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Funding Mental Healthcare in the Wake of Deinstitutionalization: How the United States and the United Kingdom Diverged in Mental Health Policy After Deinstitutionalization, and What We Can Learn From Their Differing Approaches to Funding Mental Healthcare

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CATHERINE RYAN GAWRON[*]

INTRODUCTION

"Disaster."[1]
"Catastrophe."[2]
"A psychiatric *Titanic*."[3]

[1] CHRISTOPHER JENCKS, THE HOMELESS 39 (1994).
[2] *Id.*

"A disgrace."[4]

These labels have all been used to describe deinstitutionalization in the 1960s and 1970s in the United States. Deinstitutionalization was a widespread movement in both the United States and the United Kingdom to close state psychiatric hospitals, and release mentally ill individuals from involuntary commitment in those facilities to receive community-based care and services. The deinstitutionalization movement transformed psychiatry in the United States, and the treatment of the mentally ill community for decades to come.[5] The goal of deinstitutionalization—improving the quality of life for those with mental illness—was far from controversial. Advocates for deinstitutionalization praised the closing of asylums and the release of involuntarily committed patients back into the community to live with autonomy.[6] So, what was the problem?

While most people generally consider the goals of deinstitutionalization laudable, the practical results have been heavily criticized. Particularly, critics condemned the environment into which formerly institutionalized patients were released for its lack of social services for mental health, high rates of homelessness and violence, and dearth of appropriate inpatient or effective outpatient treatment options.[7] Some scholars and social scientists believe the issues created by deinstitutionalization were as problematic as the conditions for the mentally ill population that precipitated the deinstitutionalization movement itself.[8] Even advocates of deinstitutionalization note that this diaspora of mentally ill individuals into the community without sufficient social and medical services was "not an unmixed blessing."[9] The criticisms leveled against deinstitutionalization mostly focus on what happened after the doors of such asylums were opened: namely, the lack of care and services provided to mentally ill citizens once they were released from the institution. For many, this question has yet to be answered satisfactorily, as many of the problems that followed deinstitutionalization remain unsolved even today.

The aftermath of deinstitutionalization provides the impetus for writing this Note. While many scholars have debated the benefits and shortcomings of deinstitutionalization in a variety of contexts,[10] this Note discusses a significant factor that underlies criticisms of deinstitutionalization: funding.

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[3] E. FULLER TORREY, OUT OF THE SHADOWS: CONFRONTING AMERICA'S MENTAL ILLNESS CRISIS 11 (1997). E. Fuller Torrey is a psychiatrist and schizophrenia researcher who has authored many best-selling books on mental illness. In addition, Torrey is the Associate Director of Research at the Stanley Medical Research Institute, and Founder of the Treatment Advocacy Center, a non-profit that supports and promotes outpatient and civil commitment laws.

[4] *Id.*

[5] *See generally* Ronald Roesch & Stephen L. Golding, *The Impact of Deinstitutionalization*, *in* AGGRESSION AND DANGEROUSNESS 209-39 (David P. Farrington & John Gunn eds., 1985); GEORGE PAULSON, CLOSING THE ASYLUMS: CAUSES AND CONSEQUENCES OF THE DEINSTITUTIONALIZATION MOVEMENT (2012).

[6] *See, e.g.*, H. Richard Lamb, *Deinstitutionalization at the Beginning of the New Millennium*, *in* DEINSTITUTIONALIZATION: PROMISE AND PROBLEMS 3, 17 (H. Richard Lamb & Linda E. Weinberger eds., 2001).

[7] *See* discussion *infra* Parts II (B) & (C).

[8] *See generally* TORREY, *supra* note 3.

[9] PAULSON, *supra* note 5, at 4.

[10] *See generally supra* notes 2–7.

Deinstitutionalization created the cultural, social, and political environment out of which mental health legislation and programming stemmed. This Note analyzes the connection between this environment and the funding of each nation's mental health programming. Mental healthcare programs in the United States and the United Kingdom were funded after each nation's deinstitutionalization period, as each nation responded to the issues resulting from deinstitutionalization. In the United States, activism prompted reforms to mental healthcare related to judicial decisions, such as *O'Connor v. Donaldson*[11] and *Olmsted v. L. C. ex rel. Zimring*;[12] legislation such as the Americans with Disabilities Act;[13] and the use of mental health courts for criminal offenses. Across the pond, the United Kingdom took a different approach in caring for the mentally ill population. Rather than a mass deinstitutionalization movement marked by rapid change and civil rights activism on behalf of the mentally ill population, the United Kingdom saw a slower and less drastic deinstitutionalization period, marked by inconsistent funding and slow enactment of community-based treatment.[14]

The difference in the scope and process of deinstitutionalization between the two countries is manifested in the contrasting effects on the mentally ill communities within those countries. While the United Kingdom's National Health Service (NHS) covers a large amount of mental health services, the country has not addressed the pervasive stigma or the issue of mentally ill prison populations with the same depth and breadth as the United States. While the social attitude toward, and understanding of, mental illness in the United States is far from adequate,[15] it is decades ahead of the United Kingdom.[16] Limited funding in the NHS budget for mental health treatment in the United Kingdom has led to reduced ability to accommodate the number of individuals seeking such treatment. In addition, the United Kingdom has not widely adopted alternative programs, such as the mental health courts enacted in the United States, to divert mentally ill offenders from the traditional criminal justice system. Furthermore, future progress in the United Kingdom towards adopting these programs may be thwarted by a lack of funding for mental healthcare innovations.[17]

This Note proposes that we can better understand the resulting social and political climates towards mental health in each nation through a comparative analysis of deinstitutionalization, as well as the subsequent funding structures

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[11] O'Connor v. Donaldson, 422 U.S. 563 (1975) (holding that a person must be a danger to himself or herself or others in order for the involuntary commitment of such individual to be constitutional).

[12] Olmstead v. L.C. ex rel. Zimring, 527 U.S. 581 (1999) (holding that unjustified institutionalization of a mentally ill individual can violate the American's with Disabilities Act (ADA)).

[13] Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 et seq. (2008).

[14] *See generally* John Turner et al., *The History of Mental Health Services in Modern England: Practitioner Memories and the Direction of Future Research*, 59 MED. HIST. 599 (2015).

[15] *See* E. FULLER TORREY, AMERICAN PSYCHOSIS: HOW THE FEDERAL GOVERNMENT DESTROYED THE MENTAL ILLNESS TREATMENT SYSTEM 141–42 (2012) (discussing impediments to further change related to social understanding of mental health conditions, treatment, and rights) [hereinafter AMERICAN PSYCHOSIS].

[16] *See infra* Part III.

[17] *See* OECD Health Div., *One of the Most Innovative Mental Health Systems in the OECD, Spending Cuts in the UK Risk Undermining Progress*, OECD, https://www.oecd.org/els/health-systems/MMHC-Country-Press-Note-UK.pdf.

of mental healthcare programs in the United States and the United Kingdom. Further, this analysis identifies areas in which funding can be more appropriately addressed, which is vital in order to create a more robust and responsive mental health policy. Part II of this Note addresses the United States' history of treating mental illness, including how and why the deinstitutionalization movement began, and the United States' response to the deinstitutionalization movement over the past forty to sixty years. This Note highlights the lack of social services created to fill the void left by deinstitutionalization, and the resulting social issues, such as deinstitutionalization's effect on rates of homelessness and incarceration, and the laws enacted in response to these issues.[18] Part II concludes by examining the current state of mentally ill individuals in the United States prison system, and the establishment of mental health courts as an alternative solution.

Part III begins by analyzing the United Kingdom's mental health history leading up to deinstitutionalization. Then, it examines the mental health laws and social services in the United Kingdom, particularly the role of community care and legislation regarding mental health treatment.[19] The Note then discusses the current status of mental health treatment in the United Kingdom, specifically regarding incarceration of mentally ill individuals, funding and accessibility of care, and social issues that contribute to the treatment of mental health. This Part also focuses on the financing of mental healthcare programming through the overall NHS budget, and the effect that this has on the accessibility of care.

Finally, Part IV of this Note highlights the differences in how each nation funded mental healthcare programs after deinstitutionalization to provide a view of the policy recommendations and lessons that can be extrapolated from the experiences of each nation. The goal of this analysis is to identify key policy issues that prevented a more successful implementation of mental healthcare after deinstitutionalization in each nation, and to provide a background to support more successful future endeavors for the United States and United Kingdom. Specifically, this Note examines the differences in funding that caused the subsequent mental healthcare policies of each nation to differ. Understanding the divergence in financial context and funding between these two nations can provide vital information about how resulting policies developed and provide impetus for the United States and the United Kingdom to learn from each other's issues in mental health policy to strengthen their future mental health policy and programs.

I. MENTAL HEALTH IN THE UNITED STATES

A. *A HISTORY OF MENTAL HEALTH*

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[18] The brief summary of mental health history in the United States provided is limited to background to support my comparative review of the United States and the United Kingdom. For a more comprehensive view of the history of mental health and deinstitutionalization in the United States, see TORREY, *supra* note 3.

[19] *See infra* Part III.

From its inception, mental healthcare "treatment" in the United States consisted of removal of mentally ill individuals from society. The pervasive idea until the mid-nineteenth century was that the mentally ill were, quite simply, mad.[20] Society responded to such madness by removing affected individuals from society, through incarceration or placement in asylums.[21] Removal was designed to assuage fear that these individuals could not function as members of society and would cause harm to their communities.

Activist Dorothea Dix is often cited as the leader behind the change in attitude towards mental illness.[22] Dix was a nurse, educator, and social advocate who championed the cause of mental health treatment just prior to the Civil War. Through social work, lobbying, and opening facilities for the mentally ill, Dix crusaded against incarceration as a method of treating mental illness and spearheaded efforts for more humane treatment of the mentally ill. Dix championed the idea that mental illness was a treatable condition, not unwavering madness necessitating permanent removal from society. She was the driving force behind the establishment of over thirty psychiatric facilities that aimed to treat mental illness through therapies; by highlighting the inhumane treatment of the mentally ill who were incarcerated, Dix advocated for facilities which provided appropriate medical and psychiatric treatment.[23] Highlighting the inhumane treatment of the mentally ill who were incarcerated, Dix fought for the mentally ill to be placed in psychiatric facilities and receive medical care, rather than being removed to prisons. Dix is celebrated for changing the perception of mental illness in the United States and for beginning a movement to treat—rather than just confine—patients with mental illness.

Psychiatric facilities such as the ones Dix championed continued to be the primary mode of treatment for those with serious mental illness for much of the nineteenth and twentieth centuries. However, the conditions of such facilities began to deteriorate as the facilities became overcrowded. As the number of patients rose, it became difficult to staff the overcrowded facilities with appropriate medical personnel.[24] Patient care suffered; with severe overcrowding and sanitation issues, these facilities could do little more than house mentally ill individuals to keep them removed from the mainstream community, and "warehousing" patients became the norm. Rather than being therapeutic institutions aimed at treating the underlying mental illness of their patients, these facilities became custodial facilities for the mentally ill—simply another form of incarceration.[25] Additionally, if medical "treatments" were available to patients, they were far from the therapeutic care Dix had envisioned. The medical treatments used by institutions often did not help patients' mental conditions. In some cases, the abusive treatment exacerbated a

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[20] *See generally* GERALD N. GROB, MENTAL INSTITUTIONS IN AMERICA: SOCIAL POLICY TO 1875 (1973).

