

VIEWPOINT

Improving Long-term Psychiatric Care Bring Back the Asylum

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During the past half century, the supply of inpatient psychiatric beds in the United States has largely vanished. In 1955, 560 000 patients were cared for in state psychiatric facilities; today there are fewer than one-tenth that number: 45 000.¹ Given the doubling of the US population, this represents a 95% decline, bringing the per capita public psychiatric bed count to about the same as it was in 1850—14 per 100 000 people.¹ A much smaller number of private psychiatric beds has fluctuated since the 1970s in response to policy and regulatory shifts that create varying financial incentives.

As a result, few high-quality, accessible long-term care options are available for a significant segment of the approximately 10 million US residents with serious mental illness. This population includes adults who are assessed as lacking insight and chronically psychotic, unable to care for themselves, and potentially dangerous to themselves and the public. These persons frequently have refractory schizophrenia and bipolar disorder. The void is both ethically unacceptable and financially costly.

For the past 60 years or more, social, political, and economic forces coalesced to move severely mentally ill patients out of psychiatric hospitals. The opening of the “back doors” of state hospitals in the 1940s and 1950s marked the first phase of deinstitutionalization, as long-stay chronically ill patients were discharged.² In the 1960s and 1970s, the civil rights movement propelled deinstitutionalization. Shocking reports about abuses at hospitals, such as Massachusetts’ Bridgewater State Hospital, offended the public consciousness and added momentum to closures of psychiatric hospitals. Formerly institutionalized patients who self-identified as “psychiatric survivors” had developed alternative models of peer-facilitated community treatment such as Fountain House in New York City. These models seemed like viable alternatives to institutions. New drugs, especially chlorpromazine, made outpatient options and the ability to live independently seem both liberating and promising.

Macroeconomics and federal policies accelerated the transformation. Outpatient therapy and drug treatment were less expensive than inpatient care. In an effort to reverse the long-term hospitalization of mentally ill patients in inadequate facilities, the Community Mental Health Centers Act and the advent of Medicaid created an environment that allowed states to close or limit the size of so-called institutions for mental diseases. Progressive reformers, consumers, civil libertarians, and fiscal conservatives all advocated for a similar goal—the closure of publically funded psychiatric institutions.

Transinstitutionalization

Deinstitutionalization has really been transinstitutionalization. As state hospitals were closed, patients with chronic psychiatric diseases were moved to nursing homes or to general hospitals where they received episodic psychiatric treatment at significantly higher costs. Others became homeless, utilizing hospital emergency departments for both care and housing. Indeed, the current crisis in Nevada—where the lack of psychiatric beds has resulted in overcrowded emergency departments filled to capacity with psychiatric patients—may be a harbinger of the future. Most disturbingly, US jails and prisons have become the nation’s largest mental health care facilities. Half of all inmates have a mental illness or substance abuse disorder; 15% of state inmates are diagnosed with a psychotic disorder.³

These are not new problems. Dorothea Dix, Moses Sheppard, Thomas Scattergood, and other 19th-century reformers had decried transinstitutionalization of the severely mentally ill into jails and almshouses. They called for a new kind of refuge in which mentally ill persons could live and heal, built on principles of humane and moral treatment. This was the original meaning of psychiatric “asylum”—a protected place where safety, sanctuary, and long-term care for the mentally ill would be provided. It is time to build them—again.

At the moment, prisons appear to offer the default option and an inexpensive solution for housing and treating the mentally ill. In Texas, for instance, costs for an inmate with mental illness range from \$30 000–\$50 000 a year compared with \$22 000 a year for an inmate without mental illness.⁴ Prison and jail costs will soon increase because the US Supreme Court has ruled that the quality of states’ treatment of mentally ill inmates amounted to cruel and unusual punishment.⁵ New housing units must be built and better treatment provided for mentally ill inmates.

However, correctional psychiatry is rife with legal, ethical, and clinical challenges. Although the minimal statutory and legal standards of care can be met, it is difficult to imagine how ethically sound treatment of mentally ill prisoners can be delivered. It may be impossible for prison psychiatrists—who may have dual loyalties to the patient and the institution—to provide inmates with compassionate, private, and patient-centered care.⁶ Mentally ill inmates live in an environment anathema to the goals of psychiatric recovery; it is often unsafe, violent, and designed to both control and punish.

Once released from prison, mentally ill persons are left with little support, because their access to public assistance is suspended and requires reenrollment—a confusing and onerous process. Recent studies show that

prisoners with a serious mental illness are 2 to 3 times more likely than prisoners without serious mental illness to be reincarcerated.⁷ High recidivism generates a vicious cycle whereby mentally ill patients move between crisis hospitalization, homelessness, and incarceration, making it difficult to accurately determine the total cost of psychiatric care for this population.

A better option for a person with serious mental illness is assisted treatment in the community. For potentially dangerous patients, there is early indication that mandated outpatient treatment saves states money. In New York City, after 2 years of mandated outpatient treatment, service costs for individual patients were reduced by half.⁸ Available data on health outcomes, social functioning, well-being, and quality of life of patients receiving compulsory outpatient treatment are more equivocal.⁹

However, comprehensive, accessible, and fully integrated community-based mental health care continues to be an unmet promise that originated with President Kennedy's New Frontier. At best, community treatment can provide high-functioning mentally ill persons a foundation for recovery. At worst, severely mentally ill persons drawing Medicaid and Supplemental Security Income risk becoming "commodities" in a profit-driven conglomeration of boarding houses reminiscent of the private madhouses of 18th-century England.¹⁰

Even well-designed community-based programs are often inadequate for a segment of patients who have been deinstitutionalized. For severely and chronically mentally ill persons, the optimal option is long-term care in a psychiatric hospital, which is costly. A Joint Commission-accredited state psychiatric institution in Michigan, for example, costs more than \$260 000 per patient annually. The annual rate at St Elizabeth's Hospital—a forensic psychiatric hospital in the District of Columbia—averages about \$328 000 per patient annually.

For persons with severe and treatment-resistant psychotic disorders, who are too unstable or unsafe for community-based treatment, the choice is between the prison-homelessness-acute

hospitalization-prison cycle or long-term psychiatric institutionalization. The financially sensible and morally appropriate way forward includes a return to psychiatric asylums that are safe, modern, and humane.

A Way Forward

The public's perception of institutionalized mental health care remains dissonant. It is characterized by beliefs about the dangerousness of persons with mental disorders, combined with images of abuse and institutional warehousing. Realistically, the deployment of both private and public resources is now imperative to provide appropriate care and refuge for seriously mentally ill persons. These individuals cannot help themselves or live independently, and they deserve a safe place to live with proper supports—not cycling between the streets, emergency departments, and prisons.

Asylums are a necessary but not sufficient component of a reformed spectrum of psychiatric services. A return to asylum-based long-term psychiatric care will not remedy the complex problems of the US mental health system, especially for patients with milder forms of mental illness who can thrive with high-quality outpatient care. Reforms that ignore the importance of expanding the role of such institutions will fail mental health patients who cannot live alone, cannot care for themselves, or are a danger to themselves and others.

Fortunately, new models of fully integrated, patient-centered long-term psychiatric care now exist in the United States. For instance, a transformed state hospital that is now the Worcester Recovery Center and Hospital provides a full range of integrated treatment services, psychiatric research, and medical education programs and has been at the forefront of using electronic medical records and patient-centered treatments. With its 320 private rooms and recovery-inspired residential design and treatment programs, the hospital cost \$300 million to build and has a \$60 million annual budget. More facilities like this one are needed to provide 21st-century care to patients with chronic, serious mental illness.

ARTICLE INFORMATION

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