

With America's prisons crowded with mentally ill inmates, Medicaid costs for the mentally ill soaring, and homeless Americans with schizophrenia on our streets, it is clear that our mental health system is dysfunctional. The Center for Policy Innovation invited Dr. E. Fuller Torrey to offer his solutions to this crisis. Dr. Torrey is a leading psychiatrist and researcher and has written widely on the problems associated with U.S. mental health policy.

How to Bring Sanity to Our Mental Health System

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Abstract: *Fifty years ago, America began a grand experiment by transferring to the federal government the fiscal responsibility for individuals with mental illnesses. During that half-century, it has become increasingly clear that the experiment has been a costly failure, both in terms of human lives and in terms of dollars. The outcome was, in fact, clear as early as 1984, when the chief architect of the federal community mental health centers program proclaimed it to be a failure: "The result is not what we intended, and perhaps we didn't ask the questions that should have been asked when developing a new concept...." Bringing sanity to our present mental health system is dependent on one essential change: Return the primary responsibility for such services to the states.*

In 1963, the United States embarked upon a grand social experiment. Since the nation's founding, responsibility for providing services for mentally disabled individuals had been assumed by state and local governments. The new plan proposed by President John F. Kennedy envisioned the closing of state psychiatric hospitals and the opening of federally funded community mental health centers (CMHCs) to provide psychiatric services. This effectively shifted the burden of responsibility from the states to the

federal government. The states viewed it as a way to save state funds and effectively ceased their efforts to develop or improve existing services on their own.

Half a century later, the results of this noble experiment are clear. Rarely in the history of American government has a program conceived with such good intentions produced such bad results. The patients were deinstitutionalized from the state hospitals, but most of the 763 federally funded CMHCs failed to pro-

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vide services for them. The majority of the discharged patients, and those who became mentally ill after the hospitals closed, ended up homeless, incarcerated in jails and prisons, or living in board-and-care homes and nursing homes that were often worse than the hospitals that had been closed.

As sociologist Andrew Scull noted, the federal plans for treating the mentally ill individuals in the community turned out to be “castles in the air, figments of their planners’ imagination.”¹ John Talbott, one of the few American psychiatrists to focus on the magnitude of the disaster, summarized it as follows: “With the knowledge that state hospitals required 100 years to achieve their maximum size, the precipitous attempt to move large numbers of their charges into settings that did not exist must be seen as incompetent at best and criminal at worst.”²

The consequences of this failed experiment for mentally ill individuals, for their families, and for the public at large are legion. Mentally ill homeless persons live on our streets like urban gargoyles and expropriate parks, playgrounds, libraries, and other public spaces. Jails and prisons have become progressively filled with mentally ill inmates, thereby transforming these institutions into the nation’s new psychiatric inpatient system. Police and sheriffs have become the first responders for mental illness crises in the community and are fast becoming the nation’s new psychiatric outpatient system—“armed social workers” in the words of one law enforcement official.³ Mentally ill individuals who are not being treated are responsible for approximately 1,400 homicides each year, 10 percent of the nation’s total, including rampage shootings such as occurred in Tucson in January 2011. To make matters even worse, we are spending

over 100 billion mostly federal dollars on this dysfunctional system each year.

There are ways to bring sanity to our present mental health system, but they are dependent on one essential change: Return the primary responsibility for such services to the states.

There are ways to bring sanity to our present mental health system, but they are dependent on one essential change: Return the primary responsibility for such services to the states. Fixing responsibility for these services squarely on governors and state legislatures would be a major step forward. Since responsibility must be accompanied by resources, all federal Medicaid and Medicare funds currently going for services for mentally ill individuals should be block granted to the states with only one condition: The state must set up a system to measure the outcomes of its services for mentally ill individuals.

In addition to the block granting of Medicaid and Medicare funds, the federal government should do the following:

- Allow states to put conditions on SSI and SSDI payments;
- Clarify and amend HIPAA confidentiality laws;
- Improve the Department of Justice information base regarding the effects of mental illness on homicides and law enforcement officer critical events;
- Improve federal research on serious mental illnesses; and
- Abolish the Substance Abuse and Mental Health Services Administration (SAMHSA).

States would also have several tasks to accomplish in order to make the state system function effectively:

¹ Andrew Scull, “A New Trade in Lunacy: The Recommodification of the Mental Patient,” *American Behavioral Scientist*, Vol. 24 (1981), pp. 741–754.

² John A. Talbott, “Deinstitutionalization: Avoiding the Disasters of the Past,” *Hospital and Community Psychiatry*, Vol. 30 (1979), pp. 621–624.

³ *NAMI E-News*, Vol. 01-20, September 22, 2000.

- Develop a services plan and select measures by which the services can be assessed,
- Prioritize services, and
- Identify new leadership.

“REFORMS” OF THE 1960S...

Almost 50 years ago, on February 5, 1963, President John F. Kennedy delivered a historic speech to Congress, “Mental Illness and Mental Retardation.” The speech announced a new program that proposed to close state psychiatric hospitals, shift patient care to newly developed community mental health centers, and finance the new centers with federal funds. Prior to that time, the care of individuals with psychiatric disorders had been regarded exclusively as a state and local responsibility; Kennedy’s proposal to use federal funds to build and staff CMHCs was thus a major departure from historical precedent.