[21] *Id.*

[22] Manon S. Parry, *Dorothea Dix (1802–1887)*, 96 AM. J. PUB. HEALTH 624, 625 (2006).

[23] *Id.*

[24] PAULSON, *supra* note 5, at 58.

[25] *See* GROB, *supra* note 20.

patient's mental illness—or was simply cruel. [26] On the severe end, electroconvulsive therapy (ECT), dunking or spraying patients with cold water, and psychosurgery were all used to treat severe cases of mental illness in institutions across the United States.[27]

Psychosurgery, most notably lobotomies, became extremely popular to treat uncontrollably emotional or violent patients. Imported from Portuguese neurologist Egas Moniz in 1936, the lobotomy was a dominant psychological treatment used in institutions for over twenty years. [28] In 1949, Moniz was even awarded the Nobel Prize for the innovation of the lobotomy. [29] A prefrontal lobotomy, the most common type, consisted of cutting or scraping away part of the brain to sever the connection to the pre-frontal cortex. [30] The goal was to stunt and block any emotional reactions or behavior resulting from conditions such as depression, nervousness, and anxiety.[31] Lobotomies rapidly became popular to treat severely mentally ill patients resistant to other treatment methods, due to the relatively "quick" procedure time, inexpensiveness, and initial positive results of reduced extreme and violent behavior in its patients. Lobotomies were performed disproportionally on female patients.[32] When the severe and debilitating effects on the thousands of patients who had been "treated" with lobotomies came to light, the practice fell out of fashion. The popularization of pharmacology in the mid-twentieth century was also partially to blame for the demise of the lobotomy.[33] The first psychoactive drug, Thorazine (also known as Chlorpromazine), was created in 1950 as a pharmacological or "chemical lobotomy." [34] Psychoactive drugs eventually became a more effective treatment for severe mental illness than the lobotomy—but not before tens of thousands of lobotomies were performed in the United States.[35]

In the early to mid-twentieth century, it became clear that individuals being "treated" in psychiatric institutions were not being treated at all. They were either warehoused away from their communities in squalid conditions, or, more likely, involuntarily undergoing abusive medical procedures to "treat" their mental illness. A fundamental change to the system was desperately needed.

B. *DEINSTITUTIONALIZATION IN THE UNITED STATES*

Deinstitutionalization was the mass reduction and elimination of large state-run mental hospitals and the release of patients back into the

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[26] Allison M. Foerschner, *The History of Mental Illness: From Skull Drills to Happy Pills*, 2 INQUIRIES J. 1 (2010).

[27] *Id.*

[28] JENELL JOHNSON, AMERICAN LOBOTOMY: A RHETORICAL HISTORY 2 (2014).

[29] *Id.*

[30] *Id.*

[31] *Id.*

[32] *Id.* at 20.

[33] Michael Rosenbloom, *Chlorpromazine and the Psychopharmacologic Revolution*, 287 MS J. AM. MED. ASSOC. 1860 (2002).

[34] *Id.* at 1861.

[35] JOHNSON, *supra* note 28, at 2.

community.[36] The magnitude of deinstitutionalization was immense; from 1955 to 1994, there was an approximately ninety percent reduction of those living in public psychiatric hospitals and institutions.[37] Most of this movement occurred in the 1960s and 1970s, but the exact time frame varied from state to state, as did the exact method of closure of state hospital facilities. While the mechanisms of deinstitutionalization varied, the overall effect was a "reduction, and elimination of the large state hospitals originally built to help the mentally ill; and the release, shift, of the clients, patients, or inmates, as they were once called, out of those hospitals and into the community."[38]

Increased social concern for the welfare of the mentally ill spurred deinstitutionalization, which occurred against the backdrop of the deplorable conditions in state psychiatric institutions.[39] Once the severity of the conditions in such facilities became known, advocates of deinstitutionalization argued that mentally ill patients in the facilities were receiving "treatment" simply akin to incarceration, as many of the patients were involuntarily committed and could never choose to leave a facility. In a parallel to the conditions about which Dix warned from eighty years prior, these state hospitals seemed no better than prisons.

This social concern was followed by legislation aimed at better protecting the mentally ill, and a better medical understanding of mental illness led to innovations in medical treatment options. The development of psychoactive drugs, such as Thorazine (Chlorpromazine),[40] improved treatment for severe mental illnesses, such as schizophrenia.[41] These psychoactive drugs provided new forms of medical treatment that allowed patients to function outside of the institutional environment.[42] In addition, zealous lawyers litigated suits against the state for involuntary confinement. These cases, coupled with the medical advances, legislation, and societal concerns indicated that fundamental attitudes about mental illness and the mentally ill were shifting.[43]

One piece of legislation credited with supporting deinstitutionalization was the Community Mental Health Act of 1963 (CMHA).[44] In response to growing public pressure in the 1960s, President John F. Kennedy identified mental health reform as one of his policy goals.[45] Kennedy's dedication to the cause was also influenced by his personal life: his sister, Rosemary, suffered from a mental illness, and even received a lobotomy herself during a period of institutionalization.[46] Kennedy subsequently put together a robust platform on mental health reform, including the establishment of an Interagency Committee on Mental Health, which advised him on how best to approach a

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[36] PAULSON, *supra* note 5, at 4.

[37] TORREY, *supra* note 3, at 8–9. The ninety percent reduction reflects the overall reduction in institutionalized patients when adjusted to 1994 population numbers. *Id.*

[38] PAULSON, *supra* note 5, at 4.

[39] *See generally* TORREY, *supra* note 3.

[40] *See* Rosenbloom, *supra* note 33.

[41] *Id.* at 1860.

[42] *Id.*

[43] PAULSON, *supra* note 5, at 5–6.

[44] Mental Retardation Facilities Construction Act, Pub. L. 88-164, 77 Stat. 282 (1963).

[45] AMERICAN PSYCHOSIS, *supra* note 15, at 1, 41–44.

[46] *Id.* at 37.

revision of the mental health system. [47] This committee, like the Joint Commission on Mental Illness and Health, created in 1961, [48] strongly recommended ceasing to treat the mentally ill in state institutions. In 1963, the Commission delivered a report to Congress, which recommended shifting mental healthcare from public hospitals, which were "bankrupt beyond repair," to community-based care, along with an allocation of significant governmental funding to do so. [49] With the Interagency Committee and Joint Commission both pushing for closure of state facilities for mental health treatment, the government had little choice but to respond with legislation for deinstitutionalization.

Congress passed the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, also known as the Community Mental Health Act. [50] The Act provided federal funding through state grants for community mental health centers and research facilities, enabling community-based healthcare for the treatment of mental illness. [51] This Act, coupled with the community mental health centers (CMHCs) proposed by the Interagency Committee, ushered in a swift move towards community care, paving the way for deinstitutionalization.

C. *THE RESULTS OF DEINSTITUTIONALIZATION*

Despite good intentions to improve the quality of life for mentally ill individuals in state institutions, deinstitutionalization had disastrous results. When patients were released from these hospitals, they had nowhere to go. The Community Mental Health Act of 1963, which intended to improve care conditions, "included no plan for the future funding of . . . mental health centers" and "encouraged the closing of state mental hospitals without any

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[47] *Id.* at 42–44.

[48] *Id.* at 45. Interestingly enough, while the members of the Interagency Committee on Mental Health were all respected psychologists, they had no personal experience with community care prior to their recommendations. E. Fuller Torrey believes this was significant:

> The rejection of state hospitals by the Interagency Committee would have profound effects on the subsequent failure of the emerging system. Because no Committee member really understood what the hospitals were doing, there was nobody who could explain to the committee that large numbers of patients in the hospitals had no families to go to if they were released; that large numbers of patients had a brain impairment that precluded their understanding of their illness and need for medication; and that a small number of patients had a history of dangerousness and required confinement and treatment. Nobody could explain to the committee that the state hospitals were playing a role in protecting the public, and in protecting mentally ill individuals from being victimized or becoming homeless. Whatever their other shortcomings, state mental hospitals were still functioning as asylums in the original sense of the term.

Id.

[49] *Id.* at 44.

[50] Mental Retardation Facilities Construction Act, Pub. L. No. 88-164, 77 Stat. 282 (1963); *see also Community Mental Health Act*, NAT'L COUNCIL FOR BEHAV. HEALTH (2019), https://www.thenationalcouncil.org/about/national-mental-health-association/overview/community-mental-health-act/.

[51] PAULSON, *supra* note 5, at 170.

realistic plan regarding what would happen to the discharged patients."[52] The idea was that patients would transition to community-based treatment and receive social and medical services outside of institutional facilities; however, the absence of structure and funding to accomplish these goals meant services were not adequately available to those who needed them, nor to a patient's family members who would now responsible for caregiving. Prominent deinstitutionalization scholar David Rothman notes "[t]hat deinstitutionalization has generally failed to deliver appropriate services to ex-mental patients or other persons in need of them is hardly debatable."[53]

Beyond the dearth of medical and social services available to newly liberated institutional patients, the rapid emptying of the institutions made it exceedingly difficult to secure housing.[54] One of the most significant and long-lasting issues to arise from deinstitutionalization was the increase in homelessness among the mentally ill. Once patients were released, there was not enough social support—social workers, community advocates, or medical professionals—to help them relocate and apply to appropriate outpatient programs, community housing, or to find other housing options. More fundamentally, there was simply not enough affordable housing. This led some scholars to declare that "[i]t is now an axiom that deinstitutionalization caused the contemporary epidemic of homelessness for the mentally ill."[55] Though scholars disagree on how directly deinstitutionalization affected homelessness, most would strongly agree that, at minimum, deinstitutionalization contributed to an increase in the incidence of homelessness. [56] This housing crisis contributed to disproportionally high levels of mentally ill individuals within the national homeless population. In the 1990s, one-third of the homeless population had a mental illness.[57]

While rates of mental illness among the homeless population have fluctuated since the 1990s, statistics continue to show the extreme disparity between rates of mental illness among the homeless compared to the population at large.[58] According to the Department of Housing and Urban

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[52] AMERICAN PSYCHOSIS, *supra* note 15, at 58.

[53] Samuel R. Bagenstos, *The Past and Future of Deinstitutionalization Litigation*, 34 CARDOZO L. REV. 1, 3 (2012) (quoting David J. Rothman, *The Rehabilitation of the Asylum*, AM. PROSPECT (Sept. 21, 1991), http://prospect.org/article/rehabilitation-asylum).

[54] *See generally* JENCKS, *supra* note 1.

[55] Robert Weisberg, *Restorative Justice and the Danger of "Community"*, 2003 UTAH L. REV. 343, 364 (2003).

[56] Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, 28 HOUS. L. REV. 63, 67–68 (1991) (arguing that equating homeless individuals with deinstitutionalized individuals is "misplaced," and that "it ignores the concessions made by virtually every critic of deinstitutionalization policies: deinstitutionalization is not the sole cause of the increase in homelessness" (emphasis omitted)).

