

**The Revolving Door of Inpatient Psychiatry**  
**Looking Beyond Padded Cells and Pills to Cure the Recidivism Epidemic**

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## Thesis Statement

When United States leaders closed often-deplorable state mental hospitals, they failed to establish adequate, financially sustainable community-based programs thus engendering a revolving door phenomenon for patients across the country. To assure quality care and patient wellbeing for those with serious mental health disorders, the problem of inpatient psychiatric recidivism requires a multi-faceted solution that alleviates healthcare disparities and effectively develops community-based programs that supplement pharmacotherapy.

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## I. Introduction

Often times in the acute inpatient psychiatric unit, G1, of Rochester General Hospital, there are patients deemed “frequent flyers”: individuals who are in and out of the hospital, repeat admissions, essentially passing through a revolving door. For one patient, diagnosed with multiple co-morbid disorders such as paranoia and depression, the circumstances that resulted in one of their readmissions to the hospital was especially troubling. After decompensating off medication while in the community, the patient’s delusions had returned, this time making them believe there was something stuck in their neck. As a result, the patient sliced their neck open, right next to their carotid artery, an effort to remove what they truly believed was trapped inside. They were readmitted back to our unit as a result.

To be very clear, I do not share this story to perpetuate the stigma of people with mental health disorders, as they are challenged by chronic conditions that may be difficult to treat within the limits of our mental health care system. I tell this story to assert that this reality is the picture painted for people with mental health disorders not only in Rochester, New York, but also across the entire country. While circumstances look very different for every patient and typically do not involve self-harm nor violence toward others, the unfortunate revolving door imagery is the narrative that has been written for a disproportionate number of people with mental health disorders. Furthermore, in sharing stories of readmission, the goal is to help us understand how we can better help individuals not return to the hospital. Recidivism, or readmission back to the hospital under the same mental health diagnosis, is a direct reflection of the shortcomings of the mental health care system currently existing in the United States. The inherent deficiencies in the treatment of mental health illnesses are not in the care given while in the acute psychiatric units of the nation’s general hospitals as there are many nuances and challenges in treating mental

illness and practitioners work within the constraints of the system. The deficiencies, however, are in the lack of care, support, and resources in the community for all, and for those most in need, following discharge.

Such deficiencies are engendered by the long-held conundrum in treating mental health in the United States: baseline versus bottom-line. Prior to the mid-20<sup>th</sup> century, mental health care was primarily characterized by an “out of sight, out of mind” policy. The acceptable “baseline” for patients with mental health disorders was arguably wasting away in state institutions with minimal treatment and living conditions, so governments could hold to an economic bottom line to keep costs down for a stigmatized population lacking much public support.

Deinstitutionalization plans in the 1960s promised community-based treatment yet instead ended up focused on the miracle of medication. As a result, this transition led to a standard still in place today: patients achieve baseline in the acute psychiatric units of general hospitals after decompensating due to shortcomings of the primary, and sometimes only, treatment for mental health conditions, medication. The patients may resist taking the drugs due to negative side effects, a difficulty in adhering to a regimented schedule, and the chance that the drug might not actually work. But drug therapy saves the most money for insurance companies and government providers while making money for pharmaceutical companies and providing effective solutions with limits. In addition to other root causes that lead to readmission, the inability to put an individual’s natural born right to adequate and comprehensive healthcare over insurance and governmental expenditures has ultimately engendered the revolving door of inpatient psychiatry.

Whether you can empathize with the readmission story shared or not, we should realize that a disproportionate number of people with serious mental health disorders endure troubling life stories riddled with pain and hospital admissions, thus this epidemic of psychiatric

readmission necessitates reformation. I chose this dramatic word, “epidemic,” to create an imagery of the readmission problem at present. One could use “problem” or “issue,” but for the sake of my argument, this word has the power to engender passion and interest in those who may not necessarily have a background in mental health and effectively communicates that readmission is an issue that necessitates a solution.

Thus, the “cure” for this epidemic will be complex, multifaceted, collaborative, and will inevitably consume money, time, and energy. At present, healthcare practitioners work very hard and are often challenged with difficult mental health disorders that treatments do not always resolve or patients who resist treatment altogether. Thus, the time has come for the United States to realize that patients with mental health disorders are more than just their symptoms or their diagnosis: they are people, people who are too often wrongly portrayed in the media as violent to others rather than people with chronic illness. And these people deserve more than an unsustainable “baseline.” Thus, intentional efforts such as developing new treatment with drugs or beyond drugs and a community-based system that ensures treatments are available to all will necessitate both research and funding but may likely lead to closing the revolving door of inpatient psychiatry.

## II. Deinstitutionalization of Mental Health in the United States

The mid-20<sup>th</sup> century was characterized by a period of protests and reform efforts that led to some advances and some unintended problems. Vulnerable populations such as people with mental health disorders and racial or ethnic minority groups that were once alienated and isolated began moving into better schools, jobs, and neighborhoods. The integration of people with mental health disorders seemed particularly consequential as a major step away from often overcrowded institutions with inadequate care. Although the theoretical framework of the deinstitutionalization of people with mental health disorders was a progressive movement toward the future, the deficiency of concrete preparation for this rapid changeover engendered lasting negative effects including the hospital readmission epidemic apparent today.

The deinstitutionalization of patients with mental health disorders was a multi-stage transition that occurred nationwide over approximately half a century. The movement became official when President John F. Kennedy called on Congress to pass the Community Mental Health Act of 1963 (Bachrach, 1976). In his statement, Kennedy proposed "...to use Federal resources to stimulate State, local and private action. When carried out, reliance on the cold mercy of custodial isolation will be supplanted by the open warmth of community concern and capability" (Sheffield, 2013). The transition these words propose provides both the definition and the process for the deinstitutionalization transformation. Broken down into two general components, deinstitutionalization included moving people with mental health disorders out of state institutions followed by the closing of those very institutions, thus largely affecting the people who were already deemed mentally ill and those who would become ill in the indefinite future (Frontline PBS, 2005). In addition, this changeover directly meant placing the burden of care and responsibility for patients on local communities; a major tenet of the

deinstitutionalization “plan” that was never developed or managed appropriately. The swiftness with which this transition occurred and the lack of preparation as a result was arguably warranted, although extremely consequential, given the circumstances leading up to the movement. A congruence of driving forces including the advent of medical breakthroughs characteristic of both internal medicine and psychiatry, the spike in awareness and attention to the mental health epidemic arising during World War II, the absolute need for an improvement in patient care and treatment, the opportunity for governments to potentially reduce expenditures, plus the personal concerns of the Kennedy family engendered the perfect climate for deinstitutionalization to occur rapidly without precise preparation and mobilization of adequate resources.

### **The Genesis of Transition: World War II**

Before the mid-twentieth century, mental health in the United States followed an out-of-sight-out-of-mind theory until the draft of World War II. Federal government ignorance and avoidance of mental health issues was interrupted when potential soldiers were screened to detect traits that indicated vulnerability for mental health issues while deployed. Individuals were excluded from the draft if found to be “insane, feeble-minded, psychopathic, and neuropathic...” (Salmon, 1917). As a result, between 1941 and 1944, 12% of over 15 million men examined were excluded from the draft (Glass, 1956). Of these two million people excluded, 37% of those rejected for medical reasons were disbarred on neuropsychiatric grounds (Appel, 1945). Additionally, the severity of these numbers is heightened when considering that those actually enlisted had an incidence rate for war neurosis, in World War II, at least double the rate during the first World War of 1914-1918 (Pols, 2007). Furthermore, the military experiences of World War II demonstrated that both community and outpatient treatment, such as that in veteran’s

facilities, were far superior to that of state institutions (Grob, 2016). These numbers attracted governmental concern and alluded to the fact that the mental health epidemic greatly needed attention.

As a result, the government took action and began making strides toward changing the face of mental health in America. In 1946, President Harry Truman signed the National Mental Health Act into law which called for the establishment of a National Institute of Mental Health, otherwise known as the NIMH (NIH, 2017). Three years later, in 1949, the NIMH was formally established as one of the first four National Institute of Health institutes, thus developing its own specific research and advocacy agenda that focused on mental health treatment in the community. This development was the first time in United States history that mental health was addressed on both a legal and public level nationally. But the mental health problem, and the failures in its treatment in state institutions, would not be solved by the creation of this dedicated institute alone.

### **The Genesis of Transition: Horrifying Inhumanity**

The creation of the NIMH was absolutely necessary as the American psychiatric institutions before the 1960s were often overcrowded and reliant on inhumane treatments and procedures, thus procuring unimaginable conditions for the patients housed there. At its peak in the 1950s, the number of patients in mental health institutions totaled more than 560,000 people while there were only 7,000 psychiatrists, 13,500 psychologists, and 20,000 social workers in the entire country (Amadeo, 2019). This underwhelming and inadequate number of providers was accompanied by a similar lack of institutions and beds to house the patients. Through additional public neglect and legislative penny-pinching, institutions across the country allowed their care

and treatment of patients to degenerate into a system resembling that of concentration camps (Maisel, 1946). These horrifying conditions were documented in a powerful report in 1946.

Albert Maisel, a former investigative journalist, painted a vivid picture of such asylums resembling the horrific Nazi camps, in his 1946 *Bedlam* story in the pages of the very popular *Life Magazine*. He depicts a scene in Philadelphia's Byberry state institution, where a stone wall lies in a basement ward, commonly known as the "Dungeon," with the engraved words, "George was kill here 1937" (Maisel, 1946). In addition to the horrific act these words allude to, Maisel exposed state institutions for: beatings just short of manslaughter, starvation diets, extreme overcrowding forcing patients to sleep on the bare floor, depletion of resources to the point where patients lived in "stark and filthy nakedness," unpaid labor, traumatic and extended restraints for weeks at a time, and a grave lack of care providers (Maisel, 1946). Patients with mental health disorders were treated as if they were not even human; they were brutalized, neglected, and ultimately stripped of their rights as, not only American citizens, but as patients and as people. Thus, Maisel's Holocaust comparative and accompanying disturbing photos effectively awakened public and government concern.

The desperate search for new ways to save such patients led to trying extremes like the pre-frontal lobotomy. This medical procedure won its inventor the 1949 Nobel Prize for Medicine or Physiology even though it was arguably very inhumane (Nasrallah, 2014). Dr. Walter Freeman, the man behind the creation of the ice pick lobotomy procedure, was a celebrated physician and scientist at the time (Sheehan, 2017). He believed that hitting certain nerves in the brain could eliminate excess emotion and therefore stabilize an individual's personality (NPR, 2005). As a result, he designed an operation that did not even require a sterile surgical room: stabbing the patient's brain with an icepick through the eye socket in hopes it

would hit the appropriate area to cut the right nerves (Hall, 2015). This procedure was developed for patients with severe mental illness who were often aggressive, volatile, or insubordinate. In addition, other common reasons for lobotomizing a patient were to treat schizophrenia, chronic pain, or suicidal depression. In some instances, patients appeared unchanged or even died as a result, although that was rare (NPR, 2005). But more often than not, lobotomy made the patient lose central aspects of their personality and ability to function, essentially creating living zombies that were submissive to their care providers. Nonetheless, about 50,000 people received lobotomies in the United States between the years 1949 and 1959, with Walter Freeman performing approximately 2,500 of them himself (NPR, 2005). Of course, practitioners and researchers were simultaneously looking for better alternatives, but the icepick lobotomy remained the notorious symbol of mental health procedures in that time.

### **The Genesis of Transition: Medical Miracles**

The combination of increased mental health awareness with a desire for cheaper and more humane treatment led to paramount breakthroughs in mental health research that catalyzed the birth of psychopharmacology. Following the discovery of penicillin in 1947, a golden age of pharmaceutical research occurred leading to the discovery of lithium in 1948 (Nasrallah, 2014). This drug treated mania, a condition characteristic of bipolar disorder, and further sparked research into treating other mental illnesses with medication. In 1952, the first effective antipsychotic medication, Chlorpromazine (commonly known as Thorazine), was introduced and revolutionized treatments for people with serious mental health disorders (Frontline PBS, 2005). Only 15 years after its approval by the Food and Drug administration, more than 50 million people around the world had taken the drug (PBS, 2019). Thus, this medical miracle took the world by storm and drew all government and public attention toward pills. While the government

was deliberating on the appropriate response, researchers continued to produce medical miracles. In the late 1950s, monoamine oxidase inhibitors became the first pharmacotherapy to treat depression and tricyclic antidepressants were introduced in attempt to synthesize another antipsychotic drug (Nasrallah, 2014). These medical breakthroughs seemingly offered a miracle way out of deinstitutionalization by providing cheaper and effective treatment that was substantially more humane than lobotomy.

As a result, even experts began to question the institutional care system. Furthermore, they began advocating for new evidence-based treatment options as well (Sheffield, 2013). In 1952, an expert committee on mental health of the World Health Organization laid out the functions of community-based treatment: outpatient services, rehabilitation, research, and community education (Talbot, 1982). As a result, in the following years some states such as New York established community mental health boards and provided state aid to local counties with intent to enable communities to provide outpatient, inpatient, rehabilitation, and community consultation and education services (Talbot, 1982). The remainder of the decade was characterized by efforts to develop an organized plan for community-based treatment growth and to reevaluate state mental hospitals. As a result, facilities were constructed to replace state institutions: psychiatric units in general hospitals, halfway houses, night and weekend hospitals, vocational rehabilitation, travelling clinics, 24-hour emergency walk-in services, suicide prevention centers, and even community consultation (Talbot, 1982). In addition, there was also a great amount of research being done in both the pharmaceutical industry and in social and community psychiatry.

The congruence of numerous medical discoveries, the introduction of some community-based services, and continued research, led to the analysis called for by the National Mental

Health Study Act getting published in 1961 in a 10-volume series, *Action for Mental Health*, which assessed the mental health conditions and resources in the country (NIH, 2017). This work commanded the attention of former President John F. Kennedy who then established a committee to propose a federal response to the mental health crisis, ultimately culminating in the Community Mental Health Act of 1963.

### **The Genesis of Transition: Family Ties**

President John F. Kennedy truly spearheaded deinstitutionalization and perhaps differed from those who served before him because his family had a personal connection to mental health. His younger sister, Rosemary Kennedy, was born with intellectual disabilities. While growing up she participated in family activities, kept a diary, and even travelled with her family on many excursions. But in 1940, when Rosemary was in her early twenties, her family began to notice that she "...was not making progress but seemed instead to be going backward," as her elder sister had documented (JFK Library, 2019). As a result, in the following year the family was persuaded to authorize lobotomy in hopes of calming Rosemary and preventing her violent mood swings.

To the Kennedy's dismay, the procedure left their beloved family member permanently incapacitated and unable to function in the home nor society. From that fateful moment on, Rosemary spent the rest of her life in a facility where she would be cared for away from her family (JFK Library, 2019). As a result, her older sister Ethel Kennedy feeling greatly impacted, started a summer camp in 1962 in her own backyard for those with intellectual disabilities. This camp evolved into what is now known as the Special Olympics; a global competition that involves over 1.4 million athletes (JFK Library, 2019). In addition, the direct exposure to a mental health condition and limited solutions likely contributed to John F. Kennedy's motivation

to advance civil rights for those with mental illnesses in America and to officiate deinstitutionalization in 1963.

### **The Logistics of Transition: Economic Failures and Legislation**

At the start of deinstitutionalization in 1963, the US government was faced with the question: who will be responsible for mental health costs? The transition from state mental hospitals to community-based care mirrored a transition in economic responsibility from the state government to the local level. Initially, the transition was supposed to occur in three parts: state governments would transfer the responsibility to the federal government, the federal government would build local and community facilities, and such sites would be operated and funded on a local level over time. Unfortunately, John F. Kennedy was assassinated before the transition plan from deinstitutionalization was finalized, thus making this transformation an unequal trade that was never clearly carried out. As a result, resources that funded food, clothing, housing, rehabilitation, and psychiatric treatment were no longer adequately funded (Osher, 2016). In 1965, President Lyndon B. Johnson did continue advances in government-funded healthcare in signing the Social Security Amendments into law. This law established Medicaid as a public, federally-funded insurance, that would cover low-income families seeking healthcare. Unfortunately, it only covered patients in hospitals and not for any other mental health treatment or facility (Amadeo, 2019). How then, were patients of poorer socioeconomic status supposed to access treatment and avoid hospitalization?

