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THE ASYLUM WE ALREADY BUILT

TRANSINSTITUTIONALIZATION, FISCAL FEDERALISM, AND THE CASE FOR A RIGHTS-PROTECTIVE LONG-TERM PSYCHIATRIC CARE TIER — EVIDENCE FROM LOS ANGELES, SAN FRANCISCO, PHOENIX, AND PORTLAND

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ABSTRACT

The United States did not so much deinstitutionalize its most severely mentally ill citizens as *trans*institutionalize them — relocating a population that once lived in state hospitals into jails, emergency departments, and the street. This paper argues, on economic grounds, for the deliberate restoration of a missing tier of care: dedicated, licensed, rights-protective long-term psychiatric facilities, reclaimed in the original sense of *asylum* as sanctuary, operating as one rung in a continuum rather than a return to the custodial warehouse. The argument blends three lenses. A public-economics account locates the failure in market non-provision, large negative externalities, and a fiscal-federalism distortion — the Medicaid Institutions for Mental Diseases (IMD) exclusion — that paid states to empty hospitals for reasons unrelated to patient welfare. A cost analysis shows that the status quo already funds institutional-scale management of this population at the highest available unit cost (a jail bed-day, an emergency-department boarding-day) and the worst clinical outcomes, while honestly conceding that the long-term tier is cost-*effective* and more humane rather than cost-*saving*. A comparative-institutional analysis of four western cities — Los Angeles, San Francisco, Phoenix, and Portland — treats their divergent legal and funding regimes as natural experiments that, read together, reveal the common shape of the missing tier. The paper closes by mapping each historical cause of the asylum's downfall to a specific modern design safeguard, and confronts the strongest objections: the Housing First evidence base, the Americans with Disabilities Act's integration mandate, the ethics of coercion, and the limits of cost-offset claims. A companion implementation framework operationalizes the argument for government adoption.

1 Introduction: reclaiming a poisoned word

No phrase forecloses serious argument about severe mental illness faster than "bring back the asylum." The word imports a century of documented horror — Willowbrook, the lobotomy ward, the eugenic commitment, the snake pit — and a reader who encounters it in a policy proposal is entitled to assume the worst. Yet the word's original meaning is the opposite of its modern connotation: an *asylum* is a place of refuge and sanctuary. The most-cited contemporary version of the argument advanced here, a 2015 *Journal of the American Medical Association* viewpoint by Sisti, Segal, and Emanuel, makes its case precisely by reclaiming that older meaning — calling for safe, modern, humane long-term psychiatric facilities as an addition to, not a replacement for, community care, restricted to those with "severe and treatment-resistant" illness who are unsafe in community settings (Sisti, Segal, and Emanuel 2015). This paper adopts that move. It keeps the provocation but relocates the precision: the operative object of analysis is a *long-term psychiatric care tier*, and the analysis disowns the carceral model as firmly as any critic would.

The provocation is warranted because the conventional story is false in a consequential way. The United States is routinely described as having "deinstitutionalized" the seriously mentally ill over the second half of the twentieth century. It did empty the state hospitals — from a peak of 558,239 public psychiatric beds in 1955, roughly 340 per 100,000 people, to about 36,150 beds, or 10.8 per 100,000, by 2023, of which more than half are now occupied by forensic patients committed through the criminal courts (Torrey et al. 2008; Treatment Advocacy Center 2024). But it did not return that population to liberty so much as redistribute it into other institutions: county jails, hospital emergency departments, and the carceral geography of the sidewalk. The asylum was not abolished; it was decentralized, hidden across agency budgets, and made crueler and more expensive in the process.

The thesis of this paper follows from that observation. The case for re-institutionalization is not, at its core, a case for new spending; it is a case for **re-allocating spending that is already being made** — out of the most expensive and least therapeutic settings society currently uses to contain this population, and into a restored institutional tier governed so that the failures that ended the first asylum era cannot recur. The argument is deliberately narrow in its target population and deliberately demanding in its safeguards, because both the economics and the ethics require it.

The paper proceeds in eight further sections. Section 2 reconstructs how the asylum rose and fell, emphasizing that its downfall had legal, fiscal, and moral causes that were each, in their own terms, real. Section 3 develops the central empirical move — transinstitutionalization — and quantifies it carefully, including its limits. Section 4 gives the public-economics account of why neither markets nor the existing fiscal structure provide this care. Section 5 builds the cost argument and states honestly what it can and cannot support. Section 6 uses Los Angeles, San Francisco, Phoenix, and Portland as natural experiments. Section 7 maps each cause of the historical downfall to a modern design answer. Section 8 confronts the strongest objections. Section 9 concludes.

2 The arc: how the asylum rose and fell

The collapse of the American state hospital was not a single decision but a convergence of a clinical innovation, a legal revolution, a moral reckoning, and a fiscal incentive — and any account that reduces it to one cause will misdiagnose the remedy.