[57] OFFICE OF RESEARCH & PUB. AFFAIRS, TREATMENT ADVOCACY CTR., SERIOUS MENTAL ILLNESS AND HOMELESSNESS (2016); *see also* E. Fuller Torrey, *Documenting the Failure of Deinstitutionalization*, 73 PSYCHIATRY: INTERPERSONAL & BIOLOGICAL PROCESSES 122, 122–24 (2010).

[58] *Compare Mental Health Information: Statistics*, NAT'L INST. MENTAL HEALTH, https://www.nimh.nih.gov/health/statistics/mental-illness.shtml (last updated Nov. 2017) [hereinafter *Mental Health Information: Statistics*] ("Nearly one in five U.S. adults lives with a mental illness (44.7 million in 2016)."); *Mental Health by the Numbers,* NAT'L ALLIANCE ON MENTAL ILLNESS (2019), https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers [hereinafter *Mental Health by the Numbers*]("Approximately 1 in 25 adults in the U.S. (11.2 million) experiences a serious mental illness

Development's 2018 Continuum of Care report, approximately one out of every five homeless individual suffers from a serious mental illness.[59] This is higher than the rate of serious mental illness in the general public—in 2016, just under twenty percent of the United States population at large suffered from any mental illness,[60] and only four percent suffered from a serious mental illness.[61] These statistics indicate that homeless individuals suffer from serious mental illness at a rate of five times the general population.

An equally, if not more, concerning issue is the staggeringly large number of incarcerated mentally ill individuals in the American criminal justice system. Dix's crusade to remove the mentally ill from prisons did not stand the test of time; plagued by over-crowding and lack of funding and personnel, psychiatric facilities could not accommodate the large number of individuals who needed them. By the 1970s, the prisons of the United States once again housed a large number of mentally ill people, a figure which only increased in the following decades. Various state surveys in the 1980s and 1990s indicated that six to ten percent of the general prison population had a serious mental illness.[62] Deinstitutionalization only exacerbated the problem; more recent studies have found that up to twenty-five percent of inmates have a serious mental illness,[63] and a 2006 report by the Bureau of Justice Statistics indicates that over half of inmates—in both state and federal prisons—have some type of mental health condition.[64]

The conditions in these prisons for the mentally ill were (and often still are) inhumane. For prisoners who suffer from mental illness, the distinct lack of psychiatric care available is compounded by high rates of sexual assault and physical violence (mentally ill prisoners are often singled out for physical abuse by other prisoners, either as retaliation for behavior resulting from an underlying mental condition, or because they are seen as being easy targets).[65]

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in a given year that substantially interferes with or limits one or more major life activities."), *with* U.S. DEP'T OF HOUSING AND URBAN DEV., HUD 2018 CONTINUUM OF CARE HOMELESS ASSISTANCE PROGRAMS HOMELESS POPULATIONS AND SUBPOPULATIONS (2018) [hereinafter HUD 2018 CONTINUUM] (noting that for the Fiscal Year 2018, 111,122 individuals were reported as "Severely Mentally Ill", compared to the total number of 552,830 homeless individuals).

[59] HUD 2018 CONTINUUM, *supra* note 58.

[60] *Mental Health Information: Statistics*, *supra* note 58. "Any mental illness (AMI) is defined as a mental, behavioral, or emotional disorder. AMI can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment." This is different from a serious mental illness (SMI), which NIMH defines as "a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities." *Id.*

[61] *Id.*

[62] TORREY, *supra* note 3, at 28–31.

[63] *See* Pamela M. Diamond et al., *The Prevalence of Mental Illness in Prison*, 29 ADMIN. POL'Y MENTAL HEALTH (2001); *see also* Seth J. Prins, *The Prevalence of Mental Health in U.S. State Prisons: A Systematic Review*, 65 PSYCHIATRIC SERVS. 862, 866 (2014) (comparing twenty-eight studies of mental illness and recidivism published between 1989 and 2013, to find that the "reviewed studies generally confirm what researchers, policy makers, practitioners, and advocates have long understood: the current and lifetime prevalence of numerous mental illnesses is higher among incarcerated populations than in nonincarcerated populations, sometimes by large margins").

[64] DORIS J. JAMES & LAUREN E. GLAZE, U.S. DEP'T OF JUSTICE, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES: BUREAU OF JUSTICE STATISTICS SPECIAL REPORT 1 (2006).

[65] *Id.* A 2006 study from the Bureau of Justice Statistics found that, "State prisoners who had a mental health problem were twice as likely as State prisoners without to have been injured in a fight since admission (20% compared to 10%)" and had higher rates of sexual or physical abuse compared to jail inmates without mental health problems (24% to 8%, respectively). *Id.*

In addition, corrections facilities use isolation and solitary confinement to punish inmates for outbursts or behavior related to mental illness, which can often exacerbate serious mental illnesses or put individuals suffering from a serious mental health condition in danger of harming themselves. Michael Perlin, one of the most prolific authors on mental health and the law, asserts that these effects are worse for women and racial minorities: "[s]een as 'the other,' individuals who are racial minorities, women, or both are marginalized to an even greater extent than other persons with mental disabilities in matters related to civil commitment and institutional treatment . . . discharge planning, community mental healthcare, and forensic mental health."[66]

Inadequate social services and lack of available housing upon release from prison, coupled with a lack of outpatient medical services necessary to transition to life outside of prison or an institutional environment, make it almost impossible for individuals with mental health issues to transition to a stable life. Without these crucial supports and basic living necessities, many individuals have no practical alternative to reoffending and returning to prison. This leads to the "revolving door" phenomenon, which is the continuous cycling of mentally ill individuals from homelessness to prison and back again—all while mental health conditions remain untreated.[67]

Deinstitutionalization is not without its defenders, however. Proponents modestly argue that while the methods and details of deinstitutionalization may have left something to be desired, deinstitutionalization created positive benefits in the lives of many mentally ill individuals by moving them out of psychiatric facilities and back into their communities.[68] In addition, scholars point to outside factors such as cuts in social programs like supplemental security income and low-income housing that may have contributed to the "failures" attributed to deinstitutionalization—homelessness and lack of social services—more than deinstitutionalization itself. [69] Perlin argues that to conclude deinstitutionalization caused an increase in homelessness is to oversimplify the relationship between the social conditions at the time and the resulting consequences. [70] Drawing such a direct correlation between

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[66] Michael L. Perlin & Heather Ellis Cucolo, '*Tolling for the Aching Ones Whose Wounds Cannot Be Nursed': The Marginalization of Racial Minorities and Women in Institutional Mental Disability Law*, 20 J. GENDER, RACE & JUST. 431, 432 (2017); *see also* Michael L. Perlin & Deborah A. Dorfman, *'The Sources of This Hidden Pain': Why a Class in Race, Gender, Class and Mental Disability?*, *in* VULNERABLE POPULATIONS & TRANSFORMATIVE LAW TEACHING: A CRITICAL READER 313 (2011).

[67] Jacques Baillargeon et al., *Psychiatric Disorders and Repeat Incarcerations: The Revolving Prison Door*, 166 AM. J. PSYCHIATRY 103 (2009).

[68] Lamb, *supra* note 6, at 17 ("But overall, most chronically and severely mentally ill persons now live in the community rather than in institutions. With adequate treatment and support, this change has greatly improved their lot, leading to a much richer life experience and a higher quality of life.").

[69] *See* Michael L. Perlin, *Book Review*, 8 N.Y. L. SCH. J. HUM. RTS. 557, 568 (1991) (reviewing ANN BRADEN JOHNSON, OUT OF BEDLAM: THE TRUTH ABOUT DEINSTITUTIONALIZATION (1990)) [hereinafter *Book Review*] ("SSI has allowed (encouraged) states to release patients, since the entitlement program ensured a disability-based, federally funded grant to provide for the ex-patients' support in community settings. When these payments suddenly and dramatically dried up, it should not have been a real surprise to policymakers, behaviorists (or editorial writers), that some former patients would now be without homes."); *see also* BRENDAN O'FLAHERTY, MAKING ROOM: THE ECONOMICS OF HOMELESSNESS 235 (1996) (suggesting that after 1975, movement into nursing homes and correctional institutions adequately offset movement of mentally ill patients out of state and county mental hospitals, and that the rise of homelessness among the mentally ill in the 1980s rose due to housing conditions).

[70] *Book Review*, *supra* note 69.

deinstitutionalization and homelessness, as Perlin puts it, is "all wrong. Dead wrong."[71]

University of Michigan law professor Samuel R. Bagenstos argues that those who show support for the deinstitutionalization movement and those who abhor it share the general view that deinstitutionalization had some positive consequences. Bagenstos notes that these two opposing views of deinstitutionalization are "not a disagreement about the facts so much as one about how to characterize and interpret those facts."[72] Further, "supporters and opponents will agree that deinstitutionalization has caused significant positive results for a large number of people who would otherwise have been set apart from their communities and denied the basic interactions of human civic life."[73]

D. *MENTAL HEALTHCARE AFTER DEINSTITUTIONALIZATION*

Regardless of whether one views deinstitutionalization as a failure or a success for those with mental illness, it is impossible to ignore the lasting consequences and remaining issues that plague the mentally ill in the United States, such as the continued unavailability of appropriate outpatient social and medical services. The high rate of mentally ill individuals in our prison system stems, in part, from this lack of infrastructure and services, as discussed previously in Section A.

Simply put, the prevalence of mental illness among inmates in the United States prison system is extreme. The lack of appropriate and available medical treatment, resulting, in part, from deinstitutionalization, has led to high numbers of arrests and incarcerations of the mentally ill.[74] Once individuals who were released from institutions found themselves without adequate social services and housing, there was a higher likelihood they would end up in prison. Some scholars dub this process of sending individuals who previously would have been institutionalized to prison as the "transinstitutionalization" movement,[75] directly linking deinstitutionalization to the increase of mentally ill prisoners.[76] This meant, in practice, prisons became de facto treatment facilities for the mentally ill.[77]

The National Alliance on Mental Illness (NAMI) estimates that two million individuals with mental illness are booked into jails each year, with

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[71] *Id.* at 560.

[72] Bagenstos, *supra* note 53, at 3.

[73] *Id.*

[74] *See generally id.*

[75] Steven Raphael & Michael A. Stoll, *Assessing the Contribution of the Deinstitutionalization of the Mentally Ill to Growth in the U.S. Incarceration Rate*, 42 J. LEGAL STUD. 187 (2013).

[76] *But see* Seth J. Prins, *Does Transinstitutionalization Explain the Overrepresentation of People with Serious Mental Illnesses in the Criminal Justice System?*, 47 CMTY. MENTAL HEALTH J. 716 (2011) (arguing that while transinstitutionalization is a widely accepted explanation for the number of individuals with Serious Mental Illness (SMI) being overrepresented in correctional settings, a more nuanced approach is recommended for explaining why people with SMI become involved in the criminal justice system, and to develop more effective strategies to move these individuals out of the criminal justice system).

