; social strain on familial and other interpersonal relationships; negative effects on earnings, employment, and educational success; increased risk of suicide and self-harm; and incarceration and homelessness.

Ultimately, the current mental health system in the U.S. is lacking for far too many individuals in need. This is a serious societal problem and change is necessary.

Section 2. Issues with the Current Mental Health System

Despite the recent developments in mental health services and policy, there are still many problems with the U.S.'s mental health system. One persistent and major problem has been the lack of funding, which has subsequently contributed to a lack of access to services. The U.S.'s mental health system has changed significantly throughout the past several decades; the process of deinstitutionalization transitioned the principal setting of mental health services from psychiatric hospitals to community-based programs. However, the combination of the sustained closures of psychiatric hospitals and a lack of sufficient community-based services has resulted in a deficiency of access to appropriate mental health care, especially for individuals with SMI. It is important to note that community-based mental health care is generally effective and preferred to institutionalization. The systematic, bipartisan failure to adequately establish and (financially) support a community-based mental health network of care following the medical and social advances and a select, few pieces of influential legislature (e.g., the Community Mental Health Act of 1963) in the 1950s through the 1970s can be attributed to gradual and unrelenting budget cuts and plateaus (i.e., disinvestment in public mental health services), a lack of ability to pass meaningful mental health reform legislation, reckless indifference, and arguably, the intensification of stigma. Positive gains in the most recent decades (e.g., enactment of insurance parity, development of evidence-based practices/new psychotropic medications, integration of mental and physical health care, etc.) and renewed efforts for states to increase their mental health budgets have not been able to offset the historical chronic underfunding and insufficient infrastructure of the public mental health system.

Over the past couple of decades, as aforementioned, mental health expenditures have increased overall, but have decreased as a percentage of all-health expenditures. States have cut more than $1.8 billion from their non-Medicaid mental health budgets for mental health services following the recent recession.[9] Thus, given the austere mental health financial conditions, it is critical that the limited funds are spent wisely; for example, mental health expenditures should support

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[8] Ibid.

[9] Honberg, R., Diehl, S., Kimball, A., Gruttadaro, D., & Fitzpatrick, M. (2011). *State mental health cuts: A national crisis*. Arlington, VA: National Alliance on Mental Illness.

preventative and evidence-based, community-based mental health interventions for most individuals seeking services and support more intensive interventions for individuals with SMI.

Mental health services are often particularly inaccessible for individuals with low-incomes and those in rural areas, in spite of these populations being especially vulnerable to mental health problems.

Relatedly, mental health services are very expensive and frequently unaffordable, notably for individuals without insurance. The Affordable Care Act (ACA) has sought to expand coverage for individuals in need and behavioral health issues, however the extent of the increased coverage enabled by this Act varies across the U.S., due to each state possessing the ability to decide on whether or not to implement Medicaid Expansion. It is important to note that expansion of mental health coverage, however, does not necessarily automatically translate into improved access to treatment and/or quality mental health care.

Mental health providers are in limited supply; the U.S. is facing a mental health workforce shortage. Additionally, many psychiatrists do not accept insurance. According to a study by Bishop et al. (2014),[10] acceptance rates for all types of insurance are significantly lower for psychiatrists than for physicians in other specialties and these acceptance rates have fallen recently for private noncapitated insurance and Medicare.

The mental health services that are available are not always adequately assessed for quality. Pincus et al. (2016)[11] reveals that: many behavioral health care quality measures have not been subjected to and are unlikely to meet the requirements expected for national endorsement and use in federal programs; many such measures have insufficient evidence to establish their usefulness in improving outcomes; and the impact of quality measurement and reporting on behavioral health has been limited.

Furthermore, the delivery of mental health services is incredibly fragmented. Mental health services can be received in primary care, mental health specialty, community-based, emergency department, correctional facility, educational, nursing home, assisted living facility, and home-based settings. Navigating the various systems of care, accessing appropriate services, and maintaining sufficient continuity of care can thus be very difficult. Diminished quality of care, strain on limited resources, and duplication of unnecessary services are other consequences of fragmentation.