The following decade, the 1970s, was characterized by economic set-backs in some states while other states made strides toward comprehensive care outside of the institution. In New York, the governor proposed his 1971-1972 budget that allocated 630 million to the mental hygiene department. A series of reductions were made, resulting in a budget of only 580 million

toward mental health in the end. As a result, the state's psychiatric institutions experienced greater underfunding than ever before, which only worsened the already desperately inadequate conditions characteristic of state psychiatric institutions. Geraldo Rivera documented the effects of this economic deficiency for one institution in particular, the Willowbrook State School in Staten Island, New York, in his exposé, "The Last Disgrace 1972."

Following the budget cuts, Willowbrook lost more than 200 employees due to attrition. As a result, when Rivera and his team arrived to Willowbrook unannounced they witnessed a horrific site. They captured video footage of children lying on the floor naked smeared with their own feces and described the institution in that "It smelled of filth, it smelled of disease, and it smelled of death" (Rivera, 1972). Not only were the patients deprived of proper hygiene, but their facilities and "home" was so filthy that 100% of patients contracted hepatitis within six months of admission. In addition, over 5,300 patients lived there, making Willowbrook the largest institution for people with mental illness in the world, yet never built for that many patients (Rivera, 1972). Most wards in the facility only employed one attendant for the care of over 50 patients that were considered severely mentally ill or disabled. As a result, patients experienced severe trauma in fighting one another for the attention of care providers. They were also subjected to inadequate care. For example, assisted feeding times that normally required 20 to 30 minutes of time were cut down to only two or three minutes, leading to aspiration and cases of pneumonia that typically resulted in death.

Geraldo Rivera also exposed the Letchworth Village institution of New York, which employed four care providers for every 100 patients. As described by a state senator who accompanied Rivera, the institution was worse than the worst brigades in the military and had the "worst possible conditions I've ever seen in my life" (Biaggi, 1971). The institution received

25% of its funding from the government with the requirement that each patient would get their own 80 square feet space. But this requirement was lost in practice, and patients ended up receiving only 35 square feet (Rivera, 1972). There was even an entire building left empty, squeezing patients together in other buildings, due to a lack of care providers. One of the biggest injustices to patients at Letchworth, was experienced by the 300 able-bodied and able-minded patients who had the potential to work outside of the institution but were not allowed to. Instead, they were paid a mere two dollars a week, a wage they could make in one hour on the outside, caring for the other patients they lived with. Rivera summarized life in this institution, and Willowbrook, comparing patient existence to that of “human vegetables in a detention camp” (Rivera, 1972). The state government and many citizens wanted people with mental health disorders out of sight and out of mind and by greatly reducing funding toward mental health, the stigmatized citizens with mental disorders were kept in institutions where they were treated as less than even animals.

In contrast, when news of the conditions at Willowbrook reached healthcare providers in California, the state decided to lead the change toward community-based care and subsequently funded that change. In 1965, the system in California mirrored that of New York but come the 1970s, healthcare providers and local politicians had created a system that cut the rate of institutionalization by half at one Los Angeles children’s facility to start (Rivera, 1972). Institutions were replaced with 13 different regional centers located throughout California that aimed to keep patients at home by providing care in the community. Their priority was education and training programs, some of which were entirely supported by the state. In addition, the system even provided 24/7 residential care for the one and a half to three percent of patients who actually required full time treatment. The price for families to utilize this service was a mere

fourteen dollars a day, with help from the state if needed, while residence at Willowbrook cost upward of 21 dollars a day for far worse conditions and inhumane treatment (Rivera, 1972).

Patients with mental health disorders in California were finally beginning to receive the care they needed and deserved. Significant deinstitutionalization across the entire country would take a few more decades and often did not receive the full-fledge community support needed.

Geraldo Rivera's documentary greatly increased attention toward the treatment of mental health bringing some momentum for passage of the Community Mental Health Centers Act of 1975. Essentially, this act included a series of amendments to revise and extend the Community Mental Health Act of 1963 (Gov Track, 2004). The amendments contained three requirements for quality assurance in community mental health centers. These include: the development of national standards for the centers, the development of quality assurance programs, and the collection of data to be used in program evaluation (Towery, 1978). Thus, community-based care was finally gaining federal attention and advocacy.

Following the Community Mental Health Centers Act of 1975, President Jimmy Carter's President's Commission on Mental Health was established in 1977. The commission was responsible for reviewing the mental health needs of the nation and making recommendations as to how to actually meet those needs (NIH, 2017). The four-volume report from this commission was submitted to the president one year later in 1978. But while all of these actions were committed in effort to deinstitutionalize and transition the responsibility of care, they served more as ideals toward alternatives to institutionalization that were advertised but not substantially executed when actually put into practice.

Throughout the 1980s, the United States experienced more economic, legal, and social change that decreased access to care for those with severe mental disorders. In 1980 President

Jimmy Carter signed the Mental Health Systems Act into law which aimed to allocate greater funding to community health centers. At first glance this effort presents positively, but in reality, the focus on a broad range of mental health needs ended up shortchanging the specific needs of those with chronic and severe mental health illness (Amadeo, 2019). This law manifested in a lack of resources for patients with disorders such as schizophrenia or other “psychotic” illnesses. As a result, the most vulnerable, of an already vulnerable group, were left with little to no resources or care for their mental health disorders.

President Ronald Reagan further exacerbated this issue in his attempts to accelerate deinstitutionalization by “releasing” large number of patients with mental health disorders, cutting social programs, and truncating federalism. While asserting that institutions harmed the mentally ill, Reagan became famous for cutting mental health funds. Reagan established block grants for the states and ended the federal government’s role in providing services to the mentally ill in his Omnibus Budget Reconciliation Act of 1981. In return, federal mental-health spending decreased by over 30% (Pan, 2013). By 1985, federal funding dropped to 11% of the community mental health agency budget, achieving Reagan’s goal of reducing federal influence and involvement which had disastrous consequences for those with mental disorders and without funds for private care.

The numbers documented in the 1990s quantify the magnitude of deinstitutionalization and Reagan’s release of tens of thousands of patients without alternative care. According to *Frontline*, a PBS documentary series, forty years after deinstitutionalization had been “completed,” in 1994, the number of patients in institutions had been reduced to 71,619 patients; a 486,620-person difference compared to forty years earlier (Frontline PBS, 2005). When considering the exact population size in each year and their proportion to one another, this data

shows a 92% total decrease from 1955 to 1994. In other words, 92% of the people who would have been considered for institutional care in 1955 were instead inhabiting local communities in 1994 (Frontline PBS, 2005). Thus, even though the method of care and facility was changing, the mental health disorders, symptoms, and qualities of patients were stagnant.

More importantly, patients required the same level of intervention and specialized care that they always had but no longer had the public institution as an option. In addition, these numbers disproportionately represent different mental health disorders. The composition of past institutions was made-up of approximately 50 to 60 percent of patients diagnosed with schizophrenia, 10 to 15 percent diagnosed with diseases of the brain such as epilepsy and Alzheimer's disease, another 10 to 15 percent diagnosed with bipolar disorder and severe depression, and the remainder having various conditions related to psychosis and substance use disorders (Frontline PBS, 2005). Therefore, the transition adversely affected patients with disorders such as schizophrenia in addition to those patients already requiring greater care.

In the 21<sup>st</sup> Century, the United States experienced economic turmoil that directly affected mental health expenditures and the lives of those with mental health disorders yet again. In 2008, the government forced states to remove over four billion dollars initially allocated to public mental health funding (Osher, 2016). This budget cut was a direct result of the 2007-2009 Great Recession; the most severe economic downturn in the United States since the Great Depression of the 1930s. Unfortunately, the mental health sector took the brunt of this devastation, as they have limited political influence or lobbies (Chappelow, 2019). Looking at the numbers in 2015, state-run psychiatric facilities, that provided long-term care options with a drastically improved quality of care compared to past asylums, housed only 45,000 patients. This number is less than a tenth of the number of patients in state-run facilities in 1955, an overall 95% decline

(Kozłowska, 2015). In 2019, there were admittedly far more options for care than in 1955 including public and private psychiatric hospitals, nonfederal general hospitals with psychiatric units, veteran medical centers, residential treatment centers, community mental health centers, outpatient treatment or partial hospitalization, and multisetting mental health facilities (SAMHSA, 2019). The decline of patients in state-run psychiatric hospitals and the increase in the utilization of alternative services will likely continue in the new century, so the focus should be on establishing more accessible alternative services and on researching new mental health treatment to know what services can be most effective.

Deinstitutionalization, in theory, was a necessary transition in regards to ethical considerations: patients' rights to autonomy, justice, and beneficence, quality of care and treatment, and the general human condition of all patients. But this radical movement ultimately reduces to an ideal theory that resulted in the accomplishment of one goal but the abandonment of other promised goals as well as the patients it strived to protect. In the words of Dr. Leona L. Bachrach, author of Deinstitutionalization: An Analytical Review and Sociological Perspective, "as a definition of what deinstitutionalization *should* or *might be*, it is an eloquent statement; as a definition of what deinstitutionalization *is*, it is still anticipatory" (Bachrach, 1976). Thus, at the time of writing her book, in 1976, the components of deinstitutionalization still had yet to be fulfilled, a phenomenon still observed today.

The country released patients from state institutions, but failed to adequately prepare them for such a change. Furthermore, those fueling this transition, government officials and healthcare providers under Reagan politics, not only failed to establish a network of sustainable community programs that would assume the former responsibilities of the institution but also failed to develop resources that would maintain and support said programs long term. When

analyzing each cause and motivation of deinstitutionalization, it is obvious that this rushed and radical transition was doomed to create some lasting unsatisfactory consequences.

### **A Failed Transition: Inadequate and Unsustainable Alternatives**

The principle motivation driving the deinstitutionalization movement, aside from economic incentive, was ultimately the need for reformed patient care and treatment options. Thus, the proposed alternative to state institutions was community-based care. Unfortunately, too much emphasis was placed on advertising the attractiveness of community-based care and not on adequate organization, planning, and preparation for what these actual programs would entail. Therefore, the community-based care designed by the United States government and healthcare system, in response to the need for increased quality of care, was merely an ideal. In practice, it often proved to be both problematic and insufficient with an entire taxonomy of issues as expertly outlined in Dr. Leona Bachrach's *Deinstitutionalization: An Analytical Review and Sociological Perspective*. Furthermore, these lasting issues are observable in the psychiatric hospital readmission epidemic of today's age.

The first issue stemming from the community programs designed as an alternative to institutionalization was disparate selection of patients for community care. In the 1960s, community health centers had diffuse missions that often followed the easiest route of community-based care and thus only dealt with the population of patients with mental health disorders deemed easier to treat such as depressive disorders and suicidal ideation (Bachrach, 1976). This unwarranted bias, present both then and now, neglected chronically and severely ill patients, leaving them with little to no community resources for their mental health disorders. With the absence of both community-based treatment and state institutions, the only place for

patients with more severe mental health disorders, such as schizophrenia, was in and out of inpatient psychiatric units of the nation's hospitals.

The selection of patients by community programs based on both mental health disorder and identity not only decreased the number of patients with the opportunity to utilize community services but further perpetuated health disparities for various demographic groups and minorities beginning in the 1970s. According to Dr. Bachrach, community-based services were irrelevant to the needs of patients identifying as either Latino or black as services often ignored cultural difference or were not geographically nearby for access. In addition, there were difficulties in treating rural patients, elderly patients, and patients of low socioeconomic status with the assertion that "adjustment in the community is most difficult for lower-class patients" (Bachrach, 1976). Government funded healthcare, Medicaid, only covered mental health hospitalization and the community treatments failed to be tuned in to the cultural needs of the patients they served.

In addition, Dr. Bachrach cites three components of accessibility: geographic, financial, and psychological. She argues that community services are less accessible to patients than institutional services as the former often has limited hours of operation and greater time, distance, and financial resources required to travel to and utilize such facilities (Bachrach, 1976). Therefore, those afflicted with mental health disorders, who already have highly stigmatized and little access to care, are further inhibited in their right to treatment based on their identity and demographic information.

The actual treatment of patients within the community was also inadequate, incomprehensive, and too narrow to truly serve patients. Not only was an inadequate range of treatment services established, but they were fragmented and bestowed a questionable quality of care. Relevant agencies did not communicate with one another and ultimately lacked a

centralized administration that would otherwise coordinate care and designate responsibility of care (Bachrach, 1976). The community also lacked overall support systems such as those related to friendship networks, employment opportunities, leisure and social activities, setting up appointments, and transportation to and from therapy and treatment sessions (Bachrach, 1976). In addition, the greater community even exhibited resistance and opposition to the movement of people with mental health disorders from institutions into society. Bachrach writes, “former patients are not welcomed back into communities with open arms; instead they are often confronted by formal and informal attempts to exclude them from the community...” (Bachrach, 1976). How then were patients supposed to access community-based care if they were not welcome in the community?

Unfortunately, the long list of issues resulting from rapid and unplanned deinstitutionalization, continues on. These problems include: a lack of evaluation studies to actually assess the programs created, difficulty in locating and following patients in the community, inadequate attention to the desires of patients, failures to establish communication between hospitals and community-based facilities, and an overall resistance to further change and the development of more treatments (Bachrach, 1976). Most importantly, the community-based programs established at the time did not even address the true function of the asylum, according to psychiatrist Robert M. Edwalds in 1964. Providing long-term care for “chronically disturbed” individuals, removing the patient from his or her former environment that may perpetuate “sick behavior,” and providing constant and continuous monitoring of the patient’s course of illness are a few of many functions of the institution that were otherwise not addressed by the established community-based programs and treatments (Bachrach, 1976). It is evident that

community-based care, when not appropriately organized and developed, is ridden with issues that undermine the purpose of the system in the first place.

This epidemic is not only rooted in the issues associated with the community-based care systems developed as the care providers and their clients together are victims of funding deficits that exacerbate health disparities in the United States. With all of the reductions in funding and budget cuts over the past fifty or more years, there ultimately has not been enough federal funding for the mental health centers and programs designed to replace the institutions: financial expenditures were seriously underestimated in regards to coordinating community resources scattered throughout the nation's cities and states (Amadeo, 2019). As a result, many centers have closed or become increasingly selective of what type of patient they would treat and accept, thus creating an environment lacking both facilities to serve patients with mental health needs and fully comprehensive community-based programs.

The effects of the economic failures following deinstitutionalization should not be underestimated. The drastically reduced mental health funding over the past several decades and the injustices due to healthcare disparities experienced by minorities and other demographics created the perfect storm, in the 1970s onward to now, to prevent the utilization of community-based care by patients with mental health disorders. Furthermore, these financial deficits led to an over-emphasis on the cheaper option: medication.

### **A Failed Transition: Drug Tunnel Vision**

The advent of new psychiatric medication was a major driving force for the deinstitutionalization movement but it also served to limit the range of community-based programs that were created. In general, there was a "lack of knowledge about what would

constitute an effective and inexpensive treatment...The only partially effective treatments are the psychotropic drugs, but these are clearly only a first step” (Bachrach, 1976). This mindset, a focus on medication, stayed constant from its origin in the mid-twentieth century well into the present day. And while medication is successful in reducing symptoms that otherwise disrupt daily life and functioning, especially for mental health disorders such as schizophrenia, drugs may lose some value when considering the multitude of factors that deter patients from continuing use. Yet drugs work quickly for many patients which accomplishes the goal of doctors and their patients who desire a rapid, and often effective, treatment that does not require a large commitment to time and travel. But for patients who need more forms of treatment or are unwilling to take medication consistently, the lack of adequate community programs to provide or supplement treatment can culminate in two lasting and unfortunate effects: a dangerous cycle for patients and a revolving door for psychiatric hospital units.