The clinical innovation was pharmacological. The introduction of chlorpromazine in the mid-1950s made it possible, for the first time, to manage acute psychosis outside a locked ward, and it underwrote a genuine optimism that long-term institutional care might become unnecessary (Harcourt 2011). The moral reckoning was equally genuine: the mid-century state hospital was frequently a site of overcrowding, neglect, and abuse, and the case for closing such places was a humane one, not a mistake. It is essential to the argument of this

paper to concede this fully. The reform impulse drew, as Sisti and colleagues note, a heterogeneous coalition — "progressive reformers, consumers, civil libertarians, and fiscal conservatives" — whose motives ranged from the liberationist to the budgetary (Sisti, Segal, and Emanuel 2015).

The legal revolution gave the impulse force. California's Lanterman-Petris-Short Act of 1967, signed by Governor Reagan and operative from 1969, ended open-ended involuntary commitment by judicial fiat and replaced it with a graduated structure of due-process-protected holds keyed to a narrow standard: a person could be detained only if, by reason of mental disorder, they were a danger to self, a danger to others, or "gravely disabled" — unable to provide for their own food, clothing, or shelter (Cal. Welf. & Inst. Code §5000 et seq.). The federal courts supplied the constitutional perimeter. *Jackson v. Indiana* (1972) forbade indefinite commitment of defendants merely incompetent to stand trial; *O'Connor v. Donaldson* (1975) held that a state cannot confine a non-dangerous person capable of surviving safely in freedom; and *Addington v. Texas* (1979) fixed the constitutional standard of proof for civil commitment at "clear and convincing evidence." A parallel line, beginning with the district court's decision in *Wyatt v. Stickney* (1971), established that the involuntarily committed have a constitutional right to *treatment* — a right that, by raising the standard of adequate care, also raised its cost.

The fiscal incentive is the most overlooked and, for the economics of this paper, the most important. When Medicaid was enacted in 1965, Congress wrote in the Institutions for Mental Diseases (IMD) exclusion, barring federal Medicaid matching funds for most adults aged 21 to 64 in a psychiatric institution of more than sixteen beds (Social Security Act §1905(a); MACPAC 2024; Congressional Research Service 2023). The exclusion was designed to preserve a traditional division of labor in which states paid for psychiatric hospitals. Its practical effect, as the Treatment Advocacy Center's history puts it, was to create "a huge incentive for states to discharge patients to the community and thus effectively shift the cost of their care from the state to the federal government": a patient in a state hospital was a near-total state expense, while the same patient discharged to the community became eligible for federally funded Medicaid, Supplemental Security Income, and disability benefits (Torrey et al. 2008). Deinstitutionalization was thus propelled, in substantial part, by a budgetary arbitrage unrelated to whether patients were better off.

What was promised in exchange was a community system that never arrived. President Kennedy's Community Mental Health Act of 1963 envisioned roughly 1,500 community mental health centers blanketing the country; only about half were ever built, none was fully funded for operations, and the categorical program was effectively dismantled and converted to block grants under the Omnibus Budget Reconciliation Act of 1981 (Sharfstein 2000). Lanterman-Petris-Short's own authors recognized the gap almost immediately; Assemblyman Lanterman's lament that "the dollar has not followed the patient" became the epitaph of the era. The most rigorous economic history of the period, Frank and Glied's *Better But Not Well*, reaches a conclusion that should discipline any reform proposal: people with mental illness are indeed better off than in 1950, but the gains came overwhelmingly from "mainstreaming" — their inclusion in broad programs not designed for them, such as Medicaid, SSI, and housing vouchers — rather than from specialized mental-health policy, which left a "policy void" in which no institution retained the resources or authority to serve the most severely ill (Frank and Glied 2006). That policy void is the space this paper proposes to fill.

3 The asylum we already built

The hinge of the argument is an old observation. In 1939 the British psychiatrist Lionel Penrose, comparing eighteen European countries, documented an inverse relationship between the size of a country's psychiatric institutional population and the size of its prison population (Penrose 1939). The modern restatement — "Penrose's Law" — holds that as psychiatric beds fall, incarceration rises, because the two institutions are, in part, substitutes for the same population. Bernard Harcourt extended the point to the United States, arguing

that the standard narrative of an "incarceration revolution" is an artifact of measuring prisons in isolation; when one constructs an *aggregated institutionalization* series combining mental-hospital and prison populations across the twentieth century, the late-century carceral expansion looks less like an unprecedented spike and more like a return, after the hollowing-out of the hospitals, toward the aggregate institutional footprint the country maintained at mid-century (Harcourt 2006, 2011).

The claim must be made carefully, because it is easy to overstate, and overstatement discredits it. The most disciplined econometric treatment, by Raphael and Stoll, finds that deinstitutionalization explains only about **4 to 7 percent** of the growth in the U.S. incarceration rate between 1980 and 2000 (Raphael and Stoll 2013). Reopening psychiatric capacity would therefore *not* empty the prisons, and no honest version of this argument should claim it would. What Raphael and Stoll also find, however, is that the transinstitutionalization that did occur was real and concentrated in exactly the population at issue here, and that by the 1980s the relationship had become statistically significant after being absent in earlier decades. The point is not that mass incarceration is a mental-health phenomenon; it is that a specific, identifiable population of seriously mentally ill people, for whom hospital beds no longer exist, now lives under institutional control in settings designed for other purposes.