Significantly, there has been neglect regarding the distinction in needs for individuals with various severities of mental illness. Specifically, inadequate attention has been given to the problems specific to individuals with severe and chronic mental illness; this has resulted in increased homelessness and incarceration for individuals with SMI. The vicious and economically-draining cycle (revolving door) of individuals, typically with SMI, repetitively encountering bouts of

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

[11] Pincus, H. A., Scholle, S. H., Spaeth-Rublee, B., Hepner, K. A., & Brown, J. (2016). Quality measures for mental health and substance use: Gaps, opportunities, and challenges. *Health Affairs*, *35*(6), 1000-1008.

homelessness and/or the criminal justice system because of a lack of access to necessary services in the mental health system is endless.

The prevalence of individuals with mental illness who are currently held within jails, prisons, or other correctional facilities is increasing, and the severity of these illnesses among those incarcerated is also on the rise.[12] According to a report by Torrey et al. (2014),[13] in 2012, there were approximately 356,268 inmates with SMI in jails and prisons; this number is shockingly 10 times greater than the number of individuals with SMI residing in state psychiatric hospitals. Research indicates that over half of all jail and prison inmates have a mental health problem, yet most individuals in the criminal justice system with mental health issues do not receive treatment.[14] Essentially, the criminal justice system has been forced to house and treat an expanding number of individuals who are unable to receive the necessary mental health care and support services in the community, making it a safety net for the public mental health system.

It is important to note that many individuals with severe mental health issues have also ended up waiting for prolonged periods of time for care (e.g., for inpatient beds to become available) in costly emergency departments, becoming "boarded" patients. Sometimes, more intensive treatments (e.g., long-term medication, supervision/close case management, involuntary treatment [bear in mind that voluntary treatment is always preferable], hospitalization, etc.) are necessary for certain individuals, for the health and safety of these individuals and the public at large. Ignoring and/or denying appropriate care for individuals with severe and chronic mental illness is harmful to everyone, including the broader public.

Finally, another problem surrounding the current mental health system is the stigma that is associated with mental illness. The presence of this stigma perpetuates abuse and mistreatment toward individuals with mental illness, inhibits individuals from seeking help (and especially a diagnosis) and/or complying with treatment, and can prevent meaningful societal and policy changes.

Section 3. Recommendations for Improvement

Specific recommendations for the enhancement of the mental health system in the U.S. include:

A. **Increasing mental health funding**
   a. Increasing mental health funding would help to increase relevant services and resources. Better access to sufficient and appropriate mental health care is critical. A wide body of evidence supports the efficacy and cost-effectiveness of various pharmacological and psychosocial treatments for many mental disorders. More community-based services (e.g., community behavioral health centers, counseling and medication management, Fountain House-type centers, peer support, supported

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[12] Torrey, E. F., Zdanowicz, M. T., Kennard, A. D., Lamb, H. R., Eslinger, D. F., Biasotti, M. C., & Fuller, D. A. (2014). *The treatment of persons with mental illness in prison and jails: A state survey*. Treatment Advocacy Center.

[13] Ibid.

[14] James, D. J., & Glaze, L. E. (2006). *Mental health problems of prison and jail inmates*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

housing, job training and placement, case management, rehabilitation services, Assertive Community Treatment [ACT], mobile crisis services, integrated primary care medical services, etc.) are needed first and foremost, but more inpatient beds for more severe cases in both psychiatric units in general hospitals and in specialized psychiatric hospitals are also necessary.

 i. Respectively, improved resources and conditions in hospital/institutional settings are key; adequate staffing and security protocols (e.g., the proper utilization of cameras and personal body alarms) are essential to protect both the patients and the employees in these settings. Hospitalization may be necessary to more closely monitor/treat individuals with mental illness, to accurately diagnosis a mental disorder, to adjust or stabilize medications, to tend to co-occurring substance use disorders/physical illness, or following an episode whereby an individual's mental illness temporarily worsens.