The failure of deinstitutionalization in the United States can be demonstrated in the following words dating back to concerns in 1976, “The State mental hospital system, and the patients in it, are in danger of being ‘phased out’ without an effective alternative source of care being available. It is a ridiculous abrogation of our responsibility if psychiatrists and other mental health professionals allow the existing poor treatment of mental patients to be replaced with something even worse” (Bachrach, 1976). While the former state psychiatric institutions offered ineffective and dangerous conditions, the various consequences of deinstitutionalization have been negatively impacting patients with mental health conditions since they were released from the asylums in the mid-twentieth century in addition to those experiencing mental health disorders today. Most importantly, rapid deinstitutionalization without effective or available

alternatives created the perfect storm for an epidemic: the psychiatric inpatient recidivism injustice in the United States.

### **III. Zooming In: The Current Recidivism Epidemic**

The United States deinstitutionalized mental health in the 1960s, ultimately removing patients from often overcrowded, unsafe, sometimes deplorable state institutions and releasing the burden of care onto local communities. While the allocation of responsibility of care was reformed in writing, or in idea, the appropriate financial means and tangible efforts to make this transition successful did not adequately occur, if at all. The extensive list of issues with the community-based care created in the latter half of the 20<sup>th</sup> Century not only prevented patients of that time from receiving treatment, but created a modern-day world plagued with similar deficits in community-based mental health programs. While some problems have been remedied, others have remained constant and new issues have arisen all culminating in a culture that forces patients to seek treatment in inpatient hospital units, thus inhibiting their daily life and human condition. But unlike other hospital admissions, patients with severe mental health disorders often do not experience sustained stability nor extended periods of life outside of the hospital following discharge because of their complex needs and stigmatization that undercuts support. This failure in healthcare generates a revolving door phenomenon of inpatient psychiatric units: an injustice to people with mental health disorders as evidenced in various cities of New York State as well as in the broader context of the country as a whole.

#### **The Revolving Door in Rochester, NY: A History of Mental Health**

Rochester has a long history of caring for those with mental health disorders that arguably matched the trends of each era. In the early nineteenth century, the city established an Alms House that was responsible for the care of those most vulnerable in society: the young and old, those with disabilities or mental conditions, and those living in poverty. In 1843, Dorothea Dix, an activist who fought for the humane treatment of those with mental illness, visited this facility and reported the good condition of both the building and the residents (Opacity, 2006). She described the environment to be well arranged, clean, and with appropriate space for each patient (Opacity, 2006). In 1857, an addition to the County's Alms House was established which designated separate care for those with mental illness. Known as the Monroe County Insane Asylum, this facility cared for patients across the entire county for over 30 years (URMC, 2019). Thus, the city of Rochester cared for those with mental health disorders as early as the mid-1800s.

In 1890, the state government passed legislation, the State Care Act, which established a state-wide system of psychiatric hospitals. If asylums had already existed, the State offered to acquire and fund them. As a result, in 1891, Monroe County sold its insane Asylum to the state for \$50,000 and it became the Rochester State hospital (Opacity, 2006). The hospital operated well into the next century, but unfortunately did not maintain the moral treatment and adequate living conditions it once provided patients. This travesty was caused by great overcrowding in that by 1916, the hospital was caring for over 1,500 patients yet only had approximately 1,200 beds (Opacity, 2006). This level of overcrowding and the resulting treatment of patients, both characteristic of American psychiatric institutions in that time period, continued through the following decades until the surge of deinstitutionalization in the mid-1970s. As a result, the hospital was re-named as the Rochester Psychiatric Center, greater numbers of patients were

discharged while fewer were admitted, and the closing of various buildings followed in the mid-1990s (Governale, 2015). Therefore, the city of Rochester, NY, had experienced deinstitutionalization firsthand and would experience its subsequent consequences for the indefinite future.

Not only did Rochester experience deinstitutionalization, it is also known as the home of the biopsychosocial model. In 1977 at the University of Rochester, George Engel, an internist and psychiatrist, proposed a system of medicine that linked science with humanism (Smith, 2002). Engel argued that medicine, psychiatry in particular, ought to shift from solely a biomedical perspective of disease to a biopsychosocial perspective on health (Henriques, 2015). This idea mirrored a transition from the previous linear, cause-effect thinking to care that integrates psychosocial components with biological and physiological knowledge and treatment (Smith, 2002). As a result, disorders with a large neurochemical and biological component, like depression, bipolar disorder, and schizophrenia, mainly receive somatic treatments such as medication or electroconvulsive therapy as a means of brain stimulation. But for other illnesses, as a Rochester psychiatrist stated, "...medication is more cosmetic..." (Leibovici, 2019). This statement is namely in regards to cases such as attempted suicide or personality disorder, where medication only mitigates some symptoms and the major pathology is addressed through psychotherapy that is either behavioral, cognitive, or a mixture of both (Leibovici, 2019). But if both treatments were used in combination, somatic and alternative treatments such as psychotherapy, for the totality of mental health disorders, it may be possible to provide people with more comprehensive care and thus, reduce readmission rates as a result.

That same psychiatrist argues that intervening in the social aspects of a patient's adjustment back into the community is also important. Furthermore, mobilizing resources that

the patients lost or are not able to mobilize themselves, is essential to their success outside the hospital (Leibovici, 2019). Therefore, psychosocial interventions were developed in Rochester in the form of varying levels of providers and programs to supplement the medications that address the biological component of mental illness. But even in light of the existence of this comprehensive model, the inpatient psychiatric recidivism issue still burdens patients and hospitals residing in Rochester.

### **The Revolving Door in Rochester, NY: Rochester General Hospital's G1**

While the Rochester Psychiatric Center still operates in 2019, on a much smaller scale with greatly improved conditions and humane treatment, it surrenders the responsibility of acute care to the psychiatric units of general hospitals. One such ward is the inpatient psychiatric unit in Rochester General Hospital, also known as G1 for being located in the Gordon building. I have personally been working in this unit for over two years as a patient care technician, providing direct and indirect patient care that corresponds with treatment plans determined by a team of psychiatrists, nurses, and other healthcare providers. My responsibilities include: rounding on patients every 15 or seven and a half minutes, being a one-to-one with patients deemed a danger to themselves or others, and generally being the first line of communication and care provider for whatever patients may need. It is with this experience that I have grown passionate about mental health and gained valuable firsthand exposure to the central topic of this thesis and its associated components. In addition, this position has motivated me to specifically focus on the psychiatric unit at Rochester General Hospital and further extend the information discovered there to the broader context of hospitals and data from other American states.

The inpatient psychiatric ward at Rochester General Hospital, G1, is an acute care unit: it provides care for those experiencing mental health crisis. Traditionally, people are first brought

to the hospital's emergency department where they are psychiatrically evaluated if mental health has to do with their chief complaint or presenting problem. This happens for repeat patients or first-time patients and often occurs in cases of attempted suicide, adverse reactions to illegal substances, police reports or mental health arrests for violent or obscene behavior, family, guardian, or outpatient care provider concern, and general decompensation from the individual's baseline mental state that inhibits them from their typical functioning. From this evaluation, patients are typically transferred to the psychiatric emergency department to receive yet another evaluation of their mental health by a psychiatric assignment officer. If a person's symptoms are found to be severe and an inpatient setting is deemed appropriate, they are admitted to G1 and transferred to our unit by a patient care technician and a security guard. While in the psychiatric unit, the patient receives 24-hour care for their mental health and any physical health needs that may arise: they are provided with a team of patient care technicians, nurses, nurse practitioners, psychiatrists, medical doctors of necessary specialties, social workers, case managers, and even security if ever needed.

Patients are not typically kept for long periods of time and their discharge is always on the forefront of both their mind and their care-team's. The goal on the unit is helping the patient get back to their baseline, which looks different for every individual, for every mental health disorder, and for the various reasons that cause people to get admitted in the first place.

Similarly, the means of reaching this goal are also very different for each case but are generally centered around medication: whether that is prescribing a new medication, adjusting dosages, or changing the method of drug delivery such as oral versus injected medication. Once a patient is found to be back at their baseline state, an individualized plan is developed including referrals for post-hospitalization services related to medical, mental health, vocational, housing, and

psychosocial needs. This plan is finalized and communicated to the patient who is then discharged from the inpatient unit under the notion that they no longer need acute care and are able to continue their lifestyle in the community.

Unfortunately for patients with mental health disorders, this observed stability before discharge sometimes diminishes when outside of the hospital and leads to both readmission and the revolving door of inpatient psychiatric units in general hospitals. To quantify the magnitude of this issue at Rochester General Hospital specifically, I obtained data from G1 depicting 30-day readmission rates. Data was broken down into the number of readmissions and discharges for each month in the years 2014 through 2017. The following graph presents these percentages by month for 2014 through 2017.

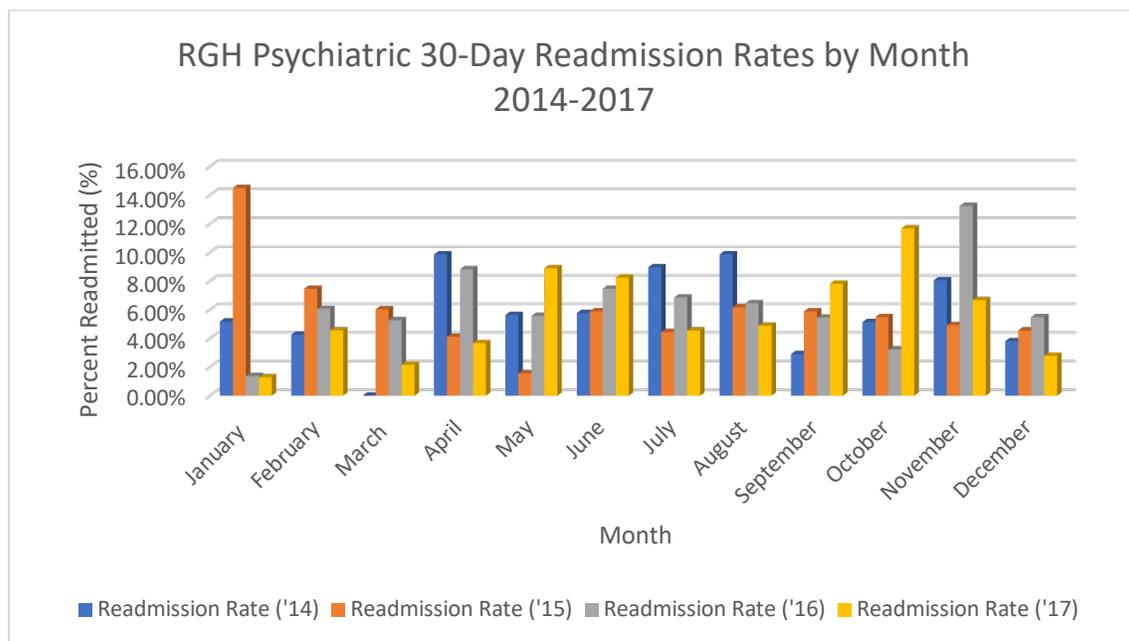


Figure 1. Percent of patients readmitted within 30-days of discharge by month from 2014 through 2017 at Rochester General Hospital's inpatient psychiatric unit.

The month of the year lies on the horizontal axis while the percent of readmitted patients, 30-days after their discharge, lies on the vertical axis. The readmission “rates” are represented as the percent of discharges that were readmitted within 30-days of discharge. Therefore, these rates take the total number of discharges for each month into account which eliminates systematic bias in analyzing the data. In addition, readmission rates within 30-days of discharge are a standard data kept for hospitals across the country. They often serve as a representation of the quality of care in that unit and can be used for comparison between units of different hospitals. The years 2014 through 2017 are shown in blue, orange, grey, and yellow, respectively.

As the graph demonstrates, no month has a particularly constant readmission rate over the four-year time period nor a significantly higher percentage than any other month(s) over that same time period. This evident fluctuation in the data may be attributed to the fact that every case and every reason for readmission is different. For example, if considering the homeless population of patients with mental health, one might expect readmission rates to be higher in colder months. However, we only see random peaks in some of these months rather than the actual expected trend. Therefore, this rather pattern-less data lends into the notion that readmission cases are very different from one another. Furthermore, it leads us to believe that there are many causes of readmission that do not necessarily succumb to proposed and expected theories, making the solution to this issue both complex and multifaceted.

Additional numbers of significance are the average readmission percentages by year for the years 2014 through 2017. This data is presented in the bar graph below.

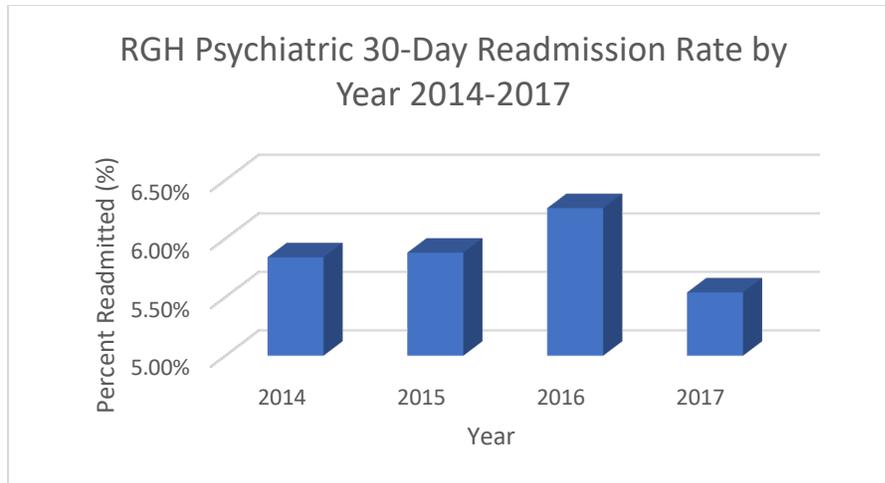


Figure 2. Yearly average percent of patients readmitted within 30-days of discharge from 2014 through 2017 at Rochester General Hospital's Inpatient Psychiatric Unit.

In Figure 2, the year lies on the horizontal axis while the percent of readmitted patients, 30-days after their discharge, lies on the vertical axis. Again, these rates take the total number of discharges for each month into account, as they are a percent of those totals, thus eliminating systematic bias in analyzing the data. The rates for 2014 through 2017 are 5.84%, 5.88%, 6.26%, and 5.54%, respectively. In comparison, the numbers across the years are relatively constant, with a slightly higher percentage of readmission per discharge in 2016. Similarly, to the data split up by month, there is no single nor simple explanation for this observation. Readmissions stem from a multitude of causes and therefore do not produce data that is easily explainable. This difficulty heightens the complexity of the readmission epidemic and may serve as reason as to why the issue has not been widely addressed.

In 2018, the inpatient psychiatric unit at Rochester General Hospital stopped running reports on readmission data and that responsibility fell onto a different office of Rochester Regional healthcare. However, the unit staff still has access to the reports for those years and can

run them at any time when that data is necessary. Thus, my coworker and I ran the reports and reviewed the data to extract the psychiatric inpatient readmission data for 2018 and 2019, through the month of September. The percent of readmissions per discharge for the 2018 and 2019 years are 7.64% and 8.87%, respectively. These percentages are larger than all of the yearly percentages presented previously, which may show that the psychiatric recidivism issue is getting worse but more statistical analysis and research into this assertion is needed to either confirm or deny.