It is sometimes claimed by defenders of Kennedy’s program that the new federally funded centers were needed because states were failing in their responsibility to provide services. In fact, by 1963, the deinstitutionalization of psychiatric patients from state hospitals was well underway, having been made possible by the 1950s discovery of chlorpromazine (Thorazine), the first effective antipsychotic medication. Between 1955 and 1963, the census of state psychiatric hospitals had decreased from 559,000 to 503,000, a 10 percent drop.

Most states were already developing community programs to provide care for the released patients. A publication at the time identified 234 programs, funded by state and local entities, that were said to be in essence community mental health centers.⁴ These centers included model programs such as the Massachusetts Mental Health Center, Colorado’s Fort Logan Mental

Health Center, Kansas’s Prairie View Center, and the San Mateo County Mental Health Services in California. These and similar programs were later claimed by federal officials as model CMHC programs, but they had in fact been in existence before the federal program ever began.

In retrospect, it is clear that using federal funds to develop local mental health treatment programs was a grave mistake, but bypassing state mental health authorities further compounded that error.

It is important to note that once the federal CMHC program got underway, the development of programs by state and local officials effectively ceased. Federal officials made the decision to fund CMHCs directly, thereby bypassing state mental health authorities. In retrospect, it is clear that using federal funds to develop local mental health treatment programs was a grave mistake, but bypassing state mental health authorities further compounded that error. State officials were essentially being told that they were no longer responsible for patients being released from state psychiatric hospitals, since the federal government was taking over this responsibility. This was fine with most state officials, who viewed the shift to federal control as a way to save state money. This shift in responsibility for mentally ill individuals from state to federal authority in 1963 is the linchpin for understanding the ensuing disaster, as well as for understanding possible solutions to the present situation.

President Kennedy’s 1963 message was one of great hope. He said that the new CMHCs would replace state hospitals, which were “shamefully understaffed, overcrowded, unpleasant institutions from which death too often provided the only firm hope of release.” The new community mental health centers would be “a bold new approach.... When carried

⁴ Pierre-René Noth, “Care, Safety of Patients Should Trump Cost Issue,” *Rome [Georgia] News-Tribune*, March 13, 2011, at http://www.romenews-tribune.com/view/full_story/12478868/article-Care--safety-of-patients-should-trump-cost-issue.

out, reliance on the cold mercy of custodial isolation will be supplanted by the open warmth of community concern and capability.”⁵

The CMHC program was fatally flawed from the outset. It brought about the closing of state hospitals without any realistic plan regarding what would happen to the discharged patients, especially those who refused to take medication they needed to remain well. It included no realistic plan for the future funding of the centers. And by bypassing state mental health authorities, it encouraged them to take a seat on the sidelines. Half a century after Kennedy inaugurated his new program, we look with sadness upon the detritus of the dreams and the lees of lost lives.

...AND ENORMOUS PROBLEMS TODAY

Taking into consideration the increase in America’s population in the past half-century, there are more than one million individuals with serious psychiatric disorders now living in the community who 50 years ago would have been in state hospitals. Studies have reported that, at any given time, approximately half of these individuals are receiving no treatment for their psychiatric illnesses, despite the fact that such treatment can be given in the community in most cases; rehospitalization is rarely necessary.

The consequences of this situation for those who are afflicted, for their families, and for the public at large are predictable. These consequences can be grouped into three categories: community living, law enforcement, and violence and homicides.

1. Community Living

On March 10, 2011, Martin Harty, a member of the New Hampshire state legislature, was asked what could be done for the state’s mentally ill homeless

people. Harty suggested that the state might “rent a spot in Siberia” for them.⁶ In the ensuing media firestorm, nobody seemed to be aware that, ironically, mentally ill homeless persons now receive better care in most parts of Siberia than they do in most parts of New Hampshire.

An increasing number of seriously mentally ill individuals have been noted among the homeless population since the 1980s. They now constitute at least 40 percent of the homeless in most communities. Los Angeles, for example, has an estimated 48,000 homeless individuals; when Mayor Antonio Villaraigosa visited the city’s Skid Row in 2005, he said that it “almost looked like Bombay or something, except for more violence.”⁷ Not to be outdone by its neighbor to the south, in 2008, San Francisco claimed to have “the highest per capita number of homeless in the nation.... These days, the streets of San Francisco resemble the streets of Calcutta.”⁸

Mentally ill individuals in the community living in board-and-care homes or nursing homes are sometimes no better off than those who are homeless.

This problem is not confined to the nation’s largest cities. In Roanoke, Virginia, it was claimed that 70 percent of the city’s 566 homeless persons “were receiving mental health treatment or had in the past.”⁹ In Colorado Springs, “two-thirds of the 400 chronically

⁵ Henry A. Foley and Steven S. Sharfstein, *Madness and Government: Who Cares for the Mentally Ill?* (Washington, D.C.: American Psychiatric Press, 1983), pp. 163–169.

