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Megan Leopold
University of Kansas, mleopold@ku.edu

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Problems and Politics: A Multiple Streams Analysis of The Excellence in Mental Health Act of 2014

Megan Leopold
University of Kansas

Inadequate funding of community mental health has led to a variety of problems, including a shortage of available providers and services. After decades of being ignored, Congress acknowledged these difficulties in 2014 with the passage of the Excellence in Mental Health Act. The Excellence in Mental Health Act, one of the first to target community mental health in decades, created national standards of care and more adequate reimbursement rates for centers able to meet these new standards. The Multiple Streams framework is used to study the success of the Excellence in Mental Health Act in becoming law, examining how policy entrepreneurs were helped by a national focusing event in finally getting their policy solution to the desk of politicians and into law.

Key words: Mental health policy, community mental health, multiple streams, policy analysis

In 2015, an estimated 43.4 million adults suffered from mental illness, yet only 18.6 million adults received mental health services in that same year (Bose, Hedden, Lipari, & Park-Lee, 2016). This lack of available services impacts individuals with low-incomes and serious mental illness the most (Cunningham & McKenzie, 2006) and is increasing. According to one study, between 1997 and 2011, the number of Americans who reported needing but not receiving mental health care increased by

approximately two-thirds, or 2.9 million people (Roll, Kennedy, Tran, & Howell, 2013), leaving many without the care they need (Bose et al., 2016). The discrepancy between the number of individuals in need of mental health services and the availability of these services is an ongoing problem as communities struggle to provide services despite inadequate funding and a shortage of qualified providers (Dickson, 2015; Schaper, Murphy, & Wirshing, 2014).

The problem of people going without the mental health services they need can often be traced to either a lack of affordability or a lack of availability. Many individuals lack the insurance coverage necessary to afford services and, for those who do have insurance coverage, a shortage of high quality, convenient options prevents them from obtaining services (Blair & Espinoza, 2015). While the recent Patient Protection and Affordable Care Act of 2010 and Mental Health Parity Act of 1996 legislation made strides in bridging the coverage gap (Dickson, 2015), decades of inadequate funding have left the current community mental health system struggling. Today, community mental health centers struggle to provide basic services and meet the diverse needs of many locations, cultures, and mental illnesses (Cunningham, 2009).

In 2014, lawmakers moved toward addressing the lack of available and consistent mental health treatment options with the passage of the Excellence in Mental Health Act. This act, which aimed to improve quality and expand access to community-based mental health services (National Council for Behavioral Health, 2015), has been hailed as the most significant investment in community services since former President John F. Kennedy signed the Community Mental Health Act of 1963 (Rosenberg, 2014). The Excellence in Mental Health Act increased Medicaid funding to aid several states in the establishment of Certified Community Behavioral Health Centers. These centers are held to specific standards to help ensure quality and availability while benefitting from a more adequate federal reimbursement system, similar to that of their community health counterparts (National Council for Behavioral Health, 2015).

Using the Multiple Streams framework, this analysis will demonstrate how the Excellence in Mental Health Act became a viable policy solution for Community Mental Health Centers. The Multiple Streams framework describes three independent

streams—the problem stream, the policy stream and the political stream—that carry a problem from policy idea to law. When the paths of two streams converge, a policy window is created, providing an optimal time for policy entrepreneurs to advance their policy idea into law (Zahariadis, 2014). This framework will illustrate how the growing problem of unavailable mental health services was illuminated by a series of mass shootings that sparked political interests and opened a policy window. Exploring the creation of this legislation through this framework will benefit future policy entrepreneurs and service professionals alike in a better understanding of how some policy solutions gain the attention of the government while others sit idly on the sidelines.

The History of Community Mental Health in America

While community-based centers provide the majority of mental health services today, this has not always been the case. Prior to the movement to deinstitutionalize mental health treatment in the 1960s, the majority of mental health treatment took place in in-patient settings such as psychiatric hospitals (Drake, Green, Mueser, & Goldman, 2003; Grob, 1994; Kemp, 2007). The outlook on best-practice treatment for mental illness changed due to a variety of forces. One catalyst was the creation of the National Institute for Mental Health in 1949, which began a strong push for de-institutionalization and a move toward community-oriented care (Grob, 2005). In addition, the 1950s brought the increased efficacy and safety of psychiatric medication, which increased the ability of individuals with mental illness to successfully reside in their communities (Drake et al., 2003; Kemp, 2007).

