The New York Times

The Solution to America's Mental Health Crisis Already Exists

By The Editorial Board

October 4, 2022

Across the country hundreds of thousands of Americans with serious mental illnesses, such as schizophrenia and bipolar disorder, have been consigned to lives of profound instability. Instead of therapists to help them manage their illnesses or doctors to oversee their medication regimens or evidence-based treatment for their substance use disorders, they cycle through homeless shelters and the jails and prisons that have become the nation's largest mental health providers. Or they make their homes on the streets. They are victims of a mental health system that is not designed to meet their needs — and of a society that has proved mostly indifferent to their plight.

Few Americans are receiving adequate psychiatric care or psychological support these days — either because their health insurance doesn't cover it, or because they don't have insurance to begin with, or because wait lists run far too long. But even amid such pervasive insufficiency, society's neglect of the most severely mentally ill stands out. Of the 14 million or so people who experience the most debilitating mental health conditions, roughly one-third don't receive treatment. The reasons are manifold — some forego that treatment by choice — but far too many simply cannot access the services they want and need.

The most obvious reason is money. Community-based mental health clinics serve the vast majority of Americans with serious mental illnesses. These patients tend to be low-income, disabled and to rely on Medicaid, whose reimbursement rates are so abysmal that clinics lose money on nearly every service their doctors provide. "They get 60 to 70 cents on the dollar," says **Chuck Ingoglia**, president of the National Council for Mental Wellbeing, a nonprofit representing thousands of U.S. community mental health centers. "I don't know any other part of health care where your physician is your loss leader." As a result, staff vacancies can run upward of 30 percent in public mental health clinics and waiting lists can stretch for months, even for people in crisis.

In many ways, the criminal justice system has become the only reprieve: Because court-ordered patients are granted priority, pressing charges against loved ones is a common way to get them psychiatric attention in a crisis. Jails and prisons also serve as final landings for those who fall through the cracks: They make up the three largest psychiatric facilities in the country, and more than 40 percent of the nation's inmates have been diagnosed with mental disorders.

Americans have long accepted that, tragic though it may be, there are no other options. That apathy is easy to understand. When it comes to caring for the mentally ill, the arc of American history has nearly always bent toward failure. But the policies and programs that could undo this crisis have existed for decades.

In 1963, in what would turn out to be the last bill he signed into law, President Kennedy laid out his vision for "a wholly new emphasis and approach to care for the mentally ill." It involved closing the nation's state psychiatric hospitals — which had become dens of neglect and abuse — and replacing them with a national network of community mental health centers. The centers, unlike the hospitals, would

support and treat the formerly institutionalized so that they could live freely in their communities, with as much dignity as possible.

Lawmakers and health officials executed the first half of that vision with alacrity. Thanks to a roster of forces — Kennedy's bill, new and effective antipsychotic drugs and a rising tide of activism for patients' rights — the number of people housed in large psychiatric hospitals fell by 95 percent between the 1950s and 1990s. But nearly 60 years after Kennedy's bill became law, health officials and lawmakers have yet to realize the second half: There is still no community mental health system in America, but it is possible to start building one now.

Steven Sharfstein remembers the Boston State Hospital in Mattapan, a creaking 19th-century building where he and his fellow psychiatry residents were forced to send their most intractable patients.

"It was a terrible place," says Dr. Sharfstein, who served as president of the American Psychiatric Association. "The lights didn't always work, the patients wandered around like zombies. Nobody got better."

Eventually, he and his fellow residents banded together and refused to go. Move the patients back to central Boston, they insisted, and treat them at the community mental health center. Their small protest was part of a growing movement to close state psychiatric hospitals across the nation and replace them with community-based care.

Those hospitals had also arisen from a movement: In the mid-1800s, after visiting hundreds of almshouses, jails and hospitals and seeing the horrid conditions that most people with mental illnesses lived in, the reformer Dorothea Dix begged health officials to create asylums where those patients could be treated more humanely. The first such facilities were small, designed for short-term, therapeutic care, and functioned more or less as Dix had hoped they would. But as local officials began foisting more of their indigent populations onto the states, they morphed into human warehouses. By the time Dr. Sharfstein started his career, most of them held upward of 3,000 patients, often for years at a time.

Advocates of a community-based approach argued that even the sickest psychiatric patients deserved to live in or near their own communities, that they should be cared for in the least restrictive settings possible, and that with the right treatment (humane, respectful, evidence-based) the vast majority of them could recover and even thrive.

