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# DIMENSIONS OF THE PRESENT DISASTER: 2000–2013

In the fall of 1941, Joseph Kennedy arranged for his daughter Rosemary to have a lobotomy. He did so because she had become psychotic, was behaviorally out of control, and was in danger of becoming pregnant. The operation was a disaster, leaving Rosemary profoundly brain damaged. Twenty years later, Jack Kennedy assumed the presidency and authorized a new mental health and retardation program to honor his sister, although he never publicly acknowledged her connection to these programs. The program involved closing state psychiatric hospitals, shifting outpatient care to federally funded community mental health centers, and preventing mental illnesses. As implemented, the new federal program effectively lobotomized both the existing and the emerging state mental health programs. The federal program has been a disaster, and the current chaotic, dysfunctional mental health system is, in one sense, Rosemary's baby.

It is important to recognize that this failed federal mental health program was not merely a one-time disaster. By aborting the development of emerging state systems and replacing them with a potpourri of uncoordinated federal programs, it set in motion an ongoing disaster that continues today. With each passing decade, the situation has become progressively worse, and it will continue to do so until corrective action is taken.

## THE GOOD NEWS

As described in the previous chapter, the federally initiated mental health disaster has not affected all individuals with mental illnesses. Many of those with less severe symptoms and with awareness of their need for medication have done reasonably well, especially if they live in areas where rehabilitative programs are available. The employment of mentally ill individuals by state or county mental health agencies has been especially successful. In approximately one-third of the states, there are active programs to train and employ mentally ill individuals as "peer counselors" in outpatient treatment teams,

substance abuse programs, and housing programs. Studies of the effectiveness of these "peer counselors" have been positive, and it is a promising line of employment for mentally ill individuals who are stable.[1]

Another generally positive development for mentally ill individuals has been the recent "recovery movement." This movement focuses first on the needs and treatment goals of the patient, so that treatment becomes a shared endeavor between the patient and the treatment team. As characterized by one summary, "recovery requires reframing the treatment enterprise from the professional's perspective to the person's perspective." The major problem, of course, is that many people with serious psychiatric disorders have anosognosia, meaning that they are not aware they are sick, because of their brain disorder. The concept of "recovery" is meaningless to them, because they believe they have nothing to recover from. The "recovery movement" thus is useful for some individuals with mental illnesses but not for many others. In large measure, "recovery" is simply a restatement of what should be the optimal relationship between a patient and doctor, and it is unclear at this point whether the movement is merely an anodyne of hope or a fad.[2]

Unfortunately, both the employment of mentally ill individuals as peer counselors and the "recovery movement" have been partially discredited by the parallel "psychiatric survivor" movement. This consists of a small but vocal group of individuals who have more or less recovered from their previous mental illness and who profess four beliefs (although, of course, not every "survivor" agrees with all four): (1) psychiatric medications are extremely dangerous and best not taken at all; (2) no mentally ill person should ever be treated involuntarily; (3) electroconvulsive therapy (ECT) should never be used; and (4) serious psychiatric disorders are not physiological brain disorders but, rather, merely states of "emotional distress." The "survivors" had their philosophical origin in their own experiences of having been mentally ill as well as in the writings of Thomas Szasz (*The Myth of Mental Illness*) and R. D. Laing; a few were also influenced by the antipsychiatry teachings of Scientology. They have organized themselves over the years into groups such as the Insane Liberation Front, the Network Against Psychiatric Assault, and the National Association of Psychiatric Survivors. By claiming to speak for all "psychiatric consumers," they have discredited the others, especially regarding the issue of involuntary treatment, which is an essential treatment strategy needed for a small number of mentally ill individuals. By claiming that mental illness does not exist or is merely an "alternate reality," this group has also discredited the recovery movement. I will return to the effect of the "survivor movement" on possible solutions to the mental illness problem in the final chapter.[3]

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The good news, therefore, is that one group of individuals with serious mental illnesses is doing reasonably well. Most of them are living on their own in the community and remain stable on their medication. Some are raising families and working. This group, however, is a minority. The majority of individuals with serious mental illnesses in the United States are experiencing the effects of the misguided federal decisions made half a century ago, and the situation grows worse with each passing year.

## JAILS AND PRISONS AS THE NEW PSYCHIATRIC INPATIENT SYSTEM

In 1955 there were 340 public (state and county) psychiatric beds in the United States per 100,000 population. In 2010 there were 14 beds per 100,000 population, and states are continuing to close additional beds. One study estimated that the minimum number of public psychiatric beds needed in the United States is 50 per 100,000 population, almost four times the number that currently exist.[4]

The relationship between the decrease in public psychiatric beds and the subsequent increase of mentally ill persons in jails and prisons is very clear. In Atlanta following the closure of the Georgia Mental Health Institute, "the number of inmates [in the county jail] being treated for mental illness . . . increased 73.4 percent." After the Northwest Georgia Regional Hospital closed, the administrator of the local county jail estimated that "prisoners with mental problems . . . increased by 60 percent." Nationally, a 2010 survey reported that "there are now more than three times more seriously mentally ill persons in jails and prisons than in hospitals." In states like Arizona and Nevada, the difference was more than ninefold. The three largest *de facto* psychiatric inpatient facilities in the country are the county jails in Los Angeles, Chicago, and New York. In fact, there is not a single county in the United States in which the public psychiatric inpatient unit holds as many mentally ill persons as the county jail holds.[5]

How bad is the situation now? Recall that in the 1970s estimates of the number of seriously mentally ill persons in jails and prisons were around 5%. In the 1980s this had increased to around 10%, and in the 1990s, to around 15%. Estimates for 2007 to 2012 vary between 20% and 40%. Thus, 20% of Alabama prison inmates "were thought to be mentally ill"; 20% of prisoners in Michigan "had severe mental disabilities—and far more were mentally ill"; and 20% of jail inmates in the Denver metro area have "a serious mental illness."[6]

In Florida's Broward County, "23 percent of the jail system's population [are] on psychotropic drugs." In Virginia the Roanoke County sheriff claimed that "between 25 percent and 30 percent of his inmates suffer from mental illness." In the Corrections Center of Northeast Ohio, 25% of the inmates "were on psychotropic medications," which cost "nearly half of the medical budget." In Texas's Harris County Jail, 25% of

inmates take psychotropic medications. In Massachusetts, 26% of all inmates in county jails have a "major mental illness." And in Illinois 28% of the inmates in the Cook County Jail "are taking serious psychotropic medications." Such estimates are consistent with a 2006 national survey by the Department of Justice that reported 24% of inmates in county jails had psychoses.[7]

Other reports have been higher. In Boone County, Missouri, "at least 30 percent of the jail population" was said to be mentally ill. Similarly, in Stark County, Ohio, "roughly 30 percent of the jail population suffers from a mental illness." At New York's Riker's Island Jail, "one in three prisoners... [is] mentally ill, and the number is climbing." And in the Tennessee prison system, "nearly one of every three inmates is mentally ill."[8]

