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Inpatient Psychiatric Rehabilitation:
An Alternative to Bringing Back the Asylum

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Abstract
Recent recommendations by medical ethicists advocate for the return of asylums to improve long-term psychiatric care for individuals who have treatment refractory psychiatric conditions. Long-term inpatient psychiatric hospital environments are not conducive to learning tenancy and recovery skills necessary for optimal community integration. Psychiatric rehabilitation and alternative community interventions provide greater opportunities for learning practical and recovery-oriented skills. Increasing evidence-based psychiatric rehabilitation interventions in the inpatient setting while adequately funding community-based service options is a better alternative. Returning to the asylum-model of long-term psychiatric treatment will harm advances made in the field of psychiatric rehabilitation and the reduction of stigma.

Keywords: Psychiatric rehabilitation, recovery, hospitals, severe and persistent mental illness, medical ethics

Introduction:

Sisti, Segal, and Emanuel (2015) asserted that long-term institutionalization is the “optimal” course of treatment for individuals diagnosed with treatment refractory severe and persistent mental illness. Their opinion was offered despite long-standing contradictory evidence. In a 32-year longitudinal study of long-stay

patients, researchers found that 50-75% of participants achieved considerable improvement or recovery following discharge (Harding, Brooks, Ashikaga, Strauss, & Breier, 1987). Rather than press for the return to newer versions of the "asylums" of old, a more ethical approach would be to advocate for the increase in funding and support for evidence-based practices (EBPs), including psychiatric rehabilitation, in the least restrictive community setting. In some cases, inpatient hospitalization may serve as the least restrictive community setting for periods of time for individuals with significant psychosocial impairment. Therefore, such settings must increase their provision of interventions aimed at restoring or improving upon previous skills individuals require to live fully integrated lives in the community.

We agree with Sisti, et al, (2015) on one point: inpatient institutional settings should be safe and modern. They should also utilize scientifically proven interventions to improve individualized outcomes. State psychiatric hospitals are a vital component in the continuum of psychiatric services. These hospitals serve individuals during periods when they cannot otherwise remain in the community due to dangerousness to self or others.

However, psychiatric inpatient facilities often do not provide an environment in which individuals living with psychiatric disorders can best learn and practice the skills necessary to improving community integration. State psychiatric hospital services should be further integrated within a continuum of community services in order that persons can be served in the community wherever possible and appropriate (National Association of Mental Health Program Directors, 2014). Integration begins by psychiatric rehabilitation practitioners being increasingly included into the hospitals' staffing, bringing with them the ability to inspire the change from a culture of stabilization and maintenance to one of action and improvement. For far too long, psychiatric rehabilitation has been emphasized in the community-based setting alone. Increasing psychiatric rehabilitative interventions in the inpatient setting may contribute to the paradigm shift our aging institutions urgently require.

Large psychiatric hospitals frequently lack high-fidelity evidence based treatment interventions and practices. These settings are large and change happens slowly. It is imperative for any initiative to be championed by and monitored by leadership. For EBPs to be effective, they must be delivered with fidelity to intended clinical standards.
Without adequate clinical supervision within institutions, it is difficult to achieve delivery of high-fidelity EBPs. Until clinical service settings can administer EBPs as they are developed and studied, the problem of the imperfect and inadequate application of research to clinical practice will persist (Dixon, L.B., Dickerson, F., Bellack, A.S., Bennett, M., Dickerson, D., Goldberg, R.W., Lehman, A., Tenhula, W.N., Calmes, C., Pasillas, R.M., Peer, J., & Kreyenbuhl, J., 2009). Hospital executive administrators and senior state governmental leaders must be supportive of the human and financial resources required to effectively implement EBPs. It is our role as psychiatric rehabilitation practitioners to advocate to these stakeholders. There are benefits for the service participants and long-term cost-savings to communities when individuals recover and require shorter and less frequent hospitalizations.