The exhibits are by now familiar. The Los Angeles County jail system, Chicago's Cook County Jail, and New York's Rikers Island are each routinely described as the largest de facto psychiatric facility in the United States; in Los Angeles, the share of the jail's average daily population with a mental-health need rose to roughly 46 percent, about 5,861 people, by early 2025 (Los Angeles County data; RAND Corporation 2020). The emergency department has become the de facto admitting ward: psychiatric patients "board" in emergency rooms awaiting placement for an average of roughly 18 hours against 6 for medical patients, at an estimated cost of $2,264 per boarded patient and with most receiving no psychiatric treatment while they wait (Nicks and Manthey 2012). And the unsheltered street population, concentrated in precisely the western cities examined below, contains a large share of people with untreated serious mental illness and co-occurring substance use disorder.

The economic punchline is that society already pays for the institutional-scale management of this population — but at the highest unit cost the system can generate and with the worst outcomes it can produce, and it pays in a form fragmented across so many agency budgets that no one ever sees the total bill. The status quo is not liberty. It is an asylum system that has been disaggregated into jails, emergency rooms, and sidewalks, and then billed to whichever level of government happens to be standing closest.

4 Why markets and the fiscal structure fail

That the seriously mentally ill end up in jails rather than care is not a market outcome that policy has failed to improve; it is a market failure that policy has actively produced. Three features of the problem place it squarely within the standard public-economics rationale for collective provision.

First, untreated serious mental illness generates large negative externalities. The costs of public disorder, uncompensated emergency care, victimization, and the degradation of shared public space fall on third parties, not on the untreated individual, and a system that ignores them will under-provide care relative to the social optimum. Second, long-term psychiatric care for this population is, in economic terms, a good that no private market will supply at scale. The patients are typically uninsured or under-insured, frequently lack the capacity to contract, and require a long-horizon, labor-intensive, non-remunerative service; the result is a textbook provision failure in which the socially valuable service simply is not offered. Third — and this is the feature most specific to the American case — the intergovernmental fiscal structure is distorted in a way that systematically pushes the population toward the wrong settings.

The distortion has a name: the IMD exclusion. By refusing federal matching funds for non-elderly adults in psychiatric institutions while funding their care once they are discharged, the exclusion converts a clinical decision into a fiscal one. A state that keeps a patient in a state hospital bears nearly the entire cost; a state that discharges the same patient shifts much of the cost to Washington through Medicaid, SSI, and SSDI (Torrey et al. 2008; MACPAC 2024). The exclusion thus functions as a standing federal subsidy for the *absence* of long-term inpatient capacity. Its companion distortion is the fragmentation of who pays for the consequences: counties bear the cost of jails and much emergency response, states bear the cost of hospitals and courts, and the federal government bears Medicaid and disability — so each actor faces a private incentive to push the population onto another's ledger, and none has either the authority or the incentive to optimize the system as a whole. This is the institutional form of Frank and Glied's "policy void."

Recent federal policy has begun, tentatively, to erode the IMD exclusion. Since 2017 and 2018, the Centers for Medicare and Medicaid Services have permitted states to draw federal matching funds for short-term IMD stays through Section 1115 demonstration waivers for substance-use and serious-mental-illness populations (Centers for Medicare and Medicaid Services 2017, 2018; Kaiser Family Foundation 2025). But these waivers are conditioned on a statewide *average* length of stay of roughly thirty days — they are designed to finance acute stabilization, not the long-term tier this paper concerns. The waiver program is therefore evidence that the structural barrier is recognized, and simultaneously evidence that it has not yet been addressed for the population that most needs a durable setting.

5 The cost-offset, honestly

The intuitive economic case for a long-term tier is that the status quo is so expensive that almost any alternative would save money. The intuition is half right, and the discipline of this paper is to say which half.

Consider the per-person annual cost of the settings in which the high-need seriously mentally ill population currently cycles. Incarceration averages about $33,274 per inmate per year nationally, but that figure understates the relevant cost, because inmates with serious mental illness are widely documented to cost two to three times more than the general population; in Los Angeles, officials have estimated the cost of holding a severely mentally ill person in the Twin Towers jail at more than $600 per day against roughly $70 per day in a diversion program (Vera Institute 2017; LAist 2020; RAND Corporation 2020). Emergency-department boarding adds roughly $2,264 per episode (Nicks and Manthey 2012). To these direct costs must be added repeat short-term hospitalization, emergency medical and police response, shelter, and the largest and least-counted cost of all — premature death. People with serious mental illness die roughly a decade earlier than the general population on average, and the most severely ill subset served by the public mental-health system die some two decades early; unsheltered homeless adults die at several times the age-adjusted rate of the housed population, with an average age at death around 48 (Walker, McGee, and Druss 2015; Colton and Manderscheid 2006; Baggett et al. 2013; National Health Care for the Homeless Council 2024).