In 1955, a Joint Commission on Mental Illness and Health issued several recommendations, including a greater focus on the rehabilitation of individuals with mental illness and a focus on community-based mental health treatment (Kemp, 2007). These recommendations culminated in the passage of the Community Mental Health Centers Act of 1963 (Kemp, 2007). This Act, passed under President John F. Kennedy, began a new era in mental health where individuals with mental illness could

receive therapy, medication management, and other needed services while living in their communities (Glied & Frank, 2016; Grob, 1994).

The necessity for community-based care for mental illness was reinforced in 1965 through the creation of Medicaid. Because it rarely covered inpatient treatment, individuals paying for their mental health treatment with Medicaid became more likely to choose community-based care (Glied & Frank, 2016; Grob, 2005). At the same time, however, Medicaid has been continuously criticized for not providing adequate funding for those providers, creating funding barriers for community mental health centers (Blair & Espinoza, 2015; Glied & Frank, 2016). Another force at work in encouraging community based care for mental illness was the 1972 introduction of Supplemental Security Income. This new income stream for people living with disabilities, including mental illness, provided those otherwise unable to earn a traditional income with the ability to support themselves while remaining in their community (Blair & Espinoza, 2015; Glied & Frank, 2016; Grob, 2005).

As an increasing number of individuals sought outpatient mental health treatment, the newly designed system of community-based care struggled to meet demands (Grob, 1994; Kemp, 2007). In an attempt to better understand the causes behind these struggles, President Jimmy Carter created the President's Commission on Mental Health, at the suggestion of John W. Gardner, former secretary of the U.S. Department of Health, Education, and Welfare in the Johnson administration (Kemp, 2007). After a year of research, this group found that a large number of Americans did not have access to mental health services and that the services in place often failed to meet the needs of special populations such as children, adolescents, and people of color (The President's Commission on Mental Health, 1978). These findings inspired the 1980 Mental Health Systems Act (PL 96-398), which appropriated federal funds to community mental health centers and grants designed to support these underserved populations. Before this could be fully implemented, however, the Reagan administration's 1981 Omnibus Budget Reconciliation Act (H.R. 2264) rescinded the legislation and, under its provisions, provided mental health funding by way of block grants to states (Grob, 2005; Kemp, 2007). This created two significant changes: it decreased federal funding by 20 to 25%

of what had been anticipated under the Mental Health Systems Act, and it decreased federal influence by providing considerable leeway to states in how they chose to disperse the funding (Grob, 2005).

In 1990, the National Alliance for the Mentally Ill and the Public Citizen Health Research Group released a report concluding that public mental health services in the U.S. were breaking down (Kemp, 2007). Among its findings were that only one in five people with serious mental illness was receiving adequate care, funding for public mental health services was chaotic, and qualified mental health professionals were increasingly leaving public settings to pursue private sector work (Kemp, 2007). While individuals with privately funded insurance could access private services, those with low incomes and public insurance, such as Medicaid, were largely dependent on the struggling public system (Kemp, 2007).

Moving into the 21st century, the public mental health system saw an increased demand for services and continuing financial woes (Olfson, 2016). Along with states decreasing the dollars allocated toward mental health services (Mantel, 2013), the failure of insurance reimbursements to cover the cost of care proved to be a barrier to community mental health providers (Appelbaum, 2009; Dickson, 2015). In 2002 a task force from the Minnesota Psychiatric Society reported that psychiatrists are paid 10 to 40% less than primary care physicians for providing equivalent outpatient services (Minnesota Psychiatric Society, 2002). These funding deficiencies have forced community mental health centers to reduce services or close their doors, creating gaps in services (Appelbaum, 2003; Cunningham & McKenzie, 2006), particularly for adults with serious mental illness (Cunningham, 2009; Olfson, 2016).

