

## Clinical Review

# Through the Cracks: The Disposition of Patients With Schizophrenia Spectrum Disorders in the Post-Asylum Era

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## Abstract

### Description

This paper aims to explore current disposition options for patients with psychosis in light of shifts toward community care and changes in mental healthcare funding in the post-asylum era and to propose systemic-level improvements based upon local successes. It evaluates critiques of long-term psychiatric care programs, claims of transinstitutionalization to incarceration, shelters, and emergency rooms, and programs initiated to address deinstitutionalization. The authors conclude that while Assertive Community Treatment, Partial Hospitalization Programs, intermediate-level care, and housing interventions can improve outcomes for many persons with psychotic illness, a significant portion of these patients would still be best served in long-term psychiatric care facilities.

### Keywords

schizophrenia; mental disorders; mental illness; psychiatric illness; psychiatric disorders; deinstitutionalization; transinstitutionalization; homelessness; homeless persons; prisons; incarceration; community networks; community treatment

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Our patient believed he was receiving secret government messages through artificial neuronal implants in his brain. A pleasant homeless man in his early 30s, he was not suicidal or homicidal, but he ended up in the inpatient psychiatric unit for bizarre public behaviors suggestive of grave disability. Patients with thought disorders often encounter police for minor charges such as trespassing or being a public nuisance and, through disorganized behaviors during the arrest, find their way to the emergency room followed by an acute behavioral health facility. In the case of our patient, we discovered in his belongings an unfilled antipsychotic prescription dating back to his last admission a few months previously at another facility. Sadly, this cycle continued when our patient stabilized after a few days of inpatient treatment. Without other viable options, he was discharged to a shelter with a printed prescription he was unlikely to fill.

This repetitious cycle has become commonplace for a subpopulation of mental health patients. It is detrimental to patient care and costly to society. In a controversial opinion piece for *JAMA* in 2015, "Improving Long-term Psychiatric Care: Bring Back the Asylum," Dominic Sisti et al. describe the 95% decline in the per capita number of state psychiatric beds since 1955 and what they term a subsequent "transinstitutionalization" to jails, prisons, homeless shelters, and emergency rooms.<sup>1</sup> However, journalist Alisa Roth argues that this perspective oversimplifies the situation and that other subtle sociopolitical shifts have also impacted the care of severe mental illness. Examples of other factors are the failure of community care centers to serve their intended patient populations adequately, changes in funding, laws regarding inpatient psychiatric treatment, and the growth of the disabilities rights movement.<sup>2</sup> This paper aims to ex-

plore current disposition options for patients with psychosis in light of these shifts in the post-asylum era and proposes systemic-level improvements based upon local successes.

Schizophrenia and other psychotic disorders represent a leading cause of disability and are associated with premature mortality, increased suicide rate, and higher financial costs related to healthcare, social services, criminal justice needs, and loss of productivity.<sup>3</sup> Thought disorders affect roughly 1% of the population but are much more prevalent in the incarcerated and homeless communities. As many as 10% of federal prisoners, 15% of state prisoners, and 24% of jail inmates endorsed at least one symptom consistent with a psychotic disorder as reported in a special report of the US Department of Justice in 2006.<sup>4</sup> Additionally, a recent meta-analysis found 21% of homeless people to have a psychotic disorder.<sup>5</sup>

These numbers have risen alarmingly in recent decades, which is at least partly attributable to the consequences and methods of deinstitutionalization.<sup>6,7</sup> Deinstitutionalization has been described as the replacement of long-stay psychiatric hospitals with community-based support for the mentally ill, with the intended results of depopulating hospitals, diverting would-be admissions, and providing alternative community services.<sup>8</sup> Deinstitutionalization has proceeded to varying degrees on a global scale with a diverse array of alternatives and levels of success.

One response to the increased need for outpatient treatment due to deinstitutionalization has been the development of Assertive Community Treatment (ACT), an integrative, multidisciplinary approach supporting community-based care delivery for those who suffer from severe and chronic mental health issues. Initially developed in Madison, Wisconsin in the early 1970s for patients with persistent schizophrenia, ACT can be most notably differentiated from other modalities by the *in vivo* delivery of services: brief but frequent contact in the individual's own environment.<sup>9</sup> Ideally, this care delivery vehicle provides support in real-time for those with severe mental illness in the places and contexts when they need it the most. Evidence suggests that ACT successfully reduces the rate and duration of psychiatric

hospitalization for these patients, though ACT has had less success in reducing incarceration rates.<sup>2-10</sup> Some factors that limit the efficacy of ACT include the difficulty of anticipating and reacting to psychosocial changes that occur throughout serious mental illness, as well as the need for evolving competencies of multidisciplinary team members to carry out new practices effectively.<sup>11</sup>

Community care for mental health appears more humane and therapeutic than institutionalization, and ACT is reducing psychiatric hospitalizations to an extent. Yet, a significant number of the severely mentally ill, like our patient, are still falling through the cracks of post-asylum systems. Differing approaches to this dilemma are evident from state to state with varied results. In California, for example, Institutions for Mental Disease (IMDs) provide restricted and structured, intermediate-level care to those with severe mental illness. However, in a 1-year follow-up study, more than half of patients discharged from an IMD could not function in the community and had high rates of acute hospitalization, homelessness, and incarceration during the follow-up period. Although attempts to transfer these patients after median stays of 196 days to lower levels of care were ineffective, almost half (44%) of those discharged were able to lead relatively stable lives in the community. This outcome suggests that an intermediate level of care can succeed for some patients with severe mental disorders. The authors of the follow-up study suggest that increased ACT resources might improve outcomes for some of those with remaining unmet needs.<sup>12</sup>

With the rise of community care in the wake of deinstitutionalization, partial hospitalization programs fell out of favor not because they were ineffective but because they appeared old-fashioned and expensive compared to ACT and home-based treatments.<sup>13</sup> A systematic review found partial hospitalization programs to be as effective as inpatient hospitalization in terms of readmission rates; they may even be superior in terms of patient satisfaction. Additionally, partial hospitalization (also known as "day hospitals") was found to be a feasible and less restrictive alternative for at least 20% of acutely hospitalized patients.<sup>14</sup> Increasing accessibility to these programs nationwide

could fill some of the cracks in the post-asylum system for those with severe mental illness.