Possessing the complete readmission reports for 2018 and 2019 additionally allowed me to extract more comprehensive data such as insurance provider, primary diagnosis, and discharge disposition. Of all those readmitted in 2018 through September of 2019, more than half, 58%, were on federally funded health insurance programs such as Medicare, Medicaid, or the Veterans Administration. The other 42% of patients readmitted back to the hospital within 30-days of their previous discharge were on private insurance with the majority, 26%, having Excellus healthcare coverage. This data might mean that people with mental health disorders are largely insured by federally funded programs, but it may also mean that type of health insurance influences readmission rates for those with mental health disorders. While this interpretation is my best guess, one must be careful about such assertions as there are other variables at play and further statistical analysis or research is needed.

Another significant dimension in readmission data and analysis is the patient's primary diagnosis. The primary diagnosis, occasionally referred to as the principal diagnosis, is best defined as the condition established after study that is most responsible for the admission of the patient to the hospital for care (NYS Department of Health, 2003). For the readmits back to the inpatient psychiatric unit of Rochester General Hospital, 23% of patients were primarily

diagnosed with some type of schizophrenia, such as paranoid schizophrenia, and 45% of patients were diagnosed with some type of schizoaffective disorder, such as schizoaffective disorder with bipolar type. To explain these diagnoses further, schizophrenia is characterized primarily by symptoms such as hallucinations, delusions, and a general disconnect from reality while schizoaffective disorders encompass these symptoms as well as symptoms of mood disorders such as mania and depression (NAMI, 2019). If one were to combine the numbers of each disorder, as they stem from mostly the same symptoms and are treated similarly, there is a total of 68% of patients readmitted in 2018 and 2019 diagnosed with these mental health disorders. The remaining 32% of patients had other diagnoses: a majority of patients with bipolar disorder, followed by major depressive disorder, psychosis, and antisocial personality disorder. It is evident that individuals with mental health disorders associated with schizophrenic symptoms are disproportionately affected by the revolving door of inpatient psychiatry. Thus, this disparity necessitates greater research into schizophrenia specifically, in order to come up with more and better treatments to keep patients out of hospitals.

The last significant variable presented in the 2018 and 2019 readmission reports from G1 is discharge disposition, a critical factor in reducing hospital readmission. Disposition is equivalent to where a patient is discharged to: home with or without extra care, skilled nursing facilities, rehabilitation centers, or alternative psychiatric hospitals, to name a few (Besler, 2015). For the readmissions back to Rochester General Hospital specifically, 87% returned back to the hospital after previously discharged to “home and self-care.” The next largest group of patients, 6%, were discharged to a short-term hospital prior to readmission. The discharge dispositions with the lowest percent of the readmissions, under 2%, were skilled nursing facilities, jail, long term care hospitals, intermediate care facilities, and home with home health aide. Therefore, the

transition of care from inpatient to outpatient is a very vulnerable period for patients with mental health disorders and bestows great influence over the readmission epidemic. Those discharged to self-care exemplify the patient needing more and alternative supports outside of the hospital, and with almost 90% of all readmits initially discharged to home or self-care, making change in the care patients are discharged to could positively impact the readmission epidemic and overall reduce recidivism rates.

### **The Revolving Door in Rochester, NY: Current Services**

While recidivism data may lack concrete trends and possess unexplainable peaks and lulls by month or by year, we can still begin to explain psychiatric inpatient recidivism to RGH in general. In order to do so, we must first discuss what is currently prescribed and offered post-discharge by psychiatrists, unit managers, and treatment teams at Rochester General Hospital's G1, using services they employ most often and shared with me in personal interviews. Therefore, there may be other services or programs that exist in Rochester but are not explicitly or widely used by the care providers at Rochester General Hospital.

Currently, the central treatment for patients, both in the hospital and after discharge, is medication. The medications differ by mental illness, often with each disorder having a large array of medications which are used to treat every single patient that enters the psychiatric ward. This style of treatment follows the pattern and accepted standards for inpatient psychiatric care which is centered on prescribing a new drug, altering the dosage or method of delivery of a drug, or simply getting the patient to re-start their medication if they had stopped taking it while outside of the hospital. Since medication is the primary means of keeping patients stable and at their baseline, the hospital's pharmacy provides each patient with a 30-day supply of medication after discharge (Landry, 2019). This service prevents challenges such as transportation to a

pharmacy and purchasing expensive medication that patients may not be able to afford otherwise.

In addition, if a patient is known as a “frequent flyer,” someone who is frequently readmitted to the psychiatric unit, psychiatrists will even prescribe a long-acting injectable of the patient’s medication. These shots are loosely comparable to the long-term insulin pumps used to treat diabetes, in theory. These injectables, often heavily encouraged by insurance companies, are known as depot antipsychotics and are just the same as an antipsychotic taken orally, but are both slow-releasing and slow-acting in the body (Mind, 2016). Injectables can last two weeks, four weeks, and even up to three months depending on the brand and medication chosen. According to a psychiatrist at G1, delivering medication automatically but in a gradual fashion with very few administrations, that is without consciously taking it by mouth, is currently being researched and made “better” (Leibovici, 2019). He argues that hospitals, as a result of the long-acting injectable, are recognizing huge improvements in terms of adherence as well as in the monitoring of adherence to medication and cites many studies that show that the rate of readmission actually decreases when injectables are used (Leibovici, 2019). This argument may explain why insurance companies support this treatment and why patients could benefit from certain drug use.

In extreme cases of medication noncompliance, psychiatrists attempt to achieve what is known as Assisted Outpatient Treatment, or AOT. This type of treatment refers to Kendra’s Law which mandates mental health services for those who have difficulty with rehabilitation and are a danger to themselves or others. Whereas the majority of mental health treatment must be voluntary, AOT is instead granted at the request of the psychiatrist over the patient in civil court (NYC Health, 2019). This method of treatment is almost always won by the psychiatrist,

ultimately forcing patients to get their depot-antipsychotic, even if that means an emergency room visit to receive the shot (Landry, 2019). Nonetheless, the patient's symptoms are addressed and they are able to remain in the community as opposed to the hospital.

While medication is the principal treatment for people with mental health disorders, there are still some supplemental services offered in Rochester, specifically. The psychosocial model included the role of social workers in the healthcare of patients with mental health disorders. These individuals are responsible for matching patients with appropriate services available in the community: services that are both truly accessible and likely to help as they largely contribute to the success or failure of patients following discharge (Leibovici, 2019). In addition, social workers schedule a phone call from the call center, within 24 hours of discharge, to evaluate how the patient is adjusting to being home and back in the community. In addition, patients are given an appointment with an outpatient clinic designed to care for them within the first 48 hours, up to the first five days, of the patient being discharged (Landry, 2019). These immediate services exist to monitor the patient in their most vulnerable period following a stay in the hospital.

Similar to the role of social workers, designated care managers aid in the transition of inpatient to outpatient care. This profession is largely encouraged and implemented by insurance companies, such as Excellus or Medicaid, to reduce recidivism (Ohm, 2019). Care managers may do home visits to ensure that patients are keeping up with their follow-up visits as well as aid in the discharge planning by identifying financial, community, and emotional support for patients (Rochester Regional Health, 2019). An additional role, peer supports, were developed to help care managers tighten the gaps in transition of care (Ohm, 2019). Dr. Ohm admits that unfortunately, this new asset has not been utilized often by G1 specifically, but nonetheless is an existing service in Rochester, NY.

Alongside these services are a series of programs, with varying levels of care, that are built on biopsychosocial values and ideals. The most intensive level of care is that found in the Rochester Psychiatric Center, commonly referred to as RPC. This center is actually located where a state institution once was, but forgoes the sometimes-inhumane treatment conditions characteristic of mental health institutions in 20<sup>th</sup> century America. At Rochester Psychiatric Center, providers “partner with people with serious mental health challenges by providing recovery-oriented services in a safe environment” (Office of Mental Health, 2019). This rather vague mission statement materializes as services characteristic of residential and community supports for both adults and adolescents. In general, RPC provides transitional housing in between a patient’s stay in an acute care center and their return to community living. RPC further stabilizes a patient’s symptoms and provides a safe environment with 24-hour care for patients that require a comprehensive and intensive level of care after hospitalization, typically up to three months.

At a similar intensity of care, but not quite an “institution,” are the adult partial hospitalization program at Strong Memorial Hospital and the Pros Programs at a series of mental health facilities within Rochester Regional Health. While Strong Memorial Hospital is Rochester General Hospital’s competitor, the partial hospitalization program is often an appropriate transition from an inpatient psychiatric admission. This program is a short-term treatment for further stabilization of mental health symptoms that affect safety and daily function. The end goal is to have the patient resume functioning and be more successful in outpatient treatment as opposed to those directly discharged to home or self-care (URMC, 2019). Patients in the partial hospitalization program have access to: five group treatment sessions every day, individual therapy contact one or two times a week, safety planning, medication assessment and

management, education and support, coordination with other providers, discharge planning, and referral to mental health follow-up (URMR, 2019). Similarly, the PROS program stands for “Personalized Recovery Oriented Services” program and has been implemented throughout the Greater Rochester area. The goals for individuals participating in this program include: living independently, finding and keeping a job, reaching higher levels of education, securing preferred housing, and improving medication management (Office of Mental Health, 2019). Thus, this program is providing patients with basic living skills, financial management, intensive relapse prevention, family psycho-education, and more comprehensive treatment which may even include clinical treatment. Ultimately, in either program, patients are given a more supportive setting to assist them in a high risk and vulnerable transition period from the hospital.

A step-down level of care from the aforementioned services is a product commonly known as Health and Recovery Plans, or HARPs for short. HARPs are a care product that manage physical health, mental health, and substance use for patients with mental health disorders. In general, they manage Medicaid services and benefit packages associated with home and community-based services, as well as provide enhanced care management that integrates the different tiers of a patient’s health mentioned previously (Office of Mental Health, 2019). According to a psychiatrist at Rochester General Hospital, HARPs are a program funded by New York State that ultimately provide professionals that can help a patient who resides at home: whether that is to ensure patients attend their follow-up appointments or to ensure they have a successful discharge from the hospital in general (Ohm, 2019).

The final service offered in Rochester’s communities is known as the Behavioral Health Access and Crisis Center of Rochester Regional Health. This clinic treats patients who need assistance right away but do not require the full resources of the emergency department or the

inpatient psychiatric unit. Thus, it is not a program recommended upon discharge for transitional success, but rather an emergency service for individuals who decompensate from their baseline and require immediate and acute attention. Patients that fit these needs may have been unable to follow up with a mental health provider or may be experiencing thoughts of self-harm, relationship problems, depression and anxiety, or substance use concerns. The clinic accepts these patients on a walk-in basis and they are free to come and go as they please. Once in the clinic, the patient meets with a nurse for a health screening. Patients also have access to a licensed clinician who can determine the necessary components of the patient's care and further help the patient smoothly transition to another outside provider or resource that is most appropriate (RRH, 2019). The behavioral health access and crisis center is ultimately responsible for problem solving and safety planning with patients who are in need of acute care, but do not require a full-fledged inpatient psychiatric admission.

### **The Revolving Door in Rochester, NY: Root Causes of Readmission**

In addition to medication and drugs, there are also a wide array of services, largely based on the biopsychosocial model first introduced in Rochester, New York, that are designed to supplement medication and care for those with mental health disorders following their admission to an inpatient psychiatric unit. But unfortunately, while all of these programs and services exist, patients with mental health disorders are still being readmitted back to the hospital's psychiatric unit. Thus, there are challenges present in the American mental healthcare system as a whole, further perpetuating the psychiatric recidivism epidemic apparent in both Rochester General Hospital and beyond. Furthermore, these challenges, the root causes of readmission, are all interwoven and reciprocal: the many factors at play are complexly connected and often blend into one another.

## I. American Insurance Companies

One external force that may be causing and prolonging the inpatient psychiatric recidivism epidemic is the American insurance system both private and public, which is at the center of a majority of the other causes of readmission. This negative role of insurance companies can be explained in the term alone: insurance companies are companies. And for any company, any business, the ultimate goal is to spend the least while making the most profit. For health insurance companies, which are responsible for covering a wide array of medical expenses incurred by a patient's illness or injury, this goal transpires into cutting corners for the cheapest route at the cost of the patient (Kagan, 2019). This uneven balance, between the cheapest methods and what the patient actually needs, is a major problem associated with insurance companies as well as the other causes of readmission that they create. This conundrum is present in Rochester and is likely similar in other places although further work is needed to assess those places.

The major way in which insurance companies cut costs is by applying pressure on the length of stay. In other words, insurance companies want their patients out of the hospital quickly. For patients with mental health disorders, this pressure may mean getting discharged before actually reaching a sustainable and stable baseline, thus leading to readmission back to the hospital. Insurance companies reduce length of stay in the hospital by various means.

The first is through care plans, or pathways, that are considered "one size fits all": they are rigid, standardized and believed to fit every patient's circumstances and situation. For Rochester General Hospital, insurance companies use a system entitled "InterQual." According to InterQual's official website, the service aligns payers and providers with evidence-based clinical information to support appropriate care and optimal utilization of resources (Change

Healthcare, 2019). The foundation of this system is the companies' clinical criteria which is designed to aid in clinical decisions such as those pertaining to admission and discharge. The website also shares that InterQual reduces administrative cost by streamlining the medical review process. In other words, insurance companies are able to pay less when they have the hospital use a service that gets patients out of the hospital faster using a standardized pathway.

While a system that creates criteria for admission and discharge may sound beneficial in theory and may even work for some patients, the inevitable rigidity of this system ultimately leads to premature patient discharge that can engender rapid readmission for those who defy fixed criteria. This rigid system cannot fully consider various patient circumstances that the standardized InterQual system ignores: patient history including average length of stay and medical history, socioeconomic factors, home environment, co-occurring illnesses, and other relevant patient details. In Layman's terms, a set of rigid criteria that determines whether a patient can be discharged or not will inevitably exclude other factors significant in a patient reaching a sustainable and stable baseline. Thus, by leaving these essential components of a patient's recovery unaddressed, an insurance company that uses a system like InterQual will ultimately cause readmissions. In fact, this trend was observable at Rochester General Hospital's inpatient psychiatric ward when a former psychiatrist, who no longer works there, strictly followed InterQual's criteria for admission and discharge. In an interview with the nurse manager of the unit, she mentioned that they actually saw a spike in his readmissions with a decrease in the length of stay (Allison, 2019). A doctor or hospital following particular insurance metrics could end up fueling readmissions that could be more costly financially and for the patient's health.

Both readmission and length of stay are metrics of the quality of care a hospital provides. But as one can see by the use of a service such as InterQual, insurance companies consider length of stay to be far more significant than readmission data. A Rochester G1 psychiatrist explained that in consultations with hospitals and care providers, insurance companies actually characterize, consider, and rank an inpatient psychiatric positively or negatively based on average length of stay (Leibovici, 2019). For example, if G1's average length of stay is 12 days while the national average is only seven days, then G1 is viewed poorly in the eyes of the insurance company. This comparison occurs even if evidence-based research has not determined that seven days is the "gold standard" or optimal amount of time for an inpatient admission, according to Dr. Leibovici. He also argues that, as a result, hospitals and care providers often internalize the value that good care is to get the patient out of the hospital as quickly as possible (Leibovici, 2019). And often times, there may even be rationalization for reducing a patient's length of stay such as the idea that the patient would regress on the unit or get worse, hospitalization is not good for them, or hospitalization is too expensive.

Therefore, it can be the pressure from insurance companies that causes care providers to discharge patients prematurely as has occurred at Rochester General Hospital's G1. In fact, the only specific restriction standing in the way of a patient's discharge at G1, when using a set of discharge criteria such as InterQual, is a concern for safety. One psychiatrist at G1 shared that, "if the person is clearly not suicidal or not violent, short of having achieved a sustainable improvement for the outpatient world, people [they] are being discharged" (Leibovici, 2019). In addition, if there are treatment resistant cases causing the patient to reside in the hospital for longer, psychiatrists may start to place blame on a different disorder and again, discharge the patient earlier than they should. Thus, psychiatrists and other members of care teams may be

discharging patients too early, patients possibly still experiencing symptoms and who are not at their sustainable baseline. The future of these patients shorted of a proper hospital stay, is often readmission back to the hospital.