⁶ Catalina Camia, “N.H. Legislator Resigns After Remark About Mental Illness,” *USA Today*, March 14, 2011.

⁷ Steve Lopez, “Now Comes the Heavy Lifting,” *Los Angeles Times*, October 23, 2005.

⁸ Cinnamon Stillwell, “Homeless by the Bay,” *San Francisco Chronicle*, March 5, 2008.

⁹ Laurence Hammack and Mason Adams, “Roanoke Turns Its Focus on eHomeless,” *Roanoke [Virginia] Times*, December 16, 2007.

homeless people...are said to suffer severe mental illnesses."¹⁰

Mentally ill individuals in the community living in board-and-care homes or nursing homes are sometimes no better off than those who are homeless. The disgraceful depths to which board-and-care homes can descend was illustrated by Clifford Levy's 2002 Pulitzer Prize-winning series in *The New York Times*. Levy described for-profit homes in New York in which mentally ill residents had been raped or killed. At one home, 24 seriously mentally ill residents had been subjected to unnecessary prostate and/or cataract surgery, thereby generating "tens of thousands of dollars in Medicaid and Medicare fees" for the physicians and home owners.¹¹

An additional 560,000 seriously mentally ill individuals in the United States live in nursing homes, and since 2002, the number of nursing home admissions with mental illness has exceeded the number with dementia. Of increasing concern has been the mixing in nursing homes of young individuals with schizophrenia or bipolar disorder with elderly individuals with dementia. For example, in Illinois, which has heavily utilized nursing homes for the placement of mentally ill persons, a 21-year-old man with bipolar disorder raped a 69-year-old woman with dementia.¹² This is surely not what President Kennedy intended in 1963 when he spoke of "the open warmth of community concern and capability."

Having hundreds of thousands of untreated mentally ill individuals living in the community also

¹⁰ Veronica Chufo, "200 High-Risk Patients Locked Out of Mental Health Treatment," *[Virginia] Daily Press*, June 1, 2011.

¹¹ Clifford J. Levy and Sarah Kershaw, "For Mentally Ill, Chaos in an Intended Refuge," *The New York Times*, April 18, 2001; Clifford J. Levy, "Doctor Admits He Did Needless Surgery on the Mentally Ill," *The New York Times*, May 20, 2003; Clifford J. Levy, "Home for Mentally Ill Settles Suit on Coerced Prostate Surgery for \$74 Million," *The New York Times*, August 5, 2004.

¹² Carla K. Johnson, "Nursing Homes Patients Endangered by Mentally Ill," *Pottstown [Pennsylvania] Mercury*, May 4, 2009.

has an impact on the quality of community life. For example, many public libraries, especially those in urban areas, have become de facto day centers for mentally ill individuals who live in board-and-care homes or are homeless. A 2009 survey of 124 libraries reported that mentally ill individuals had assaulted staff members in 28 percent of the libraries. Almost all of the libraries had had to call the police because of the behavior of mentally ill patrons, including a man who ran "through the circulation area, near the children's department, repeatedly without clothing." As one librarian noted, "many, many library customers don't come downtown to our Central Library because they're afraid of these customers."¹³

2. Law Enforcement

A May 5, 2011, article in the *Norfolk Virginian-Pilot* epitomizes the degree to which the failure of President Kennedy's CMHC program has affected law enforcement. City officials in Virginia Beach had voted to cut \$121,596 from the city's mental health budget. Virginia Beach Sheriff Ken Stolle then offered to transfer that amount of money from his jail reserve fund to restore the mental health cuts. He said that "the money being cut would dramatically impact the people coming into my jail with mental illness.... This is money well spent, and it will decrease the money I'd spend housing them."¹⁴

Sheriff Stolle was making a correct calculation, because the nation's jails and prisons have become de facto the nation's public psychiatric inpatient system. This has become a progressively growing problem since the implementation of the CMHC program in the 1960s. As patients were released from state hospitals without aftercare, jails and prisons began to receive increasing numbers of them, most charged with

¹³ E. Fuller Torrey, Rosanna Esposito, and Jeffrey Geller, "Problems Associated with Mentally Ill Individuals in Public Libraries," *Public Libraries*, March/April 2009.

¹⁴ Jennifer Jiggetts, "Va. Beach Sheriff Offers to Aid Mental Health Program," *Virginian-Pilot [Norfolk, Virginia]*, May 5, 2011.

misdemeanor crimes but some charged with felonies. The vast majority of the crimes were committed in response to delusional thinking as a consequence of these individuals' untreated mental illness—for example, assaulting a neighbor you believe is sending deadly rays into your home.

In the 1970s, it was estimated that 5 percent of jail and prison inmates were seriously mentally ill. In the 1980s, this had increased to 10 percent; in the 1990s, to 15 percent; and in the 2000s, to 20 percent or higher. A 2010 survey reported that “there are now more than three times more seriously mentally ill persons in jails and prisons than in hospitals.”¹⁵ The three largest de facto inpatient facilities in this country are the county jails in Los Angeles, Chicago, and New York, and there is not a single county in which the public hospital has as many mentally ill individuals as the county jail has.