Alarmingly, there are even higher estimates. In Texas's El Paso County Jail, 40% of the inmates are taking psychotropic medications. In Alabama's Tuscaloosa County Jail, 40% of the inmates "receive some form of psychiatric care." In Pennsylvania's Erie County Jail, 44% of inmates "have a serious mental illness." In Iowa's Black Hawk County Jail, "more than 60 percent of the inmates... are mentally ill." And in Mississippi's Hinds County Jail, "about two-thirds of the 594 inmates... take anti-psychotic medication."[9]

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The problems caused by the increasing number of mentally ill inmates in jails and prisons are legion. In Florida's Orange County Jail, the average stay for all inmates is 26 days; for mentally ill inmates, it is 51 days. In New York's Riker's Island Jail, the average stay for all inmates is 42 days; for mentally ill inmates, it is 215 days. The main reason mentally ill inmates stay longer is that many find it difficult to understand and follow jail and prison rules. In one study, mentally ill jail inmates were twice as likely (19% vs. 9%) to be charged with facility rule violations. In another study in the Washington State prisons, mentally ill inmates accounted for 41% of infractions although they constituted only 19% of the prison population. In a county jail in Virginia, 90% of assaults on deputies were committed by mentally ill inmates.[10]

Mentally ill inmates are also major management problems because of their impaired thought processes.

- In an Oklahoma prison, "screams, moans and chanting are normal. The noise level rises as the sun goes down.... One inmate believes he is in a prisoner of war camp in Vietnam while another screams that communists are taking over the facility."
- A deputy at Mississippi's Hinds County Detention Center said: "They howl all night long. If you're not used to it, you end up crazy yourself." One inmate in this jail was described as having "tore up a damn padded cell that's indestructible, and he ate the cover of the damn padded cell. We took his clothes and gave him a paper suit to wear, and he ate that. When they fed him food in a Styrofoam container, he ate that. We had his stomach pumped six times, and he's been operated on twice."
- Many other mentally ill inmates are quiet. In an Oklahoma prison, "one resident of the acute-care unit sculpted figurines out of his feces." In California an inmate in San Mateo County Jail's maximum security wing "lies curled up naked in a pool of urine."
- Mentally ill prisoners are also victimized much more frequently than nonmentally ill prisoners. According to a 2007 prison survey, "approximately one in 12 inmates with a mental disorder reported at least one incident of sexual victimization by another inmate over a six-month period, compared with one in 33 male inmates without a mental disorder." Among female mentally ill inmates, this difference was three times higher than among male mentally ill inmates.[11]



Not surprisingly, mentally ill inmates cost significantly more than nonmentally ill inmates. In Florida's Broward County Jail in 2007, the difference was $130 versus $80 per day. In Texas prisons in 2003, mentally ill prisoners cost $30,000 to $50,000 per year, compared to $22,000 for other prisoners. In Washington State prisons in 2009, the most seriously mentally ill prisoners cost $101,653 each, compared to approximately $30,000 per year for other prisoners. And these costs do not include the costs of lawsuits being increasingly brought against county jails, such as the suit brought in New Jersey in 2006 by the family of a "65-year-old mentally ill stockbroker [who was] stomped to death in the Camden County Jail."[12]

Sheriffs, however, originally applied for their jobs as law enforcement officials, not as custodial mental health workers, and in many counties they have begun to fight back. In Chicago, Cook County sheriff Tom Dart announced in 2011 that he was considering filing a lawsuit against the county for "allowing the jail to essentially become a dumping ground for people with serious mental health problems." In Summit County, Ohio, Sheriff Drew Alexander took it one step further in 2012 when he announced that "the county jail no longer will accept violent mentally ill and mentally disabled people arrested by area police." "We're not going to be a dumping ground anymore for these people," he said.[13]

The degree to which jails and prisons have become the nation's new psychiatric inpatient units can also be measured by bricks and mortar. It is now common—almost routine—for jails and prisons to have special sections set aside for mentally ill inmates. These units are readily identifiable by their nicknames, such as "Fantasy Island" in an Oklahoma prison. Like psychiatric hospitals, some jails and prisons have their own pharmacies; in Cleveland, the Cuyahoga County Sheriff's Department expected "to save more than $100,000" a year by opening its own pharmacy.[14]

In Maine in 2007, the governor proposed that some county jails be transformed into "specialty facilities for people with mental illnesses." That same year saw proposals in Florida's Dade and Broward Counties to provide funding for "the first county jails ever to be built specifically for inmates with chronic and severe mental illness." Also in 2007, the warden of Montana State Prison proposed "opening a special prison for the mentally ill who are now housed in the regular prison." In Raleigh, North Carolina, they are already doing this; a new, five-story hospital for 216 mentally ill prison inmates was built as part of Central Prison and opened in 2012. It sits directly across the street from Dorothea Dix State Hospital, which was simultaneously closed.[15]

But perhaps the most revealing development that illustrates how jails and prisons have become the new psychiatric inpatient system is proposals to take over closed state psychiatric hospitals and then turn them over to the Department of Corrections to become psychiatric hospitals for prisoners. In Pennsylvania the state legislature in 2010 was said to be "looking into the possibility of moving prisoners with mental illnesses into state hospitals" that were being closed. In New York State, Marcy State Psychiatric Hospital was closed many years ago and turned over to the State Department of Corrections to become the Marcy Correctional Facility. Then, in December 2009, it was announced that the Marcy Correctional Facility would open a 100-bed Residential Mental Health Unit for inmates with serious mental illness. Thus, seriously mentally ill individuals who were once treated in the psychiatric hospital may end up being treated in exactly the same building, except now it is called a prison. Office of Mental Health Commissioner Michael Hogan lauded the special unit as "a collaborative and innovative approach that to our knowledge is the first of its kind anywhere." Governor David Paterson characterized the new unit as "government at its best." Such thinking would have given Jonathan Swift much material for his satires.[16]

## SHERIFFS, POLICE, AND COURTS AS THE NEW PSYCHIATRIC OUTPATIENT SYSTEM

Just as jails and prisons have become America's new psychiatric inpatient system, the sheriffs, police, and courts have become the new psychiatric outpatient system. As a consequence of having discharged hundreds of thousands of seriously mentally ill individuals from hospitals to live in the community without adequate medications or support, psychiatric crises occur frequently. The people who respond to these crises are mostly law enforcement officials, and for many officials such calls have become a significant part of their jobs. In California's San Diego County, for example, sheriff's calls related to mentally ill individuals approximately doubled between 2009 and 2011. In 2011 police in Medford, Oregon, were dealing with "an alarming spike in the number of mentally ill people coming in contact with the police on an almost daily basis," the



number of contacts having doubled since 2010. Many of the police calls were repeats, such as the 88 calls made between 2000 and 2006 by the West Des Moines, Iowa, police to the home of Joe Martens. Martens, who periodically stops taking medication for bipolar disorder, becomes violent and threatening to his neighbors. When police respond to a Martens call, "they bring two units; a third helps if things are slow."[17]