Crucially, these costs are concentrated. A small minority of high utilizers accounts for a disproportionate share of crisis contacts — in one canonical study, 4.4 percent of psychiatric-emergency patients generated about 23 percent of visits (Pasic, Russo, and Roy-Byrne 2005) — which is why the "familiar costs" literature finds such large numbers attached to individual chronically homeless, mentally ill people. Culhane and colleagues found that a homeless person with severe mental illness consumed roughly $40,449 per year in public services, of which placement in supportive housing offset about 95 percent (Culhane, Metraux, and Hadley 2002); the same phenomenon, rendered as anecdote, is Malcolm Gladwell's "Million-Dollar Murray" (Gladwell 2006).

Against these avoided costs must be set the cost of the tier itself, and here candor is required. A state psychiatric hospital bed costs roughly $215,000 to $340,000 per year to operate, with charge rates in some states exceeding $600,000 (California Legislative Analyst's Office 2017; Texas Legislative Budget Board 2022;

Washington Department of Social and Health Services 2026); behavioral-health inpatient construction costs 22 to 37 percent more than general acute capacity (ECG Management Consultants); and the clinical workforce required to staff such beds cannot be expanded quickly (Health Resources and Services Administration 2025). A long-term tier is not cheap, and the high-utilizer offsets, while real, are study-specific and do not generalize cleanly. The cost-offset literature is beset by selection bias (people who enter care differ from those who do not), counterfactual ambiguity (offset against what?), and regression to the mean in high-utilizer panels.

The honest conclusion, which the World Health Organization reaches for community mental-health reform generally and which applies with equal force here, is that this care is **cost-effective, not cost-saving** (World Health Organization Regional Office for Europe 2023); the U.S. National Academies similarly found no substantial evidence that permanent supportive housing reduces system-wide health costs, even as it improves housing stability (National Academies of Sciences, Engineering, and Medicine 2018). The economic case for the tier therefore does not rest on a promise that it pays for itself. It rests on three more defensible claims: that the status quo spends large sums to produce institutionalization in its most expensive and least therapeutic form; that re-allocating those sums toward a purpose-built setting buys substantially better outcomes per dollar; and that the residual net cost, if any, purchases a reduction in premature death and a restoration of dignity that a civilized fiscal accounting should be willing to name as a benefit rather than treat as an externality.

6 Four cities as natural experiments

Los Angeles, San Francisco, Phoenix, and Portland are not chosen as four interchangeable illustrations of west-coast disorder. They are chosen because they are running four different policy experiments on the same underlying population, and read together they triangulate the shape of the missing tier more persuasively than any single case or national aggregate could. Two share a state legal regime and differ in local capacity; a third operates under a markedly different commitment standard and a nationally celebrated crisis system; the fourth ran, and then partially reversed, the country's boldest experiment in de-coercion.

Los Angeles is the missing tier at maximum scale, and the clearest exhibit of transinstitutionalization. Its jail system is the canonical "largest mental institution in America," with roughly 46 percent of the average daily population — some 5,861 people — carrying a mental-health need by early 2025, at a daily cost that the county's own diversion officials estimate at nearly an order of magnitude above community alternatives (RAND Corporation 2020; LAist 2020). Los Angeles is also the test of whether money alone closes the gap: through Measure H, Proposition HHH — whose permanent supportive housing units drew an auditor's finding of an average cost near $597,000 each — and the new Measure A sales tax generating over $1 billion per year, the county has committed enormous resources, and it began enrolling residents in the state's new CARE Court in December 2023 (Los Angeles City Controller; Los Angeles County). The persistence of the crisis amid that spending is itself a finding: capital and housing dollars, absent a clinically appropriate long-term tier and a legal pathway to it, do not by themselves resolve the situation of the most severely ill.

San Francisco sharpens that finding by holding the state legal regime constant while pushing per-capita resources to among the highest in the nation; its Department of Homelessness and Supportive Housing budget alone approached $786 million in fiscal 2025–26 (San Francisco HSH). And yet San Francisco produced the single most telling data point in this study: under SB 1045, the 2018 law authorizing housing conservatorship for the most severely impaired, the city conserved a grand total of **three people**, against projections of fifty to a hundred per year (San Francisco Department of Public Health 2023). The lesson is that in a high-resource city operating under the same Lanterman-Petris-Short framework as Los Angeles, the binding constraint is not money and is not even, primarily, housing; it is the legal pathway and the bed type. A conservatorship statute

that almost no one uses, attached to a system with almost no appropriate long-term beds to use it for, is a right without a remedy.