## **II. Pill Problems**

Insurance companies and hospitals aim to reduce expenses which can justify relying on the cheapest and easiest treatment for mental health disorders that can also be effective: medication. To quantify this magnitude, consider the cost of the drug Zyprexa compared to the cost of staying in the hospital. Zyprexa is a medication used to treat schizophrenia, bipolar disorder, and other psychotic illnesses that currently retails at an average price of \$172.47 for 30-days' worth of the medication (GoodRx, 2019). In contrast, average hospital costs are currently almost \$4,000 per day (Debt, 2019). Therefore, for only a weeks' time in the hospital, it would cost upwards of \$28,000. It is very clear that medication is the cheapest treatment option. As a result, insurance companies might pressure care providers to reduce a patient's length of stay in the hospital and prescribe drugs over any other treatment. In addition, health insurance often covers most prescription drugs a patient may need but does not always cover supplemental services such as counseling, therapy, and other mental health care (Ochalla, 2018). Having tunnel vision on medication to save money or time must be avoided as drugs benefit many but a pill alone is not sufficient to treat mental health disorders especially because those with severe disorders may need support even to follow their drug regimen.

The fact that medication, alone, cannot completely manage symptoms of mental health disorders is largely due to the very nature of mental health illnesses and the notion that care providers do not have reliable and effective means of controlling the course of mental illness for the totality of those affected by these disorders. Chronic mental health disorders come with

inherent challenges; even with the use of often effective treatments, more research is needed. Thus, when asking a psychiatrist in G1 what the cause of readmission back to the unit was he responded that "...we are not as good as yet in treating these illnesses" (Leibovici, 2019). He explained that while psychiatrists will explain the complex scientific concepts behind neurotransmitters and other aspects of the neuroscience, there is ultimately an unfulfilled prophecy in treating mental illness. This unfulfilled prophecy is equivalent to the promises of medication as given by the psychiatrist and as advertised in the media (Leibovici, 2019). Instead of admitting that they do not actually know why medications work beyond observing that they are associated with patients getting better, they can create the notion that medication resolves all.

In addition, treating mental health is very complex and variable. In other words, everyone's brain is a little bit different (Landry, 2019). Consider a disease such as diabetes, a chronic disorder that affects an individual's blood sugar. In treating this disease, there is a specific set of medications that works well for every patient. In contrast, when it comes to treating mental illness, psychiatrists must consider a combination of factors related to medication: is an antipsychotic needed to augment an antidepressant, does the patient need multiple antipsychotics because one is not enough, has the dosage and duration of the medication created a treatment resistant case, is the medication actually working (Landry, 2019). These are just a few of many considerations that go into treating mental health disorders chemically, and thus portray the complexity in controlling mental illness as precisely as one might control other types of chronic illnesses. Researchers and psychiatrists work hard in their field ensuring that medication is effective for many but that success is not typically experienced by every patient due to the very nature of mental health disorders and the complexities of pharmacotherapy.

In addition, numerous problems can arise from an over-emphasis on the use of medication which stem from the nature of the drugs themselves. One challenge with medication is that while it may actually be the best and most appropriate treatment option for patients given current research findings, there are likely some patients for which treatments do not work or they require individualized treatment plans for either co-morbid disorders or complex mental illness in general. In addition, medication often procures negative side effects. For antipsychotic medications, the side effects may include: Parkinson's disease like symptoms such as stiffness and shakiness, uncomfortable restlessness, tardive dyskinesia or movements of the jaw, lips, and tongue, sexual problems, sleepiness and slowness, weight gain, an increased risk for diabetes, constipation, dry mouth, and blurred vision (Rethink Mental Illness, 2019). For antidepressant medications, some of the side effects are similar to that of antipsychotic drugs and may include: dizziness, fatigue, blurred vision, sexual problems, weight gain, constipation, insomnia, dry mouth, nausea, numbness, and increased anxiety (Schimelpfening, 2019). But more extreme side effects can arise. For example, if multiple antidepressants are taken, a patient may develop Serotonin Syndrome in which serotonin reaches dangerously high levels. As a result, the patient experiences confusion, agitation, muscle twitching, sweating, and in severe cases, very high fever, seizures, irregular heartbeat and unconsciousness. In addition, most antidepressants cause a temporary worsening of the depressive symptoms and may even increase thoughts of suicide. They can additionally trigger manic episodes for those whom are susceptible to bipolar disorder and finally, increase a person's risk of seizure (Schimelpfening, 2019). And while a patient may endure all of these side effects, the medication(s) is not completely guaranteed even to work.

As a result of these side effects or the effectiveness of the drugs, patients often stop taking their medication. This effect is actually heightened when the medication has been

working, as the patient begins to feel better mentally and stops taking their medication to alleviate the harmful side effects. This drug noncompliance characterized by a lack of medication to control the symptoms of the mental health illness will cause the patient to decompensate to a level requiring a psychiatric inpatient readmission. To reduce this trend, psychiatrists often prescribe long-acting injectables to prevent medication noncompliance. And while these may work in theory, in reality they require prior authorization, the patient has to meet specific requirements, the injection is not formulary, and in the words of a G1 psychiatrist, “it costs a billion dollars” (Ohm, 2019). Therefore, the long-acting injectables are not necessarily reasonable nor realistic and medication noncompliance remains as a central perpetrator of inpatient psychiatric recidivism.

There are additional factors that cause psychiatric readmission that are related to the patients themselves including: patient disposition, co-occurring substance use and psychosocial factors. These factors are cited by the individuals I interviewed at Rochester General Hospital’s G1, the psychiatrists and a unit manager. The patient, however, should never be blamed for their mental health disorder which can arise from genetics, brain chemistry, or even life traumas. In addition, certain life circumstances and situations, substance use, and psychosocial determinants are not the fault of the patient either, but are more often a product of the environment in which they live or the system as a whole. These factors often correlate to an increased rate of readmission and can be logically compiled into a group of components related to the patients themselves.

### **III. “Self-Sabotage”**

In general, patient disposition describes how the patient “self-sabotages” and essentially perpetuates their own hospital readmission. In the opinion of G1’s nurse manager, “patients are

probably the biggest offender of their readmissions...” (Landry, 2019). While in the hospital, the main focus of almost all patients is their discharge. Just like insurance companies, patients want to leave the hospital quickly, but for vastly different reasons. And as two G1 psychiatrists noted, they cannot legally hold patients against their will. This concept demonstrates the challenges of balancing patient rights with mental health treatment; while practitioners may know best, patient autonomy and decision making is also of importance. Rights for people with mental health disorders are granted to patients in an extensive document entitled, “Rights of Inpatients in New York State Office of Mental Health Psychiatric Centers.” To summarize the admission and discharge laws, one must consider three different types of admission: informal, voluntary, or involuntary. Under informal admission, a patient requests treatment and gets admitted without formal or written application and is therefore free to leave the hospital at any time. If a patient has been voluntarily admitted, they apply in writing for admission and may make a written request for discharge at any time. A patient who writes a request must be released unless the director of the psychiatric center believes that involuntary admission for that patient is appropriate. The psychiatrist must then apply to a judge within 72 hours for authorization to keep the patient in the psychiatric unit.

Finally, for patients admitted involuntarily, the request for discharge is a little more complex. If the patient has been admitted by medical certification, two physicians and someone familiar with the individual certify that the individual requires a hospital admission, they may be kept in the hospital for up to 60 days. If the end of those 60 days is reached, the psychiatrist may appeal to a judge for authorization to hold the patient further. The same procedure is followed for those involuntarily committed by certification from a director of community services or an examining physician whom sees the patient within 72 hours of arriving at the hospital’s

emergency department. Finally, if a patient is brought to the hospital by way of emergency admission, they may be kept for up to 15 days. Again, this time can be extended if the psychiatrist applies to a court judge (Office of Mental Health, 2019). All of these rights can be found in the Office of Mental Health's document on the rights of psychiatric inpatients in New York State.

While these laws may be a reflection of an administrative failure in the state and federal governments giving people too much influence over their discharge against health professional advice, they ultimately provide patients with the opportunity to cut their admission short. As Dr. Ohm of G1 noted, "...they have a right not to be here. Even if we think they will benefit, even if they refuse meds, if we cannot prove they are imminently dangerous to self or others, we have to let them go" (Ohm, 2019). And because of this legal point of view, psychiatrists and the care teams at Rochester General Hospital place great value on patient autonomy. As a result, it may be a patient not an insurance company pushing discharge, thus cutting their own care. Either way, patients leave the hospital too quickly, without establishing a sustainable baseline, and their symptoms cause them to commit risky behaviors and get into situations that lead them back to the hospital for another inpatient psychiatric admission.

#### **IV. Co-Morbid Substance Use Disorders**

Substance misuse may be a product or cause of this cycle and stands alone as a major contributor in psychiatric inpatient readmission. Over the two plus years that I have worked in G1, I have seen this pattern again and again, but I recall two patient's stories in particular. The first, whose name will not be shared in effort to respect confidentiality and patient privacy, lives with a diagnosis of paranoid schizophrenia. After reaching baseline, the patient was discharged from the unit only to come back approximately a week or two later. I asked the patient what had

happened and they responded, “weed.” The second patient, a well-known “frequent flyer” in G1, also has a diagnosis of schizophrenia. For this patient, their substance of choice varies, but they come back to the unit rapid readmission multiple times a year. While both patients are subjected to widely different circumstances and environments, they have two common denominators: mental health illness and co-occurring substance use.

In either patient, and for most cases that follow this pattern, the substances used brings out the symptoms of the mental health disorder more predominantly. When substances are in a person’s system, it can be difficult to identify what is actually causing symptoms: it could be the substance, the mental health disorder, or a nasty combination of both (Landry, 2019). In addition, when patients are using, they often stop treating their mental health. Whether the substance alleviates symptoms for a short-time or makes them forget to take their medication, patients are neglecting to treat their mental health symptoms and/or seek help when needed.

## **V. Psychosocial Determinants of Health**

The final contributor to the inpatient psychiatric readmission epidemic, which may also be the most difficult to remedy, is the social component of the psychosocial determinants of health and healthcare. This recidivism cause is largely related to the various tiers of support a patient will experience in their community, including housing and social supports. For example, Dr. Ohm, a psychiatrist in G1, argues that homelessness is one of the main reasons why patients are readmitted back to the hospital. She shared that in caring for very marginalized and financially vulnerable patients, the RGH care team recognizes that some patients are not well enough to go to a shelter and are therefore kept in the hospital longer (Ohm, 2019). Therefore, care providers at G1 do not always follow insurance pressure to reduce length of stay. In addition, some patients are in what she refers to as the “gray zone” (Ohm, 2019). These patients

are well enough to leave the hospital, but have nowhere stable to go nor the means of financing a stable residence if placed there upon discharge.

Since Rochester General Hospital would never discharge a patient to the streets, patients often go to homeless shelters where no one is making sure they take their medication, go to their mental health appointments, or any other actions toward treating their symptoms and mental health disorder. As a result, patients decompensate from their baseline and end up readmitted back to G1. In addition, for less marginalized patients who might not even be homeless, a lack of social supports in the community, in general, can breed readmission. In fact, the unit manager of G1 noted that “if you look at the patients that are readmitted, they do have fewer social supports than the ones that are not readmitted” (Landry, 2019). Thus, there is a large social aspect in psychiatric recidivism.

Psychosocial factors that perpetuate psychiatric inpatient recidivism are the product of systematic injustice typically based on an individual’s socioeconomic status. Regardless of political belief, there is an undeniable presence of inherent privilege for those with a higher socioeconomic status in the United States. Unfortunately for patients living with mental health disorders, the case is no different. Dr. Leibovici, a psychiatrist in G1, stated that, “the major disadvantage of disadvantaged people has to do with education and the ability to utilize existing services as opposed to the availability of services” (Leibovici, 2019). While stating that there is an educational difference between people of different socioeconomic statuses is rather vague, the educational gap relevant to our discussion is that surrounding one’s mental health. For those of lower socioeconomic status, they may not receive education about all of the treatment options available to them as those treatments may not be completely accessible to various demographics. In addition, they may receive decreased education on their mental health condition in general if

physicians and care providers assume stigma and assume a lack of understanding. Therefore, the education gap between patients of different socioeconomic status deprives patients of lower socioeconomic status from multiple treatment options that have the possibility to keep them out of the hospital.

The second “major disadvantage of disadvantaged people,” has to do with the disparities in accessing pre-existing services. Essentially, the problem is not the presence or availability of services, but in the utilization and accessibility of such services. This issue stems from multiple factors that perpetuate health disparities for all healthcare: geographic distance from relevant treatment centers, transportation to those treatment centers, cost of treatment, the stigma(s) associated with seeking treatment, and the education and awareness of existing services. These barriers to accessing healthcare significantly burden those with lower socioeconomic status as they may not have the appropriate and necessary financial or social means to overcome such issues.

If patients do not have access to comprehensive care and the numerous treatment options within the community, then their only chance of treatment is medication. When medication is not sufficient nor sustainable, the patient ends up readmitted back to G1. This cycle may serve as a possible explanation for the readmission data according to insurance provider presented previously. Those on government funded health insurance, who are typically of lower socioeconomic status, experienced significantly greater readmission rates back to the hospital. This inability to utilize pre-existing services, and the lack of education around mental health, not only disproportionately affects those of lower socioeconomic status but presents as one of the most difficult problems to solve as health disparities caused by psychosocial factors are deeply rooted in national systemic injustices.

Ultimately, there are so many sources that contribute to recidivism that many solutions will probably need to be developed or expanded. The desire for rapid cures, low costs, and seemingly effective treatments for many disorders has led to medication as the common response to a mental health problem. While medications are an important part of mental health treatment that benefit many individuals, medication on its own is typically not sustainable or sufficient for many serious mental disorders. Patient disposition, co-occurring substance disorders, and health disparities related to psychosocial factors can further complicate each individual case. The sheer number of factors that can lead to patient recidivism, and the fact that each influence another, makes the cure to the readmission epidemic necessarily complex and comprehensive at multiple levels. And the need for a solution only intensifies when considering that this case study of Rochester General Hospital's inpatient psychiatric unit is similar to cities all over the United States.

### **The Revolving Door in New York State**

All of the statistics, current treatment options, and roots of readmission are specifically taken from a "case study" I conducted at Rochester General Hospital's Inpatient Psychiatric Unit, G1, using interviews, data from several years, and personal experience from working there. But those numbers, services, and recidivism causes reflect experiences in other cities. Although these components may vary slightly across different locations, the general outline is essentially the same: patients with mental health disorders reach their baseline at their hospital inpatient unit, they are discharged to the community where various services are offered, and then one of many factors ultimately leads to some patients being readmitted back to the hospital. This psychiatric readmission epidemic reaches across all of New York State, preventing many people with mental health disorders from experiencing the deserved quality of life.

When it comes to patient information or hospital statistics, available and public information is slim, thus, there is not a clear set of data to study. I had access to specific data from the inpatient psychiatric unit, G1, at Rochester General Hospital because of my employment and interviews conducted there. As a result, the following comparisons are between slightly different data that will be explained for each comparison. Furthermore, this deficit in public reporting from both hospitals and states may mean a deficit in data to draw comparisons and conclusions that could lead to improved care rather than speculation posed here.

