MENTAL HEALTH POLICY REFORMS TO REDUCE MASS SHOOTINGS

Individuals with *untreated* severe mental illness make up nearly 2% of the U.S. population[1] but they are estimated to commit at least 10% of the homicides[2] and 50% of the mass killings.[3] They are also far more likely than others to commit suicide.[4]

When under the influence of delusion, disordered thinking and/or hallucinations that compel them to do harm, these individuals choose from a host of readily available potential weapons, including guns, knives, swords and automobiles. Even if guns are removed from this list, this small subset of the population will continue to pose a danger to themselves and others if they do not receive appropriate treatment.

The Treatment Advocacy Center applauds President Obama and Vice President Biden for seeking real reforms to reduce mass shootings and gun violence in America. The following three Gun Violence Task Force recommendations for mental health policy reform would reduce violence by making treatment more available to those at most risk for violent acts.

POLICY	STRATEGY	RATIONALE
Foster universal adoption and use of court-ordered outpatient treatment ("assisted outpatient treatment" or "AOT") for individuals with severe mental illness and a history of violence, arrest or re-hospitalization.	Establish a national AOT demonstration project providing grant funding for to up to 100 AOT programs throughout the nation. (See the 2000 Mental Health Courts legislation, S.1853, as a potential model.)	The Department of Justice has deemed assisted outpatient treatment to be an effective, evidence-based program for reducing crime and violence.[5] AOT laws exist in 44 states but are not universally used. Wider use of AOT would result in reduction of consequences of non-treatment, including violence, suicide, arrest, incarceration, homelessness and others. A study published January 2013 reports additionally that outpatient commitment of six months or more in combination with outpatient services reduces overall mental health costs.[6] (For annotated information about AOT, see the "Assisted Outpatient Treatment" backgrounder that follows this proposal or visit http://bit.ly/ZlOuk4 .)

Promote reform of civil commitment laws and practices so that intervention in acute psychiatric crisis is possible before individuals decompensate to the point of provable risk of violence or suicide.	Provide funding for stakeholder education (e.g., judicial and law enforcement training) to ensure proper implementation of new and existing civil commitment laws.	Requiring proof that an individual in psychiatric crisis is imminently violent or suicidal before he/she can undergo civil commitment severely limits the use of preventative treatment and impairs public safety. The misconception that dangerousness is a constitutional requirement stems from widespread misunderstanding and misrepresentation of U.S. Supreme Court precedent.
Provide sufficient public psychiatric beds to treat individuals in psychiatric crisis or with chronic psychiatric disease that renders them unable to live safely in the community.	Repeal the IMD (Institution for Mental Diseases) Exclusion.[7]	The "Institutions for Mental Disease (IMD) Exclusion" prohibits federal Medicaid matching payments to inpatient facilities with more than 16 beds and more than 51% of patients under treatment for severe mental illness. This exclusion creates an economic incentive for states to eliminate public psychiatric beds, which are excluded from federal funding, and thus limits the availability of beds for those who need long-term chronic care. Repealing the IMD Exclusion would result in expanded inpatient treatment options for the most ill, and help end longstanding government discrimination between mental illness and other medical conditions.

[1] The NIMH estimates that 1.1% of U.S. adults have schizophrenia and 2.6% have bipolar disorder, of whom roughly half (1.85%) are untreated in any given year. *Schizophrenia* retrieved from http://www.nimh.nih.gov/statistics/1SCHIZ.shtml; *Bipolar Disorder* retrieved from http://www.nimh.nih.gov/statistics/1BIPOLAR_ADULT.shtml

[2] E.F. Torrey et. al. (2012). Consequences of hospital bed closures. No room at the inn: Trends and consequences of closing public hospital beds. Retrieved from http://tacreports.org/consequences#violentcrimes

[3] E. Fessenden. (2000). Rampage Killers: They threaten, seethe and unhinge, then kill in quantity. *New York Times*, April 9, 2000.

[4] *Suicide: One of the consequences of failing to treat individuals with severe psychiatric disorders*. Retrieved from http://www.treatmentadvocacycenter.org/resources/consequences-of-lack-of-treatment/suicide/1380

[5] *Assisted Outpatient Treatment.* Department of Justice Office of Justice Programs. Retrieved from http://www.crimesolutions.gov/ProgramDetails.aspx?ID=228

[6] M. Swartz, J Swanson. (2013). Can states implement involuntary outpatient commitment within existing state budgets? "Psychiatric Services, 64.

7 *Fact sheet: Medicaid discrimination against people with severe mental illnesses*. Retrieved from http://firstwebsite/GeneralResources/fact12.htm .