Phoenix, in Maricopa County, supplies the contrasting legal regime and a cautionary lesson about the front end. Arizona commits under a broader standard than California's — its "persistently or acutely disabled" criterion permits intervention on the basis of predictable psychiatric deterioration without requiring imminent danger — and the Treatment Advocacy Center grades its civil-commitment law among the nation's strongest (Treatment Advocacy Center 2024b). Maricopa also operates the country's most-cited crisis system, the "no wrong door" model of crisis lines, mobile teams, and 23-hour receiving facilities run by providers such as Connections Health Solutions, with a peer-reviewed evaluation associating Arizona's crisis build-out with a significant relative decline in suicide-related hospitalizations (Mark et al. 2024). The system was itself a product of right-to-treatment litigation, the decades-long *Arnold v. Sarn* case, which settled in 2014 — a reminder that adequately funded community systems in this country have often had to be compelled by courts. And yet Phoenix's homelessness continued to rise, with a record point-in-time count of 9,734 in 2025 and the high-profile court-ordered clearance of the downtown encampment known as "The Zone"; Arizona retains only about 3.5 state psychiatric beds per 100,000 people (Maricopa Association of Governments 2025; Treatment Advocacy Center 2024). Phoenix demonstrates that a strong commitment standard and an excellent crisis front-end, real achievements both, still do not substitute for a long-term tier at the back end.

Portland ran the opposite experiment and provides the study's counter-test. Oregon's Measure 110, effective in 2021, decriminalized personal drug possession; the state's overdose deaths then rose sharply, and in 2024 the legislature partially re-criminalized possession through House Bill 4002 — a rare, clean policy reversal within roughly three and a half years (Oregon Legislature; Oregon Public Broadcasting 2024). The economically important point is one of attribution: the strongest quasi-experimental evidence finds that Oregon's overdose surge tracked the arrival of fentanyl rather than the legal change itself, so the reversal is best read as a response to political backlash and implementation failure rather than as proof that decriminalization causally failed (Zoorob and del Pozo 2024). Meanwhile, the back end collapsed visibly: the Oregon State Hospital, unable to admit jailed defendants found unfit for trial within the seven days a federal court has required since 2002, was held in contempt in 2025 and fined $500 per person per day, accumulating roughly $4.5 million by mid-2026, with the state cycling in and out of compliance by restricting admissions (Oregon Public Broadcasting 2025). Oregon retains about 16.6 psychiatric beds per 100,000 people, but roughly 93 percent are forensic. Portland shows what happens when a jurisdiction reduces coercive leverage without building the tier: demand for institutional care does not disappear: it reappears as a queue, a lawsuit, and a fine.

Read across the four, the cross-city design isolates the variables that matter. Los Angeles against San Francisco holds state law constant and varies local capacity, showing that capacity without a legal pathway and a long-term tier underperforms. California against Arizona varies the commitment standard, showing that a stronger standard and a better crisis system help but do not suffice. Oregon varies coercion over time, showing that withdrawing it without building capacity simply relocates the crisis. The throughline is that each city has built some pieces — housing, or crisis response, or a broad commitment standard — and none has built the durable, rights-protective, long-term tier into which those pieces are supposed to connect.

7 Why it fell, and how to build it so it does not fall again

A proposal to rebuild any part of the institutional system must answer the reasons the last one was torn down, and those reasons were not a single error but a bundle. The discipline this section imposes is to map each historical cause of the downfall to a specific, modern design answer. Where the paper sketches these answers, the companion implementation framework specifies them.

The civil-liberties wall. The asylum fell in part because the law, correctly, made indefinite involuntary confinement of the non-dangerous unconstitutional (*O'Connor v. Donaldson* 1975; *Addington v. Texas* 1979). A new tier cannot and should not evade that perimeter; it must be built inside it. The design answer is a graduated, due-process-rich pathway: time-limited and judicially renewable commitment, decided under the clear-and-convincing standard with appointed counsel and periodic review; a reformed "grave disability" criterion of the kind California adopted in SB 43 (2023), which extends the standard to encompass the inability to attend to necessary medical care or personal safety; and assisted outpatient treatment as the less-restrictive rung beneath inpatient care. The institution is justified only as the *least*-restrictive setting that actually works for a narrowly defined population, with structured exit ramps toward step-down and community placement built into every commitment from the start.

Documented abuse and the absence of accountability. The moral case against the old asylum was real, and a system that cannot guarantee it will not recur does not deserve to be rebuilt. The design answer is accountability engineered into the structure rather than litigated after the fact: independent licensing and dual external accreditation (for example, through the Joint Commission and CARF); a restraint-and-seclusion floor codified from the federal Conditions of Participation at 42 CFR §482.13 and exceeded through evidence-based reduction practices such as SAMHSA's Six Core Strategies; guaranteed, unannounced access for an independent rights-protection body modeled on the Protection and Advocacy for Individuals with Mental Illness program (42 U.S.C. §10801); an empowered ombudsman with jurisdiction over resident complaints; public reporting of critical-incident and restraint data; small-facility architecture; and enforceable minimum staffing ratios. The right-to-treatment standard that *Wyatt v. Stickney* (1971) had to impose by injunction should be a funded design specification, not a remedy won in court.

The fiscal cost-shift. The IMD exclusion paid states to empty hospitals; left in place, it will penalize any state that builds the tier. The design answer is to repeal or reform the exclusion, or at minimum to extend the Section 1115 waiver authority beyond its current short-term, roughly thirty-day average-length-of-stay ceiling so that federal matching funds follow patients into genuinely long-term care. This is the cleanest federal ask the argument generates, and it aligns the fiscal incentive with the clinical need rather than against it.