The problems associated with the increasing number of mentally ill individuals in jails and prisons are legion. Their average stay is twice as long as for non-mentally ill inmates, mostly because their mental illness makes it more difficult for them to follow facility rules, so they get no time off for good behavior. Mentally ill inmates are also major management problems, are victimized by other inmates more commonly, and commit suicide more commonly. Not surprisingly, costs for a mentally ill inmate are higher than costs for a non-mentally ill inmate. For example, in Florida's Broward County Jail in 2007, the differential was \$47,000 versus \$29,000 per year; in Washington State prisons in 2009, the differential was \$101,000 versus \$30,000 per year.¹⁶

¹⁵ E. Fuller Torrey, Aaron D. Kennard, Don Eslinger, Richard Lamb, and James Pavle, *More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States* (Arlington, Va.: Treatment Advocacy Center, May 2010).

¹⁶ Carol Marbin Miller and Ashley Fantz, “Special ‘Psych’ Jails Planned,” *Miami Herald*, November 15, 2007; Andy Rathbun, “Inmates with Mental Illness Bring Extra Costs to Monroe Prison,” *Everett [Washington] Herald*, November 23, 2009.

Just as jails and prisons have become America's new psychiatric inpatient system, so too have the police, sheriffs, and courts become the nation's psychiatric outpatient system. Police and sheriffs are now the first responders for most mental illness crisis calls in the community. Many such calls are to transport mentally ill persons to hospitals. In Corvallis, Oregon, for example, the police handled 30 such cases in 2001, 113 in 2003, and 162 in 2005.¹⁷ In North Carolina in 2010, sheriffs' departments “reported more than 32,000 trips last year to transport psychiatric patients for involuntary commitments.”¹⁸

Just as jails and prisons have become America's new psychiatric inpatient system, so too have the police, sheriffs, and courts become the nation's psychiatric outpatient system.

Not surprisingly, some of the encounters between untreated mentally ill individuals and law enforcement officials end badly. In 2007, sheriff's deputies in California's Ventura County used Taser guns to subdue people 107 times; “the majority of those shot by deputies were mentally ill.”¹⁹ In Santa Clara County, “of the 22 officer-related shootings from 2004 to 2009 in the county, 10 involved people who were mentally ill.”²⁰

There are also other indicators of the shift of psychiatric outpatient care from mental health personnel to law enforcement personnel. Police and sheriffs' departments now routinely offer special mental

¹⁷ Michael Booth, “Police Get Training on Dealing with Mentally Ill,” *Corvallis [Oregon] Gazette-Times*, May 1, 2008.

¹⁸ Ruth Sheehan, “Shuttling Patients Burdens Deputies,” *News and Observer [Raleigh, North Carolina]*, January 15, 2010.

¹⁹ John Scheibe, “Injuries Drop for Officers with Tasers, Officials Say,” *Ventura County [California] Star*, March 27, 2008.

²⁰ Linda Goldston, “Former Cops Changing Way Santa Clara County Deals with Mentally Ill in Crisis,” *Mercury News [San Jose, California]*, November 4, 2010.

health training courses, and some departments are hiring psychologists or psychiatrists. In 2010, Ventura County began a program in which “some mentally ill inmates will be given medicine and immediate rides to their first appointment at treatment facilities upon their release from jail.”²¹ Other departments are experimenting with similar programs, leading the president of the Los Angeles County Police Chiefs Association to observe: “Our local police forces have become armed social workers.”²²

3. Violence and Homicides

On January 8, 2011, Jared Loughner, who had been suffering from untreated schizophrenia for at least five years, killed six and wounded 13 in Tucson, Arizona. Because Congresswoman Gabrielle Giffords (D-AZ) was among the wounded, this tragedy received wide publicity. What was not publicized was the fact that such “rampage killings” by untreated mentally ill individuals had been occurring at an average rate of two each year for the previous decade, with only the 2007 massacre at Virginia Tech receiving wide publicity.

It is clearly established that untreated mentally ill individuals are now responsible for approximately 10 percent of the homicides in the United States.

It is clearly established that untreated mentally ill individuals are now responsible for approximately 10 percent of the homicides in the United States. Two previous studies in New York and California reported the 10 percent figure, and a large 2008 study in Indi-

²¹ Adam Foxman, “Jail Officials to Escort Some Inmates to Treatment,” *Ventura County [California] Star*, August 1, 2010.