Analyzing information from one hospital in the city of Rochester, NY, is a very zoomed in perspective on the recidivism issue, but these details are representative of other cities in New York. Every month, the NYS Office of Mental Health releases a report that shares various relevant data from different cities across the state. February, 2019, was the most recent month that included psychiatric readmission rates. These readmissions were defined as state psychiatric center and Medicaid psychiatric inpatient readmission events that occurred within one to 30 days after discharge (Office of Mental Health Monthly Report, 2019). The exact reason for only providing data pertaining to government funded health insurance or state centers was not specified, but I speculate that this data is for the state and federal government to see how the money is being used. The following table presents the 30-day readmission rates, as a percentage of number of discharges for those 30-days, for various cities in NYS.

<b>30-Day Readmission Rates in New York State</b>	
<b>City in NYS</b>	<b>Readmission Rate (%)</b>
Bronx	15.2
Buffalo	18.8

Capital District	11.8
Creedmoor	18.0
Elmira	12.5
Greater Binghamton	13.6
Huthchings	20.0
Kingsboro	11.1
Manhattan	22.2
Pilgrim	7.9
Rochester	8.3
Rockland	11.1
South Beach	16.4
St. Lawrence	50.0
Washington Heights	14.7
<b>Average for NYS</b>	15.9

Figure 3. Psychiatric Inpatient 30-Day Readmission Rates in New York State, taken from the NYS Office of Mental Health February 2019 Report.

In Figure 3, the name of the NYS city is given on the left, with the 30-day readmission rate as a percentage of number of discharges per those 30-days on the right. Recall that for the psychiatric inpatient unit at Rochester General Hospital, the 30-day readmission rate in 2019 was 8.87%. This number is very close to the overall readmission rate, 8.3%, for the city of Rochester as a whole. The nature of these data vary slightly, as one is taken for a single unit within a general hospital and the other is a compilation of readmission rates from state psychiatric centers

in Rochester. Nonetheless, they can still be compared as the patient population is very similar and since no other relevant data is available to the public.

When compared to other cities in New York State, Rochester has the second lowest readmission rate, being higher than only that of Pilgrim, New York. To clarify, Pilgrim is located in the city of West Brentwood, NY. While it is not itself a city, it is one of the largest psychiatric centers in New York State that serves both Long Island and the Greater NYC region (Office of Mental Health, 2019). Currently, this facility provides a continuum of inpatient and outpatient psychiatric, residential, and related services: it has approximately 278 inpatient beds in a total of 12 inpatient wards including admission, geriatric, and psychiatric rehabilitation wards, four outpatient treatment centers, residential agencies and transitional services (Office of Mental Health, 2019). Thus, while Pilgrim is actually an enormous psychiatric center, the extensiveness of the facility makes it comparable to other cities in the state. This exception therefore makes Rochester the city with the lowest readmission rate in NYS.

Another observation from Figure 3 is that the majority of readmission rates in New York State range from approximately 11% to 20% of discharges over a 30-day time period, with the average readmission rate across the entire state at 15.9%. While the outlier rate in St. Lawrence at 50.0% may drive this average up a few percentage points, most cities are close to the average for the whole state. This data demonstrates that the inpatient psychiatric readmission patterns in Rochester are observable in other cities in the state. In fact, the readmission epidemic in Rochester is under greater control than all other cities listed in Figure 3. The current services and root causes of readmission were outlined for Rochester previously, thus other cities may have even less services within the community to supplement medication or they may experience the

causes of recidivism more intensely as I hypothesize that the general framework for treating mental health is similar across various locations.

### **The Revolving Door in the United States**

Therefore, it is also significant to compare readmission rates across state lines, as to demonstrate that the recidivism crisis is present in the country as a whole. Florida, Pennsylvania and Texas were intentionally chosen for their similarities and differences with New York State. New York has a population, as of 2019, of 19,491,339 people. The state with the closest population, 21,646,155 people, is Florida followed by Pennsylvania with 12,813,969 people and Texas with 29,087,070 people (World Population Review, 2019). Additionally, the political affiliation of each state was considered. New York is a blue state, otherwise known as a Democratic state with ideals that lie on the progressive and liberal end of the political spectrum. Pennsylvania is also a blue state (Monkovic, 2019). In contrast, Texas is widely known as a red state, commonly referred to as a Republican state with ideals that lie on the traditional and conservative side of the political spectrum. Additionally, in recent times, Florida has shown to be a majority Republican. Finally, Pennsylvania borders New York on the North-Eastern side of the country while Texas and Florida are Southern states. These demographics as well as the two different readmission rates for each state are presented in the table below.

<b>30-Day Readmission Rates for Various States</b>					
<b>State</b>	<b>Population</b>	<b>Political Affiliation</b>	<b>Location in the USA</b>	<b>Readmission Rate (%) 1</b>	<b>Readmission Rate (%) 2</b>
New York	19,491,339	Democratic	Northeast	6.3	16.3

Pennsylvania	12,813,969	Democratic	Northeast	0.5	Missing
Florida	21,646,155	Republican	South	0.0	Missing
Texas	29,087,070	Republican	South	7.5	Missing

Figure 4. 30-Day Readmission Rates from the Substance Abuse and Mental Health Services Administration for various American States in 2018.

Figure 4 presents the demographic information for four comparable states: New York, Pennsylvania, Florida, and Texas. Compared to New York, these states have similar populations with some states having more people and some having less and similar or different political affiliation and location within the United States. The readmission rates provided in Figure 4 are taken from each state's "Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System" from 2018. Readmission Rate 1 is the 30-day readmission rate to a state hospital while Readmission Rate 2 is the 30-day readmission rate to any psychiatric hospital or center, both a percentage of total discharges within that 30-day time period. For each state, the readmission rate back to a state psychiatric hospital is given. In contrast, only New York has reported their readmission rate to any psychiatric hospital so one could speculate on why other states do not provide that data to the NIMH and that many questions remain, which makes the act of drawing conclusions or interpretations from the data, or lack thereof, especially difficult.

Looking at the numbers that were provided, New York and Texas have relatively similar readmission rates. While more research into this comparison is necessary, the similarity may be due to the fact that they have close population sizes and may therefore deal with mental health by similar means. The readmission rate in Texas is a little higher than that of New York which may be a reflection of the state's political affiliation and the subsequent stigma toward mental illness. Furthermore, Texas has the highest uninsured population at 17.3% of people being uninsured as

of 2018 (Keith, 2018). As a result, the length of stay in the hospital may be reduced or medication and treatments may be altogether too expensive for patients who are uninsured thus possibly perpetuating readmission. Similarly, uninsured individuals may be of lower socioeconomic status, have lesser degrees of educational attainment, possess fewer social supports in the community, or could have been immigrants to the United States. These characteristics of the Texas population may make it similar to the population in New York, producing similar rates, but Texas may have less community support thus resulting in a slightly higher readmission rate in that state. These suggestions and explanations are purely speculation, and would necessitate further research.

In contrast to the similarities between New York and Texas, both Florida and Pennsylvania have reported extremely low numbers for their 30-day hospital readmissions to state hospitals. Identifying the reason(s) for these values would require much more research and data collection that could likely substantiate a thesis of its own. With that said, I might guess that hospitals or states may not be readmitting patients so that they are readmitted elsewhere, may be “capping” their available beds (allowing no more patients in) as to avoid incurring readmissions, or might just be underreporting, or not reporting, all of their readmission data. The likelihood of these causes increases when considering that some hospitals in the United States can be financially penalized for having a higher than expected thirty-day readmission rate (Benjenk, 2018). Nonetheless, financial penalties are not characteristic for every hospital and I cannot make assertions about such serious issues like the manipulation of data or reports without proof. From examining the data from SAMHSA, it appears that there are similar rates of readmission into psychiatric hospitals in different states, thus highlighting the further need to examine recidivism rates across the United States.

The revolving door phenomenon of inpatient psychiatry gains even greater significance when considering national readmission data. Looking back to the year of 2012, approximately 25% of adults in America experienced some type of mental health disorder (Heslin, 2015). To conceptualize the magnitude of the prevalence of the mental health crisis in the United States, in 2012, consider the fact that this number equates to one out of every four people experiencing a mental health disorder. Of those who were hospitalized for their mental health condition, the majority were diagnosed with either a mood disorder or schizophrenia and other associated psychotic disorders. These diagnoses had the highest number of all-cause 30-day hospital readmissions among adult Medicaid patients over any other diagnoses (Heslin, 2015). Five years later, five years to have made progress toward solving the readmission issue, we find that nationally, hospitalization for people with mental health disorders has increased faster than any other condition (Health Catalyst, 2017). In 2017, the readmission rates for patients with schizophrenia or mood disorders are still the largest cause of hospital readmission with approximately 22.4% of patient with schizophrenia being readmitted and 15% of patients with mood disorders experiencing readmission (Health Catalyst, 2017). Thus, over time with changing legislation and advancements in clinical research and technology, progress toward reducing and preventing hospital readmission for those with mental health disorders is not coming fast enough.

Recall from Figure 2 that the 30-day readmission rate back to the inpatient psychiatric unit of Rochester General Hospital, in 2017, was 5.54% of all discharges in that time period. The national average for this metric in this year was unfortunately not available. But from the most recent national data I could find, patients diagnosed with either schizophrenia or a mood disorder were readmitted back to the hospital at either 22% or 15%, respectively, in 2017 (Health

Catalyst, 2017). These numbers are triple or nearly four times that of the G1 unit, demonstrating that the recidivism epidemic is not only common to the country as a whole, but actually worse on a national scale. Therefore, the causes of readmission outlined previously for the city of Rochester are more intense, more unaddressed, or accompanied by other factors that serve to worsen the epidemic in other cities or states. Furthermore, the wide array of services also outlined previously for the city of Rochester may not exist nor be effective in other areas. Whether that is a product of stigma, ignorance, or other financial, social, and political issues in those locations, it inevitably engenders, and worsens, recidivism crises all over the country.

### **Mental Health Disorders are Chronic Disorders**

Imagine going to the hospital for shortness of breath, a symptom of your chronic obstructive pulmonary disease. You spend one to two weeks there for testing, breathing treatments, medication adjustment, and even surgery. Finally, you are discharged with full clearance for normal activity and your doctor says, “See you back here next week!” What would cause you to have to go back to the hospital? Would not your stay in the hospital, medication, discharge instruction, and community support network be enough to keep you out of the hospital? Why would there be an acceptable expectation from care providers, society, and the American healthcare system for you to be readmitted back to the hospital? This dramatized scenario and these questions are inconceivable for those with chronic illnesses that effect the physical body: they would arguably be unacceptable considering the advancements of healthcare and modern medicine. So why is this picture the accepted reality for patients with chronic illnesses of the mind?

Some may argue that physical chronic illnesses are incomparable to mental chronic illnesses, and thus, one cannot evaluate metrics of quality of care such as hospital readmissions

of each in the same regard. But in actuality, the only difference between chronic illnesses of these sorts is that physical illness is physiologically observable while mental illness may not be (although new discoveries and medical advancements are beginning to defy even this distinction). Consider the simple definition for chronic illness given by the United States National Center for Health Statistics for example: chronic disease is any disease lasting for three months or longer (National Health Council, 2016). Therefore, while this definition is extremely general and simplified, it nonetheless encompasses a variety of conditions including any mental health illness that lasts for at least three months.

I also presented this concept as a question to one of the psychiatrists at Rochester General Hospital's inpatient psychiatric ward, asking if readmission rates for patients with mental health disorders were comparable to other chronic disorders. He immediately answered yes, expanding on the fact that in teaching medical students, he proposes the theory that, "psychiatry, clinical psychiatry, both in terms of how its organized and how good it is in treating people, is comparable to internal medicine" (Leibovici, 2019). Thus, the metrics of quality of care, specifically readmission data, can and should be compared for chronic illnesses of both the body and the mind.

When it comes to chronic illness, no patient is actually cured of their chronic disease. Unless they die, the patient generally improves and goes home where treatment is continued more or less intensively. For physical chronic disease, even though they still possess the same illness, the individual can generally stay in the community and live functionally with their illness. But when it comes to chronic mental disease, the outcomes are very different. In New York State alone, the most frequent conditions associated with preventable hospital readmissions in 2007 were mental health disorders. Medicaid recipients with mental health conditions

experienced potentially preventable hospital readmissions over 3.5 times more frequently than those without mental health disorders (Lindsey, 2007). Furthermore, across the state, hospitalized patients with a mental health condition experienced a readmission rate of 8.0 per 100 at risk admissions, while those without mental health conditions experienced a rate half of that, only 4.8 per 100 at risk admissions (Lindsey, 2007). In fact, when those without mental health conditions experienced readmission, they were most frequently readmitted for a different condition with a different diagnosis. In addition, the following table gives readmission rates among Medicaid Recipients by the major diagnosis at initial admission.

<b>Readmission Rate by Chronic Disorder</b>	
<b>Disorder/Diagnosis</b>	<b>Readmission Rate per 100 at Risk Admissions</b>
Mental Disorders	14.1
Disorders of the Circulatory System	10.9
Disorders of the Respiratory System	10.6
Disorders of the Nervous System	9.5
Alcohol/Drug Use/Alcohol or Drug Induced Organic Mental Disorders	17.7
Human Immunodeficiency Virus Infections	18.8

Figure 5. Readmission rates per 100 at risk admissions among Medicaid Recipients by major diagnosis at initial admission in New York State in 2007 (Lindsey, 2007).

Figure 5 gives the readmission rates for various chronic conditions. In the left column, the principle disorder or diagnosis is listed. Disorders of the circulatory system, respiratory system, and nervous system include all physical chronic illnesses that fit under each category. In the right column, the readmission rate per 100 at risk admissions is given. By reviewing the data, one can

see that almost all physical chronic condition categories listed have a lower readmission rate than that for mental disorders. In fact, the only disorders with higher readmission rates in Figure 5 are other mental disorders caused by alcohol or drug use and human immunodeficiency virus infections. Thus, the chronic conditions with the highest readmission rate are either mental disorders, induced by alcohol, drugs, or neither, or another very stigmatized illness, HIV, that may be complicated to manage. These numbers do suggest that the readmission epidemic disproportionately affects patients with mental health disorders across New York State. Whether that is a product of some disorders having better or more identified effective treatments than others or that mental health and physical health may not be equal in terms of research, standards, and treatments due to stigma, the data suggests disparity for chronic mental health conditions in regards to recidivism.

This trend, where patients with mental health conditions experience hospital readmission far more than those with physical conditions is present throughout the country as a whole. A few years after the data from NYS was published, the state of Wisconsin collected readmission data when evaluating the effectiveness of an organizational change model in reducing psychiatric inpatient readmissions. They found that in 2016, approximately 50% of patients discharged with either depression or schizophrenia were readmitted within one year of discharge (Molfenter, 2016). These disorders, and other psychotic disorders, also had the second highest 30-day inpatient readmission rate of all major diseases. Furthermore, throughout the entire country, patients with schizophrenia experienced readmission rates at 18.6% while those without any mental health condition had readmission rates around 8.7% (Weiss, 2015). Thus, the readmission rate for patients with schizophrenia is 115% higher than for patients with no mental health disorders.

Recognizing that mental health disorders are chronic disorders leads to recognizing that their treatment should be held at the same standard as that for physical chronic disorders while not presuming that higher hospital readmission rates are the expected standard for people with mental health disorders. These hospital readmissions may be a direct representation of deficits in community-based treatment that only serves to hinder people from living their fullest productive lives as well as a result of the unique challenges and manifestations of chronic mental illnesses that challenge the health care providers who aim to help. In addition, treating chronic mental health disorders is difficult in general, especially when research is still working to improve treatments yet is struck by multiple barriers in access as well as in experimental trials and determining their efficacy for certain disorders. Steps forward should include recognizing there are greater health disparities and injustices for Americans with chronic mental health disorders than physical health disorders likely rooted in the stigma toward those with mental illness since the out-of-sight and out-of-mind institutionalization era on. Returning to a hospital is not necessarily a failure but offering more comprehensive, accessible, and extensive alternatives for those with mental health disorders could be a more positive alternative toward easing the readmission epidemic that haunts mental health.