The unfunded community promise. The Community Mental Health Act legislated a continuum and never funded it, and patients were discharged, in the era's phrase, "to nothing." The design answer is to fund the continuum as a whole and counter-cyclically, through a dedicated, non-discretionary revenue stream rather than annually contested general funds — California's Proposition 1, a $6.4 billion behavioral-health bond paired with a restructured behavioral-health tax, is one available template (California Department of Health Care Services 2024) — so that long-term beds, step-down residential capacity, and supported housing are financed together rather than competing against one another for the same line item.

Two cross-cutting lessons govern all four answers. The first is sequencing. The international model most often held up as a success, the Trieste system in Italy, succeeded because its community services were built *before and as* its hospital beds were closed; the American failure was to reverse that order (Frances 2021). Any rebuild must fund the community and step-down continuum in parallel with the institutional tier, not after it. The second is the workforce. The United States already sits inside a behavioral-health staffing shortage — roughly 40 percent of Americans live in a designated shortage area, and the psychiatrist pipeline is effectively fixed for five to ten years by graduate-medical-education constraints (Health Resources and Services Administration 2025) — so the binding constraint on the tier may be neither beds nor dollars but the people to staff them, which the framework must plan around through team-based models, advanced-practice clinicians, and a funded direct-care pipeline.

8 Objections and limits

A thesis-driven argument earns its conclusion only by out-arguing its strongest critics, and on this subject the critics are serious. This section states their cases at full strength.

Housing First works, and the tier is unnecessary. The most powerful objection is that the evidence already identifies the solution, and it is not an institution. Housing First — immediate, low-barrier, permanent supportive housing without sobriety or treatment preconditions — has a robust randomized evidence base. The Canadian At Home/Chez Soi trial, the largest ever conducted, found that Housing First participants spent about 73 percent of their time stably housed against 32 percent for usual care (Aubry, Nelson, and Tsemberis 2015; Stergiopoulos et al. 2015). This paper concedes the point without reservation: for the large majority of people experiencing chronic homelessness, including most with mental illness, Housing First is the right intervention and the tier proposed here is not for them. But the same literature draws the boundary of its own success. Housing First reliably produces housing stability and reduced emergency service use while repeatedly failing to show improvement in psychiatric symptoms or substance use, and the National Academies concluded in 2018 that there is "no substantial published evidence" that permanent supportive housing improves health outcomes outside the HIV/AIDS context (National Academies 2018; Tsai 2020; Baxter et al. 2019). The residual population for whom housing-plus-outpatient does not suffice is identifiable: roughly a quarter of people with schizophrenia have treatment-resistant illness rising toward a third over time (Howes et al. 2017; Smith et al. 2024); about half have anosognosia, a neurologically grounded unawareness of illness that is itself a symptom rather than a choice and that predicts non-adherence and relapse; and a small high-utilizer subgroup cycles repeatedly through every system regardless of housing status (Pasic, Russo, and Roy-Byrne 2005). The tier is for that minority, and the argument is not Housing First *versus* institutions but a continuum in which both exist.

The integration mandate forbids it. Under the Americans with Disabilities Act, as interpreted in *Olmstead v. L.C.* (1999), unjustified institutional segregation of people with disabilities is discrimination, and states must serve them in the most integrated setting appropriate. A new institutional tier appears to run directly against that mandate. But *Olmstead* is conditional, not absolute: it requires community placement when treatment professionals judge it appropriate, the individual does not oppose it, and it can be reasonably accommodated — and it expressly recognizes that "for some individuals, no placement outside the institution may ever be appropriate" and that the ADA does not condone terminating institutional settings for those who cannot handle or benefit from community placement (*Olmstead v. L.C.* 1999). The tier proposed here is designed to occupy precisely that carve-out: it serves only individuals for whom professionals determine community placement is currently inappropriate or who do not consent to it, and it builds a presumption toward step-down and active transition planning into every placement. It is meant to satisfy the integration mandate, not to circumvent it.

Coercion is the wrong tool, and its evidence is weak. The deepest objection is ethical: expanding the state's power to confine and treat a vulnerable population against its will is a grave act, and the evidence that coercion itself improves outcomes is thin. This objection is correct on the evidence and should reshape the proposal rather than be dismissed by it. The randomized literature on assisted outpatient treatment finds that the court order *by itself* adds little; the 2017 Cochrane review of three randomized trials found no clear advantage to compulsory community treatment, calculating that it would take 142 orders to prevent a single readmission (Kisely, Campbell, and O'Reilly 2017). What the evidence supports is that sustained, intensive *services* improve outcomes, with legal mechanisms useful mainly as a means of delivering and maintaining them (Swartz et al. 2001). The implication for this paper is precise: the case for the tier rests on capacity and care, not on coercion, and the autonomy cost of involuntary placement must be carried in the welfare accounting as a

genuine cost, mitigated by narrow targeting, rigorous due process, and the least-restrictive-alternative principle — not treated as a regrettable detail.