 ii. The mental health system must be prepared to target and treat individuals with severe and chronic mental illness in addition to individuals with acute mental health needs. To do this, crisis intervention services and short-term crisis stabilization units should be increased and the creation of more long-term care/residential psychiatric facilities should be considered. Such facilities would have to be strongly regulated and monitored, given that past experiences with asylums for individuals with mental illness have been horrific. There is much debate among providers, advocates, consumers, family members, and policymakers regarding the benefits, detriments, and overall utility of inpatient psychiatric institutions; ample discussion and research is required given the sensitivity and gravity of the matter. Long-term psychiatric facilities must be well-staffed, be safe and suitable for patients and employees, be held accountable for patient well-being, and have pathways for patient reintegration into the community (whenever possible) and recovery-inspired designs.

 iii. It is critically important to note that the best option of care for most individuals with mental illness is treatment in the community, however, for certain individuals with more severe and persistent needs, it is arguably unethical to deny more appropriate, intensive care (e.g., structured, long-term residential settings/supports), when necessary. Strengthening community-based mental health services/networks should be the main priority for the mental health system moving forward, but adding more intensive mental health services is also imperative; these two objectives do not have to be mutually exclusive and can both be achieved successfully, simultaneously. The criminal justice system cannot and should not play the role of the long-term care provider for individuals with mental illness.

b. Increasing mental health funding would also help to support mental health providers and increase the mental health workforce capacity. There is a looming mental health workforce shortage crisis, which is at least partially attributable to low pay and lack of reimbursement. Mental health providers, especially psychiatrists, need better incentives and reimbursements and training consistency.

c. It is important to point out that the need for increased mental health funding, and subsequently services, resources, and providers, is particularly prominent in rural areas. Relevant telemedicine expansion, such as the development and utilization of online psychotherapy, could be especially beneficial in rural areas and should be pursued.

B. Continuing/supporting research on the prevention, recognition, etiology, and treatment of mental health problems

a. Advances have been made in the fields of pharmacological, psychosocial, and psychotherapeutic interventions and preventative care, but more are always needed. The answers to the questions of what treatments work best and for whom deserve attention. Continued developments and discoveries would help to improve evidence-based practices, alleviate the burden of mental illness, better the well-being of those affected by mental illness, and provide stronger guidance for health care providers and policymakers.

C. Expanding research on the comparative cost-effectiveness of different mental health interventions/services

a. Such cost-effectiveness research could enable more efficient mental health spending, which is needed given the current issue of limited mental health budgets/financing.

D. Coordinating care and integrating mental health, substance abuse, and primary care services

a. Overall, coordination and integration can prevent gaps and duplications in care and more effectively utilize services, resources, and providers.

b. Screening for mental health problems and mental disorders should be implemented and standardized in primary care settings. Mental illness is often comorbid with various physical illnesses and many individuals do not have access to specialty mental health providers nor visit such providers as readily they do their primary care physicians, so mental health screenings in primary care settings can improve prevention and early detection of mental illness and can also help with suicide prevention.

c. The creation and/or support of integrated care centers, such as community behavioral health clinics (CBHCs), is also recommended, which will allow for more individuals in need to receive comprehensive care in one location. CBHCs provide crisis care, suicide prevention services, substance abuse treatment, outpatient mental health services, and support for families of individuals living with mental health issues. The Excellence in Mental Health Act (S. 264/H.R. 1263), signed into law by President Obama on April 1, 2014, is a demonstration program that supports Certified Community Behavioral Health Clinics (CCBHCs) with enhanced Medicaid funding/incentives, establishes strict standards on relevant quality of care measures, and encourages integration of behavioral health services with physical health services.