The passage of the Mental Health Parity Act of 1996 and Patient Protection and Affordable Care Act of 2010 worked to address coverage gaps by requiring that insurance plans with mental health coverage cover those services at the same level of coverage as physical health problems and increase coverage as a whole (Cunningham, 2009; Dickson, 2015; Olfson, 2016). While these policies successfully increased the ability of individuals to access affordable mental health care, it did little to increase availability. With public programs continuing to be underfunded and many private practitioners unwilling to accept Medicaid, those

with newly found access often had nowhere to turn (Cunningham, 2009). As the safety net of community mental health continued to unravel, the number of individuals with mental illness in hospitals and prisons rose (Dickson, 2015; Kennedy-Hendricks, Huskamp, Rutkow, & Barry, 2016). Such indicators, along with the national focus on a series of mass shootings, brought the inadequacies of the mental health system to the attention of Congress and, in 2014, Congress responded with the passage of the Excellence in Mental Health Act, legislation designed to expand the reach and resources of the community mental health system (Mantel, 2013).

The Excellence in Mental Health Act of 2014

The Excellence in Mental Health Act of 2014, which was included as part of the larger Protecting Access to Medicare Act (H.R. 4302), brings a \$1.1 billion investment to community mental health centers, the largest federal investment in several decades (National Council for Behavioral Health, 2015). The goal of the Excellence in Mental Health Act is to increase the quality and availability of community mental health services through an increase in Medicaid funding and the creation of Certified Community Behavioral Health Centers (Mantel, 2013). Certified Community Behavioral Health Centers, which are currently being piloted in eight states, must meet a set of criteria specified to encourage high quality services. In turn, the center is reimbursed at a rate adequate to cover the services provided (National Council for Behavioral Health, 2017).

Certified Community Behavioral Health Clinics are required to meet a set of criteria centered on providing comprehensive and coordinated care, continuity between centers, and accountability outcomes (National Council for Behavioral Health, 2017). Each center provides a comprehensive list of services, including twenty-four-hour crisis teams, assessment, diagnosis, and targeted case management. In addition, all Certified Community Behavioral Health Clinics are required to maintain care coordination agreements with other community resources, such as health clinics, child welfare agencies, and law enforcement groups (National Council for Behavioral Health, 2017). In order to demonstrate accountability, each clinic must follow guidelines for staff training and offer a state-determined

array of evidence-based services. They are also required to report regular outcomes, such as population served, care coordination, service usage and clinical outcomes data (National Council for Behavioral Health, 2017).

The national standards of Certified Community Behavioral Health Clinics provide a potential remedy to the shortage of quality services highlighted with the passage of the Affordable Care Act and Mental Health Parity Act. The improved reimbursement plan through the Excellence in Mental Health Act will help even the field and make non-profit community-based health more attractive to qualified providers (National Council for Behavioral Health, 2015). In addition, increased requirements for staff training in a variety of evidence-based techniques will address the reoccurring issue of variability in the quality of mental health services (Glied & Frank, 2016).

The Multiple Streams Framework

The Multiple Streams framework, introduced by Kingdon in 1984, describes how some policies rise to the top of a crowded agenda to gain the attention of politicians and become law (Kingdon, 1984; Zahariadis, 2014). This framework describes three streams—the problem stream, the policy stream, and the political stream. These streams, which flow independently of one another, each have their own players and dynamics that carry a problem from policy idea to law. When two or more of the streams converge, a policy window is formed, creating a time during which policy entrepreneurs, the advocates and organizers behind a policy or solution, will have the most success getting their policy from solution to law (Kingdon, 1984).

The Multiple Streams framework has been used to analyze a variety of policies in a large array of disciplines, from policies supporting National Guard members returning home (Gorman, Blow, Ames, & Reed, 2011) to HPV vaccinations (Shapiro, Guichon, Prue, Perez, & Rosberger, 2017). Kingdon (1984) refers to the Multiple Streams framework as a way to explain the creation of policy under conditions of ambiguity or a time when there are a variety of ways to think about a particular problem and/or solution. The framework calls attention to the collective choice behind the policy-making process, emphasizing that it is not one individual or group that leads a policy into being, but a variety

of forces that combine under a specific circumstance to create the policy window (Zahariadis, 2014).

