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ASCP Corner

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Psychopharmacologists and the Medical, Legal, and Societal Problems of the Homeless Mentally Ill: An Opinion

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Someday we'll have a penicillin for Schizophrenia and we won't be allowed to use it.

—Charles Shagass, MD (personal communication)

On a daily basis, the media as well as our medical journals are filled with the complex issues of unsolved and worsening problems relating to society and the medically-psychiatrically-ill-homeless interaction.[1] In this ASCP Corner, we speak to that issue for physicians like us, who have to helplessly walk by these unfortunate sick homeless individuals every day without taking action but feeling terrible and demoralized about what we see. What hasn't been addressed is how we as psychopharmacologists are constrained from intervening to help without having better supportive medical and legal systems to save the lives of this population. There is a disconnect between the psychopharmacologists who want to treat and the laws that don't let them.

The Problem

There is clearly an epidemic of homelessness in the US. Although specifics vary by locale, the California Policy Laboratory at UCLA found that mental health cases affected 78% of the unsheltered population, who also had a substance use rate of 75%.[2] Even worse, most of these people had associated medical or surgical problems and chronic disabilities.

For many if not most of these individuals, being on the streets is the end result of long-standing psychiatric illness marked by brain dysregulation and damage plus medical diseases. Despite our medical and psychiatric training and strong desire to help the acutely and chronically ill, both we physicians and our legal colleagues historically have *not* determined a way to effectively aid those ill individuals who are often on the street, bewildered and shouting at phantoms. A person bleeding or screaming in the midst of a coronary attack would get help immediately, and there would be existing hospital and community facilities to deliver the needed acute and long-term care.

For our communities, people living on the street are a health, legal, policing, and quality-of-life problem. From a policy perspective, providing money for more housing is not the solution. Much more is needed.

When we ask clearly sick individuals if we can help or call for help, frequently they refuse or walk away often angry. Nobody takes responsibility for their help-rejecting plight. Is this a failure of the medical profession? Or is this a failure of a broken system involving police, mental health care services, judges, and conservators?

Paradoxically, the social and legal expectations concerning medical practice prevent medical intervention. The most important barrier is that within the usual rules of the doctor-patient relationship, patients must voluntarily agree to specific medical interventions even though they do not voluntarily present themselves for care.[3] Although some persons with psychiatric illness seek care, the homeless subset often have reasons that leave them unlikely to voluntarily seek medical care. They are on their own, and without the police power of the state to empower them, psychopharmacologists are left unable to help.

The assumption by laypeople that an ill street person is acting rationally is sometimes correct. However, the knowledgeable doctor sees multiple signs of what the late Donald Klein called "subverted rationality," ie, lacking usual or normal mental clarity, coherence, and/or understanding, usually due to brain disease. However, the very notion of subverted rationality as due to a treatable involuntary affliction is a modern concept that has not been incorporated into our social and legal views (Donald F. Klein, MD, personal communication, 2018).

The Human Cost

For us psychiatrists, psychopharmacology is a paramount intervention. After provisional diagnosis, medication is almost always the next step.[4] Medication is needed for a *DSM* disorder, which for example may be compounded by brain damage secondary to a substance use disorder. For psychopharmacologists, to be effective requires we be able to give medication against the patient's (and their advocates') will—thereby taking away their freedom while overriding the sick person's desire to leave things as they are. It may mean giving long-acting injectables to those at high risk for nonadherence because of the negative consequences of inadequate treatment.[5] The longer ill persons go without successful resolution of psychosis, the harder it becomes to achieve a successful antipsychotic response. The more times persons with serious mental illness interrupt successful medication treatment, the harder it becomes to get treatment response even to the same agents that worked previously.

What Needs to Be Done—Psychopharmacologically and Otherwise

The remedy for a medical-help–rejecting, often delusional and hallucinating person must include a change in the legal rules that govern treatment. Presently the police might be called if there is a public disturbance or violent behavior, but police are not social service workers. When they encounter a person living on the street, they do not usually know that person's mental health history, whether medication was recommended or is needed, or any history of hospitalization or conservatorship. So, they move on.

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Even for those taken to a mental health receiving center for crisis evaluation, ensuring appropriate treatment—especially medication—too easily fails, especially when the ill person refuses treatment or gives lip service with a promise to engage in outpatient treatment after release. For both the police and the mental health centers, operating in an environment where judges tend to favor releasing persons from involuntary detention so as not to "interfere with their freedom," much of the work becomes futile if there is no adequate follow-up for those who need involuntary treatment. Those who need treatment but cannot see the need too often are released to live again on the street.

Once on conservatorship, the situation may be better, but even so too many individuals who cannot stay in treatment are released from conservatorship prematurely. There may be many reasons, but key among the reasons for premature release from conservatorship (or commitment in some states) comes down to grave disability laws not giving judges clear guidance, leading to impromptu and idiosyncratic interpretations of the intent of the legislation.