   i. An example of an integrated care center that functions as a cost-saving, efficient jail diversion program (and is now a national model for similar developments across the country) is the San Antonio Restoration Center. The Restoration Center is an integrated complex with 48-hour inpatient psychiatric care, sobering and detox centers, outpatient primary care and

psychiatric services, a 90-day recovery program, housing for people with mental illnesses, job training, and a program to help individuals transition to supported housing.[15] Trained cops in the San Antonio area know to bring individuals with mental/behavioral health needs to this Center to get these individuals help and treatment instead of incarceration whenever possible. According to an article featured on *National Public Radio*, more than 18,000 individuals pass through the Restoration Center each year and this coordinated approach has saved the city more than $10 million annually.[16]

    d. It is important that both physical health and behavioral health providers establish and become incorporated into systems of care. Individuals must be linked to appropriate services/resources (e.g., housing, education, and/or employment support) upon diagnosis or recognition of mental illness. Increased case management of mental illness, especially for more serious conditions, is key. Interdisciplinary care teams would better allow individuals in need to receive comprehensive care that improves mental and physical health and overall well-being.

E. Refining/standardizing provider training requirements with regard to mental health

    a. This recommendation is applicable to mental health specialty training settings (i.e., for psychologists and psychiatrists) as well as to general medical training settings (i.e., for primary care physicians, pediatricians, and gerontologists).

F. Strengthening relevant protective and preventative interventions

    a. Screenings for mental health problems, mental disorders, and suicide risk, especially in primary/pediatric care settings, can help with the prevention, early detection, and treatment of mental illness. Increasing awareness, education, and access to resources for individuals with family histories of/genetic predispositions to mental illness is very important.

        i. With specific regard to suicide (and self-harm), early recognition, diagnosis, and treatment of depression and other related mental disorders is vital, especially among older adults and rural youths. Immediate access to supportive services/resources is essential.

    b. Identifying and mitigating life stressors and risk factors that have been linked to poor mental health outcomes is also key to prevention. Examples of some such stressors and risk factors include: physical illness and chronic disease; physical impairment; loss of a loved one; separation/divorce; retirement; job loss; financial difficulties and low-incomes; childhood financial hardship; schooling; exposure to trauma/neglect; prenatal exposure to viruses, toxins, alcohol, and/or drugs; nutritional deficiencies; tobacco use and excessive alcohol intake; air pollution and toxicant exposure; natural disasters; and rural geographical location.[17]

    c. The promotion of relevant, general healthy behaviors is beneficial to mental health and can be protective against mental illness. Examples of some such behaviors

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[15] Gold, J. (2014, August 19). Mental health cops help reweave social safety net in San Antonio. *National Public Radio*. Retrieved from http://www.npr.org/sections/health-shots/2014/08/19/338895262/mental-health-cops-help-reweave-social-safety-net-in-san-antonio

[16] Ibid.

[17] Heekin, K., & Polivka, L. (2015). *Environmental and economic factors associated with mental illness*. Tallahassee, FL: The Claude Pepper Center, Florida State University.

include: eating nutritiously; limiting drug and alcohol intake; keeping physically active; staying connected with social groups; engaging in mentally stimulating activities; maintaining healthy sleeping practices; and seeking proper medical attention when necessary.[18]

    d. Certain settings, including primary care centers, workplaces, and schools, need to be more mental health conscious.

G. Promoting local, state, and national collaborative efforts

    a. Since the prevalence of mental illness is high, the consequences of mental illness are severe and widespread, and the fragmentation of mental health services is extensive, cooperation among various individuals/groups is required to improve the efficiency of the mental health system; communication and partnership between the mental health system and the criminal justice system is particularly important. Health professionals, service providers, law enforcement personnel, judges, advocates, consumers, policymakers, and researchers should all work together to create and implement innovative solutions.