The Problem Stream

The problem stream represents the many problems that cross the desk of policy-makers each day. The two reasons why some of these problems pass by unnoticed while others become a priority are defined in the Multiple Streams framework as indicators and focusing events (Kingdon, 1984). Indicators are nuggets of information that suggest a problem or worsening of a problem and focusing events are large events that suddenly direct attention to a particular problem (Kingdon, 1984). Along with numerous indicators suggesting a lack of availability and disparities among mental health services, several focusing events in the form of mass shootings took place to help move the plight of community mental health centers from problem to priority.

Indicators

Inadequate resources. In the years prior to the passage of the Excellence in Mental Health Act, the mental health system was suffering the effects of the great recession. Between 2009 and 2011, states cut more than \$1.8 billion from their budgets for programs that serve children and adults with mental illness (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012a). For some centers, these cuts meant the elimination of a service, such as crisis intervention or the loss of staff; but, in other cases, entire centers were forced to close, leaving many without options for treatment (Simmons, 2002). Despite the efforts of parity legislation to remedy the lack of insurance coverage, of the 45.6 million adults with a mental illness in 2011, only 38.2% received mental health services. The most reported reason for this was that the treatment was unaffordable (SAMHSA, 2012b).

As Linda Rosenberg, CEO of the National Council of Behavioral Health pointed out, community mental health centers are expected to provide a safety net for those most in need, but these centers have long lacked the federal financial support that is given to traditional health services (National Council for Community Behavioral Healthcare, 2013). As states cut

non-Medicaid funds, Medicaid itself, which funds the majority of community-based mental health treatment, has been criticized for paying inadequate rates that do not even cover the cost of the services provided (Dickson, 2015). As the already tenuous mental health safety net begins to fray, individuals with untreated mental health needs begin to show up in jails, emergency rooms, and homeless shelters, increasing the costs to these facilities and the communities in which they reside (Dickson, 2015; Kennedy-Hendricks et al., 2016).

A study by the Justice Center (2012) reported that inmates experiencing mental illness in New York City jails rose 9% between 2005 and 2011. Another study reported that 70% of 6,000 hospital emergency departments reported boarding patients in need of mental health treatment for hours or even days while they waited for a bed to become available in a psychiatric facility. Of these, 10% reported boarding patients for weeks (Mantel, 2013). Indicators such as these create not only a financial burden for these community resources, but expand notice of the problem to other systems and, in doing so, increase the base for policy entrepreneurs.

Lack of qualified providers. The Affordable Care and Mental Health Parity Acts increased insurance coverage for mental health treatment, allowing more individuals to afford the treatment they need. The effects of Medicaid expansion under the Affordable Care Act were seen in one study's findings that, following this expansion, coverage of patients with psychotic disorders seen in emergency settings more than doubled (Schaper et al., 2014). While a seemingly positive step for mental health access, the increase in covered individuals highlighted another problem faced by the mental health system: a lack of qualified providers (Dickson, 2015; Schaper et al., 2014). This shortage left few treatment options for the newly insured and, in some cases, exacerbated already existing problems such as long wait times and difficult-to-find care (Bishop, Press, Keyhani, & Pincus, 2014; Dickson, 2015; Mantel, 2013; Olfson, 2016).

Due to low reimbursement rates, fewer and fewer providers of mental health services were accepting Medicaid, the primary source of coverage for those with low incomes and the primary funding source for community mental health (Bishop et al., 2014; Olfson, 2016). One study involving almost 3,000 primary care physicians highlighted the lack of mental health providers

with its finding that two-thirds of physicians were unable to find mental health services for at least some of their patients (Cunningham, 2009). This rate was twice as high as what these physicians experienced when referring patients to other types of specialists (Cunningham, 2009). While this shortage affects providers of all types, the lack of psychiatrists is particularly problematic due to their short supply and specialized service (Bishop et al., 2014). In a nation-wide study comparing the acceptance of insurance by psychiatrists with physicians of other specialties, Bishop et al. (2014) reported that only 43% of psychiatrists accepted Medicaid in 2009-2010, which reimbursed at an average rate of only 53% of what private insurance paid. This lack of providers made it especially difficult to find referrals for children and in rural areas (Cunningham, 2009; Olfson, 2016).