## **IV. “Curing” the Inpatient Psychiatric Recidivism Epidemic**

Jay Greene, a reporter at Modern Healthcare Communications, once stated that for mental health, “Solutions exist, but they will have to overcome obstacles that have minimized people with those problems, placing them at a lower priority for funding and treatment than those with similar physical conditions such as diabetes, heart disease, or cancer” (Greene, 2019). This quote is multilayered and encompasses various significant concepts, while foreshadowing the comprehensive reformation that must occur to begin combatting the psychiatric inpatient recidivism epidemic seen across the country in the nation’s acute hospital units. Ultimately, change needs to happen at multiple levels in America: governmental institutions and legislature, insurance companies and healthcare providers/systems, and society and communities as a whole.

Creating effective solutions to address the readmission epidemic becomes increasingly significant when considering the economics that surround it. With the newest budget proposed by the Trump Administration for 2020, \$62 million dollars have been cut that once went to funding the National Mental Health Services Administration (CHEAC, 2019). This reduction means that the country has lost \$62 million toward research, programs, treatments, and more that could potentially reduce not only readmission rates for patients with mental health disorders but also the mental health crisis in the United States. A psychiatrist at G1 lamented cuts in the President’s new budget, asserting that the funding is simply not enough for meeting mental health needs (Ohm, 2019). But meeting the bottom-line economically is of utmost importance to many political leaders.

In addition, the severity of underfunding increases when considering that there is competition between different branches of medicine in how and where the money should be

used. This competition is so prevalent that another psychiatrist at G1 noted that, “the advocacy for a patient’s interest and the self-interest are sometimes very hard to even separate” (Leibovici, 2019). In reality, this competition is in the form of researchers advocating for more funding toward biomedical research, care providers on inpatient units advocating for more funding toward remodeling their unit, and so forth. Thus, a requirement for “curing” the recidivism epidemic is greater funding that can be allocated to research and to community-based programs and broader services that sustain those with chronic illnesses. But at present, with the competition for funding and the devastating budget cuts made by the President, the money allotted to mental health expenditures must be utilized in a way that alleviates costs elsewhere. By spending on solutions that reduce and prevent readmissions, the field of mental health would save money on the most expensive expenditure of all: hospital admissions. This phenomenon comes with spending more wisely and innovatively, investing in solutions that are preventive, comprehensive, and that address the true issues at their core.

Thus, the solution to the readmission epidemic that I will propose is complex and multifaceted. It involves efforts to reform insurance companies, expand pharmacotherapy research, and address the substance-use disorder crisis. In addition to these necessary components, I will be suggesting other innovations centered on community health that could be employed or, at the least, researched more. The components of this solution are geared toward addressing the specific disorders where recidivism appears to happen more frequently, such as more severe mental illnesses like schizophrenia. But comprehensive care would likely prove beneficial for any mental illness, even if high readmission rates are not characteristic of that disorder. Thus, we must first look toward alleviating institutional health disparities so that everyone can access the solutions created, regardless of identity and demographic details.

Second, services of various levels of care intensity must be established throughout the community; patients must have more acute options beyond an inpatient hospital admission to the psychiatric unit. Finally, we must place greater emphasis on alternative treatments. These treatments will not replace medication nor act as a second choice to medication, but rather be part of a comprehensive care plan for every patient that is discharged from a psychiatric unit. The goal of all of these changes and proposed solutions is to eliminate the health injustices experienced by patients with mental health disorders and fill the gaps that otherwise engender the revolving door of inpatient psychiatry observed up until this point.

### **Alleviating Health Disparity and Injustice**

Simply put, it would be completely trivial to design solutions, let alone implement them, if not everyone had access to them. The reasons behind this inaccessibility, health disparity and health injustices, are common to every illness, disease, disorder, or general need to seek healthcare. These health disparities are perpetuated by systematic injustices toward those placed in minority groups based on demographic factors such as socioeconomic status, sexual orientation and gender expression, race, citizenship, or age, and serve to inhibit those who identify with minority groups from accessing the same level of care.

In addition to these factors, consider other health disparities identified in the country as a whole and their associated statistics. For example, patients with mental health conditions covered by government-funded insurance had higher rates of readmission, approximately 40-75% higher readmissions, than those covered by private insurance companies (Heslin, 2015). In addition, patients with mental health disorders residing in the lowest income communities had a higher rate of readmission than those who lived in the highest income communities. It was also discovered that citizenships other than American were positively associated with hospital

readmission. In other words, individuals who immigrated to America experienced greater rates of readmission than American citizens. Finally, individuals in communities with a higher educational attainment had a lower likelihood of readmission (Kalseth, 2016). Hence, this data indicates that readmission is strongly correlated to systemic and environmental factors that cause health disparity.

Thus, the first step in “curing” the inpatient psychiatric recidivism epidemic is working toward eliminating health disparities. In dismantling systemic health disparities and injustices, patients of all demographic backgrounds will have access to pre-existing and new services which will likely effectively reduce readmission rates. In the words of Jim Haveman, the former director of Michigan’s state Department of Community Health from 2012-2014, “It is important to keep in mind that this is more than a place issue (hospital) but is a systemic issue that warrants implementing new models of integrated care” (Greene, 2019). This systemic issue, health disparity, will not be easily fixed as it has been fostered and reinforced for centuries.

But efforts can be made to chip away at this issue until health disparities are eliminated for the unforeseeable future. Places to start include reducing stigma through education and promoting patient dignity, establishing services in diverse communities and staffing them with capable and knowledgeable care providers, focusing on the cultural context for the patients a facility provides for, improving communication on all levels, and finally, developing new conversation around the healthcare of minorities that focuses on bridging the gaps found within their care (Frist, 2005). Ultimately, changes that will reduce institutional health disparities will be centered around educating care providers and learning from them what is most needed from their firsthand experiences, expanding resources to increase the accessibility and use of services in the community, developing personalized care that is unique for every patient, and finally,

altering the discourse to change long held stigmas against people with mental health disorders as well as against those whom identify with the minority in general.

Tangible proposals do exist, however, for addressing socioeconomic disparities that feed into the recidivism epidemic such as creating more services focused on the homeless population. According to Dr. Ohm in Rochester General Hospital's G1, homelessness is a key reason why people come to, and come back to, the hospital because they lack supports when on their own (Ohm, 2019). As a result, Dr. Ohm argues that the money allotted to mental health in the President's budget should go to the homeless project and be spent on developing open units that address housing for the population of individuals whom are both homeless and possess a mental health disorder (Ohm, 2019). Such housing would be more medically, socially, and cost-effective over time than hospital readmissions.

While services with open beds would effectively reduce the number of people with mental health disorders on the streets, there is a more comprehensive solution that would address all aspects of the comorbid homeless and mental health problem. This solution is in the form of integrated, shelter-based, collaborative mental health care. Services would ultimately coordinate care teams with other facilities and clinical resource management (Stergiopoulos, 2007). Unfortunately, this type of mental health model has not been subjected to significant evaluation to determine its effectiveness, especially in regards to the homeless population in the United States. There was a large study done in Canada, however, on a program entitled "Fusion of Care" developed at Seaton House, one of Canada's largest shelters for homeless men, that can be used as an example (Stergiopoulos, 2007). This shelter partnered with St. Michael's Hospital near Toronto, in which they designed an integrated continuum of care model that includes: on-site

medical support, flexible referral processes, one common client record, and in-house case management system.

Since 2004, a team of client service workers, counselors, nurses, physicians and psychiatrists from both Seaton House and the hospital have provided medical care and case management, with both direct and indirect consultations, to the clients in their 240-bed Hostel program. They have the capacity to serve 40 clients at a time and specifically target people who are chronically homeless, with greater mental health needs than what the community provides otherwise (Stergiopoulos, 2007). People who utilize this system meet with a counselor to set goals and complete a psychosocial assessment, meet with a nurse for a health assessment, and are additionally referred to a physician or psychiatrist who helps to develop a comprehensive care plan individualized for every client. With a working comprehensive care plan, the client service worker aids in adherence to the plan by escorting clients to appointments as well as taking care of other logistics while the nurse dispenses medications to clients daily (Stergiopoulos, 2007). While all of these clinical aspects are going on, clients are also assured shelter in Seaton House. Finally, as a whole, this program is supported by an alternative payment plan that was not greatly elaborated on but has not required any additional external funding.

In general, the “Fusion of Care” program in Canada provides comprehensive care that integrates hospital services with residential services to provide a seamless continuum of care to its clients. This continuum includes case management, treatment of acute care needs, discharge planning, and even more services that coordinate in-house, hospital, and community-based facilities (Stergiopoulos, 2007). With all three of these entities working in collaboration, certain gaps in the transition of care are effectively eliminated and all the different needs of people whom are both homeless and affected by mental health disorders are addressed. This cohesion

has therefore led to less hospital readmissions and, as a result, other less resourced and comprehensive shelters or hospitals refer their patients to this exact program when appropriate (Stergiopoulos, 2007). Thus, comprehensive and multi-dimensional systems of care show success in reducing the number of homeless individuals with mental health disorders whom are readmitted back to the hospital's acute care units. A system like "Fusion of Care" could be a tangible solution to the psychiatric recidivism epidemic in the United States in specific regards to health disparities based on socioeconomic factors, namely, homelessness.

To reiterate, systemic health disparities and injustices can only be eliminated with tremendous shifts at every level of American institutions and society. Alleviating these obstacles to equal care for all will remove the barriers to healthcare that patients face based on their identity. Essentially, eliminating health disparity "evens the playing field": it gives people equal access to services and treatments and shifts the causes of readmission to such services and treatments, or the lack thereof, instead of on the inherent flaws in American healthcare and society. Therefore, the solution becomes improving and expanding upon current services and treatments in addition to implementing new services that could replace hospital readmissions. Alternatives exist that need to be further tested for effectiveness and expanded to realize the benefits of community-based care.

### **Alternatives to Institutions and Hospitals: Crisis Centers**

In seeking treatment for physical illnesses and their associated symptoms, people can avoid emergency room and hospital visits by utilizing an urgent or immediate care service located right in the community. So why not create the same facility for the treatment of acute mental health needs? Communities should either implement or expand upon already existing mental health crisis centers, otherwise referred to as urgent care centers with walk-in care

(Greene, 2019). The general framework of mental health urgent care is essentially the same as that of an urgent care that treats physical illness: an individual with a medical problem is able to access adequate and appropriate diagnostic medicine, treatment, and referral if necessary at a center that is cheaper and less intensive than the emergency room or hospital in general. Urgent care has become part of the medical spectrum in the 21<sup>st</sup> century so the ideal is to add specific mental health care offices as just one more specialized center for common chronic disorders.

Mental health crisis centers have existed in various states across the country but have not received much emphasis nor funding to truly be considered widespread throughout communities, and thus lack a significant impact on people with mental health disorders and the readmission epidemic. A handful of crisis centers operate in states such as Michigan, California, and Arizona as well as the one in Rochester, NY (Greene, 2019). These crisis centers are typically staffed by more than a dozen mental health professionals including psychiatrists, psychiatric physician assistants and nurse practitioners, secretaries, technicians, and other relevant positions such as maintenance and environmental staff (Greene, 2019). In addition, many of these mental health urgent cares are open 24 hours a day and provide a full range of services including observation, assessment, and support or stabilization services.

To further conceptualize the form of these immediate care centers, consider the words of Bob Nykamp, COO of a large psychiatric hospital and outpatient mental health provider in Michigan. He states that of the individuals who seek care at a hospital's emergency department, 85% of them should not have gone there in the first place. He notes the similarities to utilizing a physical illness urgent care such that, "If you are playing basketball and break your ankle, you don't go to a hospital ER, you go to an urgent care...It is the same thing with mental health" (Greene, 2019). Nykamp's support for such mental health urgent care shows the value perceived

by an expert and does raise the question as to whether such care facilities are rare is because of the disparities in supporting those with mental illness in the community or the risks some might see or fear in bringing populations with mental health crises into many neighborhoods.

While crisis centers for acute mental health needs have benefits on paper or in theory, there are some barriers standing in the way of their widespread implementation specifically regarding state laws pertaining to mental health. For example, in the state of Michigan there are both regulatory and statutory obstacles standing in the way of opening psychiatric urgent cares. In Michigan these barriers include language in mental health codes that limits the amount of time patients can be held in preadmission screening units after a diagnosis is made as well as restricts centers from using restraints in emergency situations where a patient is aggressive. In addition, the state law restricts who can transport patients to and from non-hospital facilities which would effectively prevent the use of ambulances (Greene, 2019). Unfortunately, these barriers were created by laws written in the 1970s that have not really changed despite changes in treatment and mental health needs. In addition, these laws differ by state, but generally serve to limit the widespread utilization of mental health crisis centers.

States that do have crisis centers in their communities have worked to overcome those barriers. They collaborated with healthcare attorneys and legal forces to update laws and create “common-sense” rules that allow for mental health urgent care facilities (Greene, 2019). In addition, since trained healthcare professionals of both medical and psychiatric backgrounds are present in these care centers, they can be trained just as hospital workers are on restraints and the process therein. Thus, a step toward the benefits of mental health urgent care can occur if the time and effort is put in from political leaders and health providers along with public acceptance.

### **Alternatives to Institutions and Hospitals: “Halfway Houses”**

A similar intervention in the community to curb hospital readmissions is in the form of a facility at a level of care between that of a hospital and of a residency. In the words of one of Rochester General Hospital’s psychiatrists, “The major weakness is where patients who are failing can spend the night, short of being in the hospital at one end or being in group homes who have their own standard of behavior on the other” (Leibovici, 2019). The argument for a facility that would essentially be a step-down hospital but a step-up residency comes from the fact that not all patients who decompensate from their medication require acute care yet have failed their living arrangement agreed upon by their residence supervisor and care team. This gray area is characteristic of many patients who end up readmitted back to GI: they have either become aggressive with other residents or staff, began using substances again (or for the first time), or simply engaged in behaviors or actions that caused landlords or supervisors to believe that the individual was unwell.

This type of facility would require trained staff that are educated on how to treat and interact with patients who are in crisis, in addition to supplemental roles such as environmental and secretarial staff. Furthermore, there would have to be healthcare providers who can access patient medical records and dispense medication to help patients return back to their baseline in order to keep both patients and staff safe. Thus, the logistics of creating such services are difficult not only to design, but to actually implement. There have been attempts to isolate beds with appropriate care providers and staffing, but unfortunately these attempts have been greatly underfunded at consequence to the whole system of taking care of patients (Leibovici, 2019). A facility at this level and intensity of care would safely reduce the number of patients readmitted back to the acute care units of psychiatric hospitals as some patients merely require a minimal

amount of care while in crisis: medication and a place to stay other than the streets or with potentially negative influencers. Thus, in the long run, spending on trained and competent staff and housing facilities at the level of care between that of the hospital and of residences such as group homes or shelters would save money that would otherwise go toward hospital stays. This money could then be put back into these specific services or be distributed to other areas in the field of mental health. Again, with limited budget from the federal government, smart and intentional spending is of great importance.

### **Comprehensive Community-Based Care**

As a budding chemist and future medical doctor, I fully recognize that medication, in a general sense, works. Medications for various mental health illnesses undeniably eliminate the symptoms of those diseases for a majority of patients. This achievement is especially true for the atypical antipsychotics, or second-generation antipsychotics, that are used to treat patients considered to have the most “severe” mental health illnesses. These drugs, as well as those used to treat other illnesses, are essentially miracles in modern psychiatric medicine. But, once again, as a budding chemist and future medical doctor, I also recognize the shortcomings that accompany medication as well as the harm caused by overemphasizing both their use and impact.