H. Supporting appropriate changes in the criminal justice system in relation to mental health

    a. Diverting individuals with mental illness away from the criminal justice system, whenever possible, is one of the most important societal proposals from both an ethical and economics perspective. Methods for doing this include increasing law enforcement personnel training with regard to handling situations involving individuals with mental illness/individuals experiencing behavioral health crises (e.g., through crisis intervention teams [CITs] and teaching de-escalation tactics, minimization of the use of force, and connecting with appropriate behavioral health services) and utilizing/adding more mental health (and drug) courts (for appropriate individuals/cases). Receiving mental health care and social services in the community instead of in jails and prisons is also necessary.

        i. It is important to note that the diversion of youths with mental health problems away from the juvenile justice system is likewise very important.

    b. Advancing mental health-related treatment in jails and prisons is also suggested; more mental health providers, medications, and treatment options in correctional facilities are needed. Psychological evaluation/screening upon intake into correctional facilities to determine mental health status, medication/treatment needs, and suicide risk allows for better care during incarceration and enhanced safety for both inmates and correctional staff. Continuity of mental health care, if received prior to incarceration, is critical. Other changes to improve mental health conditions in correctional facilities include limiting or banning the use of solitary confinement and implementing suicide prevention measures.

    c. Emphasis on recovery and community reintegration upon release from incarceration is significant for all prior inmates and more so for those prior inmates with mental health issues. Again, continuity of care, if received prior to and/or during incarceration, is critical. Better re-entry services, such as intensive case management, are needed.

I. Supporting positive efforts to impact mental health throughout development during childhood and adolescence

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[18] Ibid.

a. This recommendation is consequential because a significant proportion of youths in the U.S. experience a mental disorder, the prevalence of these conditions has increased over the past couple of decades, mental illness that begins in childhood can continue into adulthood, and only approximately one-third of adolescents with mental disorders receive services for their mental illness.[19] Therefore, barriers to mental health services for children and adolescents must be minimized/overcome, including: difficulty in the recognition and diagnosis of youth mental disorders; a shortage of youth mental health providers; disparity in the access to/the utilization of mental health services; safety issues regarding pharmacological treatments for youth mental health problems; and gaps in prevalence of mental disorders and utilization of mental health services data. Better access to home and community-based youth mental health services is imperative.

b. An increased focus on early identification and prevention of mental disorders would be especially beneficial for children and adolescents; more education for parents/family members, health care providers, and teachers/school administrators and screenings in schools could help. Maintaining continuity of mental health care into adulthood, when relevant, could mitigate many of the long-term consequences associated with mental illness.

J. Supporting positive efforts to impact mental health and aging

a. This recommendation, very similar to the previous recommendation, is important because the population of older adults in the U.S. is steadily growing and a significant percentage of these individuals do and will experience mental illness. Barriers to mental health services for older adults must be minimized/overcome, including: lack of recognition and difficulty in the diagnosis of geriatric mental illness, especially in primary care settings; an inadequate geriatric mental health workforce; stigmatization associated with mental/emotional issues among older cohorts; gaps in information regarding available services for consumers; service delivery fragmentation; transportation issues; and lack of money or insurance to pay for services. Better access to home and community-based geriatric mental health services is essential.

b. The integration of primary care and mental health services is particularly relevant to improving mental health care for older adults since individuals in this demographic are less likely to receive mental health care from mental health specialists and are more likely to receive this type of care in primary and long-term care settings. Implementing system-based interventions (models of care) that have proven effective for managing geriatric mental health is suggested; examples of these interventions include Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors), IMPACT (Improving Mood-Promoting Access to Collaborative Treatment), PEARLS (Program to Encourage Active and Rewarding Lives for Seniors), and PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial). Increased regulation of medication complications and usage, especially overmedication of antipsychotics in nursing homes, is needed.

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[19] 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.

Improved mental health services in long-term care settings, primarily in nursing homes, is also required. Prevalence data on mental disorders in older adults (and youths, as aforementioned) remains heterogeneous and elusive; updating the national and state date collection systems so that more accurate prevalence and utilization of services rates for age-specific populations can be obtained will help allow the mental health system to be better informed.

