

Case Study Supporting the Return of Long Term Psychiatric Institutions for Patients with Severe Persistent Mental Illness

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Citation: Aimua FA (2018) Case Study Supporting the Return of Long Term Psychiatric Institutions for Patients with Severe Persistent Mental Illness. SAJ Case Rep 5: 206

Article history: Received: 30 April 2018, Accepted: 29 May 2018, Published: 31 May 2018

Abstract

There has been a surge of greater than 30% in the rate of inpatient psychiatric readmissions amongst patients with severe mental illness following the era of deinstitutionalization and co-morbid medical illness has been found to be a consistent factor amongst this subset of patients. Hospital psychiatrists often see these patients revolve in and out of the hospital, a phenomena known to negatively impact their quality of life. Having a highly structured 24-hour long term psychiatric institutions is a much needed resource for patients with severe mental illness who are unable to take care of self.

Keywords: Severe Mental Illness; Deinstitutionalization; Readmissions; Long Term Psychiatric Care

Background

The rate of inpatient psychiatric readmissions has increased dramatically following the era of deinstitutionalization. This phenomenon has been described extensively in literature and several studies have shown a 30% to 40 % rate of readmissions within six months post discharge amongst patients with severe persistent mental illness [1]. There are several factors influencing readmissions amongst this subset of psychiatric patients but the single most consistent factor is number of previous hospitalization [2]. Medical comorbidities have also been shown to be quite common amongst patients with frequent psychiatric readmissions than in patients with single admission [3]. Hospital psychiatrists often see patients with severe persistent mental illness, comorbid with multiple medical illnesses revolve in and out of the hospital which leaves one with a sense of frustration and helplessness. The aim of this article is to contribute to the debate of reviving long term psychiatric institutions from the point of view of a hospital psychiatrist.

Case Summary

Patient is an adult female in her fifties with chronic schizophrenia, excoriation (skin- picking) disorder and mild intellectual disability with the following medical illnesses: hyperlipidemia, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, hypothyroidism, hypertension and chronic osteomyelitis of the right elbow. Patient had been admitted multiple times (ten admissions in one year), to the inpatient psychiatric hospital with multiple emergency room visits interspersed with these admissions. Long acting depot injections was the preferred mode of medication administration as patient was often non-compliant with out-patient medical or psychiatric clinic follow up. After care plan often involved case management and home health nursing but patient would not let these workers into her home. Patient was placed in group homes on numerous occasions but would often leave after a day or two in such facilities. Patient had difficulty initiating, performing and maintaining basic activities of daily living and very often on admission present malodorous, disheveled requiring staff intervention. Several attempts made by team to involve patient's spouse in care was unsuccessful and given patient's non-compliance with outpatient appointments and medications, the only time patient would get medical or surgical care was while she was in the psychiatric hospital with worsening medical presentation on every admission often requiring internal medicine co-management. The legal department was consulted on guardianship proceedings but treatment team was informed that a state guardian cannot be appointed as patient had family members who were still alive. Court ordered involuntary treatment in the community was not an option as patient resides in one of the four states in the country that does not authorize "involuntary outpatient treatment".

Discussion

Deinstitutionalization of the severe mentally ill patients in the sixties came about as shocking reports of ongoing abuse at these psychiatric institutions became public knowledge [4]. These facilities were over-crowded, structures were in deplorable states with poor sanitary conditions, and patients were being subjected to inhumane treatment with various experimental form of treatment ranging from insulin therapy, psychosurgery, to electroconvulsive therapy, often without their consent [5].

With the discovery of chlorpromazine, development of community psychosocial and rehabilitation centers, the deinstitutionalization movement was ideal as psychiatric patients were given the chance to be reintegrated into the community, providing them a chance of living a normal life in society. Patients with milder form of mental disorders benefited the most leaving the minority of patients with severe chronically mentally ill, vulnerable [6]. This subset of severe mentally ill patients are unable to care for self independently and often requires 24-hour care in a highly structured long term psychiatric facility to ensure continued psychiatric stabilization and access to medical and surgical care as needed [7].

The patient described above needs to be in a highly structured long term psychiatric facility rather than be allowed to “revolve” in and out of the hospital, a phenomenon which puts patients at increased risk of having poorer clinical outcome with a reduced quality of life [4]. Frequent re-admissions also have a demoralizing effect on medical personnel [8]. And a huge economic burden on taxpayers. In 2013, schizophrenia hospitalization alone cost the United States \$11.5 billion, of which \$646 million resulted from readmissions within thirty days of discharge [9,10]. The implementation of deinstitutionalization in the community was plagued with several flaws contributing to the large number of severe mentally ill patients either living on the streets or housed in jails [6]. The word “asylum” conjures up frightening images which are contrary to the true meaning of the word: a protected place of safety for the mentally ill where they could live and heal based on principles of humane and moral treatment [4]. Modern day long term psychiatric institutions can be patterned after memory care residential facilities with specially trained staff to provide stability, structure and vocational skills training for patients in addition to having individually tailored medication regimens and psychoeducation for the patients [11,12].

Conclusion

There are varying public opinions on “re-institutionalization” of psychiatric patients, with varying legitimate concerns however, we need to examine critically the care we are currently providing for this subset of patients, to continue dialogue and actively encourage research on how to better care for patients with severe persistent mental illness who have repeatedly failed community treatment. Author agrees with Sisti, et al. who elucidated that a return to the long term system of psychiatric care is not for all mentally ill patients but reserved for the severe persistent mentally ill patients who have repeatedly shown that they are unable to care for self mentally and physically [4].

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