Kennedy's bill was meant to enshrine these principles. The plan was to build some 1,500 community mental health centers across the country, each of which would provide five essential services: community education, inpatient and outpatient facilities, emergency response and partial hospitalization programs. Ultimately, the centers would serve as a single point of contact for patients in a given catchment area who needed not just access to psychiatric care but help navigating the outside world.

The law did not provide long-term funding to sustain these new clinics — just seed grants for planning, construction and initial staffing. The hope was that once those grants expired, states would step in with their own resources. But this thinking proved overly optimistic. Rather than invest the money saved through asylum closures on mental health clinics, most states spent it on other priorities, such as cutting taxes or shoring up pensions.

As the initial grants ran out, programs that had been designed specifically for people with serious mental illnesses shifted focus, Dr. Sharfstein says. Some turned their attention to patients with better health insurance than the indigent had. Others tried tackling an array of nonpsychiatric crises. Alleviate homelessness and food insecurity, the thinking went, and even the most seemingly intractable mental illnesses would all but disappear. "Obviously, there is inherent value in addressing social ills," says Paul

Appelbaum, a Columbia University psychiatrist and an expert on the intersection of mental illness and law. “But the concept of community mental health became diluted to the point that it neglected psychiatric treatment.”

Congress tried to revive the flailing Community Mental Health initiative in 1980, with a bill that would have more than doubled the federal government’s investment in Kennedy’s original plan. President Carter signed that bill into law, but President Reagan repealed it the following year. He replaced it with a block grant program that gave state leaders broad discretion in how they spent federal mental health dollars. “It was more or less the death knell for a national community mental health system,” Dr. Appelbaum says. “They spent the money on all sorts of things, including things that we already knew were not working.”

In the end, less than half of the centers that Kennedy had envisioned were ever built. Marginalized people continued to spill out of state psychiatric institutions but found no meaningful safety net. By the 1990s, they were turning up in prisons and homeless shelters once again.

What stands out about this history now is not how disastrously wrong it all went but how close officials came to getting it right. The catchment area model laid out in the Kennedy bill would enable people in psychiatric distress to remain anchored in their communities. And single-point-of-access clinics would help families in crisis avoid the desperate gambit of seeking care through courts and judges. “The community mental health model was the right one,” says Dr. Appelbaum. “I talk to so many families who are in crisis today, and they have no idea where to turn.”

Congress could correct course now by writing a new bill that pulls the best of these past attempts together and builds on them.

Federal officials took a promising step in that direction in 2014, when they created a new community mental health demonstration project that enables Medicaid to pay mental health clinics based on what it actually costs to care for patients. “There are so many things you do to support a person with a serious mental illness that you cannot get reimbursed for,” Mr. **Ingoglia** says. “Sending case managers to jails and prisons and state hospitals to help clients transition into outpatient care. Working with police to screen the people that they encounter in their work.” The pilot program factors these essentials into the cost of care and reimburses centers accordingly.

So far, the resulting initiatives have proved more sustainable and more effective. In Missouri, behavioral health clinics are serving nearly 30 percent more patients by switching to the new model and have been able to provide same-day service to many clients. In Oklahoma, mental health clinics have effectively “put a therapist in every police car,” officials say, by outfitting cars with an iPad that contains a specially designed app. The program has helped reduce adult psychiatric emergency room visits by more than 90 percent and is now being implemented in homeless shelters and other contact points throughout the community.

Congress has already expanded this demonstration project, and scores of states are experimenting with the new model or planning to. But it will take more than pilot programs for these new centers to succeed where the early community mental health movement failed. Individual projects will have to be evaluated rigorously so that the most effective ones can be scaled. Hospitals, police departments, homeless shelters and other institutions will have to be brought along at every step so that mental health is neither siloed nor forgotten but instead becomes a fully embedded part of the wider community.

Education and outreach will also be essential. People with serious mental illnesses are far more likely to be victims of violent crime than perpetrators. But in an age where mass shootings and random street attacks have become commonplace, that fact has been buried in stigma. And a truly robust mental health system will have to include a range of services — not only outpatient clinics but also short-term care

facilities for people facing acute crises, and some congregate institutions for the small portion of people who can't live safely in the community. To prevent abuse, these facilities will need to be well funded, well monitored and held to a high standard.

None of this will be cheap. By most estimates, it would cost several billion dollars to fully fund and implement the original community mental health vision today. But those costs would be partly offset by what police departments, jails and hospitals could save. The $193 billion in lost earnings that results from untreated mental illnesses should also be an incentive, and an eventual source of savings.

Americans have accepted the mistreatment and neglect of people with serious mental illnesses for far too long. It's within our power to break that cycle now, and to change the way that the most vulnerable among us live for generations to come.