K. Destigmatizing mental illness

    a. Increasing education, awareness, and outreach surrounding both mental health and mental illness are key. Information on the differences between normal and abnormal symptoms, development, and aging with regard to mental health must be disseminated to the public at large in a method that is understandable and provides clear instructions for subsequent access to appropriate services (i.e., mental health care regimens and/or next steps for treatment); linguistic and cultural barriers should be considered and reduced. Early diagnosis and treatment of mental health problems should be encouraged and lauded.

    b. The exaggerated association of mental illness with violence, especially by the entertainment industry and media, is one of the most harmful and stigmatizing misconceptions about mental illness. The public perception of individuals with mental illness as inherently dangerous is widespread and long-standing, despite this perception being unsupported by reality. Although mental illness, particularly untreated SMI, may increase the risk of violence in some individuals, the vast majority of individuals with mental illness are not violent. Most violent acts are not committed by individuals with mental illness and moreover, individuals with mental illness are actually far more likely to be victims rather than perpetrators of violence.

        i. It is important to note that there are many factors that affect violent behavior in both the overall population and in individuals with mental illness; these factors (e.g., substance abuse, history of [exposure to] violence, personal stressors, and poor socioeconomic condition) tend to interact in complex ways, leaving much ambiguity as to the actual causes of violence. Thus, more research is needed on what causes violent behavior in general and on identifying at-risk individuals, so that ensuing supportive legislation can help improve and protect public safety. As a caution, sweeping interventions that penalize certain individuals (e.g., individuals with any mental health problems as a factor alone) without solid evidences could be potentially unreliable at best and further damaging at worst.

    c. The consequences of the stigma of mental illness, as previously discussed, are substantial and include: inhibition of the seeking of accurate diagnosis and compliance with treatments; low self-esteem; isolationism; limitation of educational, employment, and social opportunities; and negative influence on policymakers' ability to carry out mental health reform.

    d. Support should be given to societal shifts toward compassion, empathy, kindness, and acceptance of mental illness. An example of a "community of care" approach toward treating mental illness can be found in the small town of Geel, Belgium:

> For over 700 years, residents of Geel have been accepting people with mental disorders, often very severe mental disorders into their homes

and caring for them. It isn't meant to be a treatment or therapy. The people are not called patients, but guests or boarders. They go to Geel and join households to share a life with people who can watch over them… That acceptance of mental differences has become something of a tradition in Geel. It's at the heart of the boarder program, and some observers think it's also responsible for the system's success. Around the world, many different experiments have been attempted over the centuries to provide humane care for people with mental illness and mental disabilities. Geel is one that has endured. Residents of Geel have not only accepted the eccentric or disruptive behaviors of the boarders but have come up with creative ways to help boarders and residents manage them… Several studies have found that the incidence of violence by boarders is low… (Chen, 2016) [20]

L. Enacting legislation/policies to help better support the mental health system
   a. There are currently proposed mental health legislation that, although not perfect, provide a good start for systemic reform and the opportunity for many positive changes for individuals with mental health problems. Policy alterations are obligatory, as the U.S. mental health system is in a crisis and is unable to sufficiently support far too many individuals in need; relief is urgently required. Fortunately, momentum and bipartisan support for mental health reform legislation seems stronger than anything since the 1970s. Examples of relevant proposed bills include:
      i. The Helping Families in Crisis Act of 2015 (H.R. 2646), which contains provisions to: support screening, secondary and tertiary prevention, early intervention, care integration, and expansion of evidence-based services; provide resources for suicide prevention; enhance the mental health workforce; improve data collection and outcomes measurement; remove barriers to inpatient treatment for Medicaid recipients; and support the enforcement of mental health parity law.
      ii. The Mental Health Reform Act of 2015 (S. 1945), which addresses many of the same issues in the above-mentioned H.R. 2646 bill and contains provisions to: expand Medicaid coverage for inpatient services; permit same day billing for Medicaid recipients for mental and physical health services; support integration of mental and physical health services; support the enforcement of mental health parity law; and support early intervention and mental health treatment for youths.
      iii. The Expand Excellence in Mental Health Act (S. 2525/H.R. 4567), which would enlarge the previously discussed demonstration program proposed in the Excellence in Mental Health Act (which creates/supports CCBHSs).
      iv. The Mental Health and Safe Communities Act of 2015 (S. 2002), which includes provisions to use federal resources to expand programs such as pre-trial screening and jail diversion programs, mental health courts, CIT