²² *NAMI E-News*, Vol. 01-20, September 22, 2000.

ana confirmed it.²³ This figure contrasts with studies of homicide in the United States between 1900 and 1950, before deinstitutionalization got underway; these early studies reported that “insane” or “psychotic” persons were responsible for between 1.7 percent and 3.6 percent of homicides.²⁴

Since there are now approximately 14,000 homicides per year in the United States, this means that up to 1,400 of them would not happen if those mentally ill perpetrators were receiving psychiatric treatment. These are thus preventable tragedies. Jared Loughner reflected this fact nine months following the Tucson shootings, after he had been treated for several weeks with antipsychotic medication—the first time he had ever been treated. According to a news report, “he has told his psychologists that he wished he had been taking antipsychotic medication for years and has said the shooting might not have happened if he had.”²⁵

THE COSTS OF A BROKEN SYSTEM

Among the most disturbing aspects of America’s failed mental illness treatment system is the fact that

²³ D. E. Wilcox, “The Relationship of Mental Illness to Homicide,” *American Journal of Forensic Psychiatry*, Vol. 6 (1985), pp. 3–15; Frederic Grunberg, Burton I. Klinger, and Barbara R. Grumet, “Homicide and Community-Based Psychiatry,” *Journal of Nervous and Mental Disease*, Vol. 166 (1978), pp. 868–874; Frederic Grunberg, Burton I. Klinger, and Barbara Grumet, “Homicide and Deinstitutionalization of the Mentally Ill,” *American Journal of Psychiatry*, Vol. 134 (1977), pp. 685–687; Jason C. Matejkowski, Sara W. Cullen, and Phyllis L. Solomon, “Characteristics of Persons with Severe Mental Illness Who Have Been Incarcerated for Murder,” *Journal of the American Academy of Psychiatry and the Law*, Vol. 36 (2008), pp. 74–86.

²⁴ Harold A. Phelps, “Rhode Island’s Threat Against Murder,” *Journal of Criminal Law and Criminology*, Vol. 15 (1925), pp. 552–567; Louis I. Dublin and Bessie Bunzel, “Thou Shalt Not Kill: A Study of Homicide in the United States,” *Survey Graphic*, Vol. 24 (1935), pp. 127–139; John H. Cassity, “Personality Study of 200 Murderers,” *Journal of Criminal Psychopathology*, Vol. 2 (1941), pp. 296–304; Marvin E. Wolfgang, *Patterns in Criminal Homicide* (New York: John Wiley, 1966; originally published 1958), p. 314.

²⁵ Marc Lacey, “Tucson Shooting Suspect to Have More Treatment,” *The New York Times*, September 29, 2011.

our very dysfunctional system is also very expensive. Its funding is bewilderingly complex, more thought-disordered than most of the mentally ill people it is supposed to serve. As early as 1979, it was observed that “eleven major Federal departments and agencies share the task of administering 135 programs for the mentally disabled.”²⁶ In the intervening years, the situation has only become worse. Slowly, over five decades, the fiscal responsibility for mentally ill individuals has been shifted increasingly from state and local governments to the federal government, even though this shift was mostly unplanned and unintended. In fact, the most striking aspect of this massive shift in fiscal responsibility from the states to the federal government has been the lack of planning.

The total annual cost of Medicaid, Medicare, SSI, and SSDI for mentally ill individuals is now over \$105 billion. The fact that this much money is buying such grossly inadequate and disjointed services suggests that something is profoundly wrong and needs to be fixed.

In 1965, two years after President Kennedy’s legislation had provided federal money to build CMHCs, Medicaid and Medicare were passed as part of President Lyndon Johnson’s Great Society initiatives. The architects of the programs had no intention of creating a program for mentally ill individuals; in fact, Medicaid specifically excluded coverage for individuals in state psychiatric hospitals under the institutions for mental diseases (IMD) exclusion. However, by covering the costs of psychiatric care in general hospitals and nursing homes, Medicaid and Medicare acted as strong incentives to empty state hospitals, thereby

²⁶ Ellen L. Bassuk and Samuel Gerson, “Deinstitutionalization and Mental Health Services,” *Scientific American*, Vol. 238 (1978), pp. 46–53.

shifting costs from the states to the federal government.

In the intervening years, states have become increasingly sophisticated in finding ways to shift state costs to these federal programs. Widely known as “Medicaid maximization,” this shift is characterized by the phrase “If it moves, Medicaid it.” Medicaid now covers 55 percent of all state-controlled mental illness costs, and in some states, the figure is as high as 80 percent. Medicaid is thus “the largest payer of mental health treatment services” in the United States, and such costs now constitute over 10 percent of the entire Medicaid program. Based on 2005 data, Medicaid and Medicare combined contributed approximately \$60 billion a year to mental illness costs in this country.²⁷

In 1972, nine years after the implementation of the federal CMHC program, President Richard Nixon decided to standardize the nation’s disparate state welfare and disability programs. The result was the federal Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) programs, intended to provide living support for the aged, blind, and disabled. Nixon had no intention of creating major psychiatric support programs, but over the years, that is what they have become. In 2009, 41 percent of all SSI

²⁷ Tami L. Mark, Katharine R. Levit, Rita Vandivort-Warren, Jeffrey A. Buck, and Rosanna M. Coffey, “Changes in US Spending on Mental Health and Substance Abuse Treatment, 1986–2005, and Implications for Policy,” *Health Affairs*, Vol. 30 (2011), pp. 284–292; William Gronfein, “Incentives and Intentions in Mental Health Policy: A Comparison of the Medicaid and Community Mental Health Programs,” *Journal of Health and Social Behavior*, Vol. 26 (1985), pp. 192–206; Richard G. Frank, Howard H. Goldman, and Michael Hogan, “Medicaid and Mental Health: Be Careful What You Ask For,” *Health Affairs*, Vol. 22 (2003), pp. 101–113; Diane Rowland, Rachel Garfield, and Risa Elias, “Accomplishments and Challenges in Medicaid Mental Health,” *Health Affairs*, Vol. 22 (2003), pp. 73–83; Frank *et al.*, “Medicaid and Mental Health”; NASMHPD Research Institute, 2008 State Survey, Table 24, “SMHA-Controlled Mental Health Revenues, by Revenue Source and by State, FY 2008 (in millions),” at <http://www.nri-inc.org/projects/profiles/RevExp2008/T24.pdf>; Mark *et al.*, “Changes in US Spending.”

