Fueled by optimism

I compliment Dr. Nasrallah for his courage and candor, which represents a deep commitment to the mentally ill and our society. He has articulated what many in our professional community strongly believe but don't dare say publicly. I believe his message merits a broader dissemination, especially to policy makers. Thought leaders such as Dr. Nasrallah can make a difference by launching an educational campaign and start a new kind of advocacy movement.

Although I agree that patients with schizophrenia have suffered a great deal, a deinstitutionalized mental health system has limited means to care for patients with other psychiatric disorders. Increasingly, we see inpatients with multiple psychiatric morbidities along with Axis III issues. Traumatic psychopathologies, substance use disorders, and personality disorders constitute an incomplete list of conditions that cripple our patients who need longer and better care than they receive in the current therapeutic climate.

Substance use disorders are present in approximately 66% to 75% of admissions. Patients need care under 1 roof for substance use disorders and other co-occurring disorders concurrently rather than sequentially. After acute detoxification, patients are discharged from the hospital hoping to be accepted in a recovery program. However, by the time an inpatient substance abuse rehabilitation bed is available, the patient often has returned to chemicals or maladaptive behaviors, which leads to missed opportunities and unintended complications, namely treatment failure and resistance.

The eternal optimism that fueled the deinstitutionalization movement continues to nibble at inpatient and outpatient infrastructure. Over the years, fiscal forces have sliced mental health into 3 artificial compartments: mental health, addiction, and mental retardation and developmental disorders. Additionally, parity issues continue to block equal care. Managed care is leading to mechanical care—the patient is barely in the hospital and he is out. The ability to engage in thorough diagnostic assessment is limited by pressure to discharge patients.

Aftercare planning assumes unlimited access to care and the same optimism and zeal as deinstitutionalization advocates possessed. We tend to be oblivious to real issues such as uninsured or underinsured status and unmet basic needs. It is not surprising that nearly two-thirds of discharged patients do not return for their first follow-up appointment. If a discharged patient acts out, he is put in jail as if he is guilty of being mentally ill—a case of double discrimination.

Society supports expanding our jails and prisons more than state psychiatric hospitals. Is this a case of being "penny wise and pound foolish" and further stigmatizing mental illness? I agree that labels such as "dual diagnosis" are euphemisms. I also submit that categorizations such as "seriously ill" or "severe and persistent mental illness" could minimize the suffering of others who might benefit from what "asylum" treatment settings used to offer.

Diagnostic principles expect us to identify associated disorders, so-called comorbidities. The attributes of the correctional system—for example, understaffing—and outpatient infrastructure—such as provider musical chairs—do not maximize the diagnostic rigor needed to properly diagnose psychiatric illnesses and perform subsequent re-evaluations. Even in state hospitals inpatient days are shrinking, which in turn takes away the time clinicians need to perform a comprehensive diagnostic assessment—a prerequisite for good treatment planning.

One envies stalwarts such as Kraepelin and Bleuler whose genius we remember because they came of age with the "asylums." These guys had the time but not many tools. Now we have many more tools, but we do not have time. However, I hope that common sense will prevail, and our society will advocate for a continuum of care that recognizes a legitimate role of "asylum" as outpatient health care.

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