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

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.[1] 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.[2] 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.[3] 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.[4] Additionally, a recent meta-analysis found 21% of homeless people to have a psychotic disorder.[5]

These numbers have risen alarmingly in recent decades, which is at least partly attributable to the consequences and methods of deinstitutionalization.[6,7] 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.[8] 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.[9] 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 they have had less success in reducing incarceration rates.[2-10] 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.[11]

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.[12]

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.[13] 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.[14] 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,[15] engagement with community services, and medication compliance.[16] While psychiatric illness is prevalent in the homeless community, poverty and inaccessibility of housing rather than mental illness are implicated causal factors.[17] 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.[18] 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.

Drs Cho, Kennington, Smith, and Tillman are employees of the Medical Center of Aurora, a hospital affiliated with the journal's publisher.

This research was supported (in whole or in part) by HCA Healthcare and/or an HCA Healthcare affiliated entity. The views expressed in this publication represent those of the author(s) and do not necessarily represent the official views of HCA Healthcare or any of its affiliated entities.

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