[77] M.J. Stephey, *De-Criminalizing Mental Illness*, TIME (Aug. 8, 2007), http://content.time.com/time/health/article/0,8599,1651002,00.html.

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nearly fifteen percent of males and thirty percent of females having a serious mental illness.[78] Overall, more than half of the current jail and prison population in the United States has some type of mental illness.[79] This is a staggeringly disproportionate rate of mental illness in the criminal justice system, compared to the national rates of mental illness among approximately four percent of the general population.[80] These numbers are so striking because many jails and prisons lack adequate, or even any, medical services for the mentally ill, as prisons are fundamentally designed for punishment—not treatment. As a result, mental conditions go untreated, and even worsen, during the individual's time in prison.[81] NAMI estimates that over eighty percent of inmates with serious mental illnesses are not receiving the care that they need.[82]

Lack of adequate medical care in prison can also affect rates of recidivism. Despite contradictory results from previous studies,[83] current research suggests a strong correlation between mental illness and recidivism in the criminal justice system.[84] One of the most recent and comprehensive studies affirms this view. A study of over 200,000 inmates in Florida, from 2004 to 2011, utilized multiple recidivism measures and pointed definitively to "a significant positive association between any mental health diagnosis, and particularly a serious mental health diagnosis and the likelihood of recidivating after release."[85]

One innovative solution to the overrepresentation of the mentally ill in the criminal justice system was the implementation of mental health courts (MHCs). MHCs are designed to divert individuals with mental illness from the traditional court system to an alternative rehabilitative court system.[86] MHCs are rooted in principles of therapeutic jurisprudence (also referred to as therapeutic rehabilitation),[87] best described by one of the scholars who developed the concept:

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[78] *Jailing People with Mental Illness*, NAT'L ALLIANCE ON MENTAL ILLNESS, https://www.nami.org/Learn-More/Public-Policy/Jailing-People-with-Mental-Illness (last accessed May 3, 2019) [hereinafter *Jailing People with Mental Illness*].

[79] JAMES & GLAZE, *supra* note 64.

[80] *See generally* Rosenbloom*, supra* note 33.

[81] *Jailing People with Mental Illness*, *supra* note 78.

[82] *Id.*

[83] *See generally* William D. Bales et al., *Recidivism and Inmate Mental Illness*, 6 INT'L J. CRIMINOLOGY & SOC. 40 (2017) (discussing the lack of consensus and inconclusive findings regarding the relationship between mentally ill inmates and recidivism rates in studies from the past thirty years due to methodological limitations such as small sample sizes or low follow-up periods).

[84] *Id.*; *see also* Baillargeon et al., *supra* note 67, at 103 (finding that, in a study of 79,000 inmates over a six-year period, those with major psychiatric disorders, such as major depressive disorder, bipolar disorder, and schizophrenia, had substantially increased rates of multiple prior incarcerations); Prins, *supra* note 63, at 866 (finding, in general, a strong relationship between incarceration, recidivism, and mental health).

[85] Bales et al., *supra* note 83, at 49.

[86] *See generally* Bruce J. Winick, *The Jurisprudence of Therapeutic Jurisprudence*, 3 PSYCH. PUB. POL'Y & L. 184 (1997) [hereinafter *The Jurisprudence of Therapeutic Jurisprudence*].

[87] The development of the therapeutic jurisprudence model is largely credited to David B. Wexler and Bruce J. Winick. *See* DAVID B. WEXLER & BRUCE J. WINICK, ESSAYS IN THERAPEUTIC JURISPRUDENCE (1991); DAVID B. WEXLER, THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT (1990).

> *Therapeutic jurisprudence* is the study of the role of the law as a therapeutic agent. It is an interdisciplinary enterprise designed to produce scholarship that is particularly useful for law reform. Therapeutic jurisprudence proposes the exploration of ways in which, consistent with principles of justice and other constitutional values, the knowledge, theories, and insights of the mental health and related disciplines can help shape the development of the law. Therapeutic jurisprudence builds on the insight that the law itself can be seen to function as a kind of therapist or therapeutic agent. Legal rules, legal procedures, and the roles of legal actors (such as lawyers and judges) constitute social forces that, whether intended or not, often produce therapeutic or antitherapeutic consequences. Therapeutic jurisprudence calls for the study of these consequences with the tools of the social sciences to identify them and to ascertain whether the law's antitherapeutic effects can be reduced, and its therapeutic effects enhanced, without subordinating due process and other justice values.[88]

Building on this concept, MHCs address the concern that prison environments are antitherapeutic for inmates suffering from mental illness. Rather than perpetuate the "revolving door" of mentally ill inmates by exacting retributive punishment, MHCs attempt to rehabilitate by providing judicious, therapeutic management of criminal offenders.[89] Further, MHCs aim to reduce recidivism rates of mentally ill inmates by addressing the role of mental health in the criminal offense.[90] While the application of therapeutic jurisprudence's application is not limited to mental health law,[91] the concept has its roots in mental health law and it is directly applicable to alternative legal processes for working with mental illness in the law—such as the creation of MHCs.

MHCs function in variable ways based on the structure, location, and jurisdiction of the individual court, but often share a similar basic format. An MHC is a voluntary court system based on therapeutic jurisprudence principles, modeled after the veteran and drug courts of the 1980s and 1990s. In order to participate in an MHC, defendants make an informed choice to enter into a MHC program, with assistance of their defense attorney. This decision involves determining both the defendant's competency to make such a decision and the defendant's full understanding of the MHC program.[92] This stands in stark contrast to other judicial alternatives and the traditional involuntary commitment process itself, in which prisoners are not given a choice to opt in or out. Most MHCs have specialized court dockets, which emphasize alternative treatments for certain defendants with mental illness.

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[88] *The Jurisprudence of Therapeutic Jurisprudence*, *supra* note 86, at 184–85.

[89] *Id.*

[90] COUNCIL OF STATE GOV'TS: JUSTICE CTR., MENTAL HEALTH COURTS: A PRIMER FOR POLICYMAKERS AND PRACTITIONERS (2008).

[91] *Id.* at 7–8.

[92] *Id.* at 5.

The courts are judicially run, but prescribe community-based treatment, usually involving a team of mental health professionals and various treatment options, such as outpatient medical services, as opposed to incarceration.[93] In addition, these courts often hold regular status hearings for reports on treatment plans and the status of participants, and to adjust treatment or impose sanctions as necessary.[94]

MHCs are growing in number. Since their origins in the mid-1990s, almost four hundred courts have been established across the United States.[95] Many scholars view the rapid creation and expansion of MHCs as a direct response to the high number of mentally ill individuals routed to prisons, and the conditions to which these individuals were subject.[96] Responses to MHCs have been generally positive in both the mental health and criminal justice communities. Various studies in the last decade indicate that MHCs may reduce recidivism rates among mentally ill individuals.[97] Exactly *how* MHCs accomplish this goal is a subject of continued study,[98] but the general consensus is that MHCs reduce rates of recidivism, and therefore, effectively divert mentally ill individuals from prisons and into appropriate and effective treatment.[99] Some have suggested that MHCs go even further in that they not only better address defendants' mental health symptoms and reduce recidivism, but that they also maintain the dignity and respect the autonomy of the defendants within the justice system.[100]

Despite the growing popularity of MHCs in the United States, they are still controversial. Some critics target the functioning of the courts themselves, while others criticize the effectiveness of alternative treatment court systems generally. One argument against MHCs relates specifically to problematic

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[93] MICHAEL THOMPSON ET AL., COUNCIL OF STATE GOV'TS: JUSTICE CTR., IMPROVING RESPONSES TO PEOPLE WITH MENTAL ILLNESSES: THE ESSENTIAL ELEMENTS OF A MENTAL HEALTH COURT (2008).

[94] *Id.* at vii. MHCs have been created for both adult and juvenile populations, although MHCs for adult offenders are more common. This Note will reference MHCs in general (without reference to its demographic reach).

[95] *Mental Health Courts*, COUNCIL STATE GOV'TS: JUSTICE CTR. (2019), https://csgjusticecenter.org/mental-health-court-project/.

[96] *See infra* discussion in Part III.

[97] Michelle Edgely, *Why Do Mental Health Courts Work? A Confluence of Treatment, Support & Adroit Judicial Supervision*, 37 INT'L J. L. & PSYCHIATRY 572, 573–74 (2014) (detailing the various studies conducted in the United States and Australia in the past decade showing rates of recidivism among mentally ill inmates declining); *see also* John E. Cummings, *The Cost of Crazy: How Therapeutic Jurisprudence and Mental Health Courts Lower Incarceration Costs, Reduce Recidivism, and Improve Public Safety*, 56 LOY. L. REV. 279, 281 (2010).

[98] Nancy Wolff & Wendy Pogorzelski, *Measuring the Effectiveness of Mental Health Courts: Challenges and Recommendations*, 11 PSYCHOL. PUB. POL'Y, & L. 539, 539 (2005).

[99] Edgely, *supra* note 97, at 573–74 (comparing Blackburn's 2004 study with Wolff's 2011 study to support Edgely's argument that while an exact answer to the question of why MHCs are effective may not be definitive yet, part of the answer is to design programs that address mental health as well as other criminogenic factors). For more information on these studies, see Ronald R. Blackburn, *"What Works" with Mentally Disordered Offenders*, 10 PSYCHOL. CRIME & L. 297 (2004); Nancy N. Wolff et al., *Practice Informs the Next Generation of Behavioral Health and Criminal Justice Interventions*, 36 INT'L J.L. & PSYCHIATRY 1 (2013).

[100] Michael L. Perlin, *"The Judge, He Cast His Robe Aside": Mental Health Courts, Dignity and Due Process*, 3 MENTAL HEALTH L. & POL'Y J. 1, 2, 8, 20–23, 27–28 (2013) [hereinafter *Mental Health Courts, Dignity and Due Process*].

disparities between sentencing in criminal courts and mental health courts.[101] There are also concerns over the quality of counsel representing defendants in MHCs,[102] and whether the team approach fostered by the cooperation between the judge and attorneys recognizes the true interests of the defendant in an effort to meet the goals of this "team."[103] Opponents further question whether treatment courts truly create better outcomes for defendants.[104]

Despite concerns, the adoption of MHCs shows a willingness to embrace innovation and empathy in addressing the mental health issues in the United States' justice system. The acceptance of MHCs, and the corresponding funding given to such programs, represent an acknowledgement of the United States' struggle with the "revolving door" problem, and the potential for a significant change moving forward.