Finally, interventions during acute care that target homelessness prior to the discharge of psychiatric patients have been found to reduce hospitalization and substance abuse rates while increasing quality of life,<sup>15</sup> engagement with community services, and medication compliance.<sup>16</sup> While psychiatric illness is prevalent in the homeless community, poverty and inaccessibility of housing rather than mental illness are implicated causal factors.<sup>17</sup> Improving access to affordable housing and providing specific resources for homeless patients upon discharge from psychiatric settings could disrupt the "revolving door" between shelters, jails, and hospitals that many of those with severe mental illness have experienced since the advent of deinstitutionalization.

In the wake of the civil rights movements and attempts to cut healthcare costs, deinstitutionalization proceeded rapidly and excessively.<sup>18</sup> While approaches outlined here, including increased availability and funding for ACT, PHP, intermediate level care, and housing interventions, can improve outcomes for many with psychotic illness who are currently transinstitutionalized, a significant portion of these patients would still be best served in long-term psychiatric care facilities. Long waiting lists and a lack of bed space at state institutions speak to the need to reverse some of the shrinkage that occurred with the unrealistic expectations of deinstitutionalization within the last few decades. Modern-day facilities bear no resemblance to the deplorable conditions seen in asylums of the past and are more therapeutic and humane for the gravely disabled than homelessness or incarceration.

### Conflicts of Interest

The authors declare they have no conflicts of interest.

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### References

1. Sisti DA, Segal AG, Emanuel EJ. Improving long-term psychiatric care: bring back the asylum. *JAMA*. 2015;313(3):243-244. doi:10.1001/jama.2014.16088
2. Roth A. *Insane: America's Criminal Treatment of Mental Illness*. Basic Books; 2018.
3. Schizophrenia. National Institute of Mental Health. <https://www.nimh.nih.gov/health/statistics/schizophrenia>
4. James, DJ, Glaze LE. Mental health problems of prison and jail inmates. Office of Justice Programs, U.S. Department of Justice; 2006. <https://www.ojp.gov/ncjrs/virtual-library/abstracts/mental-health-problems-prison-and-jail-inmates>
5. Ayano G, Tesfaw G, Shumet S. The prevalence of schizophrenia and other psychotic disorders among homeless people: a systematic review and meta-analysis. *BMC Psychiatry*. 2019;19(1):370. doi:10.1186/s12888-019-2361-7
6. Raphael S, Stoll MA. Assessing the contribution of the deinstitutionalization of the mentally ill to growth in the US incarceration rate. *The Journal of Legal Studies*. 2013;42(1):187-222.
7. Lamb HR. Deinstitutionalization and the homeless mentally ill. *Hosp Community Psychiatry*. 1984;35(9):899-907. doi:10.1176/ps.35.9.899
8. Lamb HR, Bachrach LL. Some perspectives on deinstitutionalization. *Psychiatr Serv*. 2001;52(8):1039-1045. doi:10.1176/appi.ps.52.8.1039
9. Dixon L. Assertive community treatment: twenty-five years of gold. *Psychiatr Serv*. 2000;51(6):759-765. doi:10.1176/appi.ps.51.6.759
10. Scott JE, Dixon LB. Assertive community treatment and case management for schizophrenia. *Schizophr Bull*. 1995;21(4):657-668. doi:10.1093/schbul/21.4.657
11. Thorning H, Dixon L. Forty-five years later: the challenge of optimizing assertive community treatment. *Curr Opin Psychiatry*. 2020;33(4):397-406. doi:10.1097/YCO.0000000000000615
12. Lamb HR, Weinberger LE. One-year follow-up of persons discharged from a locked intermediate care facility. *Psychiatr Serv*. 2005;56(2):198-201. doi:10.1176/appi.ps.56.2.198

13. Marshall M. Acute psychiatric day hospitals. *BMJ*. 2003;327(7407):116-117. doi:10.1136/bmj.327.7407.116
14. Marshall M, Crowther R, Sledge WH, Rathbone J, Soares-Weiser K. Day hospital versus admission for acute psychiatric disorders. *Cochrane Database Syst Rev*. 2011;2011(12):CD004026. doi:10.1002/14651858.CD004026.pub2
15. Forchuk C, Godin M, Hoch JS, et al. Preventing homelessness after discharge from psychiatric wards: perspectives of consumers and staff. *J Psychosoc Nurs Ment Health Serv*. 2013;51(3):24-31. doi:10.3928/02793695-20130130-02
16. Killaspy H, Ritchie CW, Greer E, Robertson M. Treating the homeless mentally ill: does a designated inpatient facility improve outcome?. *J Ment Health*. 2004;13(6): 593-599, DOI: 10.1080/09638230400017038
17. Forchuk C, MacClure SK, Van Beers M, et al. Developing and testing an intervention to prevent homelessness among individuals discharged from psychiatric wards to shelters and 'No Fixed Address'. *J Psychiatr Ment Health Nurs*. 2008;15(7):569-575. doi:10.1111/j.1365-2850.2008.01266.x
18. Yohanna D. Deinstitutionalization of people with mental illness: causes and consequences. *Virtual Mentor*. 2013;15(10):886-891. doi:10.1001/virtualmentor.2013.15.10.mhst1-1310