'Demedicalization' of mental illness often leaves homeless in the lurch

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An article published this week in the *New England Journal of Medicine* discusses the case of a homeless California man who was a frequent visitor to a local emergency room. Six times over the course of a few months the man, who had been previously diagnosed with schizophrenia, presented with auditory hallucinations and suicidal thoughts after losing

his medication. Each time, he was released back to the streets without extended psychiatric care.

The article, by Drs. Joel Braslow and Luke Messac, argues that this case and countless others like it happen because many of the consequences of mental illness—including homelessness—have been "demedicalized," or seen as falling outside the scope of medical care. All too often, as in the case of the California man, the criminal justice system ends up filling the void left by demedicalization, the authors say. The man they described was later jailed on a felony charge.

The article is part of a new series in NEJM called "Case Studies in Social Medicine," which aims to bring social science perspectives into the medical field. Braslow is a professor of neuroscience history at the University of California, Los Angeles. Messac is a resident in the Department of Emergency Medicine at Brown University's Warren Alpert Medical School. Messac discussed the article in an interview.

Q: What percentage of homeless individuals have serious mental illnesses and how has the way they're treated in the medical community changed?

Serious mental illness is a huge risk factor for homelessness. Nationwide, it is estimated that 25 percent of the homeless population suffers from a severe mental illness.

There was a push to close down inpatient psychiatric institutions during the late 20th century, but instead of replacing these institutions with supportive housing and community services, former patients were too often put out onto the street and, soon thereafter, into our jails and prisons. We "demedicalized" the social consequences of mental illness—that is, we came to see the rampant homelessness and

incarceration of the mentally ill as outside the purview of medical responsibility.

Q: What are the main takeaways from your perspective piece?

While the medical system cannot answer all social ills, physicians and other medical professionals have a crucial role in making sure their patients are not exploited or abandoned. Budget cuts to social services like housing and the criminalization of the mentally ill can be just as fatal as any infection. Doctors can work to alleviate this suffering, even if it takes place beyond the hospital walls.

Q: What should emergency department physicians faced with scenarios exactly like the one in your case study do?

This is a tough one—emergency physicians, like other health professionals, are already faced with immense responsibilities and pressing time constraints. We should learn about any resources available to homeless and/or mentally ill patients in our communities and try to connect patients to services that might help.

No one finds it humane to usher a patient out of the ED and onto the street; I have spoken with many colleagues who find this practice morally intolerable. For our patients, and for ourselves, we need better solutions. So we should join ongoing efforts in the medical and public policy communities to ensure that our most vulnerable patients have the food, shelter and support they need to live healthy, productive lives.

Q: What do you most want to convey to the broader

community about demedicalization of mental illness?

Demedicalization can sometimes be a beneficial process. It helped bring an end to the days when homosexuality was considered a mental disorder, or when, during the Civil Rights era, many black people had their dissatisfaction with segregation diagnosed as a mental pathology. The medical community should not contribute to injustice by making a disease of diversity or dissent.

But demedicalization can also be harmful, and the abdication of responsibility for the social consequences of mental illness is one of the prime examples. We can't keep seeking solutions only in pills or therapy; real care for the mentally ill requires much more of all of us than pitiful glances at panhandlers. We need policies and programs that allow people with serious mental illness to live dignified lives.

Q: If you could tell policymakers one thing about the demedicalization and criminalization of mental illness, what would it be?

As physicians, we see the toll taken on our patients by the demedicalization and criminalization of mental illness. We do our best to treat mental illness in emergency rooms and clinics, but addressing this crisis in a serious way will demand both material and moral support. Instead of spending public resources on prisons beds, we can spend them on supportive housing. Instead of discharging vulnerable patients to the street, we can help them find their way in the world with community health workers and intensive case management. We want to do better, and we need help to do it.

More information: Joel T. Braslow et al. Medicalization and Demedicalization—A Gravely Disabled Homeless Man with Psychiatric

Illness, *New England Journal of Medicine* (2018). DOI: 10.1056/NEJMp1811623