Data collected by the federal government has shown that rural areas and states with a higher percentage of individuals living in rural areas are most impacted by the shortage of qualified mental health professionals (Mantel, 2013). Individuals with low incomes and with serious mental illness are also disproportionately impacted, as they are most likely to have Medicaid, which is hardest hit by the lack of qualified professionals (Cunningham & McKenzie, 2006). Sadly, without a fix to the shortage of mental health providers, the increase of insurance coverage could potentially have no impact on the severe availability challenges faced by the previously uninsured, leaving large numbers of people with coverage but nowhere to go.

Focusing Event

Gun violence. Alongside the problems faced by the mental health system, another problem was grabbing the attention of Americans. In July of 2012, a man armed with several guns entered a movie theater in Aurora, Colorado, and shot 70 people, killing twelve (McGinty, Webster, Jarlenski, & Barry, 2014). Six months later, on December 14, 2012, a man armed with a semi-automatic rifle entered an elementary school in Newtown, Connecticut and fatally shot 26 people, 20 of whom were children (McGinty, Webster, & Barry, 2013). These two tragedies, which followed two other headline-grabbing shootings in Tucson, Arizona and at Virginia Tech, acted as focusing events that quickly gained the public's attention (McGinty et al., 2013).

Almost immediately after each tragedy, news outlets began reporting about the shootings and framing the problem with their narrative. As the public mourned, news outlets began reporting on the actions and history of each of the gunmen and, in each case, speculating about their mental health (Close, 2012; Press, 2012; Santos, 2012). Despite the accuracy or inaccuracy of the media reports, this pattern in reporting contributed to what has become a widespread acceptance of the causal relationship between mental illness and violence (Appelbaum, 2013; Metzl & MacLeish, 2015). The public reaction to the 2012 shootings in Newtown Connecticut was no exception and, as a result, the problem of this most recent mass shooting became framed by many as a problem of inadequate mental health services. While the problem indicators of inadequate resources and lack of qualified professionals were not new problems, the framing of gun violence as a mental health problem gave these indicators new life as the public's attention became more and more focused on the problem of mental health availability.

The Politics Stream

In order for a policy to be picked up and supported by politicians, it must be an issue that is of concern to the general public. The politics stream of the Multiple Streams framework is made up of the national mood and the ideology of the current administration (Zahariadis, 2014). The political stream is influenced by organized interest groups that work to steer politicians as well as the mood of the general public to whom politicians look for their own re-election (Kingdon, 1984; Zahariadis, 2014).

Despite the longstanding nature of the indicators created by an inadequately funded mental health system, they rarely grabbed the attention of politicians. As Loyd Sederer (2015), Chief Medical Officer of the New York State Office of Mental Health pointed out, "it's as if Congress went to sleep for 50 years on mental health issues. But the nightmares woke us all up: Newtown, Aurora, Tucson ..." (para. 3). The lack of political attention paid to mental health, as evidenced by a lack of policy action over the last decades, seem to support his assessment that the problem of mass shootings is what ultimately made the Excellence in Mental Health Act politically attractive. This assertion also seems to be

illustrated in the path of the Excellence in Mental Health Act from introduction to passage.

In 2010, with a Democratic majority in both houses of Congress, the Excellence in Mental Health Act (S.4038) was introduced by Senator Debbie Stabenow (D-MI) but did not reach a vote (Excellence in Mental Health Act, S. 4038). Stabenow tried again in March of 2012 (S.2257) in the 112th Congress, which had a Republican-controlled house and a Democratic-controlled Senate (Excellence in Mental Health Act, S.2257). This time the Act was attached to a gun bill, but any appeal that mental health reform may have had could not outweigh the political ambivalence around gun control. The bill was shelved (Mantel, 2013; Peters, 2013).