Many calls to law enforcement are to transport mentally ill people to hospitals. In Corvallis, Oregon, for example, the police handled 30 "police officer custody" cases in 2001, 58 in 2002, 113 in 2003, 140 in 2004, and 162 in 2005. In North Carolina, where state law makes county sheriffs responsible for such transport, the shortage of beds caused by the closing of state psychiatric hospitals has put an intolerable burden on the sheriffs. In 2010, 100 sheriff's departments "reported more than 32,000 trips last year to transport psychiatric patients for involuntary commitments.... Fourteen sheriff's offices reported having a deputy wait with a patient for five days or more until a bed in a psychiatric unit came open." On March 25, 2010, Burke County sheriff's deputies had been with a patient in a hospital emergency room for 9 days "waiting for a bed at a mental health facility to open up." The total time spent on such tasks in North Carolina in 2009 was estimated to be 228,000 hours—time, of course, that is lost for more traditional law enforcement duties.[18]

Given the psychotic thinking and behavior of many recipients of law enforcement calls, and given the lack of mental health training of many law enforcement officers, it is inevitable that some of these encounters will turn out badly. In 2007 California's Ventura County sheriff's deputies used Taser guns to subdue people 107 times; "the majority of those shot by deputies were mentally ill." In 2008 in West Warwick, Rhode Island, a city of 29,000 people, 5 persons "described as having mental health issues" died in "police-related" incidents in a 6-month period. In California's Santa Clara County, "of the 22 officer-related shootings from 2004 to 2009 in the county, 10 involved people who were mentally ill.... Many of them had numerous contacts with police before the crisis that ended in their death." In 2011 in Syracuse, three of five officer-related shootings involved "emotionally disturbed people," and in New Hampshire four of six officer-related shootings involved "mental health issues." In Albuquerque between 2010 and 2012, 11 of 24 officer-related shootings were of people with "a history of either mental illness, substance abuse or both." Although there are no national figures on such incidents, it would appear that at least one-third, and perhaps as many as one-half, of all officer-related shootings result from the failed mental illness treatment system.[19]

In 2010, in response to the numerous officer-related shootings of mentally ill people, Santa Clara County created a special task force to find ways to decrease such incidents. One member of the task force, an officer who had had 26 years' experience on the Palo Alto police force, noted that police were being repeatedly "called to the same

home or situation" and said: "We want law enforcement to start looking for remedies." Significantly, the officer did not call for the local mental health center to start looking for remedies but rather the police department, which has become *de facto* the new mental health center. This reality was reflected by a conference of county sheriffs in Colorado who agreed that individuals with mental illness were "the top problem facing sheriff's departments statewide." As the Pueblo County sheriff summarized it: "By default, we've become the mental health agencies for the individual counties."[20]

There are other indicators of this ongoing shift in responsibility for seriously mentally ill individuals from traditional mental health agencies to law enforcement agencies. An increasing number of police and sheriff's departments offer specialized mental health training, usually as part of a 40-hour training course originally developed by the Memphis Police Department in 1988. The training creates Crisis Intervention Teams (CIT) of law enforcement officers who are trained to respond to crises associated with mentally ill individuals. CIT teams have spread widely; in 2011 a bill was even introduced in the New Mexico state legislature to make CIT training mandatory "for every certified police officer in New Mexico."[21]

Another indicator of the increasing responsibility for psychiatric services being assumed by law enforcement agencies is the hiring of mental health professionals by police departments. For example, in 2010 the Seattle Police Department created a new position for a mental health professional. According to the acting police chief, "the professional can conduct 'street-level assessments' and may be able to defuse threatening situations. He or she can also direct people in distress to appropriate social services." In 2012 the Burbank, California, police department hired a psychiatric social worker because their mental illness–related calls had doubled since 2009.[22]

Several law enforcement agencies are already providing social services to mentally ill individuals. In 2010 California's Ventura County Sheriff's Department began a program in which "some mentally ill inmates will be given medicine and immediate rides to their first appointments at treatment facilities upon their release from jail." A similar program in Hillsborough County, Florida, led to "a dramatic drop in recidivism." A police officer who is also a psychologist set up a program in San Rafael, California, in which the police department works jointly with the local mental health center to provide social services to mentally ill persons. Such services include having a police officer drive mentally ill persons to doctor's appointments. According to the initial evaluation of the program, "in three years, San Rafael police have closed 39 of 61 cases [and] almost a third have been moved into permanent housing." Such activities led the president of the Los Angeles County Police Chief's Association to observe: "Our local police forces have become armed social workers."[23]

Perhaps the ultimate measure of law enforcement's progressive assumption of responsibility for outpatient mental health services was the May 2011 offer by Sheriff



Ken Stolle of Virginia Beach, Virginia. City officials had voted to cut $121,596 in mental health funds from the Department of Human Services, so Stolle offered to transfer that amount of money from his jail reserve fund to cover the mental health program. 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." By spending Department of Corrections funds on outpatient mental health services, Sheriff Stolle expects to save money in the long term. Similarly, in Tuscaloosa, Alabama, in 2012, Sheriff Ted Sexton contributed $28,000 of his department's money to help fund a mental health court.[24]

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The other component of the emerging corrections-dominated psychiatric outpatient system is the courts. Traditionally, courts have adjudicated civil and criminal cases, determining guilt and meting out punishments as necessary. In 1997, in response to the increasing number of mentally ill individuals who were repeatedly charged with offenses, Florida's Broward County created the first of what are now known as mental health courts. In such courts, mentally ill defendants are given the choice of either participating in a treatment program for their mental illness or going to jail. Legally, this is done by having the prosecutor hold the charges in abeyance, requiring a guilty plea, or obtaining a conviction but then suspending the sentence, all contingent on the person's participation in the treatment program. The court then monitors the person's compliance with the program by requiring regular court visits.[25]

Mental health courts have spread quickly because they have proven to be highly successful in decreasing arrests and incarcerations of mentally ill persons. There are now at least 300 such courts throughout the United States. Initially, they were just used for mentally ill individuals charged with misdemeanors but more recently have been used for individuals charged with nonviolent felonies and even violent felonies. The courts provide primary oversight for the treatment of a significant and rapidly increasing number of seriously mentally ill individuals and are thus a vital component of the new psychiatric outpatient system controlled by the criminal justice, rather than the traditional mental health, system.[26]

## HOMELESS SHELTERS, NURSING HOMES, AND BOARD-AND-CARE HOMES

One of the salient characteristics of seriously mentally ill people in the United States is their peripatetic lives. Chris Falzone, a 28-year-old Californian with bipolar disorder, is not unusual in having "been in more than 60 facilities in 15 years.... He bounces from board-and-care homes to hospitals, from jail cells to the streets." In 2000 in

San Francisco, 30% of mentally ill jail inmates had been homeless, and 88% had been psychiatrically hospitalized. This constant changing of venues is one factor that makes the psychiatric treatment system so ineffective and expensive. For example, a 2007 Los Angeles study of mentally ill people who regularly migrate between homeless shelters, jails, emergency rooms, and psychiatric hospitals estimated the annual cost per person to be between $35,000 and $150,000.[27]