II. THE UNITED KINGDOM'S APPROACH

Until the mid-twentieth century, the United Kingdom mirrored the United States in its history and treatment of those with mental illness.[105] However, the two countries diverged in their implementation of deinstitutionalization and in their modern approaches to addressing the needs of the mentally ill population. Specifically, the United Kingdom did not have as immediate and drastic a deinstitutionalization movement as the United States. Some scholars argue that the United Kingdom's movement followed, or even had as its impetus, the deinstitutionalization movement of the United States.[106] This slower pace of deinstitutionalization resulted in a less dramatic rash of consequences compared to the United States. However, it also led to fragmented deinstitutionalization, which stagnated at each step, leaving many services unfunded and unavailable for the individuals leaving institutions.[107]

In the same vein, patients seeking mental health services in the United Kingdom today struggle to access the fundamental services they need. Despite the provision of mental healthcare services through the NHS, [108] limited availability of services and medical professionals constitutes a large barrier to

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[101] E. Lea Johnston & Conor P. Flynn, *Mental Health Courts and Sentencing Disparities*, 62 VILL. L. REV. 685 (2017) (finding significant disparity in sentencing length between criminal courts and mental health courts in Pennsylvania's Erie County).

[102] *Mental Health Courts, Dignity and Due Process*, *supra* note 100, at 16.

[103] *Id.* at 19–20.

[104] *See* Tammy Seltzer, *A Misguided Attempt to Address the Criminal Justice System's Unfair Treatment of People with Mental Illness*, 11 PSYCHOL. PUB. POL'Y, & L. 570, 576 (2005); *see also* E. Lea Johnston, *Theorizing Mental Health Courts*, 89 WASH. U. L. REV. 519, 521–22 (2012) (discussing how therapeutic jurisprudence and therapeutic rehabilitation fail to justify mental health courts).

[105] Turner et al., *supra* note 14.

[106] Alexandra Hamlin & Peter Oakes, *Reflections on Deinstitutionalization in the United Kingdom*, 5 J. POL'Y & PRAC. INTELL. DISABILITIES 47 (2008).

[107] *Case Study 1: Deinstitutionalisation in UK Mental Health Services*, KING'S FUND (2019), https://www.kingsfund.org.uk/publications/making-change-possible/mental-health-services [hereinafter *Case Study 1*]; *see also* Hamlin & Oakes, *supra* note 106, at 47–48.

[108] *How to Access Mental Health Services*, NHS (2019), https://www.nhs.uk/using-the-nhs/nhs-services/mental-health-services/how-to-access-mental-health-services/ [hereinafter *How to Access Mental Health Services*].

adequate mental health treatment.[109] In addition, the United Kingdom has not been as innovative in addressing high rates of mental illness in the criminal justice system, as compared to the United States' adoption of MHCs or other alternative treatment plans. Most significantly, the lack of dedicated funding from the NHS prevents a more robust offering of both traditional and alternative mental health services.

A. *HISTORY OF MENTAL HEALTHCARE AND DEINSTITUTIONALIZATION IN THE UNITED KINGDOM*

The United Kingdom (comprised of England, Wales, Scotland, and Northern Ireland) has a deep history of treating the mentally ill in psychiatric institutions that stretches back to the thirteenth century. From the establishment of Bethlem Royal Hospital in London in 1247 (Europe's oldest psychiatric facility) through the 1950s, the United Kingdom primarily dealt with mentally ill individuals by placing them in "lunatic asylums"—renamed as "mental hospitals" in the 1930s.[110] Early mental health legislation in the eighteenth and nineteenth centuries[111] mandated that county authorities build asylums to house mentally ill individuals, which rapidly increased the rate of incarceration in these institutions from a few thousand in the mid-1800s to over 150,000 by the 1950s.[112] Treatment at these nineteenth century facilities was less than robust; often, institutions were a disposal ground for mentally ill individuals, and care was based on moral management, rather than medicinal treatment—reflecting the idea that mental illness was a moral or attitudinal problem, rather than a medical one.[113]

In the early twentieth century, the United Kingdom, like the United States, faced a growing disdain for the abhorrent institutional conditions to which mentally ill individuals were subject. This led to pervasive moral concerns that institutionalization was no longer an acceptable treatment for the mentally ill in the United Kingdom.[114] The Ministry of Health supported these concerns. In 1961, the Minister of Health, Enoch Powell, delivered a speech at the Annual Conference of National Association for Mental Health (referred to as the "Water Tower" speech),[115] which forecasted a decline in the number of psychiatric beds needed in the following fifteen years and expressed a desire for movement towards community care, thereby reducing admissions to institutions.[116] Powell famously called for a change in the institutional model: "We have to strive to alter our whole mentality about hospitals and about

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[109] *See infra* discussion in Part III (C).

[110] Trevor Turner, *The History of Deinstitutionalization and Reinstitutionalization*, 3 PSYCHIATRY 1 (2004) [hereinafter *The History*].

[111] *Id.* Some of the earliest mental health legislation, such as the Asylums Act of 1845, attempted to address the mental illness population by mandating the building of asylums to house the mentally ill.

[112] *Id.*

[113] *Id.*

[114] *Case Study 1*, *supra* note 107. In addition, clinical advances in medical treatment and legislation played a role in ushering in deinstitutionalization in the United Kingdom.

[115] Enoch Powell, Minister of Health, Address to the National Association of Mental Health Annual Conference (Mar. 9, 1961).

[116] Turner, *supra* note 110, at 1–2.

mental hospitals especially . . . [A] hospital is a shell, a framework, however complex, to contain certain processes, and when the processes change or are superseded, then the shell must most probably be scrapped."[117]

Powell's speech reflected a move towards community care and away from the institutionalization model of the previous centuries. This idea is also reflected in the legislation and policy documents of the time. In 1959, the Mental Health Act[118] introduced mental health review tribunals and abolished prior legislation and acts of the magistrate regarding mental health, which had previously focused only on institutionalization of the mentally ill.[119] The Ministry of Health then implemented further policy, including "A Hospital Plan for England and Wales" (1962)[120] and "Health and Welfare: The Development of Community Care" (1963).[121] These policies outlined the plans for development of local services for community care, in furtherance of the goals of the Mental Health Act.[122] Community care will be addressed more fully in the following Section, however its importance as an impetus for deinstitutionalization must be noted here. The Ministry of Health's concerns, along with legislation pushing for community care, provided further incentive for the United Kingdom to begin deinstitutionalization.

The process of deinstitutionalization began in the 1960s, but the actual closure of hospitals and subsequent establishment of community-based services did not start in earnest until the 1980s. This slow progress is one issue with the United Kingdom's deinstitutionalization movement.[123] Specifically, the lack of funding associated with the prolonged closures proved to be an impediment to effective deinstitutionalization, as "[t]he slow pace of closure resulted in institutions that were expensive to maintain and often in a poor state, which meant capital could not be released, which in turn obstructed investment to create new facilities."[124] The breakdown in funding made it impossible to fund the next stage of deinstitutionalization, leading to a stilted and drawn out deinstitutionalization period. Financial liquidity continues to remain a concern, with many of the large institutions which closed during deinstitutionalization taking five to six years after closure to sell. Many closed institutions still remain unsold today.[125]

B. *MENTAL HEALTHCARE AFTER DEINSTITUTIONALIZATION*

Following the deinstitutionalization movement in the 1960s in the United Kingdom, subsequent legislation shaped the way the United Kingdom

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[117] *Enoch Powell Delivered His '"Water Tower" Speech*, POL'Y NAVIGATOR (1961), http://navigator.health.org.uk/content/enoch-powell-delivered-his-'water-tower'-speech.

[118] Mental Health Act of 1959, 7 & 8 Eliz. 2 c. 72 (Eng.).

[119] *The History*, *supra* note 110, at 2–3.

[120] MINISTRY OF HEALTH, A HOSPITAL PLAN FOR ENGLAND AND WALES, Cmnd. 1604 (1962) (UK).

[121] MINISTRY OF HEALTH, HEALTH AND WELFARE: THE DEVELOPMENT OF COMMUNITY CARE (1963) (UK).

[122] *Id.*

[123] *Case Study 1*, *supra* note 107.

[124] *Id.*

[125] *Id.*

approached mental healthcare in the coming decades. The Mental Health Act of 1983,[126] covering England and Wales, was one of the most significant pieces of mental health legislation in the United Kingdom. This Act established methods for the care and treatment of "mentally disordered persons," and specifically detailed when, if, and how individuals diagnosed with a mental disorder could be detained in a hospital for assessment against their will (referred to as "sectioning").[127]

The NHS directs and funds mental healthcare programming in the United Kingdom.[128] NHS is a comprehensive healthcare system that provides most forms of healthcare free of charge to United Kingdom citizens .[129] The NHS was launched in 1948 to provide health services to all citizens regardless of ability to pay.[130] NHS England[131] provides health services ranging from routine healthcare services to emergency treatment, end-of-life care, transplants, and mental healthcare services to all citizens free of cost, excluding some services such as prescriptions, some optometry services and products, and dental services.[132] Though a parallel system of private health insurance also operates in the United Kingdom,[133] a large majority of citizens receive their healthcare solely from the NHS.

NHS England covers mental health treatment from a General Practitioner (GP), counseling, inpatient and outpatient treatment centers, and other clinical treatment options. Broadly speaking, citizens are guaranteed a right to choose their provider (with some exclusionary criteria), and can choose between hospital-based or community-based care teams for a variety of services, such as counseling and clinical treatment.[134] Prior to 1983, GPs directly referred patients to certified psychiatrists in hospitals who managed the care of mentally ill individuals.[135] This changed with the 1983 Mental Health Act.[136] Under the Act, GPs would refer patients to multi-disciplinary care teams—called Community Mental Health Teams—and a member of this team or the GPs themselves would manage the care team.[137] This program continued until 2000, when the Care Programme Approach (CPA) was enacted.[138] The CPA,

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[126] The Mental Health Act 1983, c. 20 (Eng.).

[127] *Id.*

[128] *NHS Structure Explained*, NHS (2016), https://www.nhs.uk/using-the-nhs/about-the-nhs/nhs-structure-explained/.

[129] *Id.*

[130] *About NHS England*, NHS, https://www.england.nhs.uk/about/ (last accessed May 3, 2019).

[131] *Id.* The current NHS system is split into four parts: NHS England covers all United Kingdom citizens. Responsibility for healthcare in Northern Ireland, Scotland, and Wales is handled by their respective governments—the Northern Ireland Assembly, the Scottish Government, and the Welsh Assembly Government. For the purpose of this Note, I generally review the policies of NHS England, as all four systems follow a similar structure. For more information on the differences between the NHS systems, see Nigel Hawkes, *How Different Are NHS Systems Across the UK Since Devolution?*, 346 BRIT. MED. J. 18 (2013), https://www.bmj.com/content/bmj/346/bmj.f3066.full.pdf.

[132] *Id.*

[133] *See* Yvonne Doyle & Adrian Bull, *Role of Private Sector in United Kingdom Healthcare System*, 321 BRIT. MED. J. 563 (2000).

[134] *How to Access Mental Health Services*, *supra* note 108.

[135] Turner et al., *supra* note 14, at 605–06.

[136] The Mental Health Act 1983, c. 20 (Eng.).

[137] Turner et al., *supra* note 14, at 606.