Despite this loss, the momentum was building. As the general public became more concerned about gun violence, mental health legislation acted as a political refuge for politicians who had no interest in being seen as infringing on 2nd Amendment rights, but who were under pressure to act (Peters, 2013). Stabenow, who worked with politicians on both sides of the aisle to drum up support for the Excellence in Mental Health Act, noted, "as we listen to people on all sides of the gun debate, they've all talked about the fact that we need to address mental health treatment" (Peters, 2013, para. 3). The next time the bill was introduced in late 2013, two important changes were made. The bill was no longer attached to gun legislation, and a lot of behind-the-scenes work from policy entrepreneurs had increased support for the bill. Sponsorship of the bill rose from two (Senator Jack Reed [D-RI] and Richard Blumenthal [D-CT]), during its 2012 introduction, to 24 senators for its 2013 introduction (Excellence in Mental Health Act, S.264). With a greater level of bipartisan support and a separation from gun laws, the bill became law.

The Policy Stream

As problems come to light, stakeholders, researchers and public officials begin to form policy solutions. These policy solutions take many forms and are pooled together in a primeval soup of ideas where they float about, sometimes changing shape or combining with other policy solutions (Kingdon, 1984; Zahariadis, 2014). Eventually a select few policy solutions arise

to the attention of lawmakers for serious consideration (Kingdon, 1984; Zahariadis, 2014). Kingdon (1984) suggests that certain qualities, such as an idea's technical feasibility, compatibility with policy-maker values, and public acceptance, help determine whether a single policy will be one of the lucky few to gain serious consideration and eventually become law.

While parity laws have addressed coverage for mental health treatment (Blair & Espinoza, 2015; Mantel, 2013), there have been no significant policies to address the quality and availability of treatment in decades (Rosenberg, 2014). Despite a clear agreement that policy change is needed among those working within the mental health field (Appelbaum, 2003) and years of advocacy and support from policy entrepreneurs, the path of the Excellence in Mental Health Act from primeval soup into law has not been easy. It required multiple introductions and tireless work from advocates before being enacted. Its eventual success can be examined through the three characteristics that make a policy attractive to policymakers: technical feasibility, cost effectiveness, and value acceptability (Kingdon, 1984; Zahariadis, 2014).

Technical Feasibility

Kingdon (1984) explains technical feasibility as whether the policy has been worked out, worked through, and is ready to go. In applying these criteria to the Excellence in Mental Health Act, there is evidence that it has these qualities. The Excellence in Mental Health Act seeks to create a national standard of quality for community mental health through two major tenets: high-quality treatment options and comprehensive care (National Council for Behavioral Health, 2017). While the creation of a national standard of quality is a new goal for community mental health, many of the requirements for meeting these standards have already been worked through and worked out by individual centers and communities, paving a smoother path for meeting new goals.

A major step of providing consistent and quality treatment is ensuring that all centers are using evidence-based treatment options (Canady, 2015). The field of mental health has a range of already recognized evidence-based treatments (Harvey & Gumport, 2015), and a 2012 study of community mental health

practitioners showed that clinicians are generally open to their use (DiMeo, Moore, & Lichtenstein, 2012). Although barriers to using evidence-based treatments include a lack of knowledge and difficulty identifying the correct treatment option (DiMeo et al., 2012; Harvey & Gumport, 2015), these can likely be overcome with staff development and training, which should be more easily implemented with the higher Medicaid rates offered to Certified Community Behavioral Health Centers (National Council for Behavioral Health, 2015).

In order to provide more comprehensive services, Certified Community Behavioral Health Centers will be required to offer a variety of services, likely forcing existing centers to expand their service array (National Council for Behavioral Health, 2017). While new additions may be necessary, however, none of the existing requirements of the Excellence in Mental Health Act, such as 24-hour crisis support and outcome reports, are new to the field (National Council for Behavioral Health, 2017). The 2016 National Mental Health Services Survey, compiled by SAMHSA (2017), found that more than a third of mental health treatment facilities already offer treatment designed specifically for persons with serious mental illness. Half of the centers already employ a crisis intervention team, and 56% report client outcomes as part of their standard operating procedures (SAMHSA, 2017). In some cases, mental health centers have been offering these services under the current system without the ability to be reimbursed for them (Meyer, 2017). This information suggests that many of the requirements that Certified Community Behavioral Health Centers will need to implement have already been worked through and worked out and that established models exist for those centers needing to add additional services.