Since the early 1980s, studies have consistently reported that at least one-third of homeless individuals are seriously mentally ill. A 2010 study estimated that there are approximately 650,000 homeless persons in the United States; thus, approximately 216,000 homeless individuals have serious mental illnesses. Los Angeles and San Francisco have vied for the dubious distinction of being the "homeless capital of America." Los Angeles, with an estimated 48,000 homeless, appeared to win the award in 2005 when Mayor Antonio Villaraigosa visited Skid Row and commented: "I mean that almost looked like Bombay or something, except for more violence.... You see a complete breakdown of society." Not to be outdone, San Francisco in 2008 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." San Francisco had distinguished itself in 2003 when a prominent member of the American Psychiatric Association, attending the organization's annual meeting, was knocked unconscious on the street by a homeless mentally ill man, an unintended but ironic comment on the failure of psychiatrists to provide treatment for such people.[28]

Homeless mentally ill people are prominent not only in large cities. In 2007 in Roanoke, Virginia, the homeless population was estimated to be 566, of which "70 percent were receiving mental health treatment or had in the past." The number of mentally ill people being turned away from hospitals and ending up homeless had increased so markedly in Virginia by 2011 that a report by the state office of Inspector General coined a new term for it: "streeting." In 2009 in Colorado Springs, "as many as two-thirds of the 400 chronically homeless people... are said to suffer severe mental illnesses." State laws in most states also make it difficult to treat such people. For example, in Kennebec, Maine, a severely mentally ill homeless man dug a cave-like home for himself in a hillside beneath a downtown parking lot. He rejected all offers of help by police and mental health workers, and Maine law did not allow for involuntary treatment except under extreme circumstances. Finally, the overlying city parking lot began to sag because of his digging, and it was decided to arrest him because he was a threat to the parking lot, not because he was a threat to himself.[29]

Homeless mentally ill individuals are indeed threats to themselves, frequently being assaulted and otherwise victimized. In 2009 it was reported that 43 homeless people had been killed, "the highest level in a decade." Such deaths now occur almost weekly, the vast majority of victims being mentally ill.



- April 25, 2011: Stephen McGuire, 61 years old, a Marine Corps veteran, homeless and diagnosed with bipolar disorder, was beaten to death in Indianapolis by four boys and one girl.
- May 1, 2011: Chantell Christopher, 36 years old, the mother of two, homeless and "suffering from profound mental illness," was beaten to death in New Orleans. Her body was found in a crawlspace beneath the Pontchartrain Expressway, where she routinely slept.
- July 5, 2011: Kelly Thomas, 36 years old, homeless, and diagnosed with schizophrenia, was beaten to death by two policemen during a confrontation on the streets of Fullerton, California.

Our failure to protect such mentally ill people by ensuring that they receive treatment is a major miscarriage of our medical care system and a blot on our claims to be civilized.[30]

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Nursing homes have continued to be heavily used for mentally ill individuals, allowing states to shift the cost of care from the state to federal Medicare and Medicaid. This is especially true in Illinois, California, Missouri, Louisiana, Ohio, and Vermont, which in 2005 had the highest percentage of nursing home admissions diagnosed with serious mental illnesses. In 2002, for the first time, the number of new nursing home admissions with mental illness as a primary diagnosis exceeded those with dementia as a primary diagnosis; by 2005 admissions with mental illness were 50% higher than those with dementia. The total number of mentally ill nursing home residents was estimated to be 560,000.[31]

Of special concern has been the rapid increase in young and middle-aged mentally ill individuals being admitted to nursing homes, thus mixing with elderly residents who have dementia. Nationally, there was a 41% increase in such admissions between 2002 and 2008, with predictable results. In one Illinois nursing home, a 21-year-old man with bipolar disorder and a history of violence raped a 69-year-old woman. In another Illinois nursing home, a 50-year-old man with a severe mental illness and a history of aggression beat to death his 77-year-old roommate, who had Alzheimer's disease.[32]

Both Illinois nursing homes were for-profit homes, as are two-thirds of all nursing homes in the United States. According to a 2007 report, for-profit homes average 33% more deficiencies than nonprofit homes during state and federal inspections. From the states' point of view, such deficiencies are of minor concern, as nursing homes allow states to save state money. For example, in 2002 in New York the annual state cost for a mentally ill patient in a state hospital was $120,000, but the state's share of the cost for

the same patient in a nursing home was only $20,000; the federal government picked up the rest of the cost, and the for-profit nursing home made a handsome profit. This helps explain the cozy relationship between governors and the for-profit nursing home industry in several states, including Illinois and New York, as mentioned previously. In the latter, for example, after George Pataki had been elected governor in 1995, a "debt-retirement dinner" at an upscale New York restaurant raised an estimated $200,000 for the governor, "most of it from the nursing home industry." Subsequently, Benjamin Landa, a prominent for-profit nursing home owner and major contributor to Pataki, was appointed to the state council that regulates nursing homes.[33]

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The situation of mentally ill persons in board-and-care homes is at least as bad and may well be worse than nursing homes. Nobody knows for certain, because a large and unknown number of these homes are unlicensed and thus unregulated. Like nursing homes, some operators are caring and try to provide decent services for their mentally ill residents, but many others are not. The total number of mentally ill residents in these homes is variously estimated to be several hundred thousand but is really unknown.[34]

The disgraceful depths to which board-and-care homes can descend was illustrated in 2002 by a Pulitzer Prize-winning *New York Times* series by Clifford Levy. He described for-profit homes in New York in which the owners had misappropriated thousands of dollars from residents, homes with "squalid conditions," and homes in which some residents had been raped and killed. At one home, 24 seriously mentally ill residents had been subjected to unnecessary prostate surgery, and others had been given unnecessary cataract and laser eye surgery, generating "tens of thousands of dollars in Medicaid and Medicare fees" for the physicians and the home owners. The ophthalmologist involved subsequently pleaded guilty to billings "for more than 10,000 services that were either improper, unnecessary or never conducted, ranging from cataract surgery to routine eye examinations.... He had billed for more than 400 procedures when he was actually out of the country."[35]

The fact that abuses of this magnitude could occur for many years in board-and-care homes suggests that there is virtually no state oversight of these homes. And that is indeed the case. The Empire State Association of Adult Homes, the trade group for owners of for-profit board-and-care homes in New York City, was one of the earliest and most generous donors to Pataki's campaign funds. After taking office, Pataki reduced the number of board-and-care home state inspectors in New York City from 25 to 5, reduced the staff of the Commission on Quality of Care for the Mentally Disabled in New York City from 15 to 3, and decided to not enforce a new law that would have required a report for every death occurring in a group home. As the chairman of the Commission on Quality of Care for the Mentally Disabled politely phrased it, Governor Pataki "didn't believe in government interference with the private sector."[36]