An institution is not a home. In accordance with the Olmstead v. L.C. United States Supreme Court decision, States are required to place persons with mental disabilities in community settings rather than in institutions when they have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities (Olmstead v. LC, 1999). Advocating for the long-term institutionalization, without also emphasizing the need for efficacious interventions, violates the spirit and intent of the Olmstead legislation. Withholding an individual's right to take risks that may allow them to grow and flourish inside and outside of the inpatient environment seems inconsistent with the traditional medical model value to "do no harm." Psychiatric recovery is not a linear process and individuals may experience periods of sustained wellness interrupted by instances of symptom relapse. The learning that occurs along the way, during either period, is

essential to one's personal recovery process. This learning can occur in the inpatient setting if rehabilitative programs are implemented effectively and receive ongoing administrative and organizational support. Psychosocial factors other than symptoms severity contribute to an individual's successful community tenure. Factors regarded as important for recovery include empowerment, hope, optimism, knowledge about illness and services, life satisfaction, increased self-esteem, self-respect, improved self-control over symptoms and stress, social connectedness, social relationships, and social support (van Gestel-Timmermans, Brouwers, Bongers, van Assen, & van Nieuwenhuizen, 2011). Recovery is possible despite the presence of manageable psychiatric symptoms. The findings by van Gestel- Timmermans, et al. (2011), indicate the need for increasing opportunities for individuals to strengthen their occupational and tenancy skills while hospitalized. Individuals may require acute intensive services when they experience a recurrence of distressing symptoms, however, by aiding individuals in building support networks and developing skills necessary to "life after the hospital," individuals can learn techniques to manage symptoms distress and strengthen their roles as citizens in the community of their choice.

Traditional long-term institutionalization should not be the only option.

Psychiatric hospitalization, when offering psychiatric rehabilitative services, should be among the evidence-based offerings in a well-integrated continuum of behavioral healthcare services available to service participants. Pratt, Gill, Barrett, and Roberts (2014) present several brief alternatives to long-term institutionalization for individuals experiencing significant psychiatric symptoms. These approaches include crisis residences, peer-delivered crisis services, partial and day programs, in-home crisis services, and early intervention teams (Pratt, et al.). At an intermediate level of care, short-term care units can further stabilize individuals who are unable to be stabilized in a less structured community or voluntary inpatient setting. This reduces the need for admission to state psychiatric hospitals and provides local communities with more intensive treatment alternatives. Short-term care units are often accessed via a psychiatric screening commitment when an individual has been deemed a danger to self or others.
This option keeps the individual in their community and does not disrupt connection to local mental health providers, social services, and natural supports.

We do not consider hospital confinement, as it exists today, the optimal course of treatment for practically any other group of medical conditions other than severe and persistent mental illnesses. Individuals make decisions on a daily basis that may hasten negative consequences of chronic illnesses such as diabetes, hypertension, and hyperlipidemia. Are these individuals not contributing to a possible early demise by being "non-compliant" with treatment recommendations? They may even be contributing to increased healthcare costs for the nation due to the secondary conditions brought on by poor management of their primary health conditions. Couldn't the poorly managed diet of the individual with diabetes cause a fluctuation in blood sugar, loss of consciousness, and a traffic accident (when that individual is behind the wheel) jeopardizing the safety and welfare of the public? If that sounds ridiculous, it is meant to be. Let's remember that we are not talking about persistently dangerous people. We are talking about a minority of the individuals diagnosed with severe and persistent mental illness who, episodically, exhibit behavior that is deemed unsafe. If we say that we desire mental health care parity with traditional primary health care, we must enforce parity on both sides. Equality for individuals living with mental illness will only come when the providers and leaders in this field walk their own talk. This change will not occur without psychiatric rehabilitation practitioners advocating for a change to inpatient settings.

In 1963, President Kennedy promised people with severe and persistent mental illness that they would be treated in the community and funds once used for psychiatric incarceration would follow them into the community. We find it unethical and counter- therapeutic to break that promise and revert to a system that didn't work the first time.

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