

The Modern Asylum

By Christine Montross

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LAST month, three ethicists from the University of Pennsylvania [argued](#) in the Journal of the American Medical Association that the movement to deinstitutionalize the mentally ill has been a failure. Deinstitutionalization, they wrote, has in truth been “transinstitutionalization.” As a hospital psychiatrist, I see this every day. Patients with chronic, severe mental illnesses are still in facilities — only now they are in medical hospitals, nursing homes and, increasingly, jails and prisons, places that are less appropriate and more expensive than long-term psychiatric institutions.

The ethicists argue that the “way forward includes a return to psychiatric asylums.” And they are right.

Their suggestion was controversial. Critics argued that people should receive treatment in the least restrictive setting possible. The Americans With Disabilities Act demanded this, as has the Supreme Court. The goals of maximizing personal autonomy and civil liberties for the mentally ill are admirable.

But as a result, my patients with chronic psychotic illnesses cycle between emergency hospitalizations and inadequate outpatient care. They are treated by community mental health centers whose overburdened psychiatrists may see even the sickest patients for only 20 minutes every three months. Many patients struggle with homelessness. Many are incarcerated.

A new model of long-term psychiatric institutionalization, as the Penn group suggests, would help them. However, I would go even further. We also need to rethink how we care for another group of vulnerable patients who have been just as disastrously disserved by policies meant to empower and protect them: the severely mentally disabled.

In the wake of deinstitutionalization, group homes for the mentally disabled were established to provide long-term housing while preserving community engagement. Rigorous regulations evolved to ensure patient safety and autonomy. However, many have backfired.

A colleague of mine who treats severely disabled patients on the autism spectrum described a young man who would become agitated in the van on outings with his group home staff. Fearing the man would open a door while the vehicle was moving, staff members told his family that he would no longer be permitted to go. When the parents suggested just locking the van doors, they were told that this infringed on patients’ freedom and was not allowed.

Group homes have undergone devastating budget cuts. Staffs are smaller, wages are lower, and workers are less skilled. Severe cognitive impairment can be accompanied by aggressive or self-injurious impulses. With fewer staff members to provide care, outbursts escalate. Group homes then have no choice but to send violent patients to the psychiatric hospital.

As a result, admission rates of severely mentally disabled patients at my hospital are rising. They join patients who are suicidal, homicidal or paranoid. We have worked to minimize the use of restraint and seclusion on my unit, but have seen the frequency of both skyrocket. Nearly every week staff members are struck or scratched by largely nonverbal patients who have no other way to communicate their distress. Attempting to soothe these patients monopolizes the efforts of a staff whose mission is to treat acute psychiatric emergencies, not chronic neurological conditions. Everyone loses.

The problem is compounded by the fact that group homes often refuse to accept patients back after they are hospitalized. One of my patients with severe autism and a mood disorder is on his 286th day of hospitalization. Another with autism and developmental disability has been on the unit for more than a year. Insurance companies won't pay for inpatient admission once patients are no longer dangerous, so the cost of treatment is absorbed by the hospital, or paid for by taxpayers through Medicaid.

So institutionalization is already happening, but it is happening in a far less humane way than it could be. The patient with autism who has spent a year in a psychiatric hospital is analogous to the patient with schizophrenia who has spent a year in prison: Both suffer in inappropriate facilities while we pat ourselves on the back for closing the asylums in favor of community care.

Modern asylums would be nothing like the one in "One Flew Over the Cuckoo's Nest." They could be modeled on residential facilities for patients with dementia, who would have languished in the asylums of yore, but whose quality of life has improved thanks to neurological and pharmacological advancements.

Asylums for the severely mentally disabled would provide stability and structure. Vocational skills would be incorporated when possible, and each patient would have responsibilities, even if they were carried out with staff assistance. Staff members would be trained to address the needs of minimally verbal adults. Sensory issues often accompany severe intellectual disability, so rooms with weighted blankets, relaxing sounds and objects to squeeze would help patients calm themselves.

Facilities for chronically psychotic patients would have medication regimens and psychoeducation tailored to the needs of those living with mental illness.

Neither my chronically psychotic nor my mentally disabled patients can safely care for themselves on their own. They deserve the relief modern institutionalization would provide. Naysayers cite the expense as prohibitive. But we are spending far more on escalating prison and court costs, and inpatient hospitalizations. More important, we are doing nothing about the chaos and suffering in patients' lives.

We can't continue to abandon our most vulnerable citizens in the name of autonomy.

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