Sadly, the situation of largely unregulated board-and-care homes in New York State is far from unique. During the past decade, horrendous living conditions and abuses of the mentally ill resident have been described in many states. Most such exposés have been documented by the media rather than by state inspectors. For example, in 2004 in Kansas, an unlicensed board-and-care home was closed by federal prosecutors who accused the owners of forcing the mentally ill residents "to work on their farm and deciding who could wear clothes." The owners had been billing Medicare for nude therapy, claiming that it was beneficial for schizophrenia. In Virginia, an exposé of the state's board-and-care homes reported that "thousands of documents kept by state and local agencies reveal repeated sexual abuse, beatings, and other assaults." In 2006 in Milwaukee, the *Journal Sentinel* published a series on the city's board-and-care homes, many unlicensed, calling them "stealth mental hospitals." It described "infestations by cockroaches, mice, and rats, backed-up toilets, insufficient heat, broken smoke detectors, dangling electrical wires, filthy carpeting, a lack of proper exits, [and] a host of structural defects." In one home, a resident had been dead for 3 days before being found. In others, "building inspectors have found people begging on the streets for food because they don't get enough from landlords who take their disability checks, leaving them with next to nothing."[37]

A special problem in board-and-care homes, as in nursing homes, occurs when young individuals with serious psychiatric disorders are placed in homes with elderly residents. For example, in 2005 at a small board-and-care home in North Carolina, Tony Zichi, 25 years old, stabbed to death Ruth Terrell, age 84 years. Zichi, diagnosed with schizophrenia, had previously been evicted from seven other homes because of very violent behavior, yet he was placed in the home with four elderly women. Over a 10-month period in 2008 and 2009, four other mentally ill residents were beaten to death in North Carolina board-and-care homes, so the U. S. Department of Justice expanded its ongoing investigation into the state's mental health programs. Similar problems have been prominent in Florida. In 2007, for example, 33-year-old Darryl McGee, diagnosed with schizophrenia and with 11 previous arrests, was admitted to a board-and-care home's "locked Alzheimer's ward with people twice his age." For 4 months, "McGee terrorized the home's elderly residents during drunken rages, beating elderly men and women... before he brutally raped a 71-year-old woman in her bedroom." In an exposé of such incidents in the *Miami Herald*, it was noted that "Florida's requirements to run a home for people with mental illnesses are among the lowest in the nation: a high school diploma and 26 hours of training—less than the state requirements for barbers, cosmetologists, and auctioneers."[38]

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Whether homeless, living in nursing homes, or living in board-and-care homes, individuals with serious mental illnesses who are living in the community have one thing in common—they are likely to be victimized. A 2008 review of 10 studies suggested that such victimization appears to be becoming more common. For example, among 308 patients living in community residences, 26% percent had experienced a "rape, robbery or mugging" within the previous 6 months. And among 936 seriously mentally ill outpatients, 25% had experienced a "physical assault, rape or sexual assault, [or] robbery" within the previous year. It is doubtful that any group in our society is as vulnerable as seriously mentally ill individuals living in the community. They are, in the words of one reporter, "rabbits forced to live in company with dogs."[39]

## EFFECTS ON COMMUNITY RESIDENTS

Individuals with severe mental illnesses are not the only victims of the breakdown of the mental illness treatment system. Many community residents are victims as well insofar as they no longer feel comfortable going downtown to shop or using community parks and playgrounds. Homeless individuals, especially those who are mentally ill, have expropriated public spaces in many American communities.

San Francisco provides an especially sad example. As described in 2008 by one resident:

> One is hard pressed to walk around just about any neighborhood without having to run a gantlet of panhandlers, step over passed-out drunks or drug addicts, maneuver around the mentally ill or try to avoid the stench of urine and the human feces littering the sidewalk. . . . I often feel sorry for the confused tourists who take a wrong turn off Union Square only to find themselves in the sudden squalor of the Tenderloin or the Hell-on-earth intersection of Sixth and Market streets. . . . In 2007, a homeless man snatched a woman's baby away from her and attempted to throw it over the railing above the Powell Street MUNI/BART station, but was stopped by several onlookers.

San Francisco has no monopoly on such frightening behavior. In Los Angeles in 2011, a mother pushing her infant son down the street watched in horror as another woman grabbed the child by his leg and swung "the child over her head . . . slamming him into a metal rail." The severely mentally ill woman told police that "she tried to break off the baby's arm so she could eat it."[40]

Less dramatic variations of such scenes are being played out in every American city. Among those being victimized are shopkeepers and store owners, whose businesses suffer because customers find shopping downtown too unpleasant. For example, in Fort Lauderdale in 2008, downtown business owners complained about homeless individuals on the streets "leaving the rancid smell of urine, stealing food off plates at outdoor cafes, chasing away business and offending tourists." Such problems are completely predictable. As two observers wrote as early as 1973: "To discharge helpless, sick people into the streets is inhumane and contributes to the decline of the quality of life in the urban environment."[41]



The situation with public parks and playgrounds is even worse. Nobody has yet made a count of the number of such places that have been effectively lost to public use because they have been taken over by mentally ill homeless individuals. Walking your dog or teaching your child to ride a bike amidst men and women who are merely drunk or drugged is unpleasant, but doing so amidst psychotic men and women who are angrily shouting at unseen voices is frightening. In addition, many city parks are now devoid of benches or other places to sit because they were removed to discourage people from sleeping there. Cities such as Santa Monica, Las Vegas, Orlando, and Fort Myers have tried to restrict the use of city parks by homeless persons, arguing that such people should use the existing soup kitchens and public shelters. Such ordinances have been challenged by civil liberties advocates. In Las Vegas, for example, it was claimed that city parks are especially important for mentally ill people because "the chronically mentally ill who make up a sizeable part of the homeless population typically resist treatment and services" and often will not use public shelters.[42]

* * *

Another community facility that has been profoundly affected by the deinstitutionalization of mentally ill individuals and our failure to provide treatment for them are the public libraries. Many libraries have become day centers for mentally ill people who are homeless or living in board-and-care homes. A 2009 survey of 124 public libraries, randomly selected from all parts of the United States, asked about "patrons who appear to have serious psychiatric disorders." The librarians reported that such individuals had "disturbed or otherwise affected the use of the library" in 92% of the libraries and "assaulted library staff members" in 28%. Eighty-five percent of the libraries had had to call the police because of the behavior of such patrons. This included benign activities such as a "patron rearranging reference books by size and refuses to stop" to less benign activities such as a man running "through the circulation area, near the children's department, repeatedly without clothing."[43]

Libraries have attempted to cope with these problems in a variety of ways. Some, such as Maryland's Hagerstown public library, have hired "security personnel [who] now blend in with patrons as they keep an eye on things." A San Francisco public library, in which the majority of patrons were said to be homeless people, hired a full-time social worker. Other libraries are training staff how

to respond to disturbed mentally ill individuals using a 12-hour course, "Mental Health First Aid." Despite such efforts, many people are now reluctant to use public libraries. As noted by librarians, "many, many library customers don't come downtown to our Central Library because they're afraid of these customers"; "a number of patrons have told us they will not be back because of unpleasant encounters they feel are unsafe"; "patrons are often frightened by strange behavior.... [They] hold onto their children more tightly and leave more quickly than they might have planned." Although public libraries have been an important part of American culture for two centuries, they are becoming yet another victim of the failed mental illness treatment system. As one librarian summarized it, "This problem [mentally ill persons in libraries], *not the invention of the Internet*, could prove to be the final demise of the public library as we know it."[44]