American healthcare systems and insurance companies must therefore shift their lens of focus beyond medication to include more alternative treatments and programs that are generally designed to supplement medication with a few exceptions. The future of medicine is not just a prescription, a pill, or a medication. Instead, it is comprehensive care that includes treatments that aid medication, that work when medication fails due to negative side effects, general ineffectiveness, or nonadherence, and that ultimately improve quality of life and one’s human

experience by keeping people with mental health conditions in the community and out of the hospital. New and better drugs will still be a part of the process based on research still to be done.

### **Comprehensive Community-Based Care: More Than Medication**

The treatment model that integrates numerous components to engender comprehensive care is known as coordinated specialty care, or CSC. This treatment model effectively combines medication, case management, psychosocial therapies, family involvement, and supported education and employment services (National Institute of Mental Health, 2019). It is a compilation of recovery-oriented treatment programs that are staffed by health professionals and specialists who work with each patient to design tangible and individualized treatment plans. The National Institute of Mental Health even states that compared to traditional care for mental health disorders, CSC is more effective in reducing symptoms, improving quality of life, and increasing involvement in work or at school (National Institute of Mental Health, 2019). Thus, its implementation is strongly recommended.

These assertions are evidenced through extensive research in the “Recovery After an Initial Schizophrenia Episode” (RAISE) project. This project involved a large-scale research initiative that evaluated the effectiveness specifically of CSC (National Institute of Mental Health, 2019). In addition to being more effective than usual treatment approaches, findings of this research include: CSC can be successfully delivered in the community, it is cost effective, and clients feel that CSC treatment is truly helping them. The ultimate goal of both RAISE and CSC is to decrease the likelihood of future episodes of psychosis, that would cause readmission, reduce long term disability, and help people with mental health conditions live their lives as part of their community (National Institute of Mental Health, 2019). And while this model was

originally designed for the comprehensive treatment of persons with schizophrenia and associated “psychotic” disorders, it is my recommendation that it be implemented and expanded upon in the treatment of most, if not all, mental health disorders as they all require more than just medication.

The psychosocial therapy aspect of CSC is a beneficial addition to treatment not typically emphasized or widely used in American healthcare. In general, psychosocial treatments give people the opportunity to learn and use coping skills to address the everyday challenges that their mental health disorder, usually schizophrenia, creates. In fact, individuals who participate in regular psychosocial treatment are less likely to have relapses or be hospitalized as these treatments lead to greater compliance with other prescribed medications or therapies and improve overall functioning and quality of life (National Institute of Mental Health, 2019). Psychosocial therapies were developed in response to the various needs of people with mental health disorders that were not addressed by either medication or acute hospital care: problem-specific psychosocial treatment, family psychoeducation, day hospital/vocational rehabilitation and educational opportunities, access to crisis counseling, and supervised residential arrangements (Bellack, 2001). In addition, psychosocial treatment directly includes the patient as a partner in both treatment planning and goal setting. This aspect of their mission secures effective cooperation and ensures that treatment is done in collaboration with the patient, instead of done on/to the patient without their input.

As a result, there are a few general types of psychosocial treatment approaches designed to address the needs listed above. These approaches include social skills training, family psychoeducation, cognitive therapy that ultimately teaches patients coping strategies for controlling symptoms that medication has not subdued, and cognitive rehabilitation that

increases neurocognitive abilities such as memory, capacity, attention, and problem-solving skills (Bellack, 2001). In addition, there are self-help and social support groups that address feelings of isolation and help people gain insight into their mental health condition (National Alliance on Mental Illness, 2019). Modern medicine is shifting toward treating patients as whole beings, thus considering needs and contributing factors that may not be present as symptoms nor medically obvious. Psychosocial therapies are the mental health version of this shift and effectively address needs that medication cannot. Therefore, psychological and social treatments facilitate the adjustment of patients as they move from the hospital back into the community, thus bridging the gaps in the transition of care and ultimately preventing readmission back to the hospital.

Another component of Coordinated Specialty Care, the wholistic approach used in caring for the whole person, is supported education and employment programs. Such programs are designed to develop life-management skills, provide vocational or educational training, and find employment for individuals with mental health disorders that can be sustained (American Psychiatric Association, 2017). While these programs could look vastly different depending on employment needs in each state, there are general frameworks for the different kind of support employment services that should be implemented. The first is vocational rehabilitation which would provide career counseling and job search assistance for individuals with mental health conditions (National Alliance on Mental Illness, 2015). Essentially, trained staff would guide people through application, hiring, and employment processes in addition to matching them with work that could be sustained in the long-run. These tasks involve evaluating both employee and potential workplace to estimate compatibility as well as consider potential conflicts.

Thus, vocational rehabilitation goes hand in hand with what is known as Individual Placement and Support (IPS) supported employment. These programs utilize evidence-based research that helps people with mental health disorders find jobs that match their own individual strengths, passions, values, and schedules as well as other logistics such as location or transportation (National Alliance on Mental Illness, 2015). Teams of employment specialists and healthcare providers accomplish these matchings and even provide continuous support, once a job has been secured, to ensure success and longevity.

Finally, if individuals with mental health illness are not quite ready to enter the workforce, there should be services in place not only to guide them through that period but to prepare them for future employment. A series of facilities that bestow these goals are termed “clubhouses.” Such clubhouses are community-based centers that give clubhouse members, people with mental illnesses, the opportunity to gain skills, find housing, pursue education, and search for jobs (National Alliance on Mental Illness, 2015). In addition, clubhouses offer social events, classes, and weekend activities that members may attend. For those who are in transition, possibly between the hospital and going back to work and community life, a service like clubhouses can provide slightly more intense assistance while still allowing the individual to engage in activities that bring them happiness and improve their overall quality of life.

Clubhouses, Individual Placement and Support, and vocational rehabilitation are all general frameworks for constructing supported employment programs. If people with mental health disorders had access to employment, hospital readmissions may effectively be reduced: people would have a sense of purpose and attainable goals to work toward, regimented schedules, income to pay for medication and other therapies, a new support network at both work and in the supported work programs, and maybe even new health insurance coverage. When

systems that address every aspect of a patient's life are present in the community, patients are typically able to successfully stay in the community.

Along the same lines as providing more support in the community to individuals with mental health disorders, is using technology to expand resources that are both fast and accessible. This advancement is in the form of 24/7 "e-Health": utilizing technologies such as the telephone, internet, and mobile devices to provide health interventions to people in areas where mental health professionals may not be easily available (National Institute of Mental Health, 2019). These approaches may involve a therapist or psychiatrist providing help from a distance while others, such as websites or apps without chat or video software, may provide information and feedback in the absence of a "live" health professional. The research on the concept of e-Health demonstrates that it is not a perfect science; using electronic media to aid in some situations is helpful while for other situations it is not as of yet (National Institute of Mental Health, 2019). Additionally, whether e-Health should be used alongside other in-person care or could replace it altogether is up for debate. Thus, more research into this matter as well as e-Health's true effectiveness is needed in addition to recognizing that evaluation fluctuates with every condition, situation, and individual.

### **Comprehensive Community-Based Care: Are Pills Really the Answer?**

I asked Dr. Leibovici, a psychiatrist in Rochester General Hospital's inpatient psychiatric ward whether Americans overemphasize and focus on medication too much? He responded that a lack of tolerance for things that are less than optimal and a desire to fix them by any means leads to a world where people thirst for explanations and a society that necessitates solutions (Leibovici, 2019). Essentially, a certain expectation has developed in American culture where anything that causes discomfort or is different from the arbitrarily constructed "normal"

narrative, regarding either mental or physical health, requires quick and easy solutions that suppress symptoms and, generally, eliminate the disease or condition. While I would never argue that illnesses should go untreated, what if people alternatively learned to live with certain conditions without the symptoms of those conditions detracting from their overall quality of life? This suggestion is arguably more abstract than the idea of a pill or drug and will inevitably require greater intervention, time, and development of practices. But alas, it might overcome challenges for some that struggle with medication and might work toward “curing” the recidivism epidemic. The Soteria paradigm is an innovative solution of this kind worth evaluating.

The Soteria paradigm was developed as means of treating schizophrenia and associated illnesses, the mental health disorders with the greatest incidence of hospital readmission. It was created as early as the 1960s and early 1970s in an effort to provide therapeutic community alternatives to both medication and hospitalization in the treatment of schizophrenia (Calton, 2008). The central tenet of these programs, both then and now, was understanding schizophrenia not as an illness with symptoms that required suppression by medical intervention, but as an aspect of an individual’s life and history. Therefore, programs following the Soteria Paradigm give people with schizophrenia the option to choose if they want medication. If so, medication is typically given in smaller doses than what many psychiatrists prescribe. If not, and even in cases where low-dose antipsychotics are used, individuals are guided through their experiences of psychosis and schizophrenic symptoms with high levels of support. The specific components of these high levels of support include: community-based therapeutic milieus with significant lay person staffing, patient autonomy and personal power, social networks, communal responsibilities, and arguably the most important of all, a relational style, maintained between

supportive staff and the patient, which aims to give meaning to an individual's subjective experience of delusions or hallucinations by developing an understanding of them in the appropriate context (Calton, 2008). Essentially, the Soteria Paradigm allows people to live with schizophrenia by engendering an understanding of the symptoms, typically hallucinations or delusions, within any given situation.

Thus, treatment in the Soteria Paradigm overcomes some obstacles or challenges of medication when used alone. Decompensation, that sometimes occurs when patients stop taking medication, may be less likely to occur under the Soteria paradigm, as patients have learned to understand their disorder and its associated symptoms. Similarly, there are no harmful side effects such as those from medication, as Soteria paradigm practices are "phenomenological" in essence and are centered around natural communication and thinking processes (Calton, 2018). Ultimately, the Soteria paradigm does not look to suppress symptoms nor remove them. Instead, it creates healthy practices that allow people with these disorders to live full and meaningful lives while simultaneously making sense of the symptoms they experience.

While this endeavor has not been widely accepted across the United States, other than in states such as California, it has grown in the United Kingdom. There, the Soteria paradigm was subjected to quantitative empirical research via randomized controlled methodology, the gold standard in modern data collection, and deemed just as effective as traditional hospital-based treatment even without the use of antipsychotic medication as the primary treatment and at a lower overall cost (Calton, 2008). As a result, patient choice in regards to medication sits at the center of governmental health reforms in the United Kingdom, with advocacy toward shifting to an evidence-based and patient-centered mental health care system. Furthermore, in the United Kingdom, a national Soteria Network was formed, an inaugural conference was held, and the

development of a “Soteria House” was discussed (Calton, 2008). Thus, the Soteria paradigm shows promise for future research and developments and even suggests positive shifts within the entire framework of governmental healthcare. The radical ideas and practices associated with the Soteria paradigm, if adopted and implemented in the United States, might benefit some with mental health disorders and effectively reduce hospital recidivism rates. The risks of patients not taking medicine might also increase recidivism so each innovation must be tested with aims for better care with safety as the first concern.

Daisaku Ikeda, a Japanese Buddhist philosopher, educator, and nuclear disarmament advocate, stated, “No matter how complex [global] problems may seem, it is we ourselves who have given rise to them. They cannot be beyond our power to resolve” (Daisaku Ikeda). Even though this statement was made in regards to worldwide issues, I believe that it can be applied to problems of smaller scale, specifically the inpatient psychiatric readmission epidemic that affects people with mental health disorders across the United States. Although this issue is both complex and deeply rooted in the history of mental health in America, it is not “unsolvable.” It is the responsibility of current political officials, healthcare providers, and citizens in their communities to take the necessary steps toward reformation. Solutions are numerous, multifaceted, collaborative, comprehensive, and maybe even a little radical, but nonetheless, they do exist. It thus becomes a matter of integrity, diligence, and not relying solely on the simplest solution, namely medication, in treating mental illness.

Implementing any or all of the aforementioned solutions has the possibility to help those with chronic mental illnesses and effectively reduce hospital readmissions: eliminating health disparity, creating more options in the community than just acute psychiatric units in general hospitals, supplements to medication, and even alternatives to medication. And based on

numbers presented previously, even if only one patient were kept from going back to the hospital for only one day, more than \$4000 would be saved in that day alone. Therefore, while solutions will be costly, they will save in ways where hospitalization once caused great debt. Ultimately, the solution boils down to preventative medicine that is patient centered, individualized, and comprehensive across all facets of an individual's life and intentionally provided for in budgeting. Furthermore, solutions and resources need to be adequately communicated to patients whereupon they receive education about all of their treatment options and how to access them.

## V. Conclusion

Imagine having arthritis, a chronic physical condition, that causes degeneration of the cartilage in your knee. The primary medical intervention would be surgery. The treatment of this physical ailment would not, however, end there: you may be admitted to an inpatient orthopedic floor, given medications for inflammation and pain, and given a regimented schedule for physical therapy and rehabilitation. In the simplified long-run, surgery will allow you to walk again while all other components of your care will allow you to run and jump. Now, if you were instead to have experienced a mental health crisis and be diagnosed with schizophrenia, the primary medical intervention you would receive is an antipsychotic. Taking this drug would permit discharge from the hospital but might often serve as the only form of treatment available in the community. Metaphorically speaking, medication will allow you to walk again, but there may not necessarily be alternative treatments in the community or you may not be able to access them that will allow you to run and jump again.

The fact that disparities in the treatment of mental health often only hold weight or gain significance when comparing them to the comprehensive treatment of physical health speaks great volumes about the challenges in our mental healthcare system at present. The deficiencies in mental health care treatment in the community, which are undeniably rooted in the history of mental health in America and the long-held stigma surrounding it, have actively engendered the revolving door of inpatient psychiatry observed in the acute psychiatric units of general hospitals across the country.

It is important, however, to avoid being too critical of the mental health care system as a whole. Such strong criticism could discourage patients from having hope that mental health

services can help and furthermore, does not support others in the field who are working toward advancing and improving treatment and the system. But on the other hand, it is important to discuss problems or deficiencies within the system, especially when it is imperfect, as that is how change is often provoked. As a future healthcare provider, it will be an ongoing journey to strike the necessary balance between motivating and supporting other professionals in my field to continue their hard work in healthcare and research while still advocating for patients, even if that means challenging the problems within the system. Thus, a congruence of factors, research, comprehensive healthcare, and continued advocacy, will make impactful and powerful change possible.

Alas, there is a “cure” to this recidivism epidemic: a cure that finally fulfills President John F. Kennedy’s fervor, in 1963, for the transition of the treatment of mental health to “the open warmth of community concern and capability.” The solution begins with eliminating health disparities for all, creating equal access to the programs and services that should be implemented, followed by actually developing such programs and services in the community, addressing the challenges in implementation of evidence-based treatments, and further researching complex readmission or “frequent flyer” cases. Furthermore, these community-based treatment options need to be multifaceted, comprehensive, and wholistic in the resources they provide.

The recidivism epidemic can and should be cured: not only do people with mental health disorders deserve more but many largescale incidences of violence in America are blamed on mental health and are followed by the public and political figures demanding reformation in the treatment of mental health. This kind of pseudo-advocacy greatly perpetuates the stigma of those with mental health issues, is consistently contradicted by budget cuts in funding toward mental health, and is used as a reason, by the President, in suggesting a return to a system of

institutionalization. Thus, in reforming the treatment of mental health to enhance community-based services and reduce the readmission crisis, an even greater impact is made: people with mental health disorders will stay out of the hospital, avoid the possible threat of returning to institutionalization, and have the ability to live their highest quality of life.

Finally, according to the latest statistics, in 2019 almost half of the adults living in the United States had experienced a mental illness within their lifetime (Kapil, 2019). With a number that great, it is almost inevitable that anyone reading this thesis is either affected by mental illness themselves or knows someone else who is affected. Therefore, it is imperative that we work toward changing the narrative for those with mental health disorders in America and curing the inpatient recidivism epidemic is only the beginning. This reformation will ultimately save significant money over time for both private and public insurance companies and hospitals, and more importantly save lives, thus eliminating the quandary that plagues a system now often trapped in a bottom-line versus baseline focus that might seem to be blind to patients needs as in the era of institutionalization.

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