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[20] Chen, A. (2016, July 1). For centuries, a small town has embraced strangers with mental illness. *National Public Radio*. Retrieved from http://www.npr.org/sections/health-shots/2016/07/01/484083305/for-centuries-a-small-town-has-embraced-strangers-with-mental-illness

programs, and Forensic Assertive Community Treatment programs. This bill would also amend the National Instant Criminal Background Check System program by clarifying the inclusion of mental health records in the system and it would replace highly offensive terminology in the current federal gun reporting law.

   1. Relatedly, mental health legislation should not be further stalled by politics, particularly gun control controversies.

b. The promising mental health parity laws of the past decade (e.g., the Mental Health Parity and Addiction Equity Act of 2008 and the ACA) must be enforced. Insurance companies must be held accountable for disparities in the coverage of mental health services and should be penalized accordingly.

c. Current Medicaid (and Medicare) laws and regulations should be examined and improved. Medicaid Expansion should be strongly considered by states that have yet to approve it; increased access to insurance in general is critically important for bettering mental health care in the U.S. Additionally, greater Medicaid coverage for evidence-based services beyond the standard medication and psychotherapy treatments, such as Foundation House-type clubhouses, ACT teams, supported housing, and inpatient services (if appropriate), is needed. Medicaid recipients should be allowed to visit more than one health-care provider in a day (e.g., both a primary care physician and a psychologist), in order to promote coordination of and comprehensive care.

d. Mental health provider incentives and reimbursement policies should be expanded/strengthened.

e. Consideration should be given to modifying/strengthening involuntary commitment laws and privacy laws, particularly for individuals with SMI and/or those who are experiencing a crisis. This consideration would have to be handled with the utmost delicacy and respect for the well-being and legal rights of all citizens. There is currently much discord within the advocacy and legal communities as to how to best proceed regarding these issues; much more discussion and research (on safety and patient outcomes) is needed before definitive recommendations should be made. Modifying such laws could help family members/caregivers and providers to better support and serve individuals with mental illness, especially in crisis situations, but it could also discourage such individuals from seeking treatment and could perpetuate discrimination.

   i. Many family members currently struggle in vain to get their loved ones with SMI access to appropriate treatment before the consequences turn disastrous (e.g., resulting in incarceration, homelessness, physical harm, or even death). Reliance on dangerousness criteria for commitments frequently results in help coming too little, too late.

      Mental health laws predicated chiefly on dangerousness criteria to the relative neglect of need for treatment, mean that systems often have no choice but to release individuals known to be in acute distress back to the streets, often with no treatment at all. The irony is that if a hospital or healthcare professional were to discharge a person with an acute, non-psychiatric medical crisis, they could be accused of malpractice. However, when

psychiatric treatment facilities engage in this behavior, most often because the imminent risk of harm has passed for the moment and/or insurance benefits will no longer pay for continued inpatient admission, they are simply following the law. This is a dangerous precedent and one which has resulted in unnecessary and harmful consequences. (Leifman, p. 11)[21]

    ii. It is important to note that the Helping Families in Crisis Act of 2015 and the Mental Health Reform Act of 2015 contain provisions that impact involuntary treatment and privacy conditions.

f. States must also strengthen their own independent mental health laws, particularly those regarding funding for the state mental health agencies (SMHAs), to better adapt each state public mental health system.

g. Overall, enhanced regulation and accountability policies concerning the mental health system and relevant services are essential. Constant monitoring of the quality of mental health services, patient-centered outcomes, and funding streams is key. Clear performance standards should be defined (e.g., for federal and state agencies, service providers, insurance companies, etc.) and associated penalties must be enforced. More research is needed for the better development and implementation of appropriate quality standards.

h. Relatedly, the public should be encouraged to elect mental health-friendly politicians.