and 28 percent of all SSDI recipients were receiving benefits because of mental illness, not including mental retardation. Their combined number was 4,741,970 individuals, and their payments totaled \$45.7 billion.²⁸

Thus, the total annual cost of Medicaid, Medicare, SSI, and SSDI for mentally ill individuals is now over \$105 billion. The fact that this much money is buying such grossly inadequate and disjointed services suggests that something is profoundly wrong and needs to be fixed.

WHAT NEEDS TO BE DONE

Fifty years ago, we began a grand experiment by transferring to the federal government the fiscal responsibility for individuals with mental illnesses. During that half-century, it has become increasingly and painfully clear that the experiment has been a costly failure, both in terms of human lives and in terms of dollars. The outcome was, in fact, clear as early as 1984, when Dr. Robert Felix, who had been the chief architect of the federal CMHC program, proclaimed it to be a failure: “The result is not what we intended, and perhaps we didn’t ask the questions that should have been asked when developing a new concept but...we tried our damndest.”²⁹

The fact that the experiment continues almost 30 years after its failure was clear is a testament to the difficulty involved in changing a government program

²⁸ *SSI Annual Statistical Report, 2009*, Table 38, “Percentage Distribution of Recipients by Diagnostic Group, by State or Other Area, December 2009,” at http://www.ssa.gov/policy/docs/statcomps/ssi_asr/2009/sect06.html#table38 (the total number of SSI recipients was multiplied by the percentage with “mental disorders, other” for each state); *Annual Statistical Report on the Social Security Disability Insurance Program, 2010*, Table 10, “Number, by State or Other Area and Diagnostic Group, December 2009,” at http://www.ssa.gov/policy/docs/statcomps/di_asr/; Howard H. Goldman, Antoinette A. Gattozzi, and Carl A. Taube, “Defining and Counting the Chronically Mentally Ill,” *Hospital and Community Psychiatry*, Vol. 32 (1981), pp. 21–27.

²⁹ Richard D. Lyons, “How Release of Mental Patients Began,” *The New York Times*, October 30, 1984.

once it has started. But change it we must, and the change must come at both the federal and state levels.

1. Federal Actions

In order to reverse the continuing disastrous deterioration of mental illness services in the United States, the single most important change is to give the responsibility for these services back to the states. It is now abundantly clear that overseeing mental illness services is not something the federal government can do. This should not surprise us in as large and diverse a country as we have. Indeed, it is fatuous to think that a planning office in Washington can draft coherent regulations to cover both California’s Los Angeles County and Montana’s Garfield County, both of equal size geographically but one with a population of 9.8 million and the other with a population of 1,184.

Currently, the ultimate responsibility for mental health services is vaguely diffused through multiple levels of government and multiple agencies. Fixing responsibility squarely on governors and state legislatures would be a major step forward in fixing the overall problem.

Giving the responsibility back to the states will effectively make governors and state legislatures responsible for mental illness services. This will allow residents of each state to express their pleasure or displeasure with these services at the ballot box. For example, in Arizona in 2010, the state legislature made major cuts in those state mental illness treatment programs that would have been most likely to have helped Jared Loughner, and it is probable that such cuts decreased the chances of Loughner’s getting the psychiatric help he needed.³⁰

³⁰ E. Fuller Torrey, *The Insanity Offense: How America’s Failure to Treat the Seriously Mentally Ill Endangers Its Citizens*, revised edition (New York: Norton, 2012).

Currently, the ultimate responsibility for mental health services is vaguely diffused through multiple levels of government and multiple agencies. When everyone is responsible, then no one is responsible, and no one can be held accountable. Fixing responsibility squarely on governors and state legislatures, as was the case prior to 1963, would be a major step forward in fixing the overall problem.

Responsibility for mental illness services can be returned to the states by block granting to the states all existing federal Medicaid and Medicare funds currently going for mental illness services, with only one condition attached. That condition would require that the funds be assessed and outcomes measured in cooperation with the Institute of Medicine and the Government Accountability Office (GAO). The Institute of Medicine and GAO would then issue an annual report with an evaluation of the effectiveness of each state's program. Other than that, there would no longer be any federal Medicaid or Medicare rules regarding what can and cannot be covered; those decisions would rest with the states. This would encourage states to experiment with different fiscal and clinical alternatives to determine the best way to deliver such services, as outlined under the state section below.

After block granting the Medicaid and Medicare funds—and accompanying responsibility—to the states, the federal government would have five additional tasks.