* * *

Another public space that has been markedly affected by the increasing numbers of untreated mentally ill individuals in the community are hospital emergency rooms. This problem surfaced on public radar in 2008 when Esmin Green sought psychiatric help in the emergency room of New York's Kings County Hospital Center. After having waited for 24 hours, a physician wrote an order on her chart to get blood tests and an X-ray and to use "sedation/restraints if needed." They weren't needed, because by the time the order was written, Ms. Green had been dead for more than an hour on the floor of the waiting room. Videotapes, which were widely played on television news shows, showed her lying there as two security guards and a hospital psychiatrist observed her but did nothing. In fact, in the period after she had died, notes written on her emergency room chart claimed that she was "sitting quietly," was "up and about," and "went to the bathroom." An autopsy showed that Ms. Green had died from blood clots caused by sitting too long.[45]

Perhaps the most shocking part of this episode is the fact that Ms. Green, if she had lived, would have had to wait *only* 24 hours to be seen. A national survey reported that almost 10% of all emergency room visits are now for psychiatric problems, not including substance abuse. Because there are very few remaining public psychiatric beds in the United States, emergency rooms become backed up with psychiatric patients waiting for beds.

2007: "Patients with acute mental illnesses are increasingly forced to wait up to three days in Georgia hospital emergency rooms before being admitted to state-run mental hospitals.... ERs in Georgia are already overwhelmed with the rising number of uninsured.... 'The mental health problem only exacerbates this [crowding] problem,'" said a hospital association official.



2008: A Washington State task force reported that many severely mentally ill people, including those with histories of violent behavior, "are being detained in hospital emergency rooms that aren't staffed to care for them."

2009: In Texas it was reported that nine individuals, seven of whom had "mental health issues," accounted for 2,678 visits to Austin emergency rooms between 2003 and 2008. The average cost of each visit was $1,000 and was paid by Medicaid or Medicare.

2010: In North Carolina it was reported that "on average, people in the midst of a mental health crisis can expect to languish in a medical hospital's emergency department for 2.8 days before gaining admission to a state psychiatric hospital." In the western third of the state, the average wait was 4 days. In a three-month period, Wake County had "13 people waiting a week or more."

2011: In Massachusetts "so many people seeking psychiatric help flooded Quincy Medical Center's emergency room... [that] 20 beds had to be set up in a nearby conference room to handle the surge." The chief of emergency medicine at the medical center said "he had seen the situation deteriorate dramatically" since 2002.

2011: In South Carolina "mentally ill patients are flooding into emergency departments as a direct result of deep cuts for treating these troubled individuals." One woman had been in an emergency room for 8 days awaiting a psychiatric bed, another woman 12 days. According to a Hospital Association report: "South Carolina's hospital emergency rooms have become the safety net for the mentally ill." The director of the emergency room in Pickens said: "They say it is going to get worse but I don't know how. It is really horrendous."

2012: In California, Fresno County officials were forced to reopen the county's psychiatric crisis center. Since it closed in 2009, "as many as 600 psychiatric patients visit the hospital's emergency room each month, more than double the number that went there before the crisis center closed."[46]

## VIOLENT BEHAVIORS AND HOMICIDES

The most publicly visible consequences of the failed mental illness treatment system are violent behaviors, including homicides. As previously noted, such acts became prominent in the early 1970s in California as deinstitutionalization accelerated, and they appear to have continued to increase over the subsequent 40 years.

It important to note that most acts of violence are not committed by mentally ill individuals and that most mentally ill individuals are not violent. Being a young male or a substance abuser is a much higher risk factor for predicting violent behavior than is being mentally ill. It is also true that individuals with serious mental illnesses are

more likely to themselves be victimized than they are to victimize others. All this is true, but it is *also* true that a small number of individuals with serious mental illnesses, especially those who are not being treated, are responsible for a disproportionate amount of community violence, including homicides.

Between 2007 and 2009, four review studies were published on the relationship between untreated serious mental illness and violence.

- A review of 22 studies published between 1990 and 2004 "concluded that major mental disorders, per se, especially schizophrenia, even without alcohol or drug abuse, are indeed associated with higher risks for interpersonal violence." Major mental disorders were said to account for between 5% and 15% of community violence.
- After reviewing the psychiatric literature from 1970 to 2007, the author of another study concluded that "sound epidemiologic research has left no doubt about a significant relation between psychosis and violence, although one accounting for little of society's violence."
- An analysis of 204 studies of psychosis as a risk factor for violence reported that "compared with individuals with no mental disorders, people with psychosis seem to be at a substantially elevated risk for violence." Psychosis "was significantly associated with a 49%–68% increase in the odds of violence."
- A review of studies from 11 countries involving more than 18,000 patients concluded that, compared to the general population, men with schizophrenia had a two to five times greater risk for committing violent acts, and women with schizophrenia had a four times greater risk.

It should be emphasized that almost all the increased risk of violent behavior by individuals with serious mental illnesses applies only to those who are not being adequately treated with medications. For those who are being treated and take their medications, there is no evidence for any increased risk.[47]

Although most public attention regarding serious mental illness and violent behavior is focused on homicides, there are other examples of this problem. During late 2011 and early 2012, for example, Ali Shahsavari, with untreated schizophrenia, caused an emergency landing of a Southwest Airlines flight in Texas when "he intimidated crew members by screaming profanity" during the flight; Oscar Ortega, with untreated schizophrenia and a belief that he was Jesus Christ, shot at the White House in Washington; and Gregory Seifert, with a severe mental illness, used a chainsaw to cut down utility poles near Buffalo, causing a loss of power to more than 6,000 homes.[48]

But it is mental illness-related homicides that receive the most media attention. As noted in Chapter 6, there are two small, older studies in New York and California that



suggest that people with untreated serious mental illnesses are responsible for approximately 10% of homicides in the United States. A more recent study from Indiana supports this. Researchers examined the records of 518 individuals in prison who had been convicted of homicides between 1990 and 2002. Among the 518, 53 (or 10.2%) had been diagnosed with schizophrenia, bipolar disorder, or other psychotic disorders not associated with drug abuse. An additional 42 individuals had been diagnosed with mania or major depressive disorder. It should be emphasized that the study included only those individuals who had been sentenced to prison and did not include those who had committed homicides but were subsequently found to be incompetent to stand trial or not guilty by reason of insanity and therefore sent to a psychiatric facility rather than prison; thus, the 10.2% is an undercount. The authors themselves did not conclude that individuals with serious mental illnesses were responsible for at least 10% of the homicides, but given the data that seems an obvious conclusion. Studies from several other countries, including Sweden, Finland, Germany, and Singapore, have also reported that individuals with serious mental illnesses are responsible for approximately 10% of homicides.[49]