Cost Effectiveness

Requirements around accountability, collaboration and evidence-based services will work to ensure that centers are operating in a cost-effective manner. The requirement to use evidence-based services will ensure that reimbursement is going toward treatments that have been shown to be effective. Requirements around the coordination of services with other

community services will also increase cost effectiveness, as research has shown collaborative care to be effective in treating mental illness such as depression and anxiety (Woltmann et al., 2012). In addition, increased coordination has the benefit of decreasing duplication of services.

Value Acceptability

In order for policies to make it out of the primeval soup, they must be compatible with presiding values (Kingdon, 1984). In the case of the Excellence in Mental Health Act, its compatibility with the values of the time is more about what it is *not* than what it is. When gun violence occurs, policy solutions tend to go in one of two directions: gun control or mental health (Barry, McGinty, Vernick, & Webster, 2013). Despite support for some measures of gun control from members of the public, gun control continues to be a politically divisive subject (Barry et al., 2013). However, while limiting access to guns continues to conflict with the values of many Americans, increasing the availability of mental health services has a higher level of value acceptance (Barry et al., 2013).

The recent path of The Excellence in Mental Health Act from idea to law is highlighting Americans' discomfort with gun control legislation, but this discomfort is not new. This value trend began earlier in the process, influencing the availability of the research required to create good policy. In 1996, in response to pressure from the National Rifle Association (NRA), Congress voted to cut funding for gun violence research, leading to a 60% decrease in peer-reviewed research publications about gun violence (Mayors Against Illegal Guns, 2013). At the same time, thanks to new medical technologies, such as neuroimaging and behavioral genetics, research about potentially dangerous people has flourished (Bufkin & Luttrell, 2005; Vicaro & Seitz, 2017). This creates a strong research base to support prevention solutions focused on people, while making it easier to dismiss ideas of gun-control as politically motivated (Vicaro & Seitz, 2017).

Policy Entrepreneurs and the Policy Window

Policy entrepreneurs are the individuals and groups creating the policy and pushing it forward. Policy windows are often recognized, and sometimes even created by, these groups which must have a policy ready to go when the streams couple and a window is created. Policy entrepreneurs are advocates for their policy and work within each stream to push their policy forward (Kingdon, 1984; Zahariadis, 2014).

In the case of the Excellence in Mental Health Act, policy entrepreneurs had the help of a focusing event in a string of mass shootings. While this helped to combine the problem and political streams by creating a politically beneficial reason to support the expansion of mental health services, the ability of the policy entrepreneurs to have a policy at the ready factored into the success of this bill. In the wake of public fear and mass media coverage resulting from the shooting in Newtown, Congress was feeling pressure to act fast. Prior to the focusing event of the Newtown shootings, however, The National Council for Community Behavioral Healthcare, a non-profit association of 2,000 providers, had been working to create this legislation and was strongly behind it when first introduced in 2010. After 2010, more policy entrepreneurs were brought onboard to increase the pull of the bill (Office of Roy Blunt, 2013). Among these were veteran groups and members of law enforcement, who often provide first responder care to those in crisis due to the lack of available mental health care. Other supporters who joined the bill were the American Psychological Association and actress Glenn Close (Office of Roy Blunt, 2013). With this level of support from a variety of areas, the bill was able to sustain movement even past its 2012 shelving.

Before its reintroduction in 2013, policy entrepreneurs focused on getting more co-sponsors. "We're pushing for co-sponsors and the more co-sponsors we get, the more likely it is that Senate Majority Harry Reid will give us a vote" said Andrew Sperling, Director of legislative advocacy for the National Alliance on Mental Illness (Mantel, 2013, p. 443). By the time the policy window was fully open and the bill was reintroduced, it was supported by a variety of groups, from veterans to law enforcement, and over 50 mental health organizations, in addition to adding over 20 co-sponsors (Office of Roy Blunt, 2013). The hard work of the policy entrepreneurs in building support

and momentum for the bill likely played a large part in pushing this legislation through in the limited opportunity provided by the policy window, a testimony to the important work of these individuals and groups.