- **Allow states to put conditions on SSI and SSDI payments.** Currently, there are no requirements for SSI and SSDI recipients to participate in any treatment program as a condition for receiving benefits. Yet there undoubtedly are some recipients who, if they were receiving treatment, would improve clinically to the point that they could work at least part time and thus require lower benefits. Congressional action would be required to amend the SSI and SSDI legislation to allow those states that wish to do so to put conditions
- **Clarify and amend HIPAA confidentiality laws.** In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA) to protect the medical and psychiatric records of individuals. Despite this law's many positive aspects, it has become increasingly clear that it is being used by state and local agencies to withhold information unnecessarily. For example, law enforcement officials are increasingly being asked to assess mentally ill individuals in the community and in jails and prisons, yet they are commonly denied access to the person's clinical records, which contain valuable information regarding suicide potential, dangerousness, medications, etc. Similarly, families, who are often the primary caregivers for seriously mentally ill individuals, are regularly denied the information they need to assist their family members. The sections of the HIPAA regulations guiding "Public Interest and Benefit Activities" and "Law Enforcement Purposes" should be clarified and amended to reflect what has been learned about the use and misuse of HIPAA since it was implemented in 1996.
- **Improve the Department of Justice information base regarding the effects of mental illness on homicides and law enforcement officer critical events.** Currently, the federal Department of Justice collects data on all homicides, law enforcement officers killed, and the killing of others by law enforcement officers, but no information is collected regarding the involvement of mental illness in such cases. It is now clear that untreated mental illness plays a major role in many such

³¹ A. G. Sulzberger, "States Adding Drug Test as Hurdle for Welfare," *The New York Times*, October 11, 2011.

cases, and federal data collection should reflect this fact. These data would also provide one measure by which states could judge themselves on the quality of their services for mentally ill individuals.

- **Improve federal research on serious mental illness.** The National Institute of Mental Health (NIMH) has the primary responsibility for supporting research on mental illnesses. A 2003 study reported that only 29 percent of NIMH's budget was allocated for research on the most serious mental illnesses, despite the fact that such illnesses account for 58 percent of the costs of all mental illnesses.³² Congress should mandate that the percentage of NIMH research allocated for serious mental illnesses, as defined by NIMH in 1993, should be a minimum of 50 percent.
- **In addition, some parts of NIMH should be abolished to save funds.** These include the Division of AIDS Research (\$184 million, 12 percent of the total budget), which is duplicative of other agencies and no longer needed, and the Intramural Research Program (\$172 million, 11 percent of the total budget), which is not doing any research that could not be done better by making extramural research grants to universities.

Shut down the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA is a \$3.4 billion federal agency that is supposed to reduce "the impact of substance abuse and mental illness on America's communities." Studies of SAMHSA have shown it to be virtually useless in accomplishing these goals.³³ Since more than half of its budget

is block grants to the states, SAMHSA will have little function once states are given the primary responsibility for mental illness services. Senator Tom Coburn's (R-OK) July 2011 deficit reduction plan ("Back in Black") made an excellent case for the abolition of SAMHSA and folding its worthwhile programs into the Centers for Disease Control and Prevention (CDC).

2. State Actions

States also would have several tasks to accomplish in order to bring sanity to our mental health system. They would include the following.

- **Develop a services plan and select measures by which services can be assessed.** Since federal Medicaid and Medicare regulations would no longer be in effect, states would be free to innovate and experiment with the best way to deliver mental illness services. This might involve delegating responsibility to the counties in large states such as California and utilizing a variety of funding mechanisms. Alternate forms of short-term psychiatric hospitalization such as respite homes, in-home delivery of psychiatric services by public health nurses, oversight of board-and-care homes and nursing homes using unannounced visits, and the statewide use of assertive community treatment (ACT) teams are examples of what would be possible. Some states or counties in which departments of corrections have already taken over large parts of the psychiatric inpatient and outpatient care system may even elect to abolish their departments of mental health and give the money and responsibility to their departments of corrections.

Once they have total responsibility, states will find that it is much more economical to maintain individuals with serious psychiatric disorders on medication rather than having them rotate endlessly through hospital inpatient units, jails and prisons, and homeless shelters. Since states and counties

³² E. Fuller Torrey, Mary T. Zdanowicz, Sidney M. Wolfe, Peter G. Lurie, Irving I. Gottesman, and John M. Davis, *A Federal Failure in Psychiatric Research: Continuing NIMH Negligence in Funding Sufficient Research on Serious Mental Illnesses* (Arlington, Va.: Treatment Advocacy Center, November 19, 2003).

³³ E. Fuller Torrey, "Bureaucratic Insanity: The Federal Agency That Wastes Money While Undermining Public Health," *National Review*, June 20, 2011, pp. 24–26.



will be completely responsible fiscally for services, they are more likely to utilize proven methods of maintaining individuals on medication using services such as assisted outpatient treatment (AOT), which has been shown to reduce psychiatric rehospitalization, homelessness, victimization, incarceration, and violent behavior.³⁴ States may also decide to mandate treatment compliance as a condition for receiving SSI and SSDI as a way to improve the rehabilitation of mentally ill individuals while also saving money.