The homicides that receive the most attention are those in which there are multiple victims. As noted in the previous chapter, there are suggestions that these "rampage killings," as they are sometimes called, are becoming more common. On January 8, 2011, Jared Loughner, suffering from untreated schizophrenia, killed 6 and wounded 13 in Tucson, Arizona. Because Congresswoman Gabrielle Giffords was among the wounded, this tragedy received wide publicity. What was not publicized was the fact that in the preceding 5 years, there had been at least 11 other "rampage killings" committed by seriously mentally ill people who were not being treated. They included Matthew Colletta in New York, who killed 1 and injured 5; Lawrence Woods in Pismo Beach, California, who killed 2; Omeed Popal in San Francisco, who killed 1 and injured 14; Jennifer San Marco in Goleta, California, who killed 8; Wesley Higdon in Henderson, Kentucky, who killed 5 and injured 1; Christian Nielsen in Newry, Maine, who killed 4; Naveed Haq in Seattle, who killed 1 and injured 5; Matthew Murray in Colorado Springs, who killed 4 and injured 5; Seung-Hui Cho at Virginia Tech, who killed 32 and injured 24; Isaac Zamora in Seattle, who killed 6 and injured 4; and Jiverly Wong in Binghamton, New York, who killed 13 and injured 4. Jared Loughner became a household name because he killed six and injured Congresswoman Giffords, whereas Isaac Zamora, who also killed six in Seattle in 2008, was quickly forgotten.

This phenomenon was also illustrated in July 2012, when James Holmes, with an untreated severe mental illness and dressed as the Joker, killed 12 and injured 59 at a Batman movie in Aurora, Colorado. Because of its bizarre nature, the killings received widespread publicity. By contrast, when Jiverly Wong, with untreated paranoid schizophrenia, killed 12 and injured 4 at an immigration center in Binghamton, New York, in April 2009, the killings were reported mostly as a local story. Within 1 month of the

Aurora tragedy, Laura Sorensen shot three shoppers near Seattle, and Thomas Caffall killed two and wounded four in College Station, Texas; both Sorensen and Caffall had an untreated severe mental illness, but these stories were not widely reported. It thus appears that homicides associated with untreated severe mental illness are more common than is generally realized. Unfortunately, the FBI does not keep separate statistics differentiating such cases from other homicides, so the true magnitude of the problem is not known.[50]

Public interest in the relationship between untreated mental illness and homicides reached a new high in December 2012, following a massacre of schoolchildren in Newtown, Connecticut. Adam Lanza, a mentally ill young man whose precise diagnosis has not yet been disclosed, killed 20 elementary school children, 6 school employees, his mother, and himself. The site of the massacre was ironic, as Newtown had been the site of one of Connecticut's three state psychiatric hospitals, but the hospital there had been closed in 1996. It was in such hospitals that mentally ill individuals such as Lanza had been evaluated and treated in the past. Thus the Newtown tragedy was a symbolic coda to deinstitutionalization.

The mass killings in Connecticut were followed closely by several other homicides committed by individuals with untreated severe mental illnesses. These included a man pushed to his death beneath a subway in New York by a mentally ill woman with at least 10 past psychiatric admissions, a history of violence, and a history of failing to take medication. Coming so soon after the massacre of theatergoers in Colorado, the Newtown tragedy, and subsequent homicides elicited an unprecedented volume of calls, from President Obama down, for gun control and improved mental illness treatment laws. Whether this public outcry will results in any meaningful change remains to be determined.

Yet another indication that mental illness-related violence is increasing is the apparent increasing incidence of repeat acts of violence committed by the same person. Such acts are often eerily similar in character, suggesting that little learning is taking place among mental health officials:

- In Detroit, Paul Harrington, diagnosed with depression with psychotic features, stopped taking his medication and killed his wife and 3-year-old son. Twenty-four years earlier he had killed his wife and two daughters, ages 4 and 9 years.
- In Everett, Washington, Steven Well, diagnosed with paranoid schizophrenia, stabbed to death his landlady, who he thought was sending electrical signals into his brain. Thirty years earlier he had attacked another landlady with a knife, but she had survived. In the intervening years he had attacked a man with a hammer.
- In suburban Washington, D.C., Antoinette Starks, diagnosed with paranoid schizophrenia, stabbed a woman shopper outside a department store. Six years earlier she had stabbed another woman shopper outside a different department store.[51]



Such repeat acts of violence by mentally ill individuals were occasionally reported in past years, but they now appear to have become common. The following, for example, all took place during a 12-month period in 2007 and 2008:

- In Virginia, Johnny Hughes, diagnosed with schizophrenia, stabbed to death an elderly woman as she walked her dog. In the mid-1990s, Hughes had been found not guilty by reason of insanity of attempted murder.
- In Washington State, Daniel Tavares, diagnosed with schizophrenia, murdered a young couple. In 1991 Tavares had killed his mother.
- In Texas, Darrell Billingslea, diagnosed with schizophrenia, killed a woman he had met through the Internet. In 1989 and 1990, he had killed two men.
- In Washington State, James Williams, diagnosed with schizophrenia, killed a young woman on the street. In 1995 he had shot a stranger at a bus stop.
- In Colorado, Audrey Cahous, diagnosed with bipolar disorder, stabbed a man to death. In 1987 she had stabbed her third husband.
- In Iowa, Richard Mutchler, diagnosed with bipolar disorder, stabbed to death a man and woman. In 1991 he had killed a man.
- In California, Ofiu Foto, diagnosed with schizophrenia, beat to death an elderly woman who worked in his group home. In 2005 he had severely beaten another elderly woman and had additional charges of assault.

Such incidents, in which seriously mentally ill individuals who have proven dangerousness are not followed up and properly monitored, suggest a widespread failure of the mental illness treatment system.[52]

If, as studies suggest, seriously mentally ill individuals who are not being adequately treated are responsible for 10% percent of the nation's homicides, then how many homicides is that? In 2009, there were 13,636 total homicides in the United States, so approximately 1,300 of these might have been prevented if the mentally ill perpetrators had been adequately treated for their illness. Since 1970, there have been a total of 765,270 homicides in the United States, so approximately 76,000 of these might have been prevented. These 76,000 individuals, their families and friends, and the perpetrators of these tragedies are all victims of our failed mental illness treatment system.[53]

In summary, homicides and other violent acts committed by individuals with serious mental illnesses who are not being treated have emerged as the most visible symptom of the failed mental illness treatment system. The situation was summarized by Keith Ablow, a psychiatrist who has written a book about such cases:

> We are not facing an epidemic of gun violence. We are not facing an epidemic of first-degree murder. We are facing an epidemic of mental illness, improperly

triaged and treated, leading to killings with no apparent motive. They will stop when we decide to stop them—by providing robust mental health care services, targeted to those individuals whose mental illnesses include a component of violent or psychotic thinking.[54]

## WHAT ARE THE FINANCIAL COSTS?

There are many disturbing aspects to the breakdown of public psychiatric services in the United States. Not the least of these is the fact that the chaotic, unplanned system that has emerged is not only very dysfunctional—it is also very expensive. It is doubtful if there are many other areas of public services in which so much money is being spent with so little effect.