[138] *Id.* at 606–07 (citing DEPARTMENT OF HEALTH, EFFECTIVE CARE CO-ORDINATION IN MENTAL HEALTH SERVICES (1999)).

underwritten by the Department of Health, gave specific workers from either the NHS or a local social services authority the responsibility of coordinating individual patient care.[139] Only after 2006 could patients access some mental health services without a recommendation from their GP under the Increasing Access to Psychological Therapies (IAPT) Programme.[140]

The mental healthcare programming and legislation of the United Kingdom developed against the background of the NHS's provision of funding. In 1974, the NHS underwent a major reorganization. This reorganization, among other matters, called for a new strategy of implementing community care for mental health treatment.[141] However, this alleged prioritization of mental healthcare did not receive a corresponding funding increase; the budget for mental health reorganization increased by only 1.8% to achieve this lofty goal.[142] A lack of budget, combined with the breakdown in funds from the sale of institutions after closure, meant that the goals for a robust community based care program became an unattainable aspiration.

C. MODERN MENTAL HEALTH TREATMENT

The effects of the stilted and underfunded deinstitutionalization movement are apparent today in the modern treatment of mental health in the United Kingdom. According to a 2015 report from the National Centre of Social Research, one in four United Kingdom adult citizens reported having a mental illness.[143] It is well known, however, that mental illness is categorically underreported in the United Kingdom, either through failure to self-recognize or report,[144] or physician failure to recognize mental health symptoms.[145] These high rates of mental illness in the population do not correlate to high levels of service; despite great need for mental health services, NHS has been unable to provide enough services to meet the demand. In addition, mental illness disproportionately affects certain groups of people. Studies point to a gross lack of mental health services in United Kingdom prisons and jails,[146]

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[139] Turner et al., *supra* note 14, at 606–07.

[140] *Id.* at 607.

[141] *Id.* at 608.

[142] *Id.*

[143] Sally Bridges, *Chapter 2: Mental Health Problems*, in HEALTH SURVEY FOR ENGLAND 2014 (Rachel Craig et al. eds., 2015), http://healthsurvey.hscic.gov.uk/media/37739/HSE2014-Ch2-Mental-health-problems.pdf; *see also* MENTAL HEALTH FOUND., FUNDAMENTAL FACTS ABOUT MENTAL HEALTH (2015), https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-15.pdf.

[144] Bridges, *supra* note 143, at 14 (suggesting that older populations have lower reporting rates of mental illness due to stigma: "Mental health has become a much more commonly discussed area of life in recent decades and this has led to a cultural shift in understanding and recognition of mental illness. Campaigns such as Time To Change have aimed to prevent discrimination, reduce stigma and encourage conversation about mental health. In decades gone by, mental illness was more stigmatized [sic] and so this may have an impact on the level of recognition, help-seeking and reporting of mental illness in older groups.").

[145] CARL BAKER, HOUSE OF COMMONS LIBRARY, MENTAL HEALTH STATISTICS FOR ENGLAND: PREVALENCE, SERVICES AND FUNDING, 2018-4, HC 6988, at 7.

[146] May Bulman, *Government Fails to Track Mental Health in UK Prisons Amid Soaring Suicide and Self-Harm Rates, Report Finds*, INDEPENDENT (June 29, 2017), http://www.independent.co.uk/news/uk/home-news/mental-health-uk-prisons-suicide-rates-self-harm-report-national-audit-office-hmpps-public-health-a7812701.html.

and a higher percentage of women than men report common mental disorders and more severe symptoms.[147]

Despite the intended breadth of the NHS's mental healthcare services, it has proven difficult to reach individuals who need care. The most glaring problem seems to be that "[f]or many . . . the patient journey never started, and for most it was very short."[148] In other words, there is a a severe inability for individuals to access care. This issue has plagued the NHS since at least the 1990s,[149] and continues to be problematic today. NHS has failed to provide services to many individuals seeking mental health services due to long waiting lists and lack of available providers.[150] Former president of the Royal College of Psychiatrists, Simon Wessel, claimed in 2014 that fewer than one-third of patients seeking medical care for mental health concerns receives care—numbers that would result in "a public outcry" if those who went without treatment had a medical condition such as cancer.[151] Even individuals with serious mental health concerns who receive *some* medical treatment may be under-treated due to the same shortage of available mental health professionals, as well as limited numbers of beds in inpatient facilities.[152]

Scholars largely agree that the United Kingdom has failed to successfully implement a sustainable community-care program.[153] One issue is the cost of funding a successful program. Overall, community care can be more cost effective than traditional inpatient programs; while it has a potential to be costlier upon implementation, in the long run, community-based care can be less expensive, as its outcomes are intended to avoid costly future intervention.[154] However, without enough money to establish these community programs, they will never able to get off the ground.

Soon after its enactment in the 1980s, community care was heavily criticized for its failure to achieve its goal. In 1986, the government published two papers illustrating this failure. "Making a Reality of Community Care"[155]

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[147] NATIONAL HEALTH SERVICES, ADULT PSYCHIATRIC MORBIDITY SURVEY: SURVEY OF MENTAL HEALTH AND WELLBEING, 2014 (Sally McManus et al. eds., 2016), https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014.

[148] Turner et al, *supra* note 14, at 607.

[149] *Id.* ("A WHO study in the early 1990s estimated that for every thousand adults, between 250 and 315 were suffering from some sort of mental disorder, of whom only 101 were detected by GPs, only 20.8 were referred to specialist mental health services (including community-based services) and only 3.4 became in-patients. In recent years the rate of referral per thousand adults has probably increased, but it remains the case that the majority of mild to moderate illness is treated by GPs, if at all.").

[150] Sarah Boseley, *Two-Thirds of Britons with Depression Get No Treatment*, GUARDIAN (Aug. 13, 2014), https://www.theguardian.com/society/2014/aug/13/two-thirds-britons-not-treated-depression; *see also The NHS Mental Health 'Service'? There Isn't One*, GUARDIAN (Jan. 27, 2016), https://www.theguardian.com/society/2016/jan/27/the-nhs-mental-health-service-there-isnt-one.

[151] Boseley, supra note 150 (citing Simon Wessely stating, "[i]f he were . . . talking about cancer, . . . you'd be absolutely appalled and you would be screaming from the rooftops" (citation omitted)).

[152] *Id.*

[153] *The History*, *supra* note 110, at 2. *But see* Julian Leff, *Why Is Care in the Perceived as a Failure?*, 179 BRITISH J. PSYCHOL. 381 (2001) (arguing that the view of community care as a failure program is largely a misconception).

[154] Martin Knapp et al., *The Economic Consequences of Deinstitutionalisation of Mental Health Services: Lessons from a Systematic Review of European Experience*, 19 HEALTH & SOC. CARE IN COMMUNITY 113 (2011).

[155] AUDIT COMMISSION FOR LOCAL AUTHORITIES OF ENGLAND AND WALES, MAKING A REALITY OF COMMUNITY CARE: A REPORT (1986).

and "Community Care: An Agenda for Action" [156] identified the lack of resources and support from voluntary and community actors as obstacles in achieving accessible community care.[157] Another report to Parliament, "Caring for People: Community Care in the Next Decade and Beyond," [158] further highlighted the failures of deinstitutionalization stemming from the absence of proper community supports, and emphasized that funding increases for social and hospital care were needed.[159] Despite these important reports, and the establishment of the National Health and Service Community Care Act[160] in 1990, necessary funding was not allocated to make these recommendations a reality. This insufficient commitment from the government, along with the general under-development of resources within the community, led to a public consensus that community care, on a whole, was a "failure."[161]

Due to the stunted progress in establishing community care and the general lack of accessible mental health services under NHS, some argue the next logical step in mental healthcare in the United Kingdom is reinstitutionalization.[162] Specifically, rising numbers of patients in secure units (a form of inpatient care), high numbers of incarcerated individuals with mental illness, and lack of available community mental health services point to "a gradual return to more institutional provision." [163] Additionally, many believe that current community-care responses, such as development of assertive outreach and crisis intervention teams, as well as monitoring of mentally ill individuals in the community through Care Programme approaches, are akin to social reinstitutionalization.[164] It remains to be seen if reinstitutionalization is the future of mental healthcare in the United Kingdom, or simply a strong response to the lack of accessible services identified above.

D. INCARCERATION AND MENTAL HEALTH

Like their counterparts in the United States, many prison inmates in the United Kingdom suffer from mental illness. While data on rates of mental illness in United Kingdom prisons are lacking, the scant existing data suggests mental health concerns are pervasive in the current United Kingdom prison population.[165] Prisons saw a seventy-three percent increase in incidents of self-harm between 2012 and 2016, as well as a one-hundred percent increase in suicides in the same period. [166] Of those who committed suicide while

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[156] SIR ROY GRIFFITHS, COMMUNITY CARE: AN AGENDA FOR ACTION: A REPORT TO THE SECRETARY OF STATE FOR SOCIAL SERVICES (1988).

[157] Kam-shing Yip, *The Community Care Movement in Mental Health Services: Implications for Social Work Practice*, 43 INT'L SOC. WORK 33, 47 (2000).

[158] DEPARTMENT OF HEALTH, CARING FOR PEOPLE: COMMUNITY CARE IN THE NEXT DECADE AND BEYOND, 1989, Cm. 849 (Gr. Brit.).

[159] *Id.*

[160] National Health Service and Community Care Act 1990, c. 19 (Eng.).

[161] Jeremy Coid, *Failure in Community Care: Psychiatry's Dilemma: Health Care Professionals Will Be More Accountable for Failures in the Future*, 308 BRIT. MED. J. 805 (1994).

[162] *See The History*, *supra* note 110.

[163] *Id.* at 4.

[164] *Id.* at 3.

[165] Bulman, *supra* note 146.

[166] *Id.*

incarcerated between 2014 and 2016, an estimated seventy percent suffered from mental illness.[167] These numbers indicate, at minimum, that mental health is a significant issue among incarcerated individuals in the United Kingdom.

The United Kingdom to date has not fully adopted therapeutic jurisprudence models, such as MHCs, as a significant solution to the problem of mental illness in the criminal justice system. In the past decade, however, the United Kingdom has started to look into MHCs as part of its approach to mental health treatment in prisons. The United Kingdom instituted its first MHC pilot programs in 2009 in Stratford, East London and Brighton, Essex.[168] This initiative was designed to "explore improvements in policy and practice to support offenders with mental health needs," and specifically, to reduce recidivism rates and ensure more available mental health services.[169] The first goal of these early programs was to identify a clear model for an MHC that identified offenders with mental health concerns, and ensured that, if convicted, the offender would receive appropriate treatment. Second, the pilots sought to determine what the actual costs of implementing such a program might be.[170] These pilot programs used many essential elements found in American MHCs, including multi-disciplinary teams involving both judicial and health officials (usually through a Mental Health Court Practitioner present in court and working with the judiciary, and probation officers), involvement of community resources in sentencing and rehabilitation services, and check-ins between the judiciary and the participant throughout the program.[171]

Those monitoring this pilot program found that multi-agency collaboration (between health services and the judicial system) yielded results that met the needs of mentally ill offenders that would otherwise have gone unmet, and that a wider implementation of effective MHCs would require much more data-sharing and collaboration among agencies.[172] Further, it presented MHCs as solutions to better address mental health needs of United Kingdom citizens involved in the criminal justice system.[173] In 2015, then-Lord Chancellor Michael Gove announced the establishment of a working group on problem-solving courts,[174] including adult, juvenile, and family treatment drug courts, domestic violence courts, and mental health courts. In December of 2015, the Center for Justice Innovation published a promising report on problem-solving courts, concluding that "[a]cross a range of outcomes, problem-solving courts have demonstrated their ability to make a difference, with the strongest evidence being on drug courts but encouraging evidence elsewhere, notably on

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[167] *Id.*

[168] Jane Winstone & Francis Pakes, *Process Evaluation of the Mental Health Court Pilot, in* MINISTRY OF JUSTICE RESEARCH SERIES 18/10 (2010).