The cost case is over-claimed. As Section 5 already conceded, it is. The defense is to claim only what the evidence supports — partial offsets, cost-effectiveness, and humanitarian benefit, bounded by explicit sensitivity analysis — and to refuse the budget-neutral framing that a less careful version of this argument would adopt.

It is not buildable. The fiscal and human realism objection is that capital costs are enormous, the federal financing structure is hostile, and the workforce does not exist. All three are true, and Section 7 treats them as binding design constraints rather than footnotes: the tier must be financed over a decade-plus horizon, paired with IMD reform, and sequenced behind a funded workforce pipeline. A proposal that pretended otherwise would deserve the skepticism.

It will become a warehouse again. The historical prior is bad, and the burden of proof sits with the proponent. The whole of Section 7 is the answer; its sufficiency is, properly, a matter for the reader and for the oversight institutions the framework specifies to judge.

9 Conclusion: the missing tier

The argument of this paper can be compressed into a single reframing. The United States is not choosing between institutionalizing the seriously mentally ill and leaving them free; it is choosing *where* and *how humanely* to institutionalize a population it already confines. The present choice — jails, emergency-department hallways, and the street — is the most expensive option available and the least therapeutic, and it is defended mainly by the fact that its costs are hidden across so many budgets that no one is accountable for their sum. A purpose-built, rights-protective, long-term tier is not a nostalgic return to the asylum; it is the honest, visible, and governable version of an institutional commitment the country has already made by default.

The asks that follow are modest in number and specific in form. At the federal level, reform the IMD exclusion so that the fiscal incentive stops penalizing the care the clinical evidence requires. At the state level, fund the continuum as a whole through a dedicated revenue stream and pair it with a reformed, due-process-rich commitment standard so that new beds are both built and usable. At the local level, capture the offsets that already exist by redirecting the resources now spent on the most expensive settings toward the tier and the community services around it. And across all three, build the accountability — independent oversight, public data, enforceable standards — that makes the difference between sanctuary and warehouse.

Even if the offsets prove smaller than hoped and the tier is, on balance, a net cost, the argument stands, because the benefit it purchases is measured in lives that currently end two decades early on a sidewalk or in a cell. The companion framework that accompanies this paper translates the argument into a model legal architecture, a tiered program design, a financing mechanism, an oversight regime, an implementation roadmap, and a set of outcome metrics, so that the case made here can be evaluated, adopted, and — most importantly — held to account.

References

Aubry, T., G. Nelson, and S. Tsemberis. 2015. "Housing First for People with Severe Mental Illness Who Are Homeless: A Review of the Research and Findings from the At Home/Chez Soi Demonstration Project." *Canadian Journal of Psychiatry* 60 (11): 467–474.

Baggett, T. P., et al. 2013. "Mortality Among Homeless Adults in Boston." *JAMA Internal Medicine* 173 (3): 189–195.

Baxter, A. J., et al. 2019. "Effects of Housing First Approaches on Health and Well-Being of Adults Who Are Homeless: Systematic Review and Meta-Analysis." *Journal of Epidemiology and Community Health* 73 (5): 379–387.

California Department of Health Care Services. 2024. *Proposition 1: An Overview.*

California Legislative Analyst's Office. 2017. *The 2017–18 Budget: Department of State Hospitals.*

Centers for Medicare and Medicaid Services. 2017. *Strategies to Address the Opioid Epidemic.* State Medicaid Director Letter #17-003.

Centers for Medicare and Medicaid Services. 2018. *Opportunities to Design Innovative Service Delivery Systems for Adults with Serious Mental Illness.* State Medicaid Director Letter #18-011.

Colton, C. W., and R. W. Manderscheid. 2006. "Congruencies in Increased Mortality Rates, Years of Potential Life Lost, and Causes of Death Among Public Mental Health Clients in Eight States." *Preventing Chronic Disease* 3 (2): A42.

Congressional Research Service. 2023. *Medicaid's Institutions for Mental Diseases (IMD) Exclusion.* In Focus IF10222.

Culhane, D. P., S. Metraux, and T. Hadley. 2002. "Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing." *Housing Policy Debate* 13 (1): 107–163.

ECG Management Consultants. n.d. *Behavioral Health Facility Construction Cost Analysis.*

Frances, A. 2021. "Save Trieste's Mental Health System." *The Lancet Psychiatry* 8 (9): 744–746.

Frank, R. G., and S. A. Glied. 2006. *Better But Not Well: Mental Health Policy in the United States since 1950.* Baltimore: Johns Hopkins University Press.

Gladwell, M. 2006. "Million-Dollar Murray." *The New Yorker*, February 13.

Harcourt, B. E. 2006. "From the Asylum to the Prison: Rethinking the Incarceration Revolution." *Texas Law Review* 84: 1751–1786.

Harcourt, B. E. 2011. "Reducing Mass Incarceration: Lessons from the Deinstitutionalization of Mental Hospitals in the 1960s." *Ohio State Journal of Criminal Law* 9: 53–88.