Begin, for example, with the Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) payments. These are federal entitlement programs intended to provide living support for the aged, blind, and disabled. As noted previously, SSI is the product of President Nixon's decision in 1972 to standardize and federalize welfare and disability payments that previously had been the responsibility of the states. Nixon had no intention of making SSI into a major mental health program, but over the years it has become so. In 2009, 41% of all SSI and 28% of all SSDI recipients qualified for benefits because of their mental illness, not including mental retardation. Their total number was 4,741,970 individuals; by comparison, in 1977 the total number of mentally ill individuals receiving SSI and SSDI was estimated to be between 225,000 and 425,000. In 2009 the annual SSI and SSDI payments to mentally ill individuals was *$45.7 billion.*[55]

As a federal entitlement, the SSI and SSDI money is given to qualified individuals with no requirements. Thus, although some recipients might be able to work if they were to receive and adhere to treatment for their mental illness, there has never been any requirement for SSI or SSDI recipients to participate in a treatment program. The SSI and SSDI programs also operate independently from all other government programs for mentally ill individuals. It was the SSI and SSDI programs that spawned the board-and-care home industry, with mentally ill individuals trading their monthly stipends for "three hots and a cot" in largely unregulated facilities.

The government programs that finance mental health services are Medicare and Medicaid. These were products of President Johnson's 1965 Great Society initiatives and were originally intended to provide medical care for elderly and poor people, respectively. Medicare is funded exclusively by federal funds and pays hospital and other medical costs for people ages 65 years and older. Medicaid is funded jointly by federal and state funds and covers hospitalization in general hospitals (but in most cases not in psychiatric hospitals), outpatient services, nursing homes, medications, and a variable list of other services, such as case management, depending on the coverage offered by that particular state.



As noted previously, the architects of Medicare and Medicaid had no intention of creating mental health programs, and in fact Medicaid specifically excluded coverage for psychiatric hospitals under a provision called the institutions for mental diseases exclusion. Nevertheless, Medicaid has become "the largest payer of mental health treatment services" in the United States, with mental health costs now constituting more than 10% of the entire Medicaid program. By covering hospitalization in the psychiatric units of general hospitals but not in psychiatric hospitals, Medicaid has encouraged states to empty state hospitals, thus effectively shifting the costs of psychiatric hospitalization from exclusively state funds to a mix of federal and state funds. An analysis of deinstitutionalization in the early 1970s reported Medicaid funds to be "very strongly associated with the amount of deinstitutionalization." By covering nursing home care for mentally ill individuals, Medicaid and Medicare together acted as an additional impetus to deinstitutionalization and spawned the for-profit nursing home industry. Indeed, as economist Richard Frank and colleagues noted, "the creation of the Medicaid program in 1965 began a process that fundamentally changed the rules governing a US public mental health care system."[56]

In the almost 50 years since Medicaid was instituted, states have become increasingly sophisticated in finding ways to shift mental health costs from state funds to federal Medicaid. Widely known as "Medicaid maximization," it has been characterized by the phrase: "If it moves, Medicaid it." Medicaid now covers 55% of all state-controlled mental health costs, and for some states, such as Arizona, Alaska, Vermont, Rhode Island, and Maine, the percentage of Medicaid funds is 80% or higher. In total, based on 2005 data, Medicaid and Medicare contribute approximately *$60 billion* a year to mental health costs in the United States.[57]

The $45.7 billion in annual SSI and SSDI costs and the $60 billion in Medicare and Medicaid costs are the major contributors to public mental health costs. In addition, the federal government contributes *$5.7 billion* to mental health programs under the Department of Defense, the Veterans Administration, and a $386 million federal mental health block grant to the states. The costs of mentally ill individuals in jails and prisons must also be included. There are approximately 2 million individuals in jails and prisons; if an average of 20% of them are seriously mentally ill, then that would be 400,000 individuals. A conservative estimate of the cost of inmates in jails and prisons is $25,000 per year, although costs are higher for mentally ill inmates. Nevertheless, even at this cost, 400,000 inmates would add *$10 billion* a year to the nation's mental health costs.[58]

In addition, the costs of law enforcement, courts, and public shelters used by mentally ill persons must be included. A 2002 estimate for persons with schizophrenia

cited law enforcement costs as *$2.6 billion* and public shelter costs as *$6.4 billion*. That survey also estimated the cost of family caregivers for individuals with schizophrenia at *$7.9 billion*.[59]

In total, it would appear that the direct costs of supporting and treating individuals with serious mental illnesses in the United States are presently at least *$140 billion* per year. This figure does not include indirect costs such as income lost by the mentally ill persons; in 2002 this was estimated to be $193 billion. Nor does it include the social costs of violent crimes committed by mentally ill persons, which have been estimated to be $925,000 per crime.[60]

One hundred and forty billion dollars per year is a lot of money. For purposes of comparison, it is three times the 2012 budgets of the National Institutes of Health, the National Science Foundation, and the Centers for Disease Control and Prevention *combined*. To obtain $140 billion dollars, each adult in the United States has to contribute approximately $650.

The fact that the $140 billion being spent on public mental health services in the United States is merely buying the grossly inadequate and disjointed services described in this book is mind-boggling. It suggests that something is profoundly wrong. One hundred and forty billion dollars should be more than sufficient to support excellent mental health services if the money was being used wisely. How this might be done will be the subject of the final chapter.

# 8

## SOLUTIONS: WHAT HAVE WE LEARNED AND WHAT SHOULD WE DO?

For more than a century, the care of individuals with serious mental illnesses had been the responsibility of state governments. The transfer of this responsibility from states to the federal government began during 1962, with the deliberations of President Kennedy's Interagency Task Force on Mental Health; this group planned the new, federally funded community mental health centers. Half a century has now passed since those meetings took place—what would members of the task force think of their plans in retrospect?

Boisfeuillet Jones, the lawyer who was the task force chairman, and Robert Manley, the Veterans Administration representative, both died without apparently publicly expressing an opinion regarding the task force's work. Daniel Moynihan is now also deceased but in 1994 expressed clear reservations about what they had done. As chairman of the Senate Committee on Finance, Moynihan convened hearings on "Deinstitutionalization, Mental Illness and Medication." In his opening statement, he criticized the failure to follow up patients after discharge from the state hospitals: "It was soon clear enough that in order for this [deinstitutionalization] to work you could not just discharge persons, they had to be looked after." The result, he said, had been a sharp increase in the number of homeless people. "To make great changes casually and not pay rigorous attention to what follows," he added, "is to invite large disturbances."[1]

Both economist members of the Interagency Task Force—Robert Atwell and Rashi Fein—are alive. Atwell later served as president of Pitzer College and president of the American Council on Education. During the 1962 discussions, he was one of the strongest voices on the task force urging the closing of state hospitals and the federalization of mental health programs. Thinking back on the program during a 2011 interview, Atwell recalled: "I really wanted this thing to work... I was a believer." When asked why the program failed, he said: "Funding was always going to be a problem and was never forthcoming." Rashi Fein has had an equally distinguished academic career and in a 2010 interview clearly recalled that members of the task force "were all troubled about the funding." In retrospect, he added, "we should have more carefully examined and discussed what it would take in dollars and commitment at the local and state levels to make the model work."[2]