[169] *Id.* at 1.

[170] *Id.*

[171] *Id.* at 2.

[172] *Id.*

[173] Not everyone was as optimistic about the implementation of further MHCs in the UK. *See, e.g.*, Adam Wagner, *Specialist Mental Health Courts Are a Good Idea Which May Never Happen*, U.K. HUM. RTS. BLOG (Sept. 17, 2010), https://ukhumanrightsblog.com/2010/09/17/specialist-mental-health-courts-are-a-good-idea-which-may-never-happen/.

[174] PHIL BOWEN & STEPHEN WHITEHEAD, CTR. FOR JUSTICE INNOVATION, PROBLEM-SOLVING COURTS: AN EVIDENCE REVIEW (2015), http://justiceinnovation.org/wp-content/uploads/2016/08/Problem-solving-courts-An-evidence-review.pdf.

mental health and domestic violence."[175] However, despite early positive reviews of the effectiveness of MHCs, the United Kingdom has not moved forward with wider implementation of MHCs or similar problem-solving judicial programs because of inadequate funding to adopt similar alternative court systems.[176]

III. A COMPARATIVE ANALYSIS OF THE UNITED STATES AND THE UNITED KINGDOM

This Note avoids a direct comparison between the United States and the United Kingdom for two reasons. First, and perhaps unsurprisingly, the preceding analysis highlights that neither nation has created a fully sufficient mental health policy capable of providing an effective model to the other. Secondly, this Note endeavors to illustrate the successes and defects of both nations in funding mental health programs after deinstitutionalization in an effort to identify the socio-political climate in which mental healthcare funding emerged in these nations. Further, this illustration aims to shed light on how this funding, or lack thereof, influenced successful implementation of mental healthcare programming. By understanding the divergence in financial context and funding between these two nations after deinstitutionalization, this Note examines how the United States and the United Kingdom can learn from each other to strengthen future mental health policy and programs.

As this Note details, the United States and the United Kingdom historically have had similar approaches to mental health treatment and policies until the mid-twentieth century. Both nations experienced a period of deinstitutionalization from the 1960s through the 1980s. Both proceeded to close large psychiatric institutions and shifted to provision of mental health services in the community. In addition, both undertook deinstitutionalization with goals of providing better medical care and more humane treatment to those who were institutionalized for mental illness.[177]

The paths of these two nations diverged once deinstitutionalization was underway. The United Kingdom struggled with a slower pace of deinstitutionalization than the United States. When comparing the speed and breadth of deinstitutionalization in the United Kingdom with that of the United States, one factor significantly stunted the United Kingdom's deinstitutionalization movement: inadequate funding. Specifically, lack of appropriate funding for mental health treatment due to the overall healthcare funding structure stunted policy and program creation, which impeded the scope of such policies.[178] The resulting delays in provision of community-based services once the institutions closed meant that many citizens in the United Kingdom went untreated in the interim. The slower pace of the United

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[175] *Id.* at 31.
[176] *See* Wagner, *supra* note 173.
[177] *Compare supra* Part II, *with supra* Part IV.
[178] *Case Study 1, supra* note 107.

Kingdom's response was not all negative: The United Kingdom's more gradual deinstitutionalization avoided the influx of formerly institutionalized patients into the community at the overwhelming pace caused by the swift enactment of deinstitutionalization in the United States. In fact, the intense speed at which institutions were shut down contributed to the scope of the post-deinstitutionalization issues in the United States, such as rapid increase in the rates of homelessness.[179] However, even though the United Kingdom may have avoided such strong immediate responses to deinstitutionalization, the lack of appropriate funding continues to be a pervasive barrier to better mental healthcare in the United Kingdom.

A. *FUNDING MENTAL HEALTHCARE IN THE UNITED STATES AND THE UNITED KINGDOM*

A lack of pragmatic structure and planning for achievement of community resources, supported by inadequate funding, explains the United Kingdom's stunted development of mental health policy directly after deinstitutionalization. However, the problems are not limited to the time immediately post-deinstitutionalization. Financial structure in the United Kingdom continues to cause issues for mental health treatment to this day.

As discussed above, the United Kingdom provides for full coverage of mental health services through the NHS, rather than through dedicated mental health funding. The United Kingdom's budget for mental health comes from a portion of the overall NHS budget, which is funded through direct taxation and supplemented through national insurance contributions and user charges.[180] Pragmatically, this means that increasing funding for a specific type of health service, such as provision of mental healthcare, requires an overall increase in the total NHS budget. By definition, the tax-funded system depends on a strong economy, and the amount of money that flows into the NHS is subject to economic fluctuation.[181] This system virtually ensures that funding will not be directly allocated to mental health treatment. It also results in a lack of social and outpatient services, which remains a significant issue for the mentally ill population of the United Kingdom. Under the NHS, many individuals find themselves unable to receive care within a reasonable time frame—if they can access care at all.

Recently, the British government has made efforts to increase the NHS budget and provide more funds to mental health programming. The NHS released a "Five Year Forward View" in 2014, which focused on improving overall access to healthcare by 2020.[182] The plan includes specific measures targeted toward parity of mental and physical health.[183] In addition to

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[179] *See generally* JENCKS, *supra* note 1.

[180] *How to Access Mental Health Services*, *supra* note 108; Helen McKenna et al., *How Health Care Is Funded,* KING'S FUND (Mar. 23, 2017), https://www.kingsfund.org.uk/publications/how-health-care-is-funded.

[181] *Funding and Efficiency*, NHS ENG., https://www.england.nhs.uk/five-year-forward-view/next-steps-on-the-nhs-five-year-forward-view/funding-and-efficiency/ (last accessed May 3, 2019).

[182] *Id.*

[183] *Id.*

determining a four percent increase in overall budget was needed, the NHS determined that significant cost savings could be refunnelled to mental health through efficiency measures, such as eliminating redundant staffing and reducing administration costs.[184] This plan has been well received, as the focus of the NHS plan's moving forward is to make the program more efficient, and more accessible for its constituents. [185] However, these plans essentially reallocate the funds funneled through the NHS to mental health, rather than increase the potential for total funds available for mental health programming.

In contrast, mental healthcare in the United States is funded by a variety of sources rather than a national healthcare system equivalent to the NHS. Instead, healthcare is funded through a mix of public payers (such as state and federal governments), private insurance, and out-of-pocket individual payments.[186] Governmental programs include Medicaid and Medicare, as well as other programs aimed at specific groups, such as Tricare, Veterans Health Administration, and the Federal Employee Health Benefits. The government funds such programs through a combination of taxes, premiums, interest earned on governmental trust accounts, and funds appropriated by Congress.[187] While some of the sources of funding for mental health programs are dependent on the United States economy (for example, payroll taxes and interest earned on trust accounts), congressional appropriation of funds directly to different healthcare programs provides a more flexible avenue for healthcare funding and specifically dictates funding dedicated to mental health programming. For example, in the Fiscal Year 2018 Federal Appropriations Budget, Congress increased funding to the National Institute of Mental Health and the Substance Abuse and Mental Health Services Administration by over $400 million dollars.[188] Such federal funding for mental health programming is also supplemented by state funding programs on a localized scale. Additionally, state funding programs supplement federal funding for mental health programming on a localized scale.

B. *WHY FUNDING AFFECTS CARE*

The overall funding structures for healthcare in the United Kingdom and the United States have a clear impact on mental health service provision, as the funding of healthcare impacts the structure and accessibility of health programs. On a fundamental level, adequate funding is necessary for any program to be successful, but funds alone are not enough. For example, the United States currently has the most expensive healthcare system in the world, yet it underperforms other well-developed countries in provision of healthcare

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[184] *Id.*

[185] Mahiben Maruthappu et al., *Out of Hours*, *The NHS Five Year Forward View: Transforming Care*, 64 BR. J. GEN. PRACT. 635 (2014).

[186] Nancy De Lew et al., *A Layman's Guide to the U.S. Health Care System*, 14 HEALTH CARE FINANCING REV. 151 (1992).

[187] *How is Medicare Funded?*, MEDICARE (2019), https://www.medicare.gov/about-us/how-is-medicare-funded.

[188] *NAMI Celebrates Mental Health Victories in Federal Funding Bill*, NAT'L ALLIANCE ON MENTAL ILLNESS (Mar. 22, 2018), https://www.nami.org/Press-Media/Press-Releases/2018/NAMI-Celebrates-Mental-Health-Victories-in-Federal.

services—including the United Kingdom.[189] Clearly, the overall amount of money funneled into a healthcare program is not the primary indication of effectiveness. A more appropriate indicator of the effectiveness of healthcare programs may be the financial structure and funding sources for such programs.

Despite the improvements by the NHS in recent years, the overall structure of the NHS imposes a ceiling on the amount of change possible in the United Kingdom's mental health system. As currently structured, the reallocation of funds is a zero-sum game; if funding to mental health is increased, it has to be subtracted from somewhere else. Whether that "somewhere else" is another category of NHS service or taxes from the United Kingdom economy, the funds dedicated to mental health are always dependent on, or come at the expense of, something else. In contrast, the United States allocates funds to mental health programming on both a federal and state level as a public payor. This is not to say that funding for mental health programming in the United States is adequate; in fact, many individuals argue that mental healthcare in the United States is grossly underfunded.[190] Sidestepping the question of whether the *amount* of funding is adequate, the distinction drawn here pertains to the source of income and how it is allocated. In the United States, Congress may designate additional funds to mental health services without sanctioning another program by reallocating its funds. In the United Kingdom, however, the structure of the NHS creates a zero-sum game for mental health programming, in which funds to increase these programs are capped by the overall budget constraints. This in turn hampers the provision of mental healthcare services, despite NHS coverage of such services.[191]

C. *SOCIAL ATTITUDES TOWARDS MENTAL HEALTH & FUNDING*

The mechanism of allocating healthcare funds in the United States and the United Kingdom plays a large role in the financial support of mental health programming in each nation. Another key factor is the social support behind these programs. The United States has had a history of activism towards civil rights for the mentally ill; this social pressure was an original factor in the push of the United States towards deinstitutionalization in the first place.[192] Such social activism has been a pervasive part of the United States' mental health culture since deinstitutionalization; non-profit groups, such as the NAMI, have been pushing for increased funding and more programming for mental health since 1979.[193] NAMI also advocates for mental health public policy, and

[189] KAREN DAVIS ET AL., THE COMMONWEALTH FUND, MIRROR, MIRROR ON THE WALL: HOW THE PERFORMANCE OF THE U.S. HEALTH CARE SYSTEM COMPARES INTERNATIONALLY: 2014 UPDATE (June 2014), http://www.commonwealthfund.org/~/media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2014.pdf.