All aspects of state services plans would be subject to measurement. There are many proven ways to assess mental illness services, including both subjective and objective measures. The former might include such things as self-ratings of quality of life, housing services, and family satisfaction surveys. The latter might include such things as interviewer ratings of severity of symptoms, rehospitalization or incarceration rates, and community surveys of the number of mentally ill homeless persons on the streets.³⁵ Such measures already exist and can be tied to funding mechanisms if states wish to reward those counties or communities that are delivering superior mental illness services.

- **Prioritize services.** Once states assume full responsibility for mental illness services, they will become more aware that those individuals with the most serious mental illnesses utilize a disproportionate share of fiscal resources. For example, in Philadelphia, 2,703 individuals were identified who were chronically homeless. Researchers calculated the cost of their medical, psychiatric, social services, jail, and public shelter costs for one year and found that 60 percent of the group's cost was accounted for by just 20 percent of the homeless; almost all (81 percent) of the high-

cost homeless "had a diagnosis of a serious mental illness."³⁶

Anecdotally, this principle is also illustrated by Murray Barr, a "chronically homeless mentally ill man" in Reno, Nevada, who in the 10 years before he died in 2005 "cost the county at least \$1 million." Barr was immortalized as "Million-Dollar Murray" in a profile in *The New Yorker*.³⁷ In fact, every city and county has one or more very expensive Murray Barrs—seriously mentally ill individuals who are usually untreated and utilize county services very heavily. Prioritizing mental illness services for such heavy service users would significantly reduce overall costs in the long run.

- **Identify new leadership.** Prior to 1963, when states were still responsible for mental illness services, many excellent professionals took leadership roles at the state and local levels. Some of these individuals continued to be active throughout the 1960s and 1970s, but they gradually died off or resigned in frustration as state responsibility was negated by federal funding. Over the past two decades, almost no professional leadership has remained at the state level. The main tasks of state departments of mental health are to find ways to shift additional state costs to Medicaid and other federal programs. Such tasks demand accountants, not mental health professionals.

A shocking example of the absence of state leadership occurred in California following the 2004 passage of the Mental Health Services Act (MHSA), also known as Proposition 63, or the "millionaire tax." The legislation created a 1 percent tax on income over \$1 million and has generated approximately \$1 billion in additional revenue each year for the state's mental health system. When voters

³⁴ Torrey, *The Insanity Offense*, pp. 190–192.

³⁵ E. Fuller Torrey, *Out of the Shadows: Confronting America's Mental Illness Crisis* (New York: John Wiley and Sons, 1997), pp. 131–140.

³⁶ Stephan R. Poulin, Marcella Maguire, Stephan Metraux, and Dennis P. Culhane, "Service Use and Costs for Persons Experiencing Chronic Homelessness in Philadelphia: A Population-Based Study," *Psychiatric Services*, Vol. 61 (2010), pp. 1093–1098.

³⁷ Jaclyn O'Malley, "\$15 Million Tab for the Homeless," *Reno Gazette Journal*, December 12, 2007; Malcolm Gladwell, "Million-Dollar Murray," *The New Yorker*, February 3, 2006.



were asked to support the proposition in 2004, it was claimed that the additional funds would improve psychiatric services by adding “hundreds more beds...new prescription drug programs...the building of more clinics and the training of more mental health workers.”³⁸ However, California has had virtually no leadership in either the state Department of Mental Health or the state legislature for the past decade, so the new funds have been largely wasted. According to published reports, “much of it has gone to a cottage industry of consultants earning up to \$200 per hour,” as well as for “programs like therapeutic drumming, yoga, horseback riding, and anti-bullying classes in elementary schools.” As one outraged member of a county board observed, “If I were a millionaire, I’d be screaming from the rooftop.”³⁹

CONCLUSION

The moral of this story is that just throwing money at the mental illness problem will not by itself neces-

sarily lead to any improvement. Leadership is also necessary, beginning with governors and state legislatures. Leadership in the states should be identified and be in place before states reassume responsibility for delivering services to individuals with mental illnesses. This is also why it is absolutely necessary to measure the outcomes of the new programs.

It has been said that “the moral test of government is how the government treats...the sick, the needy, and the handicapped.”⁴⁰ Our experiment with the federalization of mental illness services has been a profound failure, and by any standard, we are failing this moral test. It is time to try again.

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³⁸ Evan Halper, “Millionaire Tax Gains Steam in Calif.: Would Fund Help for Mentally Ill,” *Los Angeles Times*, October 17, 2004.

³⁹ Karen de Sá, “Mental Health Spending Creating Haves and Have-Nots,” *Mercury News [San Jose, California]*, June 26, 2011; Mary Ann Bernard, “How California Can Safely Release 33,000 Prisoners,” *National Review Online*, June 2, 2011, at <http://www.nationalreview.com/articles/268623/how-california-can-safely-release-33000-prisoners-mary-ann-bernard>.

⁴⁰ Hubert H. Humphrey, speech at dedication of the Hubert H. Humphrey Building, Washington, D.C., November 1, 1977.