In a better future state, we recommend the following steps:

- The use of well-trained Crisis Intervention Teams that can be called to assist with nonviolent behaviors suspected due to mental illness.
- Sufficient crisis units to acutely assess, diagnose, and treat mental illness with needed psychopharmacologic treatment on an involuntary basis.[4]
- Enhanced use of long-acting injectable medication for individuals who are unable to adhere to a medication program due to impaired decisional capacity is needed.[5] In our experience, patients and their significant others over time thank us, not sue us (as the advocates would argue).
- With either voluntary or involuntary treatment, appointment of a significant other or designated long-term case worker to monitor those with chronic severe mental illness and ensure living and treatment needs are met.[6]
- Revisions of laws to more specifically and adequately address the issue of impaired decisional capacity—the legal companion to subverted rationality. In the courtroom, judicial decisions regarding involuntary treatment need to focus on lack of insight into having a disorder, the need for medication, and the ability to perceive actual benefit achieved from treatment. An individual's track record of failing to cooperate with needed treatment should also be central, since current code does not clearly include that history as a consideration when determining need for conservatorship.
- Judicial support of long-term conservatorships or commitments so that premature release from conservatorship becomes less likely.
- Adequately funded and staffed community-based programs like Assertive Community Treatment (ACT) teams for those seriously mentally ill who need intensive, outreach support to sustain in the community.[7]
- Long-term hospital type housing to keep these persons from returning to the streets.[8] Those who are severely cognitively impaired may never be able to live independently outside a structured, humane setting. Some who cannot be rehabilitated enough may never leave this setting. For these individuals, this help may save a life or spare them from assault, rape, or robbery on the streets.[6] It can also keep decisionally impaired patients in treatment. Use of Institutions for Mental Disease (IMDs) can serve persons whose treatment needs cannot be met in the community—they can be placed in these institutions to provide food, clothing, and shelter while their behavior is closely monitored in a locked setting and needed medication administered.
- Funding for care that follows the patient. The homeless mentally ill sometimes migrate from town to town or state to state. The current system that incents states to drive the mentally ill to other states to hold down local fiscal obligations needs to end. Any locality should be able to tap funding to cover psychiatric medical needs wherever that patient moves. Funding for a revised medical and legal system should be federally based, because the population need is an interstate, although mostly urban, problem.[9]

This issue is complex and difficult to solve. It will cost money, and it will take time. It will require a campaign with strong medical leadership. To help the patients we serve, as well as the society we all live in, now is the time for psychopharmacologists to work with political and legal institutions to create systems to meet the needs of this population, who fail to receive sustained treatment, especially medication, over a lifetime.[10]

We should not just look or walk away and take no action. Saying it another way, we cannot help patients "while ignoring the world in which they live."[11(p1083)]

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REFERENCES

1. Rosenbaum L. Liberty versus need—our struggle to care for people with serious mental illness. *N Engl J Med*. 2016;375(15):1490–1495.
2. Smith D, Oreskes B. Are most homeless mentally ill? *LA Times*, Oct 7, 2019. https://www.latimes.com/california/story/2019-10-07/homeless-population-mental-illness-disability
3. Appelbaum PS. Clinical practice: assessment of patients' competence to consent to treatment. *N Engl J Med*. 2007;357(18):1834–1840.
4. Schatzberg AF, Debattista C. *Schatzberg's Manual of Clinical Psychopharmacology*. 9th ed. APPI; 2019:1–15.
5. Lindenmayer JP, Glick ID, Talreja H, et al. Persistent barriers to the use of long-acting injectable antipsychotics for the treatment of schizophrenia. *J Clin Psychopharmacol*. 2020;40(4):346–349.
6. Glick ID, Shader RI. The problem of medical-psychiatric illness in the homeless and its occurrence in the midst of a viral pandemic: a commentary. *Psychiatry Res*. 2020;290:113118.
7. Zlotnick C, Zerger S, Wolfe PB. Health care for the homeless: what we have learned in the past 30 years and what's next. *Am J Public Health*. 2013;103(suppl 2):S199–S205.
8. Warburton K, Stahl SM. Balancing the pendulum: rethinking the role of institutionalization in the treatment of serious mental illness. *CNS Spectr*. 2020;25(2):115–118.
9. Richmond LM. Federal agencies must overhaul care for people with serious mental illness. *Psych News*. 2018;53:1–24.
10. Glick ID, Zamora D, Kamis D, et al. Should antipsychotic medications for schizophrenia be given for a lifetime? replication of a naturalistic, long-term, follow-up study of antipsychotic treatment. *CNS Spectr*. 2019;24(5):557–563.
11. Holmes SM, Hansen H, Jenks A, et al. Misdiagnosis, mistreatment, and harm—when medical care ignores social forces. *N Engl J Med*. 2020;382(12):1083–1086.