[190] *See* Fred Osher, *We Need Better Funding for Mental Health Services*, N.Y. TIMES (May 9, 2016), https://www.nytimes.com/roomfordebate/2016/05/09/getting-the-mentally-ill-out-of-jail-and-off-the-streets/we-need-better-funding-for-mental-health-services.

[191] *See* Boseley, *supra* note 150.

[192] *See generally* AMERICAN PSYCHOSIS, *supra* note 15.

[193] *About NAMI*, NAT'L ALLIANCE ON MENTAL ILLNESS (2019), https://www.nami.org/About-NAMI.

actively works in local and national campaigns to improve mental health funding.[194] In addition to large advocacy groups (such as NAMI), grass-roots campaigns and individual actors call attention to the need for increased mental health programming.[195] Even American celebrities publicly talk about their own struggles with mental illness,[196] and use their own experiences with mental illness to advocate for mental health support.

Advocacy and open social support for mental health initiatives may be a factor in the United States' encouragement for funding mental healthcare programming. According to the World Health Organization, "[a]dvocacy is an important means of raising awareness on mental health issues and ensuring that mental health is on the national agenda of governments. Advocacy can lead to improvements in policy, legislation and service development."[197] In the United States, advocacy by the population at large may be a major factor in maintaining funding momentum for mental health programs and provides a consistent push for continued financial support on both the state and federal levels.

In comparison, advocacy in the United Kingdom developed more slowly.[198] While mental health advocacy began in the early twentieth century, modern advocacy groups (or "service-user" groups) did not begin to emerge until the 1980s.[199] Moreover, "[t]he small scale and transient nature of many of the service user groups"[200] made the scale of such movements hard to track. In the past few years, the United Kingdom's advocacy groups have grown in size and visibility. Groups, such as Rethink Mental Illness[201] and Time to Change,[202] have brought mental health concerns to the attention of the public and advocated for stronger programming.[203] However, these programs are recent and are still coaxing public support from a society in which acceptance and understanding of mental illness have not been the norm.[204]

Even some seemingly positive steps forward regarding mental health rights and support may be hiding inherent prejudice towards individuals with mental illness. Public discourse around mental health stresses the "protection of the public" over the autonomy and rights of the individual, despite public claims that policy is aimed at the latter goal.[205] This is not only apparent in

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[194] NAT'L ALL. ON MENTAL ILLNESS, PUBLIC POLICY PLATFORM OF THE NATIONAL ALLIANCE ON MENTAL ILLNESS (12th ed. 2016).

[195] 21st Century Cures Act, Pub. L. 114-255, 130 Stat. 1033 (2016).

[196] *See, e.g.*, Susan Scutti, *Michael Phelps: 'I Am Extremely Thankful That I Did Not Take My Life'*, CNN (Jan. 20, 2018), https://www.cnn.com/2018/01/19/health/michael-phelps-depression/index.html (recounting Olympic swimmer Michael Phelps' struggle with depression and suicidal ideations).

[197] WORLD HEALTH ORG., ADVOCACY FOR MENTAL HEALTH viii (2003), https://www.who.int/mental_health/policy/services/1_advocacy_WEB_07.pdf.

[198] *See* Turner et al., *supra* note 14, at 607–12.

[199] *Id.* at 610–12.

[200] *Id.* at 612–13.

[201] *About Rethink Mental Illness*, RETHINK MENTAL ILLNESS (2019), https://www.rethink.org/about-us.

[202] *About Us*, TIME TO CHANGE (2019), https://www.time-to-change.org.uk/about-us.

[203] TIME TO CHANGE, A MILESTONE YEAR: ANNUAL REPORT 2012/13 (2013), https://www.time-to-change.org.uk/sites/default/files/Time to Change Annual Report 2012-13.pdf [hereinafter A MILESTONE YEAR].

[204] *See generally* TIME TO CHANGE, *supra* note 202.

[205] Hamlin & Oakes, *supra* note 106, at 51. The authors find that in England and Wales, despite public policy that highlights independence, inclusion, and rights of individuals with intellectual

governmental policy, but also within the social and civilian side of mental health advocacy. A recent Time for Change report cited the watershed moment in 2012 when four sitting MPs announced past experiences with mental illness.[206] While a positive step, this marked the first time that a current MP "admitted" to having "mental health problems"[207]—problematic phraseology that itself highlights the entrenched negative view of United Kingdom citizens towards mental illness and the difficulty of increasing public advocacy.

D. *MOVING FORWARD*

The experiences of the United Kingdom and the United States after deinstitutionalization illustrate the impact that failure of inadequate funding had upon the mental health systems in both nations. For example, a clear failure of funding in community care is seen in the United Kingdom during the 1980s, in the lack of available outpatient services.[208] In contrast, a successful allocation of funding is evident in the enactment of MHCs in the United States.[209] It is clear that it is not the intent behind such mental healthcare programs alone that leads to success or failure upon implementation. The funding, infrastructure, and government and social support for these programs impact their success upon implementation of a mental healthcare program.

Funding provides a compelling explanation for divergence in mental health policies between the United States and the United Kingdom, but it is far from the only explanation. The two nations' different governmental structures affect the legislation that can be enacted. Namely, the United Kingdom's unitary parliamentary system may make it easier to legislate, while the United States may be hampered by its divided powers.[210] While the United States can create initiatives on both the federal and state level, this division of power through federalism can also lead to conflicting or superseding legislation, affecting the type of healthcare legislation that is passed and making the resulting system more complicated to navigate.

Social stigma and societal views of mental health also contribute to the divergence. Stigma is a multifaceted issue that can affect access to care on both an institutional level, by preventing the adoption of legislation or policies, funding, and support services, and on an individual level, by causing mentally ill individuals to avoid treatment for fear of ridicule or societal judgment.[211] It continues to be a significant barrier for individuals seeking mental health

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disabilities, "there is an over-riding sense that the rights of the public for protection far outweigh the rights of people with disabilities for freedom." *Id.*

[206] A MILESTONE YEAR, *supra* note 203; Hamlin & Oakes, *supra* note 106, at 54.

[207] A MILESTONE YEAR, *supra* note 203, at 6.

[208] *See generally* Boseley, *supra* note 150; *see also* Knapp et al., *supra* note 154.

[209] *See generally* Edgely, *supra* note 97.

[210] *See generally* David Arter, *Introduction: Comparing the Legislative Performance of Legislatures*, 12 J. LEGIS. STUD. 245 (2006) (discussing the different types of legislative structures and the resulting effectiveness of systems).

[211] Claire Henderson et al., *Mental Illness Stigma, Help Seeking, and Public Health Programs*, 103 AM. J. PUB. HEALTH 777 (2013). Stigma affects institutional mental health programming, but can also affect the community, in terms of social acceptance and community perception of members with mental illness. Stigma also affects access to care on an individual level (self-stigma), leading individuals to avoid seeking treatment even if adequate services are available. *Id.*

resources. The United States has actively addressed the stigma associated with mental illness since President Kennedy advocated for better mental health policies in the 1960s.[212] While stigma of mental illness has not been fully eradicated in the United States, the initial push for deinstutionalization in the United States was in part against a deep-seated stigma, and provided a strong amount of impetus for the deinstitutionalization movement.[213] Traditionally, in the United Kingdom, a silent stigma surrounds mental health issues and has discouraged its public acknowledgement.[214] Recent campaigns have begun to change this traditional view, such as the Time to Change program,[215] as well as public disclosures from the royal family[216] and recent pledges from the government for mental health parity with physical health in programming.[217] These trends are a positive step forward in both fighting stigma and increasing advocacy for mental health, which is necessary to create real change.[218] However, the recent developments in the United Kingdom against a tradition of stigma may invoke criticisms of too little, too late; while making strides towards public disclosure and acceptance, "there's still much work left to do before stigma and discrimination are experienced rarely (let alone until they are eradicated altogether)."[219]

One lesson evident from the United Kingdom's experience with mental healthcare is that programming cannot be successful unless the program has the necessary infrastructure, financial funding, and social and governmental support. As the Organization for Economic Co-Operation and Development cautions, "[c]ommunity services need to be sufficient to cope with demand for acute care for severe mental disorders. Spending cuts on mental health risk undermining community care provisions, driving up unmet needs, and putting pressure on the low volume of hospital services."[220] This reflects the concern of some scholars who fear an inevitable move towards reinstitutionalization—the failure of sustainable and accessible community services will ensure that the only workable future for mental healthcare will be to return to the institutional model.[221] While proactive legislation establishing the care alternatives in the community was necessary to spark the deinstitutionalization process in both the United States and the United Kingdom and provide the legal support for mental health reform, legislation alone was not enough; legislation needs to be accompanied by sufficient funds to carry the aims of the

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[212] AMERICAN PSYCHOSIS, *supra* note 15, at 37–44.

[213] *See* discussion in *supra* Part II.

[214] A MILESTONE YEAR, *supra* note 203, at 5.

[215] TIME TO CHANGE, *supra* note 202.

[216] *Britain's Royal Family Tackles Mental Health Stigma*, NEWPORT ACAD. (May 18, 2018), https://www.newportacademy.com/resources/mental-health/royal-family/.

[217] *Has the Government Put Mental Health on Equal Footing with Physical Health?*, KING'S FUND, https://www.kingsfund.org.uk/projects/verdict/has-government-put-mental-health-equal-footing-physical-health (last accessed May 3, 2019). Specifically, the Health and Social Care Act of 2012 focused on creating parity between physical health and mental health, which introduced the slogan "No health without mental health." *Id.*

[218] *See generally* Hamlin & Oakes, *supra* note 106 (finding that a fundamental analysis and understanding of the relationships of those with mental illness by examining the discourse around them is necessary to transform deinstitutionalization moving forward).

[219] A MILESTONE YEAR, *supra* note 203, at 5.

[220] OECD Health Div., *supra* note 17, at 1.

[221] *See generally The History*, *supra* note 110.

legislation through to implementation. Perhaps "[d]isgrace"[222] is a more appropriate descriptor for the funding of mental healthcare after deinstitutionalization, rather than the movement itself.

Moving forward, it is imperative the United States and the United Kingdom—as well as other nations embracing the effects of deinstitutionalization movements—acknowledge the key role of funding in shaping the success of mental health policy and programming. Specifically, effective funding relies on the allocation of funds and the establishment of adequate infrastructure of community-based or alternative care services backed by social and governmental support. While funding may not be the sole barrier to better mental health policies, the experiences of the United States and United Kingdom clearly demonstrate the importance of funding to the provision of services that are able to truly meet the needs of the mentally ill population. Without appropriate funding and financial infrastructure for these services, as E. Fuller Torrey cautions, it "seems clear that community mental health centers cannot now and will not in the near future be able to do what the legislature requires."[223] Failure to ensure the sustainable and accessible community-based care that legislation has promised will only continue to harm those whose mental health depends on it.

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[222] TORREY, *supra* note 3, at 11.
[223] AMERICAN PSYCHOSIS, *supra* note 15, at 84.