Health Resources and Services Administration. 2025. *State of the Behavioral Health Workforce, 2025.*

Howes, O. D., et al. 2017. "Treatment-Resistant Schizophrenia: Treatment Response and Resistance in Psychosis (TRRIP) Working Group Consensus Guidelines on Diagnosis and Terminology." *American Journal of Psychiatry* 174 (3): 216–229.

Kaiser Family Foundation. 2025. *Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State.*

Kisely, S. R., L. A. Campbell, and R. O'Reilly. 2017. "Compulsory Community and Involuntary Outpatient Treatment for People with Severe Mental Disorders." *Cochrane Database of Systematic Reviews*, no. 3: CD004408.

LAist. 2020. "How LA County Is Trying to Move Mentally Ill People Out of Jail and Into Care."

Los Angeles City Controller. 2022. *Audit of Proposition HHH.*

MACPAC (Medicaid and CHIP Payment and Access Commission). 2024. *Payment for Services in Institutions for Mental Diseases (IMDs).*

Maricopa Association of Governments. 2025. *Point-in-Time Homeless Count.*

Mark, T. L., et al. 2024. "The Association of a Comprehensive Crisis Continuum with Suicide-Related Emergency Department Visits and Hospitalizations." *Psychiatric Services* 75 (2): 148–154.

National Academies of Sciences, Engineering, and Medicine. 2018. *Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness.* Washington, DC: National Academies Press.

National Health Care for the Homeless Council. 2024. *Mortality and Homelessness.*

Nicks, B. A., and D. M. Manthey. 2012. "The Impact of Psychiatric Patient Boarding in Emergency Departments." *Emergency Medicine International* 2012: 360308.

O'Connor v. Donaldson, 422 U.S. 563 (1975).

Olmstead v. L.C., 527 U.S. 581 (1999).

Oregon Public Broadcasting. 2024. "Gov. Kotek Signs Bill Recriminalizing Drug Possession in Oregon."

Oregon Public Broadcasting. 2025. "Judge Holds Oregon Health Authority in Contempt Over State Hospital Admissions."

Pasic, J., J. Russo, and P. Roy-Byrne. 2005. "High Utilizers of Psychiatric Emergency Services." *Psychiatric Services* 56 (6): 678–684.

Penrose, L. S. 1939. "Mental Disease and Crime: Outline of a Comparative Study of European Statistics." *British Journal of Medical Psychology* 18 (1): 1–15.

RAND Corporation. 2020. *Understanding the Public Health Implications of Diversion Programs in Los Angeles County.* RR-4328.

Raphael, S., and M. A. Stoll. 2013. "Assessing the Contribution of the Deinstitutionalization of the Mentally Ill to Growth in the U.S. Incarceration Rate." *Journal of Legal Studies* 42 (1): 187–222.

San Francisco Department of Public Health. 2023. *Housing Conservatorship (SB 1045) Evaluation.*

Sharfstein, S. S. 2000. "Whatever Happened to Community Mental Health?" *Psychiatric Services* 51 (5): 616–620.

Sisti, D. A., A. G. Segal, and E. J. Emanuel. 2015. "Improving Long-Term Psychiatric Care: Bring Back the Asylum." *JAMA* 313 (3): 243–244.

Smith, J., et al. 2024. "Rates of Treatment-Resistant Schizophrenia from First-Episode Cohorts: Systematic Review and Meta-Analysis." *British Journal of Psychiatry.*

Stergiopoulos, V., et al. 2015. "Effect of Scattered-Site Housing Using Rent Supplements and Intensive Case Management on Housing Stability Among Homeless Adults with Mental Illness." *JAMA* 313 (9): 905–915.

Swartz, M. S., et al. 2001. "A Randomized Controlled Trial of Outpatient Commitment in North Carolina." *Psychiatric Services* 52 (3): 325–329.

Texas Legislative Budget Board. 2022. *State Hospitals Primer.*

Torrey, E. F., et al. 2008. *The Shortage of Public Hospital Beds for Mentally Ill Persons.* Arlington, VA: Treatment Advocacy Center.

Treatment Advocacy Center. 2024. *Prevention Over Punishment: Finding the Right Balance of Civil and Forensic State Psychiatric Hospital Beds.*

Treatment Advocacy Center. 2024b. *Grading the States: Civil Commitment Laws.*

Tsai, J. 2020. "Is the Housing First Model Effective? Different Evidence for Different Outcomes." *American Journal of Public Health* 110 (9): 1376–1377.

Vera Institute of Justice. 2017. *The Price of Prisons: Examining State Spending Trends, 2010–2015.*

Walker, E. R., R. E. McGee, and B. G. Druss. 2015. "Mortality in Mental Disorders and Global Disease Burden Implications: A Systematic Review and Meta-Analysis." *JAMA Psychiatry* 72 (4): 334–341.

Washington Department of Social and Health Services. 2026. *State Hospital Rates (FY2026).*

Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971).

World Health Organization Regional Office for Europe. 2023. *Community-Based Mental Health Care: Lessons from Trieste.*

Zoorob, M., and B. del Pozo. 2024. "Drug Decriminalization, Fentanyl, and Fatal Overdoses in Oregon." *JAMA Network Open.*