Discussion

When viewed through the lens of the Multiple Streams analysis, it is clear that all three streams played a unique role in promoting the Excellence in Mental Health Act into law. Although the problem indicators of inadequate mental health services had been visible for decades, it took a crisis in the form of several mass shootings to bring the problem to the attention of politicians. Then, because of the groundwork laid by policy entrepreneurs, the policy was at the ready. As the policy window opened, the Excellence in Mental Health Act had the support, feasibility and value acceptance to be made into law.

Following the passage of the Excellence in Mental Health Act, eight states were chosen via a competitive grant process to create Certified Community Behavioral Health Centers and participate in the Excellence in Mental Health Act demonstration program. The eight chosen states were part of a group of 24 states that had all undergone the planning phase of the process in hopes of being chosen. These eight are the first to put the law into action (Canady, 2015). In an effort to maintain the momentum created by these eight states, however, the Expand Excellence in Mental Health Act (S.2525/ H.R.4567) was introduced in March of 2016 with the goal of expanding the demonstration to all 24 states that originally applied (Farley, 2016).

Implications for Mental Health and Violence

It is not possible to say whether the Excellence in Mental Health Act would have become law on the merits of the problems within the mental health system alone. While the increase of insurance coverage helped emphasize the unavailability of mental health services, the rise in gun violence made mental health legislation and support a much more politically palatable topic (Peters, 2013). Mass shootings had caught the attention of the public and, while not all of the shooters showed clear evidence of an undiagnosed mental illness, the media coverage was quick

to suggest otherwise, creating a clear link between gun violence and mental illness in the public's eye (Appelbaum, 2013; Metzl & MacLeish, 2015). As a result, while gun control remains a divisive topic, the majority of Americans support increasing government spending on mental health (Barry et al., 2013).

This analysis has demonstrated how closely The Excellence in Mental Health Act was tied to a national spotlight on gun violence. A *New York Times* article suggested that, while mental health advocates were uneasy about the connection between mental health and gun violence, they also recognized a rare window of opportunity (Peters, 2013). As Blair and Espinoza (2015) pointed out, the challenges facing mental health availability and treatment quality have persisted for decades. This lack of action made it all the more important to take advantage of the policy window, but at what cost?

The vast majority of people with mental illness do not engage in violent activity (Appelbaum, 2013). In fact, they are far more frequently the victims of violence than perpetrators of violent acts (Crump, Sundquist, Winkleby, & Sundquist, 2013). Despite this reality, however, research has shown that the connection between mental illness and violence facilitated by media coverage and public opinion can strengthen negative public attitudes toward individuals with mental illness, a group that is already stigmatized (Appelbaum, 2013; McGinty et al., 2013). Furthermore, public perception of people with mental illness can have a significant impact on their quality of life and treatment outcomes (Stuber, Rocha, Christian, & Link, 2014). This makes the connection of mental health legislation with gun violence a significant concern for the 43 million Americans living with mental illness (Bose et al., 2016).

Linda Rosenberg, president of the National Council for Community Behavioral Healthcare, recognized this concern, but also saw the intense need for legislation that would address a failing mental health system. She summed up what many mental health advocates are likely thinking, stating, "I hate the connection between gun violence and the need for better mental health care, but sometimes you have to take what you can get" (Peters, 2013, para. 8). While an increasing focus on gun violence may make it difficult to separate these two issues in the immediate future, the impact of this close political relationship is an area for further study.

Conclusion

The plight of the community mental health system, a system that cares for a group of people who have been stigmatized for generations, has been consistently overlooked and undervalued. Only when a national tragedy linked mental health with public safety did the concerns of the community mental health system become noticed. And then, because of the groundwork laid by policy entrepreneurs, a policy was ready and change was successfully made.

The Excellence in Mental Health Act was a success story. For every policy that successfully slips through the policy window, there are thousands more that do not. Although it may appear to be a game of chance, policy analysis frameworks such as the Multiple Streams framework remind us that there is a method to the madness. The organization and insight provided through such examination of both successful and unsuccessful policy stories are important learning tools and should continue to be studied and created as advocates of all types pursue their solutions.

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