Section 4. Conclusion

Investment in mental health care is an investment in societal well-being. Mental health is one of the biggest predictors of life-satisfaction and when considering the impact of mental health on life-satisfaction, mental health expenditures are disproportionately low compared with other areas of government spending.[22] Layard et al. (2013)[23] argues that better treatment of mental illness is thus the most reliably cost-effective action to reduce misery and that to provide even basic mental health services for those in need, governments will have to spend larger proportions of Gross Domestic Product on mental health care. Effective, evidence-based treatments/solutions exist. Relevant financial reform must be guided by compassion and logic; funding must be distributed in an impactful and cost-effective manner. Improving economic conditions have allowed for the restoring of long-depleted, (state) mental health budgets.

Florida, specifically, has long maintained one of the lowest per capita mental health expenditures in the nation, and its mental health system has suffered consequently. According to the most recent available data, Florida has a SMHA per capita mental health services expenditure of $37.28, giving

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[21] Leifman, S. *People with mental illness involved in the criminal justice system*. Statement before the Subcommittee on Oversight and Investigations of the Energy and Commerce Committee of the United States House of Representatives. Retrieved from
http://mentalillnesspolicy.org/imd/judgeleifmanpsychhospitaltestimony.pdf

[22] Layard, R., Chisolm, D., Patel, V., & Saxena, S. (2013). *Mental illness and unhappiness,* CEP Discussion Paper No. 1239. London: Centre for Economic Performance, London School of Economics and Political Science.

[23] Ibid.

it a rank of 49th for mental health funding in the U.S. Florida's mental health funding situation over the past decade has been dire, especially in comparison to the nation at large. In constant dollars, Florida's SMHA total expenditure in 2012 was 33% lower than in 2002; in contrast, the total expenditure for all SMHAs in the U.S. in 2012 was 8% greater than in 2002. Fortunately, some positive changes regarding the mental health system in the state have begun to take hold within the past year (perhaps urged along by a series of journalistic investigations into the terrible conditions for individuals with mental illness in both correctional facilities and in state hospitals).

Promising mental health legislation enacted in Florida in 2016 includes the Mental Health and Substance Abuse bill (S.B. 12), which is designed to improve the delivery of mental health and substance abuse services, given the significant fragmentation of the current system, and requires collaboration among Florida's managing entities, counties, law enforcement, courts, other government departments, health professionals, consumers, and their families. This bill also defines a "No Wrong Door" model for accessing care, better clarifies performance standards, increases oversight and accountability, and supports the development of strategies to divert individuals with mental illness from the criminal justice system and emergency departments into appropriate care.

Another important piece of 2016 Florida legislation is the Mental Health Services in the Criminal Justice System bill (H.B. 439), which is designed to focus on diverting individuals with mental illness from the criminal justice system and creates a statewide framework for, and expands, treatment-based mental health courts in Florida. This bill additionally supports a forensic hospital diversion pilot program that provides treatment options for individuals deemed mentally incompetent to stand trial. Furthermore, the state has experienced an increase in mental health funding; around $16 million have been allotted to mental hospitals and $42 million have been allotted to improve community programs that address mental health. This increase is much-needed, and although it is meager in comparison to the massive cuts Florida's mental health system has sustained throughout the past decade, it is a good start on the path to repair.

Improving the mental health system is arguably one of the greatest and most urgent public policy challenges for modern society. The condition of care for individuals with mental illness today is unconscionable and inexcusable; the time for reform is now. The opportunities for change are unparalleled. For example, in addition to the current fuller docket of mental health legislation in Congress, in January 2016, the Obama Administration pledged $500 million to increase access to mental health care as a part of a series of executive actions to reduce gun violence; this is a small, and yet very encouraging and necessary step toward reversing the long trend of declining or stagnant mental health funding; a trend that began when psychiatric hospitals were systematically closed and the cost savings were not fully funneled back into community-based programs/services, as originally intended. Initiatives of this nature, in combination with unified efforts from consumers, family members, advocates, providers, etc., give reason to believe that the decades long neglect of